

*Ohio Child and Adolescent
Sexual Abuse Protocol 2009*





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This protocol was developed by the Ohio Chapter of the American Academy of Pediatrics Committee on Child Abuse and Neglect, Representatives from: Akron Children's Hospital, Cincinnati Children's Hospital Medical Center, Dayton Children's Hospital, Licking County Kid's Place, Med Central Health System, Metro Health Cleveland, Nationwide Children's Hospital, and Rainbow Babies Hospital have collaborated on this effort with the Ohio Chapter, International Association of Forensic Nurses, Ohio Department of Health and the Ohio Office of the Attorney General.

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A copy of this protocol may be obtained from the Internet in PDF format at the address below:

<http://www.nationwidechildrens.org/CCFA>
www.odh.state.oh.us/

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Protocol for the Evaluation and Treatment of Reported Sexual Abuse

I. Introduction

Since development of the first protocol in 2000 developed by the Ohio American Academy of Pediatrics Committee on Child Abuse and Neglect in collaboration with the Ohio Department of Health and the Ohio Attorney General's office, the field of child abuse pediatrics and the development of coordinated efforts to provide comprehensive, standardized, non-judgmental, equitable treatment of pediatric sexual abuse/assault has changed and improved. This protocol is a modification of the Ohio Department of Health Protocol For The Treatment Of Sexual Assault Survivors, and addresses many of the complex services necessary to facilitate consistent, comprehensive health care treatment to include emotional, social, and crisis intervention as well as provide information about available follow up services in the community.

In this second edition of the protocol, additional information is provided to address the growing knowledge and use of DNA technology in acute sexual assault evidence collection procedures, specific issues pertaining to the legal system and disclosure information, the inclusion of pediatric sexual assault nurse examiners (SANE-P) in Ohio, guidelines on the use of HIV post-exposure prophylaxis, assessments of domestic violence, use of telemedicine technology, as well as a section devoted to the expanding medical evidence for the practice and care described in this protocol. The focus of this protocol is on the evaluation and treatment of child and adolescent victims of sexual abuse. As such, it is recommended that, when possible, children be taken to facilities best equipped and with the greatest expertise to address the needs of children and adolescents. These facilities will often be a children's hospital, a child abuse clinic or a Child Advocacy Center for sexual abuse/assault evaluations. In addition, this protocol is intended to establish a standard of care that should be met in these pediatric facilities, but which could be developed in other health care communities.

Child sexual abuse is defined as sexual activities that the child cannot comprehend, for which the child is developmentally unprepared and cannot give informed consent, and/or that violate societal taboos. This may include but is not limited to: a. penetration, however slight, of the vagina or anal opening of one person by the penis of another; b. sexual contact between the genitals or anal opening of one person and the mouth or tongue of another; c. intrusion by one person into the genital or anal opening of another person, including the use of objects (other than for a valid medical purpose); d. intentional touching of the genitals, breasts, genital area, groin, inner thighs, or buttocks, or the clothing covering them, except when such touching occurs as part of appropriate child care activity, including medical care; e. intentional exposure of genitals in the presence



of a child if such exposure is for the purpose of sexual arousal or gratification, humiliation, degradation or other similar purpose; f. sexual exploitation of a child, including requiring, directing, coercing, encouraging or permitting a child to solicit or engage in prostitution, or negligently failing to prevent such sexual exploitation; g. making recorded images of a child for sexual gratification or commercial sexual exploitation; h. requiring, directing, coercing, encouraging or permitting a child to view one or more sexually explicit acts or materials or negligently failing to prevent a child from viewing such acts or materials; i. flagellation, torture, defecation or urination, or other sado-masochistic acts involving a child when for the purposes of the adult's or the child's sexual stimulation; or j. requiring, directing, coercing, encouraging, permitting or negligently failing to prevent the statutory rape of a child.

Child sexual abuse includes incidents which occur within the family and/or outside of the home. Regardless of the type of sexual abuse, the child or adolescent victim often develops a variety of distressing feelings and thoughts which challenge the long-term emotional and psychological health of these individuals, and can have devastating effects over the lifespan.

While the 1980's and 90's showed an increase in sexual abuse awareness, current statistics suggest that sexual abuse continues to be under-reported and remains an important public health issue. Due to the nature of this type of child maltreatment, there are often no physical abnormalities that would indicate sexual abuse. Therefore, it is extremely important that parents, social workers, and others encourage children to disclose abuse when it occurs. An optimal physical setting for child disclosures should be used whenever possible. Children will emotionally and psychologically benefit from the repeated assurance of family, health care providers, and investigators that they are believed and will be kept safe.

Indicators of Sexual Abuse May Include:

- ✘ Spontaneous disclosure
- ✘ New fears of persons or places
- ✘ Sexual play beyond what is considered normal
- ✘ Unusual interest in or avoidance of all things of sexual nature
- ✘ Sleep problems or nightmares
- ✘ Depression or withdrawal from friends/family
- ✘ Fear that there is something wrong with their genital area
- ✘ School refusal/Runaway
- ✘ Unusual aggressiveness
- ✘ Suicidal behavior
- ✘ Other severe behavior changes
- ✘ Vaginal or urethral discharge
- ✘ Genital or rectal pain, bleeding or trauma
- ✘ Sexually transmitted infections





Two aspects of child sexual abuse create difficulties in recognition and management:

1. The perpetrator of sexual abuse is usually a relative or close acquaintance. Consequently, family ties may be strained to the point where the reported assailant is protected by the family. It is not unusual for the child to be blamed for the incident. His or her caretakers may even deny the child's report. Frequently, parents may find the occurrence of sexual abuse unbelievable or may be unable or unwilling to believe that someone they know and trust could sexually abuse their child. As such, there is a risk for the child to accommodate his/her response to the trauma, based upon the adult/family response to the disclosure. This has been described as child sexual abuse accommodation syndrome and this dynamic (and variations of this) are evident in many children and families.
2. Frequently, little or no physical evidence may be found to corroborate the child's story since a) physical force is usually not used when children are sexually abused and b) children are often brought for evaluation of sexual abuse days to months after the event, whereby injuries sustained from the abusive event will have completely or partially healed. This reinforces denial by the family.

Disclosure of abuse may be a process that occurs over time. It is important to be aware of and respond to any attitude, action, verbal or non verbal communication when a child begins to disclose abuse. Only open-ended questions such as, "Tell me more about that." should be asked. Let the child know that it is not his/her fault that this has happened. Report all alleged child sexual abuse to the appropriate Children's Protective Services agency and/or Law Enforcement.

Sexually abused children and their families need professional evaluation and treatment. An expert medical forensic evaluation will determine the type and extent of the abuse, diagnose and treat infections that result from the abuse, and determine the appropriate mental health treatment needed to reduce the risk of developing low self-esteem, feelings of guilt, shame, and further emotional trauma. The identification of sexual offenders may prevent future episodes of sexual abuse to that child as well as others.

Providing services to individuals who have been victims of sexual abuse requires special sensitivity. Social, cultural, ethnic and religious backgrounds must be considered and may be a cause of additional stress for sexual abuse victims. Hospital and clinic staff are encouraged to seek out reliable information and training on practices and beliefs specific to people from culturally diverse backgrounds who may utilize the services of the hospital or clinic. Resources may be obtained by contacting the Sexual Assault and Domestic Violence Program at the Ohio Department of Health at 614/728-2707.

Economic status may be a factor with some individuals who already feel victimized and underserved in the community. This may affect their attitude as well as degree of cooperation with hospital staff, police officials, or others who they view as authority figures



or as representing the system. Emotional and/or psychological trauma may not always be apparent when the patient arrives at the hospital or clinic. Psychological trauma may be evidenced in many different forms, from unusual calm to heightened anxiety; extreme tearfulness to laughter; anger to withdrawal. As such, it is important to provide sensitive care when the child/adolescent and family first presents using a tailored approach that offers continued support through the evaluation.

It is imperative that evidence be properly collected, preserved, and analyzed so that, should the assailant be prosecuted, effective evidence will be available to law enforcement officials. Proper collection and handling of evidence is vital. Legal protocol dictates a “chain of custody” wherein each individual handling the evidence documents receipt and delivery of the specimens. This procedure helps rule out possible improper handling of evidence. Should prosecution occur, proper collection of evidence increases the probability of conviction.

This protocol is intended to facilitate the cooperation and communication among organizations providing services to child and adolescent sexual abuse victims. All communities are encouraged to utilize or establish a specialized service/team where children and adolescents who allege sexual abuse can receive an expert evaluation. A sexual abuse team may include representatives from the hospital child abuse program, emergency department, a Pediatric Sexual Assault Nurse Examiner, trained Pediatric Nurse Practitioner, mental health providers, law enforcement officers, prosecutors and social workers from the county social service agencies. Communities with access to a Child Advocacy Center should utilize that Center’s expertise and support services. Communities that lack medical child abuse expertise are encouraged to establish a Pediatric Sexual Assault Nurse Examiner (SANE-P) program that has linkages to a Child Advocacy Center or a child and adolescent sexual abuse medical expert. Coordination and collaboration with multidisciplinary team members helps provide adherence to established evidence collection procedures and establishes a means for an effective referral network. By utilizing these available supportive services, the child and family will less likely be required to repeat the event to service providers.

II. Definition

Sexual assault and sexual abuse are medical and legal terms. Legally, child sexual abuse includes any sexual activity with a child, including exposure; touching and penetration, defined by the Ohio revised Code 2907.01 Sexual assault includes rape and sexual battery defined by the Ohio revised Code 2907.01 as any sexual penetration, however slight, using force or coercion against the person’s will.



III. The Sexual Abuse Evaluation

To assure adequate physical and emotional care of the sexual abuse patient this protocol can be used by hospital emergency department personnel, child advocacy centers, child abuse clinics, or other child abuse providers when a child or adolescent presents with the complaint of sexual abuse or assault. This protocol must be followed when submitting invoices for payment to the Office of the Ohio Attorney General. In addition, to protect the integrity of the evidence, the procedures outlined in this protocol should be followed.

Only a physician or nurse practitioner trained and experienced in the evaluation and treatment of the child or adolescent sexual abuse patient, or a health professional, such as a Pediatric Sexual Assault Nurse Examiner, resident, or fellow who is under the supervision of, or working in collaboration with an experienced physician or nurse practitioner, should perform the examination. Given the growing development of Pediatric SANE programs in the state of Ohio, this committee developed a position statement to guide providers on best practice standards with regard to SANE services for pediatric and adolescent sexual abuse patients. (See Appendix (V.A) for this position statement.) While direct examinations by an experienced provider is the most optimal approach to offering an examination, Telemedicine may offer a timely and cost effective method for a child sexual abuse expert to provide supervision or collaboration to a SANE-P or a physician in training . A process of continuous quality assurance should be employed to ensure acceptable supervision and competency for those professionals conducting pediatric sexual abuse evaluations. Refer to IV. Section 10: Use of Telemedicine for further description.

Hospital personnel are responsible for identifying the patient and reporting the incident to the county Department of Human Services, county Children Services Board, law enforcement, or the hospital social worker per local protocol. Whenever possible, child sexually abused patients should be referred to the local Child Advocacy Center or Child Abuse Clinic.

A. Indications for the Emergency use of This Protocol

Children must be seen on an emergency basis if trace forensic evidence needs to be collected or if there are other indications requiring an emergency evaluation. The best evidence collection strategy uses a thorough basic collection that is expanded, rather than limited, by the patient's history. Assault histories may not correspond to forensic laboratory findings. For example, the patient may not recall important details due to the effects of drugs and/or alcohol or trauma. Certain acts may not be discussed due to embarrassment. Very young children may not understand the relationship between the sexual abuse act and the need for the medical evaluation. Thus, evidence collection protocols that advise to collect only at the site of the assault may cause key evidence to be missed.



A modern forensic laboratory has the ability to detect trace quantities of blood, semen, and saliva and develop DNA profiles from the remnants of as little as 300 nucleated cells or a half-inch hair fragment. Spermatozoa can be separated from other types of cells so that sperm DNA can be detected and characterized against an overwhelming background of female DNA. Furthermore, widespread development of all-felon DNA data basing legislation has made it possible to compare unknown DNA profiles against millions of other forensic case profiles as well as felon and arrestee profiles. While most of this type of evidence may never be examined in the crime lab, it is impossible to determine at the time of examination whether DNA evidence, a confession, or other evidence will be most vital to a case. It is better to conduct a comprehensive evidence collection at the time of evaluation, later collection may not be possible.

Trace forensic evidence must be collected, using the State of Ohio approved evidence collection kit, when **either of the conditions** listed below are true.

- #1. The last episode of sexual abuse / assault occurred within the past 72 hours **AND**
 - a. The history indicated contact with the alleged perpetrator's genitalia **OR**
 - b. The history indicates contact with the alleged perpetrator's semen, blood or saliva **OR**
 - c. The history indicates a struggle that may have left skin or blood of the alleged perpetrator's to be lodged under the victim's fingernails, on the victim's body or clothing **OR**
 - d. The victim's clothing or body may be covered by trace evidence (debris, fibers, etc) from the alleged crime scene.

Evidence can be collected up to 72 hours after an assault (in rare cases beyond 72 hours).

- #2. The history of contact with the alleged perpetrator is unclear (i.e. child too young to provide a history or a history is unavailable) and there is reason to believe that conditions described in #1 above are true.

B. Indications for the Deferred use of this Protocol

If there is no indication for an emergency evaluation, the hospital or clinic may elect not to complete this protocol, use an internal sexual abuse protocol instead, and if indicated, refer the patient to a child abuse clinic or child advocacy center for a medical forensic evaluation. When sexual abuse is suspected, the hospital / clinic is responsible under Ohio law to make a report of suspected sexual abuse to a mandated agency (i.e.: the police, the Department of Human Services or Children's Protective Services). When patients present to a hospital or clinic, it is the responsibility of the hospital or clinic to determine if trace evidence collection is indicated. When doubt exists, it is better to collect trace evidence than not.



All children who allege sexual abuse should be examined by a trained provider in a timely manner. Many sexual abuse victims first present days to months after the sexual abuse incident. Under this circumstance, trace forensic evidence collection is not indicated, and the Ohio Sexual Assault/Abuse Evidence Collection Kit is not needed. However, medical forensic interviews, medical forensic examination, testing, treatment, referral and reporting will need to be done. After attending to care required under EMTALA, these children should be provided an appointment for an outpatient forensic evaluation with a Child Advocacy Center or Child Abuse Clinic. EMTALA may not require that the genital examination take place at the time of the emergency evaluation.

C. Optimal Health Care Setting to use this Protocol

Children and adolescents have some unique needs which warrant a thoughtful approach to determining the optimal health care setting for the evaluation of suspected sexual assault/abuse. Given the various health care options and expertise and availability of child abuse pediatrics providers, these criteria were established to guide decision-making in this process. A summary of this approach can be found in the diagram below.

Definitions

****Acute** is defined as a sexual abuse incident occurring <72 hours for patients <16 years old; <96 hours for patients >16 years old.

****Non-Acute** is defined as a sexual abuse incident occurring >72-96 hours, based upon age as above.

Special needs are defined as an individual with cognitive and/or psychological limitations that suggest a developmental age less than chronological age (i.e. an 18 year old with MRDD and cognitive functioning level is at 12 years).

Pediatric facility[†] is a pediatric emergency department, child advocacy center or pediatric child abuse specialty clinic.

Adult facility is a general emergency department or free-standing SANE program.

***There is limited evidence to support extension of evidence collection beyond 72 hours in the pre-pubertal patient. Appropriate discretion is advised in the transition ages (16-17 years) and there is evidence to support evidence collection to 96 hours in the adult patient.*

[†]Pediatric facilities that care for patients > 18 years of age and have expertise with the medical/forensic evaluation of suspected sexual assault/abuse may also be considered an optimal health care setting for this patient population.

