# Kentucky Medical Protocol for Child Sexual Assault/Abuse Evaluation

Revisions Approved April 15, 2024, Sexual Assault Response Team Advisory Committee

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# Clinical Decision Tool for Evaluating Pediatric/Adolescent Sexual Assault/Abuse

- Contact local advocacy agency to request victim advocate
- Consult Hospital SW per hospital protocol
- Contact SANE-A/A or SANE-P/A for case consultation, per facility protocol and as appropriate for patient's sexual development. If SANE unavailable, proceed according to your facility protocol.
- Per KRS 216.400, each victim shall have the right to determine whether a report shall be made to law enforcement. **It is required to report to Child Protective Services or law enforcement where there is suspected abuse of a child, in all cases of suspected sex trafficking of a minor, and in all cases of female genital mutilation**. (KRS 216B.400, KRS 620.030, and KRS 600.020)
  - Kentucky Department for Community Based Services Hotline 1-877-597-2331

- Physician, APRN, or PA shall provide medical clearance
- Immediate medical or mental health needs always take priority over evidence collection

Patient reports **sexual abuse/assault** within the last **96 hours** and/or there is **potential to recover biologic or trace evidence**

## Yes

- **Maintain ongoing consent and/or assent**
- **Obtain information from investigators first, if available**
- **Obtain non leading medical history from caregiver without child present, and from child without caregiver present (See medical protocol)**
- **Perform mental health assessment (screen for substance use, self-harm)**
- **Assess for signs of strangulation**
- **Complete head to toe assessment including anogenital exam**
- **Collect Sexual Assault Forensic Evidence (SAFE) Kit (as indicated in the medical protocol)**
- **Record all injuries and/or points of tenderness with written and photographic documentation**
- **Assess and/or perform as appropriate:**
  - **Urine drug screen**
  - **Drug Facilitated Sexual Assault Urine/Blood Collection Kit**
  - **STI testing**
  - **HIV Risk Assessment**
  - **Pregnancy Testing**
  - **STI Prophylaxis**
  - **Emergency Contraception (Up to 120 hours)**
  - **HIV Prophylaxis (up to 72 hours)**
- **Consider additional testing and treatment based on symptoms**
- **Assess for safe discharge plan**

## No

- **Maintain ongoing consent and/or assent**
- **Obtain information from investigators first, if available**
- **Obtain non leading medical history from caregiver without child present, and from child without caregiver present (See medical protocol)**
- **Perform mental health assessment (screen for substance use, self-harm)**
- **Complete head to toe assessment**
- **Complete anogenital exam, unless timely follow-up can be assured, and patient is asymptomatic**
- **Assess and/or perform as appropriate:**
  - **STI testing**
  - **HIV Risk Assessment**
  - **Pregnancy Testing**
  - **STI Prophylaxis**
  - **Emergency Contraception (Up to 120 hours)**
- **Consider additional testing and treatment based on symptoms**
- **Assess for safe discharge plan**

**FOR ALL CASES:**

***** Prior to discharge, review with patient and caretaker testing completed, medications given, and recommended follow-up care. Coordinate care with regional Children's Advocacy Center whenever possible.**

***** Validate the child's feelings by acknowledging sexual abuse disclosures are difficult to make and take courage.**

***** If Child Protective Services (CPS) is involved, await safe disposition/CPS prevention plan prior to discharge.**

***** Additional resources at Children's Advocacy Centers of Kentucky (https://www.cackentucky.org/medical-resources).**

| HIV Nonoccupational Postexposure Prophylaxis (HIV nPEP) Considerations | | |
|---|---|---|
| **Type of Exposure within 72 Hours** | **Assailant HIV status** | **Recommendation** |
| Assailant's:<br>• Blood,<br>• Semen,<br>• Vaginal secretions,<br>• Rectal secretions,<br>• Breast milk,<br>• Body fluid that is visibly contaminated with blood (for example saliva with blood) | **Known positive** | **Initiate nPEP** |
| Assailant's:<br>• Blood,<br>• Semen,<br>• Vaginal secretions,<br>• Rectal secretions,<br>• Breast milk,<br>• Body fluid that is visibly contaminated with blood (for example saliva with blood) | **Unknown** | **Consider on case by case basis** Consideration includes:<br>• Type of assault/abuse described<br>• Age of the assailant (juvenile assailant may decrease risk)<br>• Presence of anogenital injury or genital ulcer or STI (may serve as a portal for infection)<br>• Whether assault/abuse was ongoing by the SAME individual<br>• Other high-risk factors for assailant and patient (drugs involvement, trafficking history, STIs, incarceration history)<br>• Multiple assailants may increase risk |
| Assailant's secretions not visibly contaminated with blood:<br>• Urine<br>• Nasal secretions<br>• Saliva<br>• Sweat<br>• Tears | **Regardless of assailant's HIV status** | **nPEP NOT recommended** |

When determining if HIV nPEP is indicated, do not await assailant testing results.

