**Tips and Resources for Sexual Abuse-Assault When Evaluating a Child**

**Modification and/or Additions When Evaluating a Child Presenting for Acute Sexual Assault or Abuse:**

* For guidance consider calling/referral to a specialist (refer to resources below).
* A parent can consent at times, but you must still have a child’s assent. For very young children this may simply be that you remain conscious of any opposition to proceeding, rather than asking. However, for older children, even if the caregiver provides formal consent, you must explain to the adolescent and ensure that they agree to proceed (ie. assent).
* Building rapport for a brief time with the child by directly conversing about an unrelated topic as well as explaining the evaluation in a developmentally appropriate way can help significantly in ensuring the child tolerates the evaluation without distress.
* Remember the initial history from a child’s disclosure may not be the entirety of what occurred, so it is important to not only take history from the caregiver who is present, but to also collect a direct medical history with the child. Ideally, this should occur once by the individual with the most training in doing so, and **should not** be done by multiple individuals.
	+ History collection should follow a sequence of very general and open ended questions that allow the child to provide a narrative of what occurred (ie. Do you know why you are here?; Why do you need to be at the hospital today?; Does anything hurt?; etc.).
	+ However, any disclosure pertinent to medical diagnosis, treatment, or evidence collections should clarified (ie. You said he “touched” your “private”, what “touched” your “private”?; Where do you mean when you say “private”?; When that happened did anything hurt?, If yes, where?; When that happened did you see any blood?If yes, from where?; etc.).
* If disease testing with swabs, or any swabs for evidence collection will be needed, it is important to collect these during the examination and not as a separate collection. So determine what is needed first, and then combine these collections with examination to prevent multiple examinations.
* If evidence collection is indicated, remember that not all envelopes need to be collected. In most circumstances, it is not indicated to do the following for evidence collection for a child:
	+ Pulled head hair
	+ Pulled pubic hair
	+ Swabs past the hymen should never be collected for pre-pubertal children and for pubertal children should only be collected without use of a speculum.
	+ Cervical swabbing is not indicated.
* The examination should be a comprehensive head to toe examination with particular focus on thorough examination of the skin, genitourinary, and anal examination. Remember to explain what you are doing as you move from body part to body part and also give options whenever possible (which ear do you want me to look at first), these small steps can significantly decrease stress for the patient and allow for easier examination.
	+ All surfaces of skin should be visualized during the course of the evaluation, if any findings concerning for physical abuse, or injury as a result of the sexual abuse/assault are noted, clinical photographs should be taken. Concerns for physical abuse should prompt a separate/new report to Child Protective Services.
	+ It is standard of practice to obtain clinical photography during the genitourinary and anal examination. By having an individual taking pictures at the same time as your examination, you limit the number of times you need to examine the child and you will have pictures regardless if there are findings or if the examination is normal.
	+ The genitourinary examination:
		- younger children can use supine frog leg position and older children can use supine lithotomy position. For male children might consider standing position.
			* Rarely if ever should use prone knee-chest position, mostly for confirmation of potential hymenal injury findings.
		- should utilize labial traction (grasping the labia majora between the examiner’s index finger and thumb and gently pulling toward the examiner)
		- if structures are agglutinated, a small amount of normal saline can be applied by squeezing a normal saline vial directed into the vaginal vestibule
		- **if the child is pre-pubertal, never touch the hymen when collecting swabs for testing/evidence collection; and also never use a speculum**
		- if the child is pubertal (hymenal folds may need to be explored with use of a swab, brushing lateral to medial to smooth the hymenal edge)
		- **if the child is pubertal, a speculum is rarely if ever indicated (the examination for SA concerns should be avoided as the first experience with a speculum)**
	+ The anal examination:
		- can use left or right lateral decubitus position or supine knee chest position
		- exploration beyond the anal opening is rarely if ever indicated for children
		- gluteal separation, by gently moving the gluteal cheeks to the side is all that is indicated in order to visualize the anus. (Remember this is not the rectum.)
* Testing for sexually transmitted infections, when indicated based sexual contact, would include at a minimum, testing for: gonorrhea, chlamydia, HIV 1/2, hepatitis B, syphilis, and hepatitis C.
* Prophylaxis may be indicated dependent on timeframes and history; however, for pre-pubertal children, sometime prophylaxis for gonorrhea, chlamydia, and trichomonas may be deferred.
* Ensure the family is aware of the need for evaluation at a Children’s Advocacy Center (CAC) for a forensic interview as well as a medical evaluation by a provider specializing in the evaluation of children presenting for concerns of possible sexual abuse.
	+ However, only Child Protective Services or Law Enforcement can refer to the CAC, so the provider should communicate the recommendation to investigators as well as inform the family to ask investigators for the referral.

**Contacts/Referrals to Consider:**

* **If there is any findings that you are concerned might be related to the sexual abuse, or need** guidance regarding management of findings (even when unrelated to abuse), consider consultation of a provider specializing in the evaluation of child sexual abuse.
* Pediatric Forensic Medicine:
	+ Staffed by 2 Board Certified Child Abuse Pediatricians, 1-2 Fellows, and 5 nurses.
	+ Referral/consultation resource for the entire state of Kentucky.
	+ Calling our service for clinical guidance will be a referral to us, which mean for documentation we will need a name and date of birth for the child, as well as potentially other demographic information.
	+ Afterhours, weekends, and holidays: 502-629-6000 and ask the operator for the “Pediatric Forensic Clinician On Call”
	+ Normal Hours: 8:00AM to 5:00PM: call our office: 502-629-3099 and indicate that you have a new referral.
	+ <https://louisville.edu/medicine/departments/pediatrics/divisions/forensic-medicine>
* Children’s Advocacy Center (CAC):
	+ It is recommended that any child evaluated acutely in the emergency department for a sexual abuse/assault examination have an appointment at the CAC for a forensic interview aswell as a medical evaluation by a provider specializing in the evaluation of children presenting for concerns of possible sexual abuse.
	+ Referrals need to be from child protective services or law enforcement; however, you can call the CAC for guidance if having any issues.
	+ Contact information at: <https://cackentucky.org/local-centers/>

**Articles of Importance:**

* National Children’s Alliance. (2017). Standards for Accredited Members. http://www.nationalchildrensalliance.org/sites/default/files/downloads/NCA-Standards-for-Accredited-Members-2017.pdf
* Finkel, M. A., & Alexander, R. A. (2011). Conducting the medical history. Journal of child sexual abuse, 20(5), 486-504.
* Adams, J. A., Farst, K. J., & Kellogg, N. D. (2017). Interpretation of medical findings in suspected child sexual abuse: an update for 2018. Journal of pediatric and adolescent gynecology.