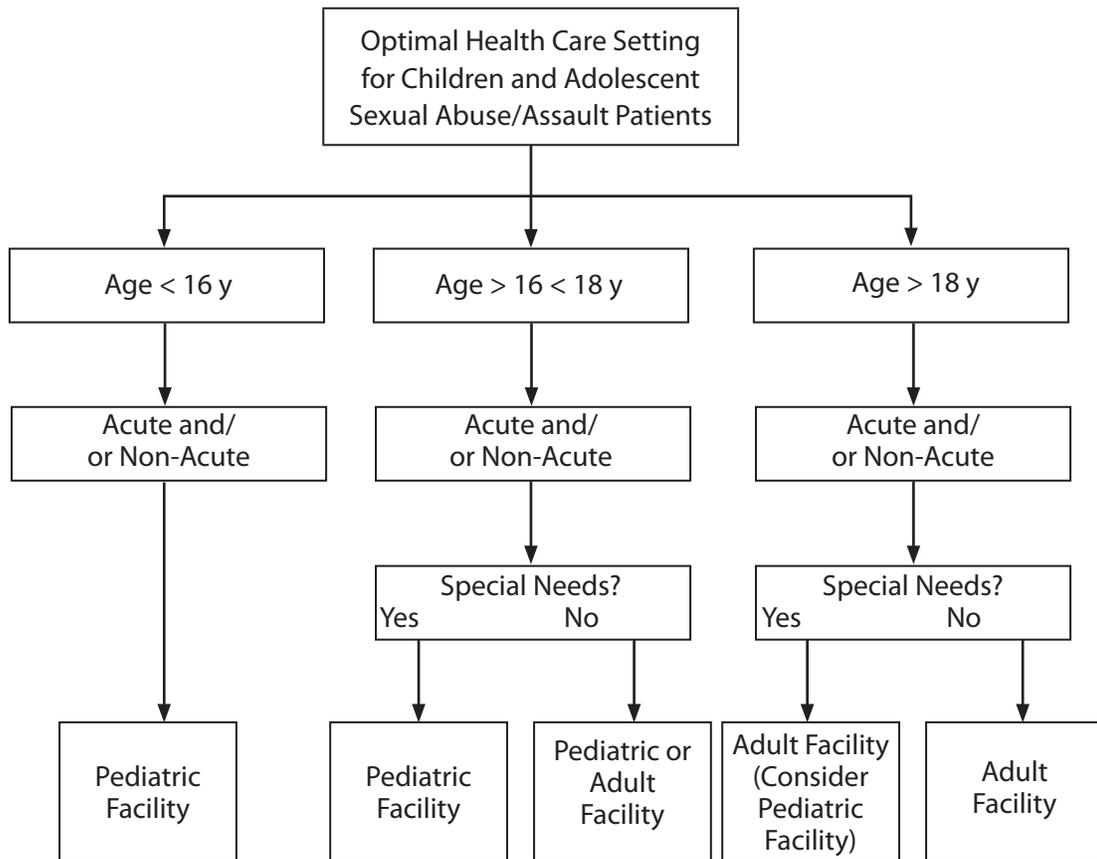


Age <16; Acute; Special needs no: pediatric facility
Age <16; Acute; Special needs yes: pediatric facility
Age <16; Non-acute; Special needs no: pediatric facility
Age <16; Non-acute; Special needs yes: pediatric facility

Age ≥16 and ≤18; Acute; Special needs no: adult or pediatric facility
Age ≥16 and ≤18; Acute; Special needs yes: pediatric facility
Age ≥16 and ≤18; Non-acute; Special needs no: pediatric facility
Age ≥16 and ≤18; Non-acute; Special needs yes: pediatric facility

Age >18; Acute; Special needs no: adult facility
Age >18; Acute; Special needs yes: adult facility (*consider pediatric facility)
Age >18; Non-acute; Special needs no: adult facility
Age >18; Non-acute; Special needs yes: adult facility (*consider pediatric facility)

**Decision regarding optimal health care setting depends upon severity of developmental disability.*





IV. Protocol Sections

Section: 1 Emergency Department/ Child Advocacy Center Patient triage

- A. A rape/sexual abuse patient should be viewed as a priority patient and should be given immediate privacy if possible. A physician, the charge nurse, a health care examiner, or professional staff person should see this patient in a timely fashion.
- B. The intake worker elicits sufficient information to complete the registration process as quickly as possible and in private, if possible.
- C. The intake worker informs the designated sexual abuse specialist and/or the primary nurse that a sexual abuse patient has presented for evaluation. A sexual abuse specialist is a staff person who may be designated to be responsible for the coordination and assurance of care for the patient.
- D. If law enforcement or social service personnel do not accompany the patient, they are to be notified by hospital/clinic staff. The hospital/clinic is obligated under Ohio law to report alleged or suspected sexual abuse whether the patient wants to speak with law enforcement or not. It is the responsibility of hospital/clinic personnel to inform the patient that law enforcement and/or social services will be notified that a sexual assault/abuse has been reported to the hospital/clinic. Unlike adult sexual assault, the name of the sexual abuse victim must be reported to the legally mandated authorities even when the patient or family wishes not to report the sexual abuse.
- E. Reporting to the legally mandated agencies (i.e. law enforcement and the county social service agency) is mandatory. Otherwise, any personal health information concerning the sexual abuse and/or identity of the child victim shall not be given by anyone to the media or any other person(s) seeking information without the written consent of the patient or legal guardian.
- F. Ohio law states that the patient is not to be billed for the collection of forensic evidence and the cost of any antibiotics administered as part of the examination in sexual assault cases. Forensic evidence collection refers to the collection of specimens in a sexual assault evidence kit and/or obtaining diagnostic quality photo-documentation of examination findings. If medical care is provided, the patient may be billed as per usual procedure for these non-forensic services. See Ohio Revised Code #2907.28. Bills are to be sent to the Ohio Attorney General. This protocol must be followed when evaluating a patient for alleged sexual abuse if a bill is to be submitted to the Ohio Attorney General. (Additional information regarding the Ohio Attorney General's office Sexual Assault Forensic Examination (SAFE) grant is described in Appendix C.)



- G Whenever possible the patient should be given priority for a room assignment in a private area.
- H. Under Ohio law, Ohio Revised Code #2907.29, each patient reporting a sexual assault must be informed of available testing for sexually transmitted infections, pregnancy, and other medical and psychiatric services.
- I. The parent or guardian must give consent for the medical evaluation. In cases of sexual abuse, specific consent is **not** required before obtaining forensic photo-documentation and tests which may document injuries from abuse. A signed release of information regarding the collected forensic evidence is **not** required in cases of child sexual abuse. The standard consent to treat is sufficient in sexual abuse cases.
- J. A minor who is a victim of sexual abuse or assault does not need to have the written consent of a parent or legal guardian before proceeding with the forensic examination. However, according to Ohio Revised Code #2907.29, parents or guardian must be notified in writing after the exam. In cases of child sexual abuse, safety issues for the child victim need to be considered before notifying a parent or guardian and the issue of safety for the child may override the requirement to notify a parent/guardian if in the opinion of the medical personnel such notification is likely to endanger or cause harm to the child. Although the Ohio Revised Code and the Ohio Department of Health adult sexual assault protocol state a minor's parent or guardian must be notified after a sexual assault/abuse examination, staff should follow the protocol determined by local law enforcement and children's protective services in cases where the suspected abuser is a parent or guardian.
- K. Hospital personnel must advise the minor patient about the requirement to notify a parent or guardian concerning the treatment. It is recommended that a custodial person (parent or guardian), be notified at the time of the hospital visit, **by the minor**, if this is possible. If the alleged perpetrator is also the parent or guardian who will receive the notification, the county Department of Human Services, the law enforcement agency involved, and the minor child shall all be advised of the nature of the notification letter and the approximate date when it will be mailed. Coordination with the Department of Human Services must be done to insure the safety of the child. ***The issue of safety for the child may override the requirement to notify a parent/guardian, if in the opinion of medical personnel such notification is likely to endanger or cause harm to the child.*** When a child is examined at the request of the Department of Human Services, it shall be the responsibility and discretion of the Department, taking into account safety issues, to notify parents/guardians who are the alleged perpetrators.
- L. If an unwilling minor is brought in for a sexual abuse exam by a parent or guardian, the minor **must agree** to submit to the exam after discussion with the physician, the nurse, social worker or other health care provider, without the necessity of restraints or





sedation. If the patient does not consent to the examination, force should not be used. In this case, the examination should be postponed and scheduled for another time. If there is concern for a serious injury which requires immediate care/intervention such as surgical repair, consideration for sedation and/or general anesthesia is warranted to provide this treatment.

Section 2: Support

- A. When appropriate, the hospital/clinic should inform the patient of the option and benefits of having additional support throughout this process. If a parent or guardian does not accompany the child, hospital/clinic staff should offer to call in social work personnel, local sexual abuse advocates, or suggest to the patient that she/he summon a family member or friend to be present during the process.
- B. Upcoming steps in the examination, and their rationale must be explained to the patient throughout the medical examination and interviewing processes.
- C. If disagreement arises between service providers and/or with support persons, discussion should be carried on at a later time or away from the patient.
- D. Hospital/clinic personnel should assure that the patient's questions are answered and information and support is provided to the patient, family and friends. Give the "Child Sexual Abuse & Assault: What will happen during the evaluation handout", or equivalent, to the patient/family. This handout is printed in the Appendix B1.

Section 3: Abuse History (including Domestic Violence Assessment), Medical History, Examination and Evidence Collection

A. Assault/Abuse History

If collection of trace forensic evidence is indicated, use the "Assault/Abuse History and Examination Form" found in the Ohio Sexual Assault/Abuse Evidence Collection Kit. A copy of this form is also available in the Appendix. In cases of sexual abuse beyond 72 hours or when other indications for using the evidence kit are absent, the evidence kit should not be used in the medical forensic evaluation. The information to be obtained includes:

1. Time, date and place of the abuse
2. Date, time of the exam
3. Sex, number and relationship of assailant(s), if known
4. Type of weapon used, if any
5. Type of penetration, if any



6. Did the patient douche, change clothes, bathe, urinate, defecate, brush teeth, rinse mouth etc. since the last assault?
7. Was patient menstruating at time of assault? At time of exam?
8. Was the assailant injured or bleeding?
9. Was a tampon present at time of assault? At time of exam?
10. Was a condom used?
11. Description and condition of clothing (e.g. torn, dirty, bloody, etc.)
12. Has there been consensual intercourse within 72 hours?
13. Narrative history (as described by the patient). Record the patient's description of the abuse. When obtaining the history from a child, it is imperative that the interviewer asks only non-leading questions and that the vocabulary used is chosen by and understood by the victim. A provider experienced in interviewing children using guidelines to forensic interviewing is highly recommended to minimize difficulties with the gathering of this narrative history.
14. The Sexual Abuse History must be documented in duplicate on the Assault/Abuse History and Examination Form. The original should be included with the Sexual Assault/Abuse Evidence Collection Kit for the forensic lab; the copy is retained with the medical record.

B. Assessment of Intimate Partner Violence

Intimate partner violence (IPV), (also known as domestic violence), has a strong co-occurrence (40-60%) to child abuse and may be co-occurring with an adolescent patient being evaluated for sexual assault. As such, it is recommended that evaluations of child sexual abuse include an IPV assessment as part of the history. Previous studies indicate that as many as 50% of adult women screened in an emergency department setting had been victims of IPV and 38%-46% of adolescents report abuse from an intimate partner.¹

The Partner Violence Screen², developed and validated for use in emergency departments, is an efficient screening tool for interpersonal violence. This tool, or a similar series of questions, may be used to determine if the patient or patient's family would benefit from resources to support victims of IPV.

Partner Violence Screen

1. Have you been hit, kicked, punched or otherwise hurt by someone in the past year?
 Yes No
If so, by whom?
 Person in current relationship
 Person from previous relationship
 Someone else





2. Do you feel safe in your current relationship?
 Yes No Currently not in a relationship
3. Is there a partner from a previous relationship that is making you feel unsafe now?
 Yes No

It is important that your questions about IPV not put the patient at increased risk for harm. Therefore, questions should be asked privately, away from a potential abuser or anyone who may reveal your patient's answers to an abuser. You must make resources regarding domestic violence shelters available to the family. If the patient/family desires to return home in spite of IPV, provide information regarding a safety plan before discharge. Documentation of IPV screening should comply with local, hospital policies to ensure safety of the caregiver of a pediatric patient who discloses IPV.

Resources:

- National Domestic Violence Hotline** 800-799-SAFE (1-800-799-7233)
- National Network to End Domestic Violence** 202-543-5566
- Ohio Domestic Violence Network** 800-934-9840
- ACTION OHIO Coalition for Battered Women** 888-622-9315

Written Information:

- List of Ohio Domestic Violence Shelters
www.actionohio.org/dvshelter.htm
- Safety Plan
www.ncadv.org/protectyourself/Safety_Plan130.htm
- Teens Health: Abuse
www.teenshealth.org/teen/

C. Patient Medical History

An "Optional Medical History and Examination Form" is provided for your convenience in the Appendix. Institutional forms that cover the following items may be used in its place and documentation such as "see hospital form" or something similar, should be made on the Ohio Sexual Assault/Abuse Evidence Collection Kit forms.

1. Patient demographic and personal information
2. Others accompanying the patient
3. Vital signs (as warranted)
4. Allergies
5. Last tetanus
6. Current Medications

- 
7. Acute Illnesses
 8. Past Surgeries
 9. Last Menstrual Period (or indicate patient is pre-menstrual)
 10. Gravida (if adolescent patient)
 11. Para (if adolescent patient)
 12. Contraception used (if adolescent patient)
 13. Approximate weight/height
 14. Family physician
 15. Gynecologist (if indicated)

D. Physical Examination and Evidence Collection

The "Assault/Abuse History and Examination Form" found in the Ohio Sexual Assault/Abuse Evidence Collection Kit and already used in "A" above, must be used to document injuries noted during the examination. This form is also available in the Appendix. The "Optional Medical History & Examination Form" is provided for your convenience to record complete examination findings. Institutional forms that cover the following items may be used in place of the Optional Medical History & Examination Form and documentation such as "see hospital form" or something similar, should be made on the Ohio Sexual Assault/Abuse Evidence Collection Kit forms.

Examination findings that need to be documented include:

1. General appearance (including description of condition of clothing e.g. torn, dirty, bloody, etc.)
2. Emotional status (objective observation)
3. Pertinent general physical findings (also mark anatomical drawings)
4. Body surface (locate & describe injury, mark findings on anatomical drawings)
5. External genitalia (describe pubertal sexual maturation status and general appearance)
6. **Female:** perineum, periurethral area, urethra, peri-anal area, anus, rectum, labia majora, labia minora, clitoris, vestibule, posterior fourchette, fossa navicularis, vagina, vaginal discharge, hymen, cervix (if visualized). **Note: An internal vaginal examination is contra-indicated in the pre-pubertal patient unless internal bleeding/trauma is present.** An internal vaginal examination of a pre-pubertal patient usually requires deep sedation or general anesthesia.
7. **Male:** glans penis, foreskin, shaft, testicles, discharge from penis, peri-anal area, anus, rectum.



All significant physical findings should be noted. Indicate body areas involved in the abuse on the Assault/Abuse History and Examination Form. Indicate all marks or evidence of trauma including subjective findings such as pain or tenderness on drawings. Record the names of those present during the exam.

An examination using a colposcope or some other technology which enables photodocumentation should be performed to record the genital and anal examinations. Photo-documentation has become a standard of care for acute sexual assault evaluations (See Section 4).

When collection of trace forensic evidence is indicated:

1. Follow carefully all directions provided in the Ohio Sexual Assault/Abuse Evidence Collection Kit and maintain the chain of evidence. Follow the "Procedure for Evidence Collection checklist (19 steps)" which is printed on the inside lid of the evidence box. Refer to the "Detailed Instructions for Ohio Department of Health Sexual Assault/Abuse Evidence Collection Kit" for detailed specimen collection instructions. These instructions can be found in Appendix (V.H). All specimen collection envelopes should be labeled, regardless of whether they are used or not. If not used, state reason for exclusion on the envelope and include it with the rest of the specimen collection envelopes in the evidence collection box.
2. An ultraviolet (UV) lamp exam, such as Blue Max or similar UV frequency lamp (The utility of the Wood's lamp has been called into question as it has been shown to be less sensitive and specific for seminal fluid, Nelson, 2002, Santucci, 1999) should be performed in a dark room checking all skin areas likely to be stained by semen or saliva or that may have been subjected to bruises. Early bruising is often evident with use of a UV lamp. Other substances will fluoresce besides semen and saliva. A fluorescent stain is NOT evidence of semen or saliva but these stains should be collected for analysis by the crime lab.
3. The law enforcement agency may ask for additional tests and/or specimens. These requests should be honored if forensically indicated. Tests related to the medical work-up should be done at the discretion of the treating physician or health care provider.

Section 4: Photo documentation

- A. Still and/or video photographic documentation of the genital examination has become a standard of care in the forensic evaluations of child sexual abuse. This documentation should be of sufficient quality to allow for expert review of the images. Copies of these photos should be made available to the mandated law enforcement or social service agency. There are two exceptions to this photo documentation requirement:

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- 1) When trace forensic evidence is collected using the Ohio Sexual Assault/Abuse Evidence Collection Kit, photo documentation is strongly encouraged but not required.
 - 2) If the physical examination is performed and documented by an examiner who is recognized in Ohio as an expert in child sexual abuse, and other circumstances preclude photodocumentation ie. patient declined to have photos taken, patient is male with normal anal examination, equipment failure).

Photodocumentation should be obtained of all trauma areas. A measuring device to document the dimensions of the trauma (laceration, bruise, scratch, etc.) should be included in the photographic frame. The photos should be identified (labeled) with the patient's name, medical record number and date. A measuring device may not be needed when documenting genital or anal trauma. A minimum of two sets of photos or a system of storing electronic images with capacity to provide photo sets are recommended. Original photos should remain with the medical records and a certified copy of the original photos may be obtained by law enforcement or social services agency by standard, institutional record requests.

Section 5: Treatment and Tests

1. **Hospital/clinic personnel must discuss and offer options for post-coital emergency contraception** with the female adolescent patient when indicated. Post-coital emergency contraception treatment should be based on current medical guidelines. Should an institution or physician be precluded from providing post-coital emergency contraception for religious reasons, referral to another physician, health care institution or agency must be made and information about this option must be provided. Hospital/clinic personnel should inform the patient that some medications might lessen the effectiveness of post-coital emergency contraception and determine if the patient is taking such medication. Refer to Appendix V.B.2 for patient information regarding emergency contraception.
2. When indicated, hospital/clinic personnel must discuss and offer prophylactic treatment for sexually transmitted infections including gonorrhea, Chlamydia, trichomonas, syphilis, HIV and hepatitis. Treatment is at the discretion of the treating physician with the permission of the patient. Prophylactic treatment should be based on current guidelines from the Centers for Disease Control. For latest treatment updates, refer to www.cdc.gov **Prophylactic treatment for gonorrhea, Chlamydia and trichomonas is usually not indicated for the pre-pubertal child but the treating physician / health care provider should consider obtaining cultures and tests for sexually transmitted infections.**

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3. When indicated, hospital/clinic personnel must discuss HIV/AIDS testing with the patient including the difference between confidential and anonymous testing. Given the special circumstances pertaining to HIV PEP, further information and suggested algorithm are included in the Appendix (V.B.3).
 4. Testing for drug facilitated sexual assault is discussed in Appendix (V.B.4)
 5. Document all treatment given and tests completed on the “Child Sexual Abuse After Care Handout” (Appendix V.B.5).