- HIV prophylaxis should be started within 72 hours and as close to the time of sexual contact as possible.
- Consider possible adverse effects and likelihood of medication adherence prior to prescribing nPEP.
- CDC's data regarding the likelihood of HIV acquisition from **an infected source based on a single exposure may be helpful in decision making:**
  - The highest risk of acquisition is associated with receptive anal penetration.
  - The lowest risk of acquisition is associated with receptive oral and insertive oral intercourse.
  - The risk of HIV acquisition as a result of a **single** act of biting, spitting, sex toy sharing or having body fluids thrown at a person is negligible.
- **Resources for Providers**
  - HIV nPEP Consultation Services for Clinicians (1-888-448-4911)
  - For additional resources, visit Children's Advocacy Centers of Kentucky: https://www.cackentucky.org/medical-resources

## This document supplements the flowchart.

# Introduction

Sexual violence is a significant health, social, and legal problem in the United States. Child sexual abuse can impact children's physical and mental wellbeing. The medical forensic evaluation is an important step in addressing patients' health care needs and promoting their wellbeing, safety, and healing. Statistics related to child sexual abuse in Kentucky can be found on the U.S. Department of Health and Human Services Children's Bureau website at https://www.acf.hhs.gov/cb/data-research/child-maltreatment.

This protocol is designed to be a guide for health care providers who conduct child sexual assault and abuse medical forensic evaluations of prepubertal and adolescent children and should be used in conjunction with patient history, clinical assessment and judgement, patient consent, and in compliance with state and federal laws.

While this protocol addresses the initial medical needs of the child, best practices encourage comprehensive evaluation, assessment, and treatment of child sexual assault/abuse in collaboration with community partners, including investigative agencies, child protective agencies, prosecutors, multidisciplinary teams, healthcare providers, child advocacy centers, and victim advocacy agencies. Furthermore, "collaboration across disciplines enhances the quality of health care, improves the quality of forensic evidence, increases law enforcement's ability to collect information, file charges, and refer an investigation to prosecution, and increases prosecution rates (U.S Department of Justice, 2017, p. 15)."

## Acknowledgements

The Kentucky Medical Protocol for Child Sexual Assault/Abuse Evaluation would not have been possible without the dedicated commitment and support of the Medical Protocol Subcommittee of the Sexual Assault Advisory Committee. The group consisted of individuals from diverse disciplines across Kentucky. Members of the Medical Protocol Subcommittee of the Sexual Assault Advisory Committee include:

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Additionally, the Medical Protocol Subcommittee recognizes the contributions of other agencies, individuals, and the National Protocol for Sexual Assault Forensic Exams- Pediatric that were instrumental in the development of this protocol.

# Kentucky Medical Protocol for Child Sexual Assault/Abuse Evaluation

## Purpose

The pediatric sexual abuse medical forensic evaluation should address the healthcare needs and minimize additional trauma to the pediatric patient and promote their safety, wellbeing, and healing. Additional objectives of the evaluation are to:

- Facilitate collection of forensic evidence.
- Document the medical history.
- Conduct a comprehensive physical exam (including an anogenital examination).
- Diagnose and address/ treat any medical conditions resulting from abuse.
- Identify and treat any infections resulting from abuse.
- Differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions.
- Diagnose and address/treat medical conditions unrelated to abuse.
- Identify any physical, developmental, emotional, or behavioral concerns needing further evaluation and treatment and make referrals as necessary.
- Provide reassurance and education to the child and family.
- Provide written and photographic documentation of the examination findings.
- Offer crisis intervention services.

**Key Principles of Protocol**

This protocol is also based on the following principles:

- A medical forensic examination should be accessible to all child sexual abuse patients, regardless of the child's background, circumstance, or geographic location.
- Mandatory reporting is required if there is reasonable cause to believe a child is abused, neglected, a victim of human trafficking or female genital mutilation. The report must be made to a local law enforcement agency, the Department of Kentucky State Police, the Cabinet for Health and Family Services or its designated representative, the child abuse hotline, or the Commonwealth or county attorney. (K.R.S. §§ 600.020, 620.030, 620.050 194A.540)
- "Do No Harm": The medical forensic exam should be trauma informed and patient centered.
- Ensure the safety of the child. The relationship between the perpetrator and the child may influence the child's disclosure and cooperation with the exam, the discharge process, as well as follow-up.
- A child should never be forced, restrained, or sedated for the sole purpose of evidence collection.
- Allow the child, whenever possible to have some control over the examination process.
- Recognize that the history regarding the abuse may be incomplete at the time of the child's presentation for care and may require collaboration with community partners.
- Recognize that the medical response to a report of child sexual abuse is a part of a larger multidisciplinary response that involves communication and collaboration with investigative agencies and community partners, including the state's regional children's advocacy centers.