Section 6: Referrals and Follow-up

1. Refer patient to locations for follow-up tests for, gonorrhea, and chlamydia in two weeks if medically indicated. Referral for follow-up serologist tests for syphilis, hepatitis and HIV should be made in 12 weeks. Preferable locations are the local Child Advocacy Center or child abuse clinic.
2. Refer patient to locations for follow-up (anonymous or confidential) HIV/AIDS testing in six months if medically indicated. Refer to the Adult Sexual Assault Protocol for Ohio locations.
3. Refer patient and family to a local counseling agency(ies) which can provide follow-up services related to the sexual abuse.
4. Give the “Child Sexual Abuse: After-Care Handout” and the “Child Sexual Abuse: Common Reactions & Follow-up Services handout” to the patient and note that they have been given to the patient. These two handouts are in the kit and in appendix V.B.5, 6).
5. Note all referrals on the Child Sexual Abuse After-Care Handout.

Section 7: Written Documentation

Health professionals should write only objective information relating to the medical findings and treatment needs of the patient and should place quotation marks around exact statements made by the patient. If the health professional is performing only the medical examination, with or without evidence collection, they should not make legal statements about whether or not rape or sexual abuse occurred. In this situation, the use of terms such as reported or stated sexual abuse or sexual assault, rather than alleged, probable, or possible, is preferable. Child abuse consultants and experts, however, should make a statement about the likelihood or probability of sexual abuse when based on the forensic interview, the examination and the lab findings.



Section 8: Handling of the Completed Evidence Kit

The nurse, physician, social worker or forensic nurse completes the documentation and signs the Ohio Sexual Assault/Abuse Evidence Collection Kit chain of evidence forms.

The “Assault/Abuse History and Examination form” and the Ohio Sexual Assault/Abuse Evidence Collection Kit are to be personally handed to the law enforcement officer or locked in a secure storage area where chain of evidence can be assured. The Ohio Sexual Assault/Abuse Evidence Collection Kit does not require refrigeration; however, swabs should be air dried, to the extent possible.

Section 9: Patient Discharge

1. The designated sexual abuse specialist, primary nurse or sexual assault nurse examiner checks all forms for completeness of information and signatures. Procedures for handling the paperwork should follow each hospital’s / clinic’s own policies.
2. The “Child Sexual Abuse: After-Care Handout” (patient discharge information) must be completed and given to the patient along with the “ Child Sexual Abuse: Common Reactions and Follow up Services handout” (Appendix V.B.5, 6). She/he should also be given a verbal explanation of the aftercare instructions and offered a final opportunity to explore any acute concerns prior to discharge. If the patient is admitted to the hospital, both pages are to remain with her/him.
3. Hospital / clinic staff must coordinate discharge planning with law enforcement, the Children Services Board or the Department of Human Services. The child must be discharged to an environment that is safe from further abuse.

Section 10: Use of Telemedicine

Telemedicine is a form of telecommunication that allows the exchange of medical data between practitioners for consultation, collaboration, supervision, continuing education, and peer review. Telemedicine uses the technologies of teleconferencing, e-mail or the internet to transmit the medical data. The utilization of any of these methods allows telemedicine to be a tool to be used in the evaluation of child victims of sexual abuse and allows for the collaboration or supervision of a health professional, such as a SANE-P, resident or fellow, by a physician or APN expert in the evaluation of pediatric sexual assault victims.





There are several important caveats that need to be included for telemedicine to be fully utilized. First, the information shared must contain all of the elements that are gathered in the face to face encounter with the patient. The history given by the patient must be shared. This can be in the form of a verbal or written summary of the patient interview or the audio or video recording of the patient interview. Second, the elements of the physical examination are shared using high resolution digital imaging and must be of diagnostic quality. Third, the elements of the diagnostic laboratory results and radiological imaging should be provided.

When considering a telemedicine system for collaboration or supervision, it must be realized that telemedicine has some limitations. The most notable limitation is to make a medical diagnosis for a patient who may present with genital symptoms and no clear history or a confusing history of sexual abuse. In such instances a medical diagnosis other than sexual abuse may be the etiology for the genital symptoms and the lack of a face-to-face evaluation presents a significant disadvantage. Telemedicine does not allow for palpation by the remote expert. There is no way to directly assess tenderness. There are clear limits to assessing the anatomy in all three dimensions and inflammatory changes are difficult to interpret. Changes in color, pallor, the hues of the resolving ecchymosis, and the color of vaginal or urethral discharge may vary from monitor to monitor. Another disadvantage is the conclusion that additional images are needed to complete the evaluation. This is often realized by the expert medical consultant after the patient has been discharged from the clinic necessitating that the patient return for another exam. Consideration that the additional exam be done face-to-face with the consultant is appropriate.

A successful telemedicine program requires a strong commitment by professionals on both ends of the equipment. It requires a great deal of attention to detail by the professional at the patient's bedside and a great deal of instruction and patience by the expert medical consultant. This is a tool to enhance lines of communication, it does not replace those lines of communication.

Section 11: Children/ Adolescents with Special Health Care Needs

The Centers for Disease Control and Prevention defines developmental disabilities as a diverse group of chronic conditions that result in difficulties in major life domains. These include physical disabilities; cognitive or learning disabilities; motor or sensory dysfunctions; mental illness; or any other type of physical, mental, or emotional impairment. Children with disabilities are believed to be sexually abused at a rate that is 2.2 times higher than that for children without disabilities. Many of these children have decreased contact with other individuals, thereby limiting the child's opportunity to disclose the abuse. Children with multiple caregivers may be at increased risk of all types of abuse, including sexual abuse, due to increased opportunity. Many children with disabilities have limited access to



information about personal safety and sexual abuse prevention. They may be accustomed to having their bodies touched by adults due to increased dependency for their physical needs. Finally children in this group may be perceived as “easy targets” because their cognitive delays may prevent them from understanding the experience as abuse or they may have impaired communication which may limit their ability to disclose abuse.

The evaluation of suspected sexual abuse in children with disabilities should consist of a structured interview with the child, if possible, as well as, a comprehensive physical examination including use of a colposcope with photo-documentation and screening for sexually transmitted infections, if appropriate. All children require an explanation of the interview and exam process at a developmentally appropriate level. Consultation with a developmental pediatrician or other expert in children with disabilities can be helpful in guiding this process. During the interview, children with communication deficits may require additional time to process and answer questions. At the conclusion of the interview, the child with disabilities should be carefully prepared for the medical exam. They should be allowed to have a non-offending caretaker accompany them for this part of the assessment. Many children with chronic health conditions have undergone painful procedures prior to coming for the medical examination for suspected sexual abuse and they may be wary of medical professionals. Careful demonstration of the medical examination with additional time for questions is essential. During the ano-genital exam, individuals with orthopedic or other motor disabilities may require special positioning (i.e., knee-chest) due to contractures or other joint mobility limitations. Because the ano-genital examination in cases of suspected sexual abuse is usually normal, a high index of suspicion is needed in this vulnerable population particularly when communication and other deficits prevent a detailed disclosure that abuse has occurred. In cases where sexual abuse is believed to have taken place, children with disabilities should be offered a mental health assessment and treatment that is appropriate to their developmental level.

References

1. Hibbard R, Desch L, and Committee on Child Abuse and Neglect and Council on Children with Disabilities. *Pediatrics*. 2007; 119:1018-1025.
2. Murphy N, Elias E and Council on Children with Disabilities. *Pediatrics*. 2006; 118:398-403.



V. *Appendices*

A. Physician Competency Criteria for Child Sexual Abuse Evaluations

Medical/ forensic evaluations are provided by health care providers with pediatric experience and child abuse expertise at an appropriate facility.

Medical provider must demonstrate that he/she meets at least ONE of the following Training Standards:

- ✘ Child Abuse Pediatrics Sub-board eligibility
- ✘ Child Abuse Fellowship training or child abuse Certificate of Added Qualification
- ✘ Pediatric Emergency Medicine Sub-board eligibility
- ✘ Documentation of satisfactory completion of competency-based training in the performance of child abuse evaluations
- ✘ Documentation of 16 hours of formal medical training in child sexual abuse evaluation and equivalent experience of peer-reviewed child sexual abuse evaluations

In addition, there must be demonstration of the following *Continuous Quality Improvement Activities*:

- ✘ Ongoing education in the field of child sexual abuse consisting of a minimum of 3 hours per every 2 years of CEU/CME credits
- ✘ Photodocumented examinations are reviewed with advanced medical consultants. Review of all exams with positive findings is strongly encouraged.

The provider must have a system in place so that consultation with an established expert or experts in sexual abuse medical evaluation is available when a second opinion is needed regarding a case in which physical or laboratory findings are felt to be abnormal.

The provider should be familiar and keep up to date with published research studies on findings in abused and non-abused children, sexual transmission of infections in children, and current medical guidelines and recommendations from national professional organizations such as the American Academy of Pediatrics Committee on Child Abuse and Neglect and the Centers for Disease Control and Prevention.

B. Nursing Competency Criteria for Child/ Adolescent Sexual Abuse Evaluations

C. Position Statement: Best Practice Standards for Child Abuse Pediatrics Physicians and Advanced Practice Nurses working with Sexual Assault Nurse Examiners (SANEs) in Performing Pediatric Sexual Abuse Evaluations



Sexual assault patients deserve compassionate and timely care delivered by competent practitioners. SANEs, working in collaboration with experts, fill this role in many Ohio communities. This collaboration enables timely assessments in which medical forensic evidence is preserved, family and patient anxiety is reduced, and access to care is increased. The purpose of this position statement is to describe best practice standards for physicians and advanced practice nurses (child abuse pediatrics practitioners) and SANEs to perform pediatric (18 years of age or younger) sexual abuse evaluations, so that the needs of the children/families presenting for medical and forensic care of sexual abuse are effectively met.

SANEs have a clear role in Ohio, which is defined, in the Office for Victims of Crime's Development and Operations Guide for SANEs. The primary mission of a SANE nurse working in collaboration with a multidisciplinary team, is to meet the needs of the sexual assault patient by providing immediate, compassionate, culturally-sensitive, and comprehensive medical forensic evaluation and treatment by trained, professional nurses. SANEs adhere to the scope and standards of SANE and forensic nursing practice set forth by the International Association of Forensic Nurses and American Nurses Association (ANA) and defined rules set forth by the Ohio Board of Nursing.

Best Practice Recommendations for Effective Consultation and Collaboration:

The Ohio Chapter of the American Academy of Pediatrics Committee on Child Abuse and Neglect and Ohio Chapter of the International Association of Forensic Nurses recommend the following:

1. SANEs who provide care to pediatric patients work in collaboration with a physician or advanced practice nurse expert who is experienced in the evaluation of child sexual abuse. Consultation with an established expert should be obtained for examination and laboratory test interpretation to establish a diagnosis and render treatment.
2. Only professionals with specialized forensic interview training should obtain a detailed forensic history of the reported abuse. Professionals without such training should limit questions to only those concerning the immediate medical assessment.
3. All health care professionals should be available to testify in child sexual abuse cases within the scope of his/her practice. Court testimony should be objective, fact-based and reflect current best practice and evidence-based research. Experts must be available to testify regarding examination and laboratory test interpretation for determining diagnosis and treatment. Fact witnesses should testify regarding the collection of evidence and observations made at the time of assessment. The courts will determine expert status of the individual witness.
4. All health care professionals should ensure that suspected cases of child maltreatment are reported to the appropriate county child protective services agency.



5. All health care professionals working within, or in a jurisdiction which has a child advocacy center (CAC) should adhere to the standards of practice as defined in the most recent recommendations by the American Academy of Pediatrics Clinical Report on the evaluation of sexual abuse in children and the most recent Ohio American Academy of Pediatrics Sexual Abuse Protocol, including those standards that pertain to medical and forensic evaluation. In addition, SANEs who care for child sexual abuse patients should adhere to the scope and standards of SANE and forensic nursing practice as defined by the IAFN and ANA. Efforts to coordinate interagency services should be made to comply with ORC 2151.425-428 as it pertains to the role of CACs in the state of Ohio and the assembly of multidisciplinary teams.

Maintaining Continuous Quality Improvement:

1. All health care professionals involved in the evaluation and treatment of child sexual abuse should demonstrate continuing education, licensure, and certifications in the field.
2. All health care professionals involved in the evaluation and treatment of child sexual abuse should maintain quality assurance by regular case reviews with expert practitioners in the evaluation of child sexual abuse. Review of all cases with positive physical or laboratory findings is strongly encouraged.



B. HANDOUTS

B.1

Child Sexual Abuse and Assault: What will happen during the evaluation handout.

You (your child) are here for an evaluation of sexual abuse or sexual assault. The hospital staff is here to help. During the evaluation, you may be asked questions that are difficult and sometimes embarrassing to answer. We will try and be sensitive and understanding of your needs during the evaluation.

The information and specimens obtained will enable us to get a complete medical history, treat and identify any medical problems, and to investigate the allegations of abuse/assault. The specimens will help document circumstances and events in regard to the assault. Doctors, nurses and other medical staff will ask some of these questions so that they can provide the best medical care to ensure your physical health. A law enforcement officer or social worker may ask some of the same and additional or similar questions as part of their investigation.

After the history is collected, you (your child) will be examined. Some of your (your child's) clothes may be retained as a part of evidence collection. If you did not bring additional clothing to wear home, you may call a family member or friend and ask them to bring clothes to the hospital or inform hospital personnel of your need for clothing.

A doctor or qualified nurse examiner will examine you (your child) for physical injury. Because much of the evidence of the assault could be on your (your child's) body, it is important that specimens be taken from various areas, including the fingernails, hair, swabs of the inside of the mouth, genitalia, and rectum. A blood sample may be drawn. Depending upon the kinds of injury, x-rays may be taken. You may want to discuss with the attending physician, nurse or social worker your concerns about pregnancy and sexually transmitted infections, including HIV/AIDS.

We recognize that you have been through a terrible experience. We are here to help. Information about other services that may assist you will be provided before you leave.



8.2

Emergency Contraceptive Fact Sheet

What is Emergency Contraception?

Sometimes called the “morning after pill”, emergency contraception is used to prevent pregnancy immediately after unprotected sex. Depending on when in your menstrual cycle you had unprotected sex, you could have 1 in 3 chances of becoming pregnant. When used within 72 hours, the risk of pregnancy after a single act of unprotected intercourse is reduced from 8% to 1%.

When do you use Emergency Contraception?

Plan B is for *emergencies*. It is not as effective as regular birth control in preventing pregnancies.

It is most effective when started within 24 hours after unprotected sex but no later than 72 hours after unprotected sex. The first dose will be given immediately after the sexual assault exam. The second dose should be taken 12 hours after the first dose. Some health care providers will tell you to take both tablets at the same time, which seems to work just as well as taking them 12 hours apart.

Is it Safe?

Twenty years of study by the FDA says emergency contraception is safe and effective, but it isn't for everyone. Your health care provider will ask some questions to determine whether it is safe for you.

Are there any side effects?

You may feel nausea and have vomiting; these symptoms go away a day or two after treatment. If you vomit within one or two hours after taking a dose call your health care provider, you may need to repeat a dose.

When will I have my period?

Your next period may start a few days earlier or later than usual. If your period has not started within three weeks, call your health care provider. Emergency contraceptives may not prevent an ectopic pregnancy (pregnancy where the fertilized egg implants outside the uterus).

How soon can I get pregnant after taking emergency contraception?

You can get pregnant if you have unprotected sex immediately after taking the medicine.

Where can I find more information?

You can learn more by calling 1-800-Not-2-Late, toll-free. If you have access to a computer, two web sites – www.go2planb.com or www.not-2-late.com have additional information available.



HIV Post-Exposure Prophylaxis

The use of HIV Post-Exposure Prophylaxis (PEP) after acute sexual assault is based on the efficacy demonstrated in occupational exposures and perinatal HIV exposures. To provide effective prophylaxis patients need to be promptly evaluated and assessed for the risk of HIV transmission. HIV PEP is most effective if given as soon as possible after the sexual assault and is not effective if given after 72 hours. Therefore, HIV PEP is typically recommended only for acute cases presenting within 72 hours post assault and when other indications are met.

Determination to begin HIV PEP depends on the HIV status and risk factors of the alleged perpetrator, timing and frequency of the assault, and type of contact involved in the assault. The following table summarizes the exposure risk of HIV transmission when a source is known to be HIV infected.

Exposure and Risk of HIV transmission per exposure when the Source is HIV infected

Type of HIV exposure	Risk per 10,000 exposures to an infected source
Blood transfusion	9000
Perinatal exposure	1300-4500
Needle sharing	67
Unprotected receptive anal intercourse	50
Needle stick (health professional)	30
Unprotected receptive vaginal intercourse	10
Unprotected insertive vaginal intercourse	5
Ingestion of human milk	0.1- 0.4

Risk factors that may increase the rate of transmission include multiple perpetrators, unknown perpetrator, multiple episodes of intercourse, no barrier contraception, or mucosal injuries. A flow chart is included on page 31 giving recommendations for which patients to initiate HIV PEP.

An important consideration before initiating HIV PEP should include patient’s ability to adhere to the medication regimen. Incomplete PEP treatment presents a theoretical risk of increased resistance and thus making the HIV more difficult to treat should the patient become HIV positive.



HIV PEP consists of two or three antiretroviral medications given for 28 days. The regimen typically includes two reverse transcriptase inhibitors (such as AZT). A third antiretroviral medication, typically a protease inhibitor may be added. Studies suggest that a two-drug regimen is just as efficacious as a three-drug regimen. Common side effects of antiretroviral medications include nausea, vomiting, and headache. Check with local HIV experts to determine the best HIV PEP to offer patients in your geographic area.

If HIV PEP is to be prescribed, the patient should receive baseline HIV testing. Laboratory evaluations also recommended at this time include pregnancy testing, Hepatitis B and C serology, and syphilis screening. Depending on the anti-retroviral medications used, additional baseline testing may be recommended and includes CBC with differential, liver profile, and renal profile. Patients should have follow up testing at 6 weeks, 3 months, and 6 months post-exposure which should include HIV antibody testing, STI screen as indicated, and Hepatitis B and C serology.

Some tips regarding prescribing HIV PEP:

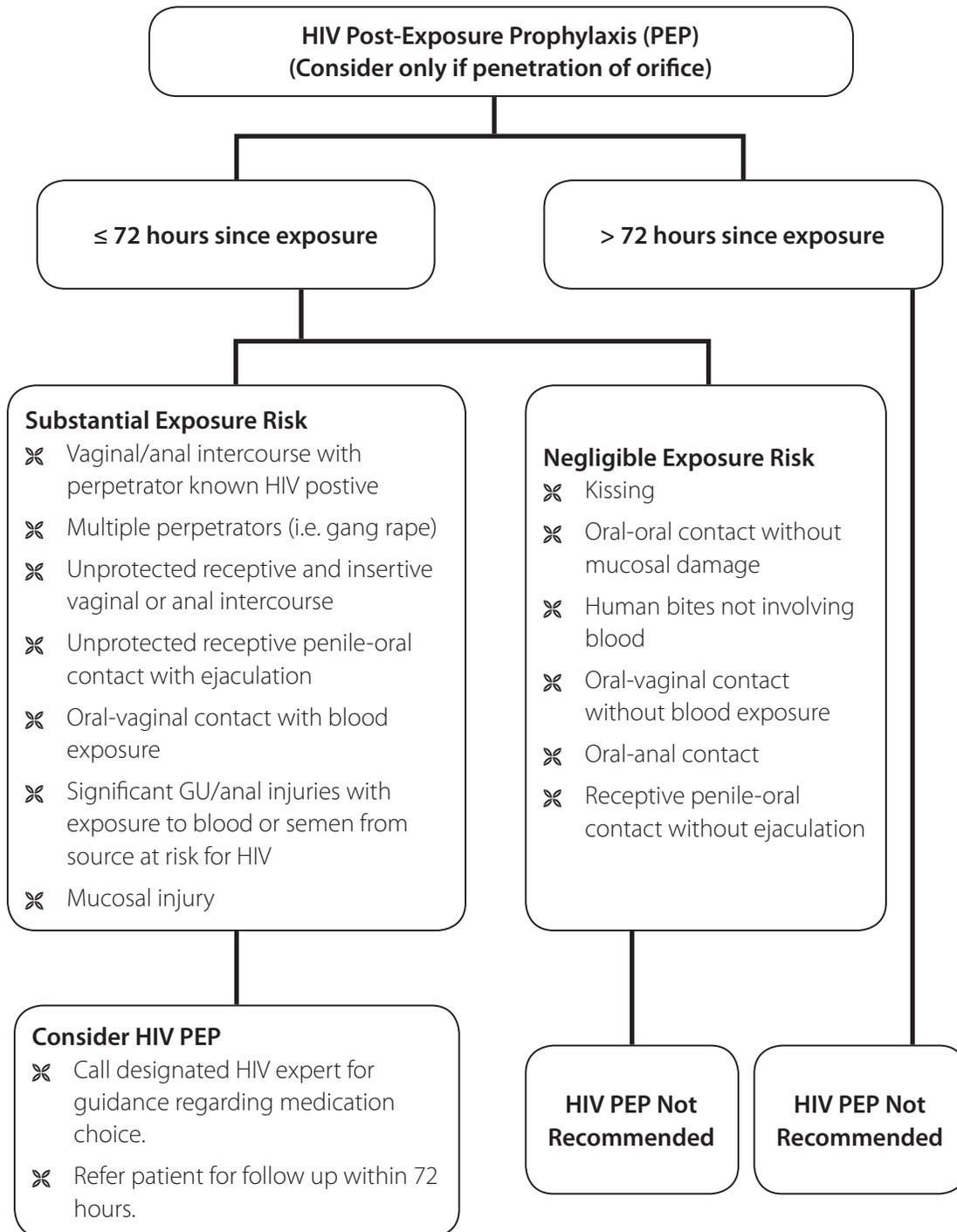
HIV PEP is expensive, and not all insurance carriers provide coverage. Some strategies to help defray costs include working with your institution's pharmacy to provide starter packs for 3-5 days in the emergency department as well as referring families to your institution's financial services office. In addition, encourage families to submit costs to the Victim's Fund through the Attorney General's Office for reimbursement.

Determine the availability of the particular HIV PEP medications within your community pharmacies. It is also helpful to determine if they carry a liquid preparation in stock.

Follow up should be arranged for the patient within 2-3 days of starting HIV PEP to monitor for side effects and assess compliance. Follow up can be done through your local advocacy center or through the local HIV clinic. Additional information on this topic may be found on the Centers for Disease Control website at:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm>

***** Begin HIV Prophylaxis ASAP *****





B.4.a

Suspected Drug Facilitated Sexual Assault / Sexual Abuse: Evaluation Protocol

- A. There are a number of ways in which the use of alcohol or drugs may contribute to an act of sexual assault. The substance most frequently involved in sexual assaults is alcohol, which the victim may consume voluntarily. Increasingly, cases have been reported in which the perpetrator surreptitiously administers a drug to the victim, most often through adding it to a drink, in order to incapacitate her/him so that she/he is unable to prevent the assault. There are several dozen different drugs, which are known to have been used for this purpose.
- B. The decision as to whether and when to collect urine and blood samples for toxicological screening is complex. The medical personnel conducting the exam should assess the assault history to determine whether any indicators of drug impairment exist (see following list of symptoms).
- C. Reported symptoms experienced by the victim may include:
- a. confusion
 - b. decreased heartbeat
 - c. dizziness
 - d. drowsiness
 - e. impaired judgment
 - f. impaired memory
 - g. lack of muscle control
 - h. loss of consciousness
 - i. nausea
 - j. reduced blood pressure
 - k. reduced inhibition
- D. If medical personnel, law enforcement, or the patient have reason to suspect the use of a drug by the perpetrator, either an advocate or medical personnel should discuss with the patient ramifications of any type of drug testing. Information provided to the patient should include:
1. Review the types of drugs that will be detected by the test.
 2. Explanation of the factors that make drug detection difficult.
 3. Clarification that a negative test result does not mean that no drug was used.
 4. Discussion of the possible consequences of a negative result, both emotionally for the patient and regarding the status of the case.
 5. Clarification that in a criminal case the results will be available to the defense and may become public knowledge, including results related to prescription drugs she/he may be taking for medical reasons and any illegal drugs she/he may have taken voluntarily, even if unrelated to the time of the assault. This could also potentially lead to the release of other private information otherwise protected by rape shield laws, such as medical or mental health conditions.
 6. Opportunity for the patient to ask questions and discuss concerns related to the test.
 7. Explanation regarding how she/he will be notified of the results of the test.



- E. If the decision is made to test for drugs, complete the following evidence collection procedures:
1. Determine time of the ingestion of the drug.
 2. Urine should always be collected if testing for drugs. If ingestion occurred within 96* hours or less, 100 ml of urine should be collected in sterile urine collection containers. If it is not possible to collect 100 ml of urine, collect as much as possible. Immediately refrigerate; follow chain of custody procedures.
 3. If ingestion occurred within 24 hours or less, 20 ml of blood should be collected in "gray-topped" blood collection tubes. Two 10 ml gray topped tubes could be used. Immediately refrigerate; follow chain of custody procedures. This collection of blood should be in **addition to** the collection of urine described above. In all cases, a urine sample should be collected.
 4. When conducting a full drug screen, confirm that the laboratory is testing the urine and blood samples for: Benzodiazepines, Amphetamines, Muscle Relaxants, Sleep Aids, Antihistamines, Cocaine, Marijuana, Barbiturates, Opiates, Ethanol, GHB, Ketamine, Scopolamine, and any other substances that depresses the central nervous system.

These forensic toxicological specimens should be collected in addition to any blood or urine specimens collected for other medical or forensic purposes. Evidence collection kits specifically for drug testing may be purchased commercially. Contact the Ohio State Highway Patrol (1-877-772-8765) for more information about purchasing these kits.

It becomes increasingly unlikely that drugs will be detected as time passes. Some toxicologists recommend shorter time frames within which it is reasonable to test for these drugs. If the laboratory conducting the analysis recommends a different time frame than recommended here, contact the Ohio Department of Health Sexual Assault and Domestic Violence Prevention Program to verify that the change is within current guidelines.

If the victim has vomited, treat the vomit as a supplemental specimen for forensic toxicology purposes. Collect as much of the liquid and solid portions of the vomit as possible by using a spoon, eyedropper-type suction devise, or other tool that is consistent with biohazard procedures. The vomit should be placed in a urine collection container or other appropriate container that has a lid with a tight seal. Then immediately place the container in a freezer; however, if vomit will be submitted to a toxicologist within five days, it is acceptable to refrigerate (rather than freeze) the container containing the vomit. If any vomit is on clothing, sheets, or other objects put the items in an appropriate container to prevent leakage and contamination and then immediately freeze the items while packaged in the container. Follow biohazard procedures when handling any body fluids. Follow chain of custody procedures.





- F. To assist the toxicologist, document the following:
 - a. Date and time the drug was probably ingested.
 - b. Date and time that the specimen(s) are collected.
 - c. All available information about what drugs may have incapacitated or contributed to the incapacitation of the victim.

- G. Specimens collected for the purpose of drug testing **should not be included with the evidence collection kit**. Only send specimens to labs approved for this type of drug testing. Contact ODH (614-466-2144) for information about qualified labs.

LeBeau, M, et.al, Recommendations for Toxicological investigations of Drug Facilitated Sexual Assaults. J. Forensic Science 1999; 44: 227-230.



B.4.b

Drug-facilitated sexual assault handout

This handout is provided to assist you in making a decision regarding whether or not to provide blood and urine samples that can be used to test for drugs that you may have ingested. The purpose of these tests will be to identify drugs that you did not know you were ingesting, used by an offender for the purpose of committing a sexual assault. Before consenting to this testing, you should receive the following:

1. Explanation of the types of drugs that will be detected by the test.
2. Information about the likelihood of detecting drugs given the circumstances of your case. Keep in mind that there are many factors that make detection of these drugs difficult; a negative test result does not mean that no drugs were used.
3. Opportunity to discuss the effect either a positive or negative test result may have on the investigation and prosecution of your case.
4. Opportunity to discuss and consider concerns you may have related to other drugs you may have taken which would also be detected. In a criminal case, the test results will be available to the defense and may become public knowledge, including results related to prescription drugs you may be taking for medical reasons and any illegal drugs you may have taken voluntarily, even if unrelated to the time of the assault. This could potentially lead to the release of other private information otherwise protected by rape shield laws, such as medical or mental health conditions.
5. Opportunity to ask other questions and discuss concerns related to the test.
6. Explanation regarding how you will be notified of the test results.

Additional information:

- ✘ Because of the techniques used to conduct these tests, any drugs in your system may be detected. All drugs detected by the test will be reported to the law enforcement agency conducting the investigation and subsequently will be available to both the prosecution and the defense in the event of a criminal case. Potential drugs that may be detected include but are not limited to ethanol, benzodiazepines, GHB, ketamine, scopolamine, amphetamines, barbiturates, cocaine, marijuana, opiates, muscle relaxants, antihistamines, and chloral hydrate.
- ✘ The kinds of drugs used by offenders to facilitate sexual assault can be very difficult to detect. Reasons for this include the speed with which the drug leaves the body and the fact that for many reasons the test may not be done within the ideal timeframe. For all sexual assaults, reporting may be delayed as victims struggle with issues of self-blame resulting from stereotypes and misconceptions about sexual assault and with discomfort and embarrassment with going through the evidence collection process. When alcohol and drugs are involved, the victim may be unconscious or disoriented during the majority of the time that the drug is still in their system, or need time to piece together what happened to them or recover from the effects of the experience.



Because of these difficulties in detecting the drug, there is a high probability that even if a drug was used the test will come back negative. This can be emotionally difficult to hear and could potentially undermine the investigation.

- ✘ Under Ohio law, sexual contact is a serious crime in both the case of intentional administration of a substance by the perpetrator and in the case of the victim voluntarily consuming the substance and therefore being in the position of being unable to consent to the sexual contact. If the victim has voluntarily consumed the substance and the offender knows that the other person's ability to appraise the nature of or control of his or her own conduct is substantially impaired, the charge would be sexual battery (a third degree felony). The sexual contact would be defined as rape if, for the purpose of preventing resistance, the offender substantially impairs the other person's judgment or control by administering any drug or intoxicant to the other person, secretly or by force, threat of force, or deception. (ORC 2907.02 and 2907.03)
- ✘ Reported symptoms experienced by victims of drug-facilitated sexual assault may include; confusion, decreased heartbeat, dizziness, drowsiness, impaired judgment, impaired memory, lack of muscle control, loss of consciousness, nausea, reduced blood pressure, reduced inhibition.

Symptoms may be similar to severe intoxication and/or those of a surgery patient coming out of anesthesia. Some of these symptoms are also typical of post traumatic stress symptoms that may be present regardless of the use of substances.

Victims who have voluntarily taken illegal drugs should disclose this information to medical or law enforcement professionals at the time that the blood and urine samples are taken for the drug test. Honesty on this topic will assist in an effective prosecution. Be aware that engaging in felonious criminal activity may make you ineligible for compensation through the victims of crime compensation fund.





8.5

Child Sexual Abuse: After-Care Handout

Patient	Examiner
Hospital	Examiner's Phone
Date of Exam	Hospital Phone

Specimens were collected from you to provide evidence in court should the case be prosecuted. The following additional medical tests were collected to provide information about your health status, as of today. It may be important to compare today's results with follow-up tests in the near future.

<input type="checkbox"/> A blood test for syphilis infection	<input type="checkbox"/> Test(s) for HIV antibody
<input type="checkbox"/> Test(s) for gonorrhea infection	<input type="checkbox"/> Test(s) for pre-existing pregnancy
<input type="checkbox"/> Test(s) for Chlamydia infection	<input type="checkbox"/> Other tests _____
<input type="checkbox"/> You were given the following medications to prevent infection	
Medication:	Dosage:
Medication:	Dosage:
<input type="checkbox"/> You were not given this preventive treatment because: _____	
<input type="checkbox"/> You were given an emergency contraceptive to prevent pregnancy and medication to prevent vomiting	
Medication:	Dosage:
Medication:	Dosage:
<input type="checkbox"/> You were not given an emergency contraceptive because:	
<input type="checkbox"/> there is no risk of pregnancy	<input type="checkbox"/> you did not want it
<input type="checkbox"/> of a pre-existing pregnancy	<input type="checkbox"/> too long an interval had elapsed
<input type="checkbox"/> Other reasons _____	

You have been scheduled — or should make an appointment — for the following kinds of care:

	Where	Date	Time	Phone
<input type="checkbox"/> Follow-up medical exam				
<input type="checkbox"/> Follow-up check for infection				
<input type="checkbox"/> Follow-up pregnancy testing				
<input type="checkbox"/> Follow-up counseling				
<input type="checkbox"/> Other				



If you wish to get counseling, or follow-up testing and treatment for venereal infection, or pregnancy prevention/management, elsewhere than this hospital / clinic or medical center, call one of these agencies:

1.	Phone
2.	Phone

Other important names and numbers that may be helpful to you:

Child Advocacy Center or Child Abuse Clinic	Phone
Detective's name:	Phone
Name of Police Department:	Phone
Social Worker:	Phone
Name of Agency:	Phone
Mental Health Center	Phone
Victim's Advocate Program	Phone
Rape Abuse & Incest National Network - a 24-hour computer system that will relay your call to the nearest rape crisis center Phone: 1-800-656-HOPE (toll-free call) (http://www.rainn.org)	
Prevent Child Abuse Ohio – Provides statewide education and resources on child sexual assault. Phone: 1-800-244-5373 (toll-free call) (http://www.preventchildabuse.org)	
Ohio AIDS Hotline (information about free testing)	Phone: 1-800-332-AIDS or 1-800-332-2437 (toll-free call)

Crime Victim Compensation

- a. To apply for compensation, contact the clerk in your County's common pleas court.
- b. This program is designed to pay expenses that are not covered by insurance or other benefits.
If eligible for the program, you may use the money to pay for medical, drug and rehabilitation expenses such as damage to teeth or eyes, replacement of eyeglasses, counseling, transportation, costs of medical exams if not covered elsewhere, etc.; for wages lost as a result of the crime; for replacement services costs (the cost of services the victim can no longer perform); for dependent's economic loss in death claims; and for funeral expenses.
- c. For more information about financial compensation for crime victims, call the Ohio Court of Claims at 1-800-824-8263 (toll-free call).

<input type="checkbox"/> I have received this Child Sexual Abuse After-Care handout. <input type="checkbox"/> I have received the "Child Sexual Abuse Common Reactions and Follow-up Services" handout <input type="checkbox"/> I have received the "Emergency Contraception Fact Sheet" <input type="checkbox"/> I do not wish to receive either of these form	
(Patient/Parent/Guardian signature)	(Date)





8.6

Child Sexual Abuse: Common Reactions and Follow-up Services handout

Common Reactions

Any form of sexual assault or abuse is one of the most painful and upsetting things that can happen to a person. After the assault or abuse, a person may experience restlessness, sleep disturbances, fear, anger, and an inability to concentrate. A person may experience disbelief or denial, depression, mistrust of people and a lack of confidence. Feeling guilty, embarrassed and ashamed are also common reactions. All of these reactions are normal, understandable reactions.

With time and understanding, these feelings and experiences will subside. Sexual assault or abuse causes a great deal of disorganization in your life. Give yourself permission to take as long as you need to heal and recover. It often helps to talk with someone, particularly someone trained in sexual assault issues, about the feelings you are experiencing.

If you are the parent or guardian of a child sexual abuse / assault victim, you may find the following suggested responses to common reactions helpful.

Reaction	Response
<i>Fear</i> A child may not want to separate from you and may need constant reassurance.	Reassure the child that he / she is safe now.
<i>Embarrassed / Guilt</i> A child may be embarrassed to talk about what happened. Older children and boys often feel a sense of guilt.	Tell the child that they are not at fault and or not responsible for what happened.
<i>Anxiety/Loss of Control</i> A child may feel out of control or vulnerable. He/she may develop a low self-image of him/herself.	Create situations in which the child feels in control and empowered.
<i>Withdrawal</i> A child may refuse to talk, may be emotionally incapable of remembering or talking about the abuse, may develop immature behaviors (i.e. bedwetting, thumb sucking, loss of toilet training).	Help the child feel secure and in control. Explain the purpose of the legal investigation, the medical exam, and treatment.
<i>Difficulty sleeping</i> Not wanting to sleep alone, nightmares, disrupted eating habits (hoarding food or reluctant to eat), reluctance to go to school, stomach-ache or headache.	Allow the child to talk about his/her fears. Show understanding about his/her physical complaints and reassure child that he/she is safe.



Child Sexual Abuse: Common Reactions and Follow-up Services handout

What to expect from this point on

Follow-up investigation

Whether or not the perpetrator is prosecuted, the law enforcement officer and/or social worker may be back in touch with you. You (your child) will probably have an interview with an individual who is trained in sexual abuse and assault investigation. If a child was removed from her/his home for protective reasons, the Juvenile Court will decide if and when it is safe for the child to return home.

Follow-up medical treatment

It is impossible to know immediately after sexual assault or abuse if you have contracted any sexually transmitted diseases or become pregnant. Any tests you may have been given at the hospital may only determine whether you had any infections or were pregnant at the time of the evaluation. Your doctor or the follow-up examiner will discuss your risk of infection with you. The examining physician or nurse may recommend that you be checked for sexually transmitted diseases and HIV in the near future. This might involve a blood test and another examination. Depending on your age and the type of assault or abuse, you may want to have a pregnancy test conducted at this same time as well.

You may make appointments for these tests with your personal doctor, local city or county health department, women's health center, hospital or neighborhood health clinic. In addition, children may schedule appointments with a Child Advocacy Center, the child's primary care physician or a children's hospital or clinic.

For information about free HIV testing you may call 1-800-332-2437 (no cost for call). Your doctor can provide you with information about the risk of HIV infection.

Support services

People who have been trained to work with survivors of sexual assault and victims of child sexual abuse are available to talk with you (your child) about your feelings and the issues that arise. Crisis counseling after assault or abuse can make a difference. Referrals to support professionals are listed on the "After Care Information and Follow-up Services" form.





8.7

Guidelines For Child Abuse Reporting Of Consensual Sexual Activity

A report of sexual abuse may be required when minors engage in consensual sexual activity. Under Ohio Law, the need to report is based upon the ages of the participants, any history of force, misuse of authority, as well as other issues. Due to a high risk for abuse, a sensitive assessment for sexual abuse is indicated when evaluating young sexually active adolescents. The section below is a guideline for reporting sexual abuse when patients describe consensual sexual activity.



Patient Age 12 or younger

Children under 13 years old cannot legally consent to sexual activity in Ohio. All children under 13 who report consensual sexual activity must be screened for sexual abuse.

File a report of sexual abuse if:

- ✘ The sexual partner is 13 years old or older
- ✘ The sexual partner used force or coercion
- ✘ The sexual partner misused their authority (i.e., baby sitter, etc)
- ✘ There is a significant difference in maturity levels between the patient and the sexual partner (i.e., victim is mentally retarded or there is a large difference in ages)
- ✘ There are protective issues (i.e., the child lives on the street or there is a significant lack of supervision which puts the child at risk for abuse, injury, etc.)



Age 13, 14, 15 years

File a report of sexual abuse if:

- ✘ The sexual partner is 4 or more years older than the patient
- ✘ The sexual partner used force or coercion
- ✘ The sexual partner misused their authority (i.e., parent or authority figure)
- ✘ There was a significant difference in maturity levels between the patient and sexual partner (i.e., victim is mentally retarded)
- ✘ There was mental or cognitive impairment (i.e., developmental delay, intoxication) rendering the person unable to consent
- ✘ There are protective issues (i.e., the child lives on the street or there is a significant lack of supervision which puts the child at risk for abuse, injury, etc.)

Consider reporting if:

- ✘ The sexual partner is over the age of 18 but less than 4 years older than the patient. In this situation, the police might charge the partner with the corruption of a minor.



The decision NOT to report consensual sexual activity may be considered when:

- ✂ There is less than four years age difference, a thorough history eliminates the above criteria, and the parent and child agree not to file a report.

The guidelines above may not prove applicable in all situations. Professional judgment must be used. In 13, 14 and 15 year olds, abuse may be present even when the age difference between partners is only 2-3 years. The professional must carefully assess the situation before deciding against reporting and may want to seek consultation with the child abuse team or with the police jurisdiction.



Age 16 or Older

Sixteen is the age of consent in Ohio. However, if the patient is 16 and his/her partner is 18 or older, a parent can file charges with Juvenile Court prosecutors. The misdemeanor charge would be contributing to the unruliness or delinquency of a minor. In this situation, we would not file an abuse report.

When interviewing an adolescent, be alert for issues of force, coercion, deception, identify the relationship of the sexual partner (relative, authority figure, etc.) and history of physical or mental impairment (such as intoxication or drugs). When these factors are present, a report of sexual abuse should be made.





Ohio Attorney General
Sexual Abuse Forensic Examination (SAFE) Program
Instructions for Reimbursement Form

The following steps correlate to the numbered boxes on the reimbursement form. In order to receive your reimbursement in a timely manner, please follow the directions for each question.

1. **Name of medical facility providing evaluation.**
2. **Name of the healthcare professional conducting the examination.**
3. **The patient's medical record number** must be provided. The patient's medical record number must be on the itemized statement. If present the patient's name and social security number may be redacted from the attached itemized statement. However, the Attorney General may request more complete information during its annual audit of SAFE Program reimbursements.
4. **Date/Time of Abuse/Assault** — If a kit is conducted a specific date and time is required to confirm kit was completed within an acceptable timeframe. If no kit was conducted, provide as precise a date for the abuse/assault as possible. If an exact date is unknown, provide an estimated range of dates based upon the best information available. Forms marked with "unknown" will be returned.
5. **Evaluation Date/Time** — The date/time when the evaluation of the patient was provided.
6. **Patient age at time of treatment** — If the patient is ≤ 15 years of age you will need to answer questions (13-15). If the patient is ≥ 16 and ≤ 18 years of age you will need to answer questions (16-18).
7. **Patient Gender Identity** - Please circle one option based on the response provided by the patient. See corresponding definitions below:
 - ✘ The term "gender identity" refers to a person's innate, deeply felt psychological identification as male or female, which may or may not correspond to the person's body or designated sex at birth.¹
 - ✘ Transgender — A broad range of people who experience and/or express their gender differently from what most people expect — either in terms of expressing a gender that does not match the sex listed on their original birth certificate (i.e., designated sex at birth), or physically changing their sex. It is an umbrella term that includes people who are transsexual, cross-dressers or otherwise gender non-conforming.¹
8. **Indicators/History** — Provide information regarding either patient disclosure or indicators that suggested abuse/assault occurred. For patients ≤ 18 years of age see page 5 of Ohio Child and Adolescent Protocol for possible indicators of sexual abuse. For patients ≥ 18 years of age please see page (???) of the Ohio Protocol for the Treatment of Adult and Adolescent Sexual Assault Patients (Adult criteria needs to be develop for protocol).



9. **Evaluation of patient** —

10. **Sexual Assault Evidence Kit** — Note that the SAFE program will reimburse for kits opened in good faith but not complete due to patient declining necessary steps.

If the patient is ≥ 18 years of age the medical facility must use a sexual assault examination kit within 96 hours of the assault/abuse, which meets the protocol guidelines, to qualify for reimbursement. The SAFE program does not reimburse for examination or photodocumentation ≥ 18 years of age.

If the patient is ≤ 15 , a kit should be completed within 72 hours of the abuse/assault. If the most recent abuse is outside of the time period for collecting forensic evidence, the SAFE Program will provide payment if physical evidence is gathered by a detailed genital and/or anal examination using a colposcope or similar technology and photodocumentation (This will require additions to ped protocol) as noted in the pediatric protocol (section 4 photodoc). The exam must be performed by a physician, pediatric nurse practitioner, or sexual assault nurse examiner who is approved by the Attorney General's Office as an expert in child sexual abuse. In order to obtain approval a current curriculum vitae or resume must be submitted which details specific (Dr. S and Jodie will submit criteria) expertise. Is there an outside timeframe in which an exam cannot/should not be done for evidence collection, ie., non-acute cases older than ?? years? Have some dating back 12 years).

If the patient is 16 or 17 years of age and they present at the medical facility outside of the time period for collecting a sexual assault examination kit, please use Addendum A (depends on if on form) to document the exam and photodocumentation.

If the patient presents with intellectual disabilities (i.e; mental retardation and developmental delays) and is ≥ 16 years of age and they present at the medical facility outside of the time period for collecting sexual assault examination kit, please use Addendum B (or add to form) to document exam and assessment.

- a. If using a kit other than the Brooks Yates Center Diversified Industries #6075/ Pickaway, specify the name of the kit.
- b. Report to law enforcement — Pursuant to ORC (????) sexual abuse/assault of children requires mandatory reporting. For adults the hospital/facility is obligated under Ohio law to report a sexual assault whether the patient wants to speak to law enforcement or not. See Adult Protocol IE.
- c. Retrieval of Kit — Document the law enforcement agency/jurisdiction that retrieved the rape kit. If the kit was not retrieved, provide an explanation (e.g., hospital stores kits, law enforcement do not retrieve anonymous adult kits, etc.).





11. **Location of Victim** — If answer is yes, document the institution in which the patient is housed.

12. **Itemized Statement** — Attach itemized statement of actual costs incurred in conducting the sexual assault forensic exam, including antibiotic prophylaxis. The SAFE Program reimburses a flat fee of \$532.00 per evidence collection kit or exam and photodocumentation for patients 17 years of age or younger. The patient’s medical record number must be on the itemized statement.

13. **ODH 2008 Ohio Child & Adolescent Sexual Abuse Protocol** —

¹ Human Rights Campaign, Gender Identity, Sexual Orientation and Gender Identity: Terminology and Definitions. http://www.hrc.org/issues/gender_identity_terms_definitions.asp

² Human Rights Campaign, Transgender, Sexual Orientation and Gender Identity: Terminology and Definitions. http://www.hrc.org/issues/gender_identity_terms_definitions.asp

Reimbursement Request Form

Ohio Attorney General Sexual Assault Forensic Examination (SAFE) Payment Program

Please Answer Questions 1-12 for All Patients

On back of form are Addendums that may also need to be completed. Please see item #10 on the instructions page

1. Name of Medical Facility:	2. Name of Healthcare Professional Conducting Examination:	3. Patient Medical Record Number:	4. Date/Time of Abuse/Assault:	5. Evaluation Date/Time:
6. Patient age at time of evaluation:		7. Patient gender (check one): <input type="checkbox"/> F <input type="checkbox"/> M Transgender		
8. What indicators/history suggested that this patient was a victim of sexual abuse/assault?				
9. Was the medical-forensic exam and history of the patient performed in compliance with the ODH 2008 Ohio Sexual Assault Protocol for Sexual Assault Forensic and Medical Examinations?				<input type="checkbox"/> Yes <input type="checkbox"/> No
10a. Was an approved sexual assault evidence collection kit used in compliance with the ODH 2008 Ohio Sexual Assault Protocol for Sexual Assault Forensic and Medical Examinations? (Check One) <input type="checkbox"/> Brooks Yates Center Diversified Industries #6075/Pickaway <input type="checkbox"/> Other (Name of Kit): _____				<input type="checkbox"/> Yes <input type="checkbox"/> No
10b. If you answered yes to 10a., did law enforcement agency retrieve the kit? * If no, why?				<input type="checkbox"/> Yes <input type="checkbox"/> No
10c. To which law enforcement agency or public children services agency was a report given?				
11. At the time of assault, was the victim confined in a county, city, or federal jail or prison, or in any other institution maintained and operated by the Dept. of Corrections or Youth Services? If yes, where?				<input type="checkbox"/> Yes <input type="checkbox"/> No
12. My signature certifies that the information above is accurate and the protocol was followed. _____ Signature* and Title Print Name (Must be same health care professional completing exam) *Original signature required				
13. Please attach an itemized statement to the back of the form of all services provided.				
14. Submit To: Ohio Attorney General SAFE Program Attn: Denise Ruby, SAFE Account Clerk 150 E. Gay St., 25th Floor Columbus, Ohio 43215		For Questions about Billing, Please Call: (614) 995-5415 or (614) 466-3552 www.ag.state.oh.us		



Addendum A

- Patient 15 years of age or younger, and when evidence collection kit not indicated presenting after 72 hours

If a kit was not completed due the patient presenting more than 72 hours after the abuse/assault, a forensic exam by an expert, an interview with the patient, and photo documentation is required.

Were the following procedures completed by a physician, or advanced practice nurse or registered nurse who is an expert in child sexual abuse evaluations? (Yes must be checked for all in order to receive reimbursement)

- ✘ Physical exam using a colposcope or other similar technology Yes No
- ✘ *Diagnostic quality Interview with patient Yes No
- ✘ **Diagnostic quality Photo documentation Yes No

*** Diagnostic quality photo documentation of the patient, even if there are no visible injuries, is mandatory in order to receive reimbursement.**

Please check if patient declined to have photos taken.

* Whether photo documentation is in fact diagnostic quality may be reviewed during auditing.

Addendum B

- Patient is 16 or 17 years of age presenting after 72 hours

If a kit was not completed due to the patient presenting more than 72 hours after the abuse/assault, a forensic exam by an expert, an interview with the patient, and photo documentation is required.

Were the following procedures completed by a physician, advanced practice nurse or registered nurse who is an expert in child sexual abuse evaluations? (Yes must be checked for all in order to receive reimbursement)

- ✘ Physical exam using a colposcope or other similar technology Yes No
- ✘ *Diagnostic quality Interview with patient Yes No
- ✘ **Diagnostic quality Photo documentation Yes No

Please have the patient or guardian explain the reason for delayed disclosure (check all that apply):

- Drug-induced assault
- Physically Restrained or Impaired
- Unconscious
- Assault occurred prior to age 16
- Other (describe): _____
- Intellectual Disability
- Familial Assault
- Reasonably felt personal safety was in jeopardy
- Emotional trauma

*** Diagnostic quality photo documentation of the patient, even if there are no visible injuries, is mandatory in order to receive reimbursement.**

Please check if patient declined to have photos taken.

* Whether photo documentation is in fact diagnostic quality may be reviewed during auditing.





Addendum C

- Patient 16 years or older with an *Intellectual Disability**

If a kit was not completed due to the patient presenting more than 7296 hours after the abuse/assault, a forensic exam by an expert, an interview with the patient, and photo documentation is required. Intellectual disability is characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, and getting along in social situations and school activities. Intellectual disability is sometimes referred to as a cognitive disability or mental retardation. (Department of Health and Human Services, Centers for Disease Control, Intellectual Disability <http://www.cdc.gov/ncbddd/dd/ddmr.htm>)

Please have the patient or guardian explain the reason for delayed disclosure (check all that apply):

- Intellectual Disability
- Physically Restrained or Impaired
- Unconscious
- Emotional trauma
- Other (describe): _____
- Drug-induced assault
- Familial Assault
- Reasonably felt personal safety was in jeopardy

Were the following procedures completed by a physician, advanced practice nurse or registered nurse who is an expert in sexual abuse evaluations? (Yes must be checked for all in order to receive reimbursement)

- ✂ Physical exam using a colposcope or other similar technology Yes No
- ✂ *Diagnostic quality Interview with patient Yes No
- ✂ **Diagnostic quality Photo documentation Yes No

***Diagnostic quality interview is defined as a gathering of information by a healthcare provider (social worker, RN, physician) to determine whether abuse has occurred or not, and determining the needs for medical diagnosis and treatment, psychological care and evidence collection. The interview will be appropriate to the child/ adolescent’s developmental level and considerate of the child/ adolescent’s culture and ethnicity and conducted in a way that minimizes further emotional trauma.**

If no interview, reasons:

- Patient declined to speak with provider
- Patient developmental age
- Other (describe): _____

*****Diagnostic quality photo documentation of the patient, even if there are no visible injuries, assures quality of evaluation, and is mandatory in order to receive reimbursement.***

If no photo documentation, reason:

- Male patient
- Equipment failure
- Please check if patient declined to have photos taken.
- Other (describe): _____

* Whether photo documentation is in fact diagnostic quality may be reviewed during auditing
 ***Intellectual disability is characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, and getting along in social situations and school activities. Intellectual disability is sometimes referred to as a cognitive disability or mental retardation. (Department of Health and Human Services, Centers for Disease Control, Intellectual Disability <http://www.cdc.gov/ncbddd/dd/ddmr.htm>)



For Sexual Assault Victim / Survivors
Important information about your medical bill

SEXUAL ASSAULT FORENSIC EXAMINATION (SAFE) PAYMENT

There are two purposes for you to receive a sexual assault evidentiary examination:

1. To assure that any physical injuries you may have received from the sexual assault, including sexually transmitted diseases, are cared for, and
2. To collect any physical evidence of sexual assault, in case you decide to report to law enforcement.

The part of the examination that collects physical evidence of sexual assault is **paid for by the Ohio Attorney General's Sexual Assault Forensic Examination (SAFE) Payment Program**. This includes the physical examination, laboratory tests and medicine you received to prevent sexually transmitted disease.

- ✘ **You do not have to report the crime to law enforcement for the state to pay for a sexual assault examination.**
- ✘ **You are not responsible for the cost of a sexual assault examination for the purpose of gathering evidence for a possible prosecution, including the cost of any antibiotics administered as a part of the examination. The hospital will bill the state directly.**

OHIO VICTIMS OF CRIME COMPENSATION PROGRAM

You may be eligible for the Ohio Victims of Crime Compensation Program to pay for medical care you needed that was not part of the sexual assault forensic examination. Medical care you can be compensated for might include x-rays, stitches, hospitalization, pain medication, and counseling you receive as a direct result of the crime victimization. Compensation is also available for clothing or bedding that was held as evidence and for lost wages you suffered as a result of the crime. Immediate family members may be eligible for reimbursement for the cost of mental health counseling.

- ✘ **The hospital or clinic will bill you for examination and care that is not for the collection of sexual assault evidence.**
- ✘ **You are responsible for those bills, however, you may be eligible to have them paid by the Ohio victims of crime compensation program.**
- ✘ **To be eligible for the Ohio victims of crime compensation program, you must report the crime to law enforcement within 72 hours of its occurrence unless good cause is shown for late reporting.**
- ✘ **You must file a completed application with the program within two years of when the crime happened, or by a minor victim's 20th birthday.**



For more information call.

Ohio Victims of Crime Compensation Program
Attorney General's Office Safe Program
150 E. Gay St., 25th Floor
Columbus, OH 43215
(614) 466-5610
Toll-Free General Information
(877) 584-2846 (877-5VICTIM)

D. Crime Victims Compensation

The Crime Victims Compensation Office of the Crime Victims Services Section of the Ohio Attorney General's Office investigates applications for compensation filed under Ohio's Crime Victims Compensation Law, a law that provides for payment to victims of violent crime to cover their economic losses. Upon completing the investigation, a recommendation is made to the Court of Claims concerning the outcome of the application. An application for patient reimbursement can be made on-line at <http://www.ag.state.oh.us/crimevic/crimevic.htm>.

Information about the Ohio Victims Compensation program should be given to the patient prior to leaving the hospital. Recent changes to the Ohio Victims Compensation program are outlined below. Information can be obtained by calling (614) 466-5610 or Toll Free at (877) 584-2846.

Summary of Ohio Crime Victims Compensation Program (since 2000)

Procedure

- ✘ Attorney General investigates claim.
- ✘ Attorney General issues finding of fact and decision within 120 days, will reconsider its decision if victim objects, and issues final decision within 60 days of receiving a request for reconsideration.
- ✘ Panel of Commissioners hears appeal and issues final decision within 150 days of receiving notice of appeal.
- ✘ Court of Claims Judge hears second appeal and issues final decision.

Benefits

- ✘ Reimbursement for cost of crime scene cleanup (\$750 per claim).
- ✘ Reimbursement for property destroyed by evidence collection (\$750 per claim).

- 
- ✘ Reimbursement for mental health counseling needed by an immediate family member of a victim of homicide, sexual assault, domestic violence, or a severe and permanent incapacitating injury resulting in paraplegia or similar life-altering condition (\$2,500 per family member).
 - ✘ Reimbursement for the cost of sexual assault examinations conducted pursuant to ORC 2907.28.

Eligibility For Participation (Expansions)

- ✘ Victims who have engaged in **non-violent** felonious **behavior**, except drug trafficking, within 10 years prior to being victimized, or while claim is pending, will be eligible to participate.

Eligibility for Participation (Restrictions)

- ✘ A victim is ineligible for participation if convicted of a misdemeanor charge of domestic violence or child endangering within 10 years prior to being victimized, or while claim is pending.

Codification of Existing Case Law

- ✘ By statute, a victim who engaged in felony drug abuse at the time of being victimized will be denied compensation.
- ✘ By statute, a passenger (age 16 or older) in a vehicle driven by a driver under the influence of alcohol or other drugs is ineligible to participate (except when 16- or 17-year-old is with parent, guardian, or care provider).

Attorney Fees

- ✘ Program will reimburse attorneys similar to current practice, but maximum of \$750 on claim of no appeal; \$1,020 if appeal to the panel of commissioners, and \$1,320 if appeal to the Judge of the Court of Claims. (Plus \$30 per hour travel expenses for appeals if attorney is outside central Ohio).

Direct Pay to Providers of Medical, Funeral, and Other Services

- ✘ The program will directly pay providers of medical, funeral, and other services any outstanding amounts covered by the award. Victims will receive reimbursement for bills paid out of their own pockets, and for other eligible expenses.

Medical Cost Containment

- ✘ Establishes legal authority for the attorney general to adjust medical bills (and bills for psychological services) for cost containment purposes, in accordance with guidelines developed by the Bureau of Workers' Compensation. Bills will be evaluated to determine their reasonableness, and only reasonable charges will be reimbursed.



Attorney General's Subrogation Rights

- ✂ Specifically establishes that the Attorney General is the legal representative of the reparations fund; that a copy of the indictment and certified judgment of conviction are admissible as evidence to prove an offender's liability for payment; establishes that the reparations fund is an eligible recipient for payment of restitution; provides that the Attorney General has six years from the date of the last payment of reparations to exercise its subrogation rights by filing an action in the Franklin County Common Pleas Court; requires a claimant to notify the Attorney General when filing a civil action against an offender or other responsible third party to recover damages related to the crime; declares that any release from liability negotiated without notifying the Attorney General shall not release a party from liability to the reparations fund; declares that an offender is jointly and severally liable to pay to the reparations fund the full amount of the reparations award granted to the victim; and provides that the costs and attorney fees of the Attorney General in enforcing its subrogation rights are fully recoverable from the liable offender or third party.

E. OUTLINE OF CRIMINAL JUSTICE SYSTEM

Complaint Made

Reports to law enforcement of sexual abuse/assault originate from many sources, including a child, a caregiver or a representative from Children Services. Once a report of sexual abuse/assault has been made, a responding officer will obtain preliminary information about the sexual assault/abuse allegation.

Investigation*

After preliminary information has been obtained, the case will be assigned to a detective. The detective will obtain detailed information regarding the abuse/assault allegation. Often this is facilitated by scheduling an appointment for the family to be seen at a Child Advocacy Center. Child Advocacy Centers offer a child-friendly approach to the evaluation of sexual abuse concerns. During this appointment the family will meet with a multidisciplinary team consisting of the Child Protective Services (CPS) worker, the detective, a forensic child sexual abuse/assault interviewer and a physician/nurse practitioner. The interviewer, preferably one who is trained in the forensic child sexual abuse interview, will interview the child separated from the caregiver. In an effort to avoid multiple interviews of the child, the other members of the multidisciplinary team will observe the interview via closed circuit video or through one-way glass. If the above facilities and expertise are not available in the local community, referral and transfer to an accredited Child Advocacy Center are strongly recommended. The National Children's Alliance has accredited the following Child Advocacy Centers in the state of Ohio:





Summit County Children’s Advocacy Center – Akron
Athens County Child Advocacy Center – Athens
Children’s Network of Stark County – Canton
Child Protection Center of Ross County – Chillicothe
Mayerson Center for Safe and Healthy Children – Cincinnati
Center for Child and Family Advocacy – Columbus
CARE House – Dayton
Hancock County Child Advocacy Center- Findlay
Child Advocacy Center of Fairfield County- Lancaster
A Kids Place- Newark
The Children’s Advocacy Center of Portage County- Ravenna
Clark County Child Advocacy Center – Springfield
Family and Child Abuse Prevention Center – Toledo
A Caring Place Child Advocacy Center – Wintersville
Kidz First Children’s Advocacy Center/The Nord Center – Lorain
Tri-County Child Advocacy Center – Youngstown
Wayne County Children’s Advocacy Center – Wooster

Case Presented to the Prosecutor

Police present all available evidence to the Prosecutor. The Prosecutor decides whether or not to accept the case. If accepted, an affidavit is filed in Municipal Court.

Many counties offer a victim witness advocate to act as a support person for the victim. The advocate will accompany the victim to court proceedings, act as a liaison between the victim and the Prosecutor and provide information to the victims about the court system. The advocate will notify victims and families of grand jury results, trial dates, continuances, bond hearings, sentencing dates and any other hearings.

Arraignment (Initial appearance before Municipal Judge)

Once the affidavit is filed and the defendant is arrested, the defendant appears before the Municipal Court Judge. The appearance is for the purpose of reviewing the amount set for bail, furnishing the defendant with a copy of the complaint, confirming legal counsel, and setting a date for preliminary hearing.

Preliminary Hearing

The preliminary hearing is held in the Municipal Court. The defendant, his/her attorney, the arresting officer, the County Prosecutor and the witnesses are present at this hearing. The burden is on the Prosecutor to prove that there is probable cause to believe a crime has been committed and that this defendant probably committed it. If there is sufficient evidence, the case is then bound over to the Grand Jury. Sexual assault/abuse victims bypass the preliminary hearing.



Grand Jury Hearing*

The Prosecutor presents the police information to the Grand Jury, consisting of nine to twelve jurors, who decide whether or not criminal charges should be filed. The Grand Jury is not open to the public and the information is kept confidential. The Prosecutor may ask some questions for clarification. There is no cross examination. After all the witnesses are heard by the Grand Jury, a vote is taken to determine if the defendant is to be indicted. If the defendant is indicted, the case continues through the legal process. If the defendant is not indicted by the Grand Jury, the charges are dropped and there are no grounds for appeal. However, a case can be re presented to the Grand Jury in the future, if additional evidence is discovered.

Arraignment (In Common Pleas Court: On the Indictment)

A court hearing is held where the defendant is told about the charges pending against him/her, and the right to a lawyer and trial. The defendant enters a plea on the Grand Jury indictment, his/her bond is re examined and pre trial conference is scheduled.

Pre Trial Motions

Motions are heard at the request of an attorney (Prosecutor or Defense) regarding issues that do not reflect the merits of the case. For example, motions for discovery, motions for continuance, motions for psychiatric evaluation, motions to suppress, etc.

Pre Trial Conference*

This is a conference between the victim/witnesses and the Prosecutor to discuss the facts and status of the case.

Trial*

In a trial, the Prosecutor presents the case for the State, attempting to prove beyond a reasonable doubt that the defendant did commit the crime as charged. The defendant may present his/her side through the use of an attorney. It is the defendant's choice whether a judge or a twelve-person jury will decide the verdict. The trial "time table" is usually as follows: the case must come to trial within 90 days if the defendant is kept in custody and within 120 days if he is out on bond. (Don't know if this still holds true?) This may be extended in either case if there are continuances approved by the judge.

Sentencing

After a verdict or plea of guilty, the judge sets a date for sentencing. During this time period the Adult Probation Officer will evaluate the defendant's potential for rehabilitation and prepare a sentence recommendation. The judge then considers that recommendation and other evidence. The victim has the right to make a written or verbal victim impact statement at the sentencing hearing. The sentence must be within the limits set by the legislature for the particular crime.





Appeal

If the defendant is found guilty, the defendant and his/her attorney will likely appeal the verdict and/or the sentence of the court. If a defendant accepts a plea bargain, there can be no appeal.

** Indicates points at which the child victim may be required to relate details of the incident.*

Information originally taken from "Guidelines for Treatment of Sexual Assault Victims." Developed by the Montgomery County Prosecutor's Office and the Miami Valley Regional Crime Lab in conjunction with the Greater Dayton Hospital Council, The Montgomery County Medical Society, and the Dayton District Academy of Osteopathic Medicine.

F. Selected Reading: Child Sexual Abuse

A careful review of the medical literature identifies a number of published reports that agree on the idea that the majority of children who have been sexually abused have normal genital examinations. In many cases, the history the child provides is most often the single most diagnostic tool in establishing a correct diagnosis. The following articles explain these concepts.

1. Adams JA, Harper K, Knudson S, Revilla J. Examination findings in legally confirmed child sexual abuse: It's normal to be normal. *Pediatrics* 1994; 94: 310-317.

This is a review of cases of sexual abuse with perpetrator convictions. Adams and colleagues report on 213 female sexual abuse victims between the ages of 8 months and 17 years 11 months, all of whose perpetrators were convicted of sexual abuse. Seventy-seven percent of the children had either a completely normal or non-specific genital exam, and only 23% had either suspicious or abnormal physical findings. In an analysis of the 29 cases in which the perpetrator confessed, there were 6 cases in which there was an admission of digital-vaginal penetration but none of these children had an abnormal exam. In contrast, abnormal findings, according to authors' strict criteria, were found in 4 of the 5 cases in which the perpetrator confessed to penile-vaginal penetration. The proportion of children with abnormal genital findings did not differ between those whose perpetrator had confessed, had pled guilty, or had been convicted at trial. The authors conclude that abnormal genital findings are not common among girls who have been sexually abused.



2. Adams JA, Knudson S. Genital findings in adolescent girls referred for suspected sexual abuse. *Archives of Pediatric and Adolescent Medicine* 1996; 150: 850-857.

In this later study of 204 adolescent girls examined because of probable or definite sexual abuse, Adams found that normal or nonspecific findings were common, unless the abuse was recent. The authors further analyzed two subgroups. The first subgroup was made up of 25 girls who had never been sexually active, and in whose case the perpetrator confessed to molestation but not to intercourse, or where the accused was convicted by jury trial. Only 40% of these girls had abnormal genital findings. The second subgroup was made up of 37 girls who had been molested and who had experienced vaginal intercourse, either because they gave history of having had consensual sexual activity, or because they had a sexually transmitted disease, or because they were pregnant, or because their perpetrator admitted to having had sexual intercourse with them. Of these 37 girls, all of whom had been sexually penetrated (either voluntarily or abusively), only 49% had positive genital findings; the majority had normal or inconclusive exam findings. The authors conclude that "It is important for medical professionals who examine adolescent girls for possible abuse to educate the patient, the parents, and the law enforcement agencies that investigate these cases that physicians may not be able to tell, with certainty, whether a girl has had sexual intercourse, and that normal results of genital examination do not invalidate the patient's allegation of abuse." The authors urge us to dispel "the myth of the hymen."

3. Bays J, Chadwick D. Medical diagnosis of the sexually abused child. *Child Abuse and Neglect* 1993; 17: 91-110.

In a detailed literature review, Bays and Chadwick analyzed 21 different published studies. They point out that in these earlier studies, between 26% and 73% of girls, and between 17% and 82% of boys, who had been sexually abused had a normal physical exam. The exam was often normal even when the offender had confessed to penetration. They conclude that not only is a normal exam common in child sexual abuse victims even when the offender has confessed, but that healing of injuries due to abuse may be rapid and complete. Bays and Chadwick explain that a normal exam after sexual abuse can be due to a variety of causes: a long delay before seeking medical attention; forms of sexual contact that do not leave physical findings; the natural elasticity of the hymen and vaginal tissues; and different definitions of what constitutes an abnormal exam.





4. DeJong AR, Rose M. Legal proof of child sexual abuse in the absence of physical evidence. *Pediatrics* 1991; 88: 506-511.

DeJong reviewed 115 child sexual abuse court cases from a 12 month period to determine the frequency and significance of physical evidence. A charge of vaginal rape was made in 88 cases, and of oral and/or anal sodomy in 67 cases. Eighty-seven cases (76%) resulted in felony convictions, even though physical evidence was present in only 23%. Felony convictions were actually obtained more often (79% of 85 cases) when there was no physical evidence than in cases where physical evidence was present (67% of 30 cases). Eight of the 10 cases without physical evidence that failed to result in conviction involved children younger than 7 years old, and the authors note that even with physical evidence available, cases involving the youngest victims had a significantly lower conviction rate (52%). They conclude that "Physical evidence was neither predictive nor essential for conviction. Successful prosecution, particularly in cases involving the youngest victims, depended on the quality of the verbal evidence and the effectiveness of the victim's testimony.

5 Heger A, Ticson L, Velasquez O, Bernier R. Children referred for possible sexual abuse: medical findings in 2384 children. *Child Abuse and Neglect* 2002; 26: 645-659.

The authors report medical findings in 2384 children referred for evaluation of possible sexual abuse over a 5-year period (1985 to 1990). Children were referred to a child advocacy center because of a disclosure of sexual abuse, behavioral changes, exposure to an abusive environment, or because of a possible medical condition. Overall, only 88 children (4%) were found to have medical findings diagnostic of sexual abuse. Of the children reporting abuse, 96% were normal. Of children referred because of behavioral changes or exposure to an abusive environment, virtually all (99.8%) were normal. Of 182 children referred because of a possible medical condition, only 15 (8%) had a sexually transmitted disease or acute or healed genital injuries when examined at the advocacy center. Interviews of the children indicated that more than two-thirds (68% of girls and 70% of boys) had experienced severe abuse, defined as penetration of the vagina or anus. A history of vaginal or anal penetration was associated with abnormal findings in 6% of girls and 1% of boys. The authors conclude that medical, social, and legal professionals have relied too heavily on the medical examination in diagnosing child sexual abuse. Only 4% of the children referred for expert medical evaluation of sexual abuse have an abnormal exam at the time of their evaluation. Even for children with a history of vaginal or anal penetration the rate is only 6%. The child's history of what happened is, therefore, the single most important element in arriving at a medical diagnosis of child sexual abuse.



6. Kellogg ND, Menard SW, Santos A. Genital anatomy in pregnant adolescents: "normal does not mean "nothing happened." *Pediatrics* 2004; 113: e67-69

This retrospective case review of 36 pregnant adolescent girls, all of whom who were seen for an expert evaluation of sexual abuse, found that only 2 (6%) had definitive findings of vaginal penetration. The authors conclude that vaginal penetration usually does not result in observable evidence of healed injury to perihymenal tissues in this population.

7. Adams JA, Botash AS, Kellogg N. Differences in hymenal morphology between adolescent girls with and without a history of consensual sexual intercourse. *Archives of Pediatric and Adolescent Medicine*. 2004; 158: 280-285

The authors compared the examination of the hymen in 27 adolescent girls who have had consensual sexual intercourse involving penile-vaginal penetration and 58 adolescent girls who denied ever having had intercourse. The subjects were 13 to 19 years old, and were recruited from an urban adolescent medical practice. Each young woman completed a detailed questionnaire and underwent a physical exam that included magnified photographs of the hymen. Posterior hymenal notches or clefts were found in 48% of the girls admitting past consensual intercourse, and in 3% of those who denied intercourse. The width of the posterior hymen was not significantly different between the two groups (2.5 mm versus 3.0 mm, respectively). Two subjects who denied intercourse but described a painful first experience with tampon insertion had posterior hymenal clefts. The authors conclude that in their sample of adolescent girls, deep notches or complete clefts in the hymen were rare in those who denied intercourse, and that of those who admitted to having had intercourse most (52%) still had nondisrupted, intact hymens.

8. Adams, JA. Medical Evaluation of Suspected Child Abuse. *Journal of Pediatric and Adolescent Medicine* 2004; 17:191-197.

In this more recent "In Training" article, Adams discusses how to correctly perform the medical examination. She notes that a colposcope, while very helpful, is not required for adequate evaluation. She lists medical conditions and accidental injuries that can be mistaken for sexual abuse. She indicates that although there is now general agreement among experts as to normal and abnormal anogenital findings, there remains a degree of controversy about how to correctly interpret the size of the hymenal opening; the width of the posterior hymenal rim; hymenal notches/clefts/concavities/ indentations; and anal dilatation. She summarizes her classification system for assessing physical and laboratory (revised as of February 11, 2004 after discussion with 18 experts in the field of child sexual abuse) but notes that this is still an ongoing work that will likely be further revised. Adams states that:





“Recent studies have shown that 85% to 95% of children who have given clear histories of being sexually abused will have normal or non-specific medical findings on examination, either because the injuries they sustained have healed by the time they are examined, or because the acts of abuse did not cause any physical injury to the child. Many children do not have a clear concept of what ‘penetration’ means, and are most likely describing rubbing or pushing against their external genitalia or, for girls, penetration beyond the labia majora but not the hymen. Even penile penetration of the anus, or the hymen in girls who have started puberty, may not cause any injury, because of the ability of the tissues to stretch, or may cause minor injuries that heal completely.”

9. Kellogg N and the Committee on Child Abuse and Neglect (American Academy of Pediatrics). The Evaluation of Sexual Abuse in Children. *Pediatrics* 2005; 116:506-512.

As of this writing, this article is the official statement of the American Academy of Pediatrics on evaluating children for the purpose of diagnosing sexual abuse. The following remarks appear on page 509:

“The diagnosis of child sexual abuse often can be made on the basis of a child’s history. Sexual abuse is rarely diagnosed on the basis of only physical examination or laboratory findings. Physical findings are often absent even when the perpetrator admits to penetration of the child’s genitalia. (references 31-33) Many types of abuse leave no physical evidence, and mucosal injuries often heal rapidly and completely (references 34-38). In a recent study of pregnant adolescents, only 2 of 36 had evidence of penetration. (reference 39)”

The AAP Committee statement further comments that children may present with clear evidence of anogenital trauma without an adequate history, and that abused children may deny that the abuse occurred. Most of the references cited above are also included in this annotated bibliography.

10. Heppenstall-Heger A, McConnell G, Ticson L, Guerra L, Lister J, Zaragosa T. Healing Patterns in Anogenital Injuries: A Longitudinal Study of Injuries Associated with Sexual Abuse, Accidental Injuries, or Genital Surgery in the Preadolescent Child. *Pediatrics* 2003; 112:829-837.

Over a 10-year period, 13 boys and 81 girls were referred with injuries caused by sexual abuse or accidental anogenital trauma. Their injuries were followed to healing, documented by means of serial 35 mm colposcopic photographs. Complete transection of the hymen was present in 17 girls, and all of the complete transections persisted in the absence of surgical repair. Except for accidental penetrating injuries, all of the complete hymenal transections were associated with penile-vaginal penetration, and none occurred after digital-vaginal penetration. Anogenital injuries other than complete transection of the hymen all healed rapidly and generally without



any residua. The authors point out that most exams for sexual abuse are normal or nonspecific because of the nature of the abuse. Delayed disclosure allows time for most injuries to have healed.

11. Kellogg ND, Parna JM, Menard S. Children With Anogenital Symptoms and Signs Referred for Sexual Abuse Evaluations. *Archives of Pediatrics and Adolescent Medicine* 1998; 152: 634-641.

A retrospective study identified 157 children less than 18 years old who had been referred to a sexual abuse center between 1989 and 1996 because of anogenital physical symptoms or signs. Children who had disclosed sexual abuse or who had exhibited behaviors thought to be suggestive of sexual abuse were excluded. Medical records and colposcopic photographs were reviewed and findings classified according to the Adams' criteria (circa 1992). Eight-four per cent of the children had no findings suggestive, probable or indicative of sexual abuse. Only 19 patients (12%) had findings consistent with sexual abuse; 4 (3%) "definitive" for abuse; and 2 (1%) consistent with "possible" abuse. Eighty-five patients (54%) had exam findings that reflected the referring symptom or sign, but in 70 these findings were either nonspecific for abuse or suggested an alternative diagnosis. All 26 patients referred because of concern that their vaginal or anal opening was "enlarged" or "scarred" were found to be normal. Anogenital bleeding or bruising was the single most common referring concern (54 patients), but 78% of these children had no evidence of abuse. Even among 32 patients who had evidence of bleeding or bruising at consultation, 85% had alternative explanatory diagnoses, and only 15% had evidence of abuse. Similarly, most patients with a presenting complaint of vaginal discharge did not have findings indicative of sexual abuse. However, of the 12 children referred because of an anogenital lesion, 7 did have exam findings suggestive or probable for abuse, and an anogenital lesion was the only reason for referral that was statistically associated with sexual abuse. It is important to note that the population of children studied differed from those generally seen in sexual abuse clinics, insofar as none had made a disclosure. The sample (157) represented only 4% of more than 3000 children referred to the center during the 7-year study period. Possible explanations for these findings include interval healing, differing interpretations of what is normal and abnormal, and failure to appreciate differential diagnostic possibilities. Additionally, the understanding of anogenital findings in children has been considerably informed by research since the early 1980s, although this information might not be generally known to referring physicians. The authors conclude, "(a) child's disclosure is key to the detection and diagnosis of sexual abuse. Many if not most examinations of sexually abused children will elicit normal findings."



G. Special Instructions- Please note prior to specimen collection and completion of an evidence collection kit

Air Drying	Dry at room temperature. Do not use any heat. Do not “blow” on any part of the kit to hasten drying. Keep away from direct sunlight.
Sealing envelopes	Each envelope has self-adhesive backing. Simply pull backing strip off to seal envelope. Do NOT lick the envelope flaps. Apply patient identification stickers as a seal over the back of each envelope after closing with self-adhesive glue and examiner initial the seal.
Slightly moisten	Use just enough sterile saline or distilled water to facilitate collection of a dried external stain or prevent discomfort during the vaginal and anal examination. Avoid excessively wetting swabs as this will decrease absorbing power and dilute the sample.
Swabbing	<p>When swabbing a stain or body cavity, allow the swab to soak up as much foreign material as possible (“roll” swab over area of stain) in order to maximize the recovery of evidence. When transferring material from swab to glass slide, “roll” all sides of the swab over the central portion of the slide.</p> <p>NOTE: Depending upon the type of sexual abuse, semen may be present in the mouth, vagina and rectum. However, embarrassment, trauma or a lack of understanding of the nature of the abuse may cause a victim to be vague or mistaken about the type of sexual contact that actually occurred. For these reasons, and because there also can be leakage of semen from the vagina or penis onto the anus or per-anal area, even without anal penetration, it is recommended that the patient be encouraged to allow examination of all three orifices and specimens collected from them.</p> <p>In cases where a patient insists that contact or penetration involved only one or two orifices (or in some circumstances, no orifices at all), the victim should still be encouraged to allow a complete examination. However, ultimately the patient may decline these additional tests.</p> <p>The patient should be cautioned not to use bathroom facilities prior to the collections of these specimens. However, if the use of such facilities is necessary, the patient should be cautioned that semen or other evidence may be present in the pubic, genital and rectal areas and to take special care not to wash or wipe away those secretions until after the evidence has been collected.</p>



H. Detailed instructions for Ohio Department of Health Sexual Assault/ Abuse Evidence Collection Kit

- ✘ Please proceed in numerical order and complete all steps.
- ✘ Attempt to complete all steps with patient consent.
- ✘ If the patient refuses a step, write “patient declined” on the collection envelope.
- ✘ These items may be used in court to prosecute a sexual offense.
- ✘ Follow instructions and write legibly.
- ✘ Remove strip to seal envelopes (do not lick).
- ✘ The **Assault / Abuse History form** is required by ODH protocol.
- ✘ The **Medical Information** and **Patient Discharge Information forms** are for your convenience and may be replaced by institutional forms.

Step 1 Authorization

- ✘ Allow the patient or parent/guardian to read **Information You Should Know as a Survivor of Sexual Assault/Abuse**.
- ✘ Explain to the patient what the sexual assault exam will entail using age-appropriate dialogue.
- ✘ Complete and have the patient or guardian sign the **Consent for Exam and Release of Evidence form**.

The release is not necessary for child abuse cases.

Step 2 Assault/Abuse History Form

The ODH Protocol requires that a readable copy of this information be placed in the kit. please write legibly

- ✘ This form is provided in the kit. An institutional form may be substituted provided that it contains ALL of the same information and is legible. .
- ✘ Complete the first two pages of the **Assault/Abuse History form**. In the **Patient Narrative** section, record the patient’s description of the assault/abuse.
- ✘ Pay particular attention to information that will assist you in locating injuries and body fluid evidence such as semen, saliva and vaginal secretions.
- ✘ **Do not** record your subjective observations and opinions.
- ✘ Use quotation marks when recording the patient’s own words.

At this time the law enforcement and/or social services representative leaves the room and the physical examination begins. A rape crisis worker, family member or other support person may remain in the room during the examination if the patient so desires.



*Note: The **Medical History Form** is provided for convenience.
Institutional forms may be used in its place.*

Step 3 Urine and Blood Toxicology Screening (IF INDICATED ONLY)

- ✘ Consider collecting urine and blood samples for toxicological screening for drug facilitated sexual assault **IF** unexplained impairment or gaps in patient recall exist.
- ✘ Refer to ODH Sexual Assault Protocol Section VII

Step 4 Clothing Collection

1. Collect all clothing worn during or immediately after the assault/abuse, even if no damage or staining is apparent.
2. As the patient disrobes, place one garment item in each bag. **Do not shake out the garments, as evidence such as hairs and fibers may be lost.** Two large bags are provided for outer garments. Two small bags are provided for intimate clothing articles. Label and seal the bags. Do **not** use staples to close the bags. Place the bag containing the underwear in the kit. Keep the other clothing bags with the kit.
 - ✘ If any of the items are wet or damp, inform the law enforcement officer to ensure that the clothing can be properly air dried.
 - ✘ If the patient is not wearing the clothing worn at the time of the assault/abuse, collect only the items that are in direct contact with the genital area (underpants/pantyhose). **Inform the law enforcement officer so that the clothing worn at the time of the assault/abuse can be collected.**
 - ✘ **Do not cut through any existing holes, rips or stains in the patient's clothing. If a panty liner or pad is in place, leave it attached to the underwear. Tampons can be collected as debris, allowing it to air dry as much as possible, place in a sterile piece of gauze and place in an envelope.**
 - ✘ **NOTE:** An additional "Step" for debris collection is no longer included it is in Step 5. *** see note above — as tampons can be collected.

Step 5 Dried Stains

- ✘ Ejaculation onto the patient's body, leakage from the patient's body and the suspect's use of his/her mouth on the patient's body may have occurred.
- ✘ Use a Wood's lamp or other ultraviolet light to examine the patient's body for dried stains.
- ✘ Saliva stains will not be visible under alternate light sources. Listen carefully to the patient's account of the incident to determine where saliva stains may be located and swab accordingly.

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- ✘ Collect any possible dried stains by slightly moistening one or two swabs with sterile water or saline and swabbing the stained area. Collect each stain in a separate envelope.
 - ✘ If oral-genital or oral-anal contact may have occurred, or if the perpetrator may have used saliva as a lubricant, swab the external genital and/or anal area in addition to collecting other anal and genital swabs (as completed in Steps 12 and 14).

- ✘ *Ask if the assailant used his/her mouth anywhere on the patient.*
- ✘ *Swab these areas as above.*
- ✘ *Any bite marks should be swabbed and photographed close-up.*

Step 6 Head Hair Standards

Using clean scissors, CUT a total of 10-15 hairs from various areas of the head. Cut as close to the scalp as safely possible. Place the head hairs in the envelope provided. Label and seal the envelope.

Step 7 Oral Swabs and Smear

Collect four oral swabs regardless of the assault/abuse history. If necessary, slightly moisten the swabs with sterile water or saline. Rub two swabs back and forth between the left cheek and lower gum and as far back on the tongue as possible without triggering the gag reflex. Using two more swabs, repeat for the right side. Use any one of the swabs to make the smear. Make the smear by rolling the swab forward and back once in the center of the pre-labeled slide. **Do not discard the swab.** Do not use any fixative on the slide. Air dry the smear and place it in the slide mailer. Place the slide mailer in the envelope. Air dry all four oral swabs in the boxes. Close the boxes and place in the envelope. Label and seal the envelope.

Hospital examination of wet mounts or smears is not necessary.

Step 8 Oral Culture for Gonorrhea (Children Only)

If indicated, culture the pharynx for gonorrhea. Non-culture tests, such as ELISA and DNA probes, may not be acceptable as evidence of infection in a court of law. Do **NOT** use swabs with WOODEN applicators. **Send culture to the hospital lab. DO NOT PLACE CULTURES IN THE EVIDENCE BOX.**

Step 9 Fingernail Scrapings/Cuttings

- ✘ Scrape or swab under the patient's nails using the stick or swabs provided in the nail scrapings envelope.
- ✘ Moisten the swabs to collect dry material. Collect the scrapings into the envelope.
- ✘ If a fingernail is broken, or if blood or other foreign material is noted on the nails, use scissors to clip off the broken end and place into the envelope. Label and seal the envelope.



Step 10 Pubic Hair Combing and/or Collection of Stray Hairs in Genital Area

- ✘ With the patient standing, hold the envelope under the pubic area and use the comb provided to comb through the pubic hairs several times. Comb directly into the envelope. Place the comb into the envelope. Label and seal the envelope.
- ✘ If the patient does not have pubic hairs, collect any stray hairs in the genital area.
- ✘ If the patient does not have pubic hairs, please note this on the envelope.

Collect any stray hairs from the genital area

Step 11 Cut Pubic Hair Standards

- ✘ After completing Step 10 above, using clean scissors, CUT a total of 10-15 hairs from various areas of the pubic region.
- ✘ Cut as close to the skin as safely possible.
- ✘ Place the pubic hairs in the envelope provided. Label and seal the envelope.

Step 12 Rectal/ Perianal Swabs and Smear

Collect four rectal swabs/ peri-anal **regardless of assault/abuse history**. If necessary, the swabs may be slightly moistened with sterile water or saline.

- ✘ If there is no evidence or report of anal penetration, it is acceptable to swab the perianal area rather than inserting the swabs into the rectum.
- ✘ Use any one of the swabs to make the smear by rolling the swab forward and back once in the center of the pre-labeled slide. **Do not discard the swab.** Do not use any fixative on the slide. Air dry the smear and place it in the slide mailer. Place the slide mailer in the envelope.
- ✘ Air dry all four rectal/perianal swabs in the boxes. Close the boxes and place in the envelope. Label and seal the envelope.

Hospital examination of wet mounts or smears is not necessary.

Step 13 Rectal/Perianal Cultures (Children Only)
If indicated, culture the rectum for gonorrhea and chlamydia. Non-culture tests, such as ELISA and DNA probes, may not be acceptable as evidence of infection in a court of law. Do NOT use swabs with wooden applicators to collect chlamydia cultures. Send cultures to the hospital lab. **DO NOT PLACE CULTURES IN THE EVIDENCE BOX.**



Step 14 Vaginal (or Penile) Swabs and Smear

- ✘ If the patient is using a tampon, it should be collected and packaged separately into one of the **Step 5 (Dried Stains)** envelopes. Do not place other items in this envelope

For Pubertal Females:

- ✘ Collect four vaginal swabs **regardless of assault/abuse history**.
- ✘ Collect two swabs at a time, swabbing any pooled fluid and the cervical area.
- ✘ Using any one of the swabs, make the smear by rolling the swab forward and back once in the center of the pre-labeled slide. Do not discard the swab. Do not use any fixative on the slide. Air dry the smear and place it in the slide mailer. Place the slide mailer in the envelope.
- ✘ Air dry all four vaginal swabs in the boxes. Close the boxes and place in the envelope. Label and seal the envelope.
- ✘ If a tampon is present, air dry and place in the **Step 4** envelope. Label and seal the envelope.

For Males:

- ✘ Collect four penile swabs.
- ✘ Slightly moisten the swabs with sterile water or saline and swab the glans and shaft of the penis using two swabs at a time.
- ✘ Follow the instructions above for smears and packaging.

For Pre-Pubertal Females:

- ✘ Swab the external genitalia and labia minora with four slightly moistened swabs (with sterile saline or sterile water) and make a smear as indicated above.

NOTE: A speculum examination is almost NEVER indicated for a prepubertal patient, and may add to the child's trauma. A speculum examination that is indicated for extensive injury should ONLY be performed at a pediatric institution under general anesthesia.

Hospital examination of wet mounts or smears is not necessary.



Step 15 Vaginal (or Penile) Cultures (Children Only)

If indicated, culture the vagina or urethra for gonorrhea and chlamydia. Non-culture tests, such as **ELISA** and **DNA** probes, may not be acceptable as evidence of infection in a court of law. Do **NOT** use swabs with wooden applicators to collect chlamydia cultures. **Send cultures to the hospital lab. DO NOT PLACE CULTURES IN THE EVIDENCE BOX.**

NOTE: If used during the exam, collection of the speculum is NOT required.

Step 16 Blood Standard

Collect the patient's blood standard. Wearing gloves, label the filter paper with the patient's name and date. If blood is being drawn for other purposes, place two or three drops of blood from the blood collection tube onto the filter. If no blood is being drawn, clean the patient's finger with an alcohol swab, use the fingerstick device provided and place two or three drops of blood on the filter paper. Allow the filter paper to air dry before placing it in the envelope. Label and seal the envelope.

For Children: Omit blood standard if it cannot be collected without further trauma.

Step 17 Complete Documentation of All Injuries

Complete the third page of the **Assault/Abuse History** form. Take photos of the patient to assist recall and to document any physical injuries. Do not place photos in kit. Keep these photos with your records. Using the anatomical outlines provided, indicate all signs of physical trauma — e.g. bruises, scratches, marks, discolorations (size and color) or bite marks on any part of the patient's body.

*Note: The use of a **Wood's Lamp**, **Colposcope** or **Toluidine Blue Dye** to help visualize stains and injuries is recommended. Refer to the **ODH Sexual Assault Protocol manual** for more information. Application of toluidine blue dye assists in identifying microscopic injury, but requires special training for proper use.*

Step 18 Give the handouts titled: Document of Care, After Care Information and Resources, and Caring for Yourself: A Note to Survivors to the patient or guardian. Parents or guardians should be given Helping Your Child: A note to parents and caregivers.

*Discuss **STI** and **pregnancy prophylaxis** with the patient if applicable. Refer to the **ODH Sexual Assault Protocol manual** for more information.*



Step 19 Seal the Kit/ Final Instructions

1. Make sure that all of the information requested on the collection envelopes and forms has been completed. Make sure that all of the envelopes are sealed.
2. **Place the carbon copy of all three pages of the Assault/Abuse History form into the kit.** Place all collection envelopes and the underwear bag (whether these items have been collected or not) into the kit.

DO NOT place STI cultures or drug screen samples in kit. STI samples should be sent directly to the hospital lab. Drug screen samples should be sent to a qualified lab.

3. Using the seal provided, seal and initial the kit, and **fill out all of the information requested on the box lid. This information is required.**
4. Complete the top portion of the Chain of Custody forms (**found at the bottom of the Step 1 Consent form and on the lid of the kit box**). Hand the sealed kit and sealed paper bags to the law enforcement officer and have him/her complete the bottom portion of both Chain of Custody forms.
 - ✘ One copy of the Step 1/Step 19 Consent and chain of custody form stays at the hospital.
 - ✘ Once copy stays with law enforcement officer.
5. If the evidence is not immediately released to law enforcement, the kit should be stored refrigerated (if possible) in a secure area. Clothing should be stored at room temperature in a secure area.



1. Forms

Assault/Abuse History and Examination Form (6 pages)

Step 2 Assault / Abuse History and Examination Form

Patient Information		
Patient Name	Age DOB	Sex
Assault/Abuse History		
Date/Time of Assault/Abuse	Date/Time of Exam	
Assault/abuse was by (stranger, acquaintance, spouse, relative, date, etc.) Identity of alleged perpetrator (if known):	Number of Assailants	Sex and approximate age of each assailant (if known): 1. <input type="checkbox"/> M or <input type="checkbox"/> F Age: _____ 2. <input type="checkbox"/> M or <input type="checkbox"/> F Age: _____ 3. <input type="checkbox"/> M or <input type="checkbox"/> F Age: _____
Indicate which of the following occurred:		
Female genital (past labia majora) penetration by:		
Penis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Fingers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Other- describe: _____		
Vaginal penetration by:		
Penis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Fingers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Other- describe: _____		
Anal penetration by:		
Penis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Fingers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Other- describe: _____		
Oral contact by:		
Patient's mouth to assailant's genitals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Assailant's mouth to patient's genitals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Patient's mouth to assailant's anus <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Assailant's mouth to patient's anus <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Patient body area kissed, licked, bitten <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
Describe location: _____		



Ejaculation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Describe location: _____	
Lubrication (including saliva) used: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Describe: _____	
Other information: _____ _____ _____	
Since the assault /abuse, patient has:	
Douched <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Changed clothes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
Defecated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Bathed/showered <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
Urinated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Had food or had drink <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
Vomited <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Brushed teeth or used mouthwash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
At time of assault/abuse, was:	
Patient menstruating	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Suspect injured/bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Tampon present?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Where is tampon now? _____
Condom used?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Where is tampon now? _____
At time of exam was:	
Tampon present?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient menstruating?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Voluntary intercourse within past 72 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Time: _____	
_____ Nurse or physician completing form—print name Nurse or physician completing form—signature	
Hospital:	City:

This copy for hospital Place carbon copy in kit



Step 2 Assault / Abuse History and Examination Form

Narrative History (in patient's own words; use quotes)

Please write legibly

Large empty rectangular box for writing the narrative history.

This copy for hospital Place carbon copy in kit





Step 2 Assault / Abuse History and Examination From

Anatomical Diagrams to Record Location of Injuries

(document size, location and description of trauma (injuries))

Method of Examination (check all that apply)

Direct visualization Yes No Colposcopic exam Yes No

Woods lamp (or other UV lamp) Yes No Toluidine blue dye Yes No

**Speculum exam Yes No

Foley catheter technique Yes No

***NOT recommended in prepubertal patient unless concern for extensive injury, and then should ONLY be performed under general anesthesia at a pediatric hospital.*

Photodocumentation:

- Photographs 35 mm
- Digital images
- Digital video images

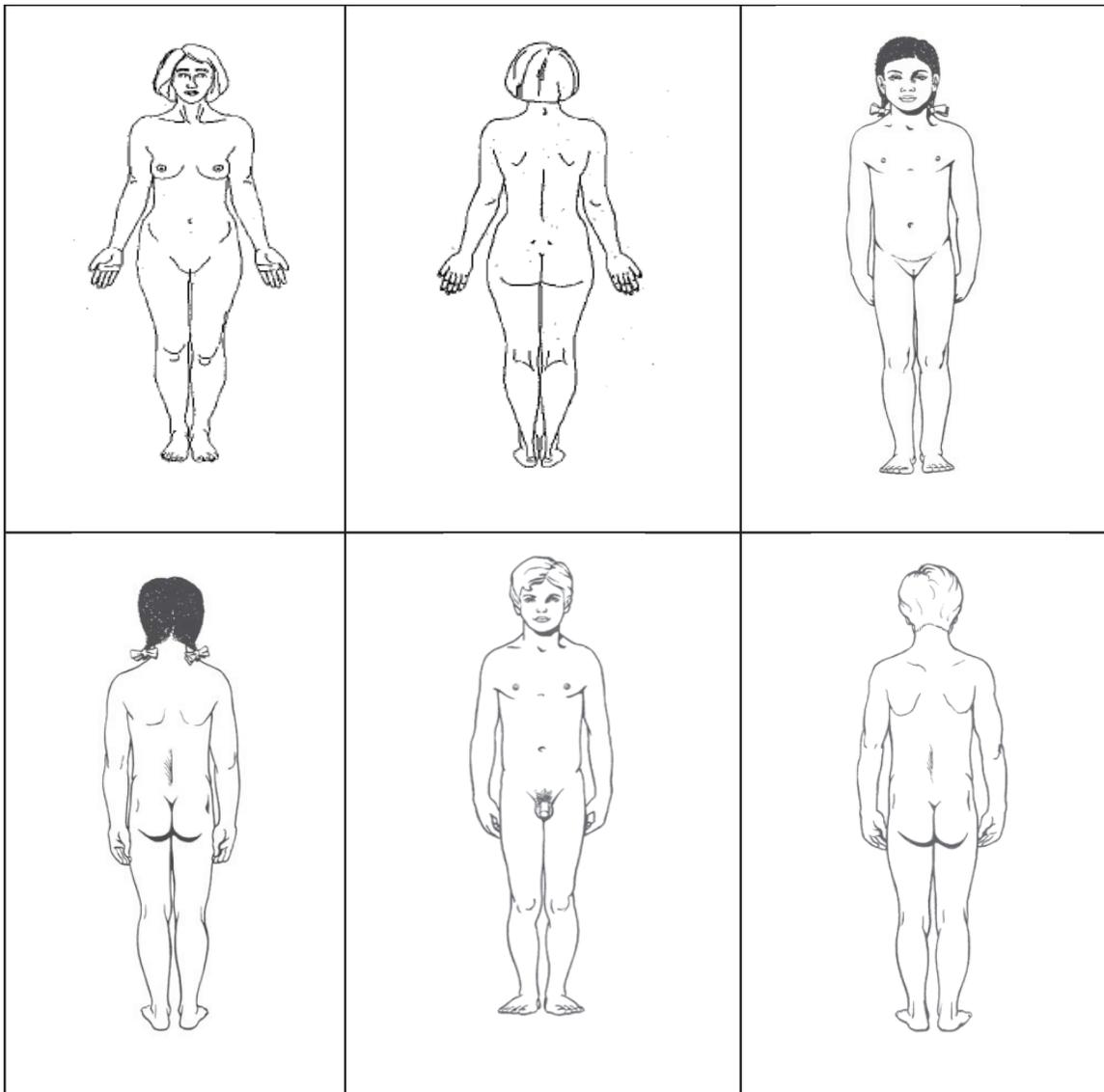
Number of images taken:

Taken by:





Step 2 Assault / Abuse History and Examination From



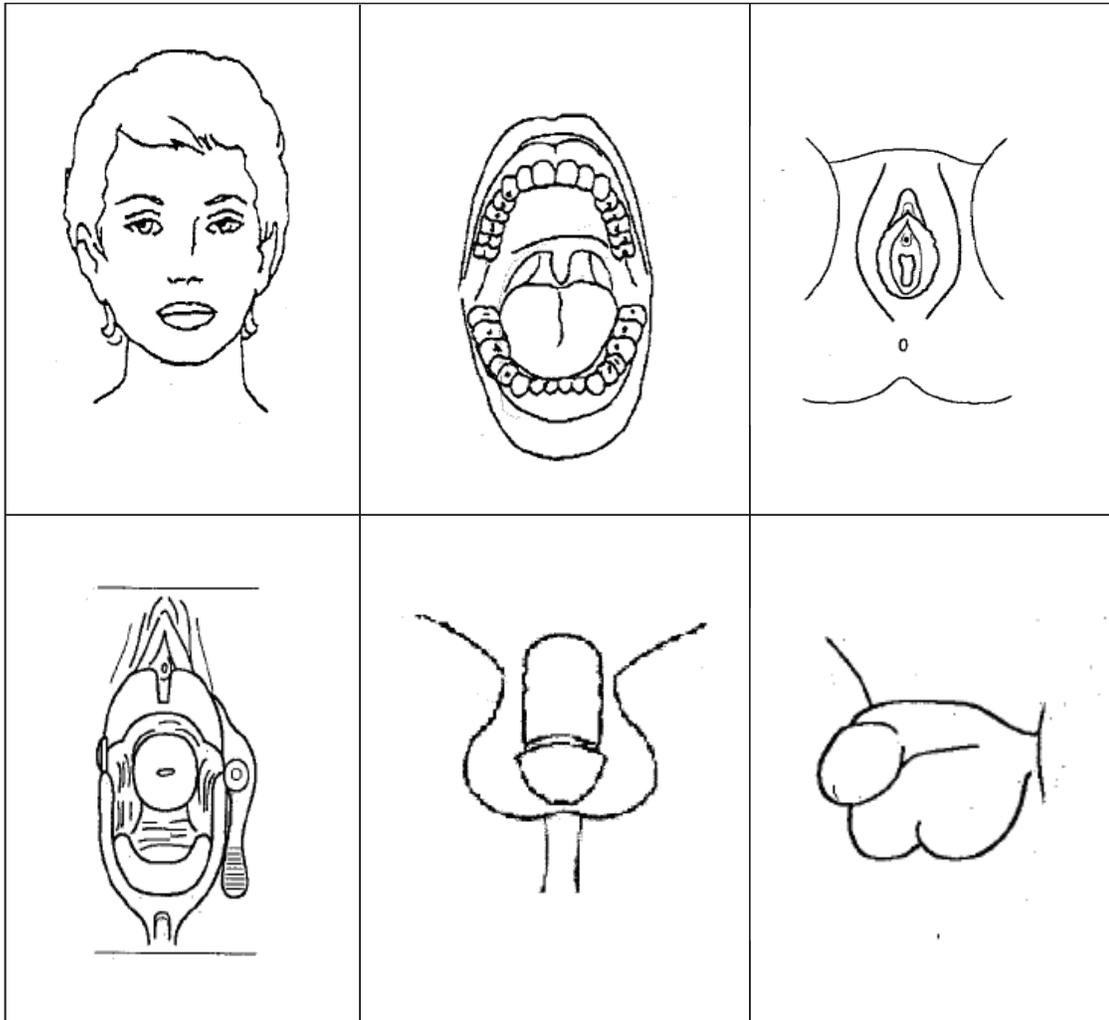
Number injuries on drawing and list sequentially. Indicate the location and type of injury: abrasions, bruises (detail shape, size and color), erythema, induration, lacerations, bites, burns and stains/foreign materials.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

This copy for hospital Place carbon copy in kit



Step 2 Assault / Abuse History and Examination From



Number injuries on drawing and list sequentially. Indicate the location and type of injury: abrasions, bruises (detail shape, size and color), erythema, induration, lacerations, bites, burns and stains/foreign materials.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

This copy for hospital Place carbon copy in kit





Optional Medical History and Examination Form

Optional Medical History and Examination Form for Sexual Assault/Abuse

(Institutional Forms May be Substituted)

Patient Information			
Patient Name	DOB	Sex	Race
SS#	Phone Number		
Address			
City	State	Zip	
Vital Signs (as warranted)			
Admission	P	R	BP
Discharge	P	R	BP
Medical History			
Allergies			
Last Tetanus			
Immunization Status			
Current Medications			
Acute Illnesses			
Past Surgeries			
Prior Hospitalization			
LMP	Gravida	Para	
Contraception Used?		Type	
Approximate Weight		Height	
Family Physician			
Gynecologist			



Optional Medical History and Examination Form for Sexual Assault/Abuse

Physical Examination
General Appearance (including condition of clothing)
Emotional Status (objective observation)
Pertinent General Physical findings (also mark pictures)
<p>Body Surface (locate and describe injury, draw findings on pictures)</p> <p>Mouth (palate, buccal mucosa, lips):</p> <p>Face</p> <p>Head/neck</p> <p>Back/buttocks</p> <p>Chest/breast</p> <p>Abdomen</p> <p>Upper extremities</p> <p>Lower extremities</p>
External genitalia (describe Tanner stage and general appearance)
Female
Perineum
Periurethral area
Urethra
Anus
Labia majora





Optional Medical History and Examination Form for Sexual Assault/Abuse

Labia minora	
Clitoris	
Vestibule	
Posterior fourchette	
Fossa navicularis	
Vaginal discharge noted?	Vaginal bleeding noted?
Hymen (document if any notch, transection, or petechiae/contusion is noted)	
Vaginal canal (if examined)	
Cervix (if examined)	
Male	
Glans penis	
Penis foreskin	
Penis shaft	
Scrotum and Testicles	
Discharge or bleeding from penis	
Anus	
Name and Title of Each Person Present During the Exam	

Nurse or physician completing form—print name	Nurse or physician completing form—signature