- Recognize that the need for medical forensic care may be acute or nonacute. Health care providers, law enforcement, and child protective service should collaboratively determine the urgency of care appropriate for a child. (National Protocol for Sexual Abuse Medical Forensic Examinations—Pediatric, 2016, p. 8).
- The minor may choose to consent or not to consent to a forensic exam; parental consent is not required.
- In all patient interactions, it is important to maintain confidentiality of forensic medical information and documentation. The Health Insurance Portability and Accountability Act (HIPAA) applies to this patient population.

## Protocol Development

In order to improve the timeliness and quality of care for patients presenting for child sexual assault/abuse concerns, Kentucky established the SANE-P/A designation and KASAP appointed a statewide committee to develop a comprehensive medical protocol and requirements for training programs. This committee was comprised of medical, legal, advocacy, and forensic science professionals with expertise and experience caring for children presenting with sexual assault/abuse concerns. This protocol combines their expertise and experience with principles from the National Protocol for Sexual Assault Medical and Forensic Examination- Pediatric and best practices from other states and experts across the nation.

**Additional medical protocol resources may be found at Children's Advocacy Centers of Kentucky (CAC Kentucky) Website (https://cackentucky.org). The specific URL is https://cackentucky.org/medical.**

## Definitions that pertain to this document:

Kentucky Statutes (KRS 600.020 and KRS 620) require reporting when "any person knows or has reasonable cause to believe that a child is dependent, neglect, or abused." Consult with the hospital legal department if there are questions regarding reporting.

- Sexual Abuse:
  - According to the American Academy of Pediatrics, sexual abuse occurs when a child is engaged in sexual activities that he or she cannot comprehend, for which he or she is developmentally unprepared and cannot give consent, and/or that violate the law or social taboos of society. The sexual activities may include all forms of oral-genital, genital, or anal contact by or to the child or abuse that does not involve contact, such as exhibitionism, voyeurism, or using the child in the production of pornography.
  - See additional Kentucky reporting requirements below.
  - Not all sexual contact between developmentally and cognitively appropriate children of similar ages qualifies as sexual abuse. Use of coercion, force, and other factors as discussed above should be considered.
- Sex Crimes can include:
  (For legal definitions refer to KRS Chapters 510, 529, 530, 531 and possibly others as statutes change each year)
  - Penetration no matter how slight of the vagina, anus, or mouth by any body part or object.
  - Any sexual touching of a child under or over clothing.
  - Production of images of sexual exploitation of children.
- Prepubertal:
  - Female child who has not yet reached menarche and is Tanner Stage 2 or less
  - Male child who has not yet reached puberty. Consider Tanner Stages less than 3 when determining puberty. See Tanner staging in Appendix A.
  - If the child is undergoing medical treatment for pubertal suppression, they are considered pre-pubertal.
- Pubertal:
  - Female child who has reached menarche, or any female child who is Tanner Stage 3 or greater (regardless of menarche)
  - Male child who has reached Tanner stage 3 or greater
- Gender Identity
  - The pronouns (she/her, he/him, they/their, ze/zir, name/names, etc.) requested by the child should be honored and utilized throughout the exam and documentation.
- SANE-A/A:
  - Sexual Assault Nurse Examiner – Adolescent/Adult
- SANE-P/A:
  - Sexual Assault Nurse Examiner – Pediatric/Adolescent

## General Considerations:

## If a SANE-P/A performs an evaluation (acute or non-acute), collaboration with a physician, nurse practitioner, or physician assistant, is strongly recommended.

A medical clearance exam by a physician, nurse practitioner, or physician's assistant shall occur in conjunction with a SANE P/A evaluation (acute or non-acute).
When evaluating acute child sexual assault/abuse:

- Care of a patient presenting for sexual assault should be prioritized regardless of patient acuity, and treatment should be initiated without delay.
- Consult Hospital Social Work per hospital protocol.
- Contact SANE-A/A or SANE-P/A for case consultation, per facility protocol and as appropriate for patient sexual maturity. If SANE unavailable, proceed according to facility protocol.
- **Report suspected child sexual abuse to DCBS (Department of Community Based Services) (in Kentucky), or local or state law enforcement, or prosecutor.**
    - **DCBS Hotline 1-877-597-2331 or 1-877-KYSAFE1.**

# Kentucky General Mandatory Reporting

| WHAT? | WHO must report? | WHEN? | TO WHOM? |
|---|---|---|---|
| **Harm to Children: Abuse, Dependency, Neglect**<br><br>**Human Trafficking**<br><br>**Female Genital Mutilation** | Everyone.<br><br>(All healthcare providers are mandated to report). | **If harm/abuse/neglect is caused or allowed by:**<br>• Parent or other caregiver<br>• person in position of authority or special trust<br>• person 21 y.o. or older when a child <16 y.o. for sexual abuse/exploitation<br>• any person for human trafficking (labor and sex trafficking)<br>• any person for female genital mutilation | **Must report to at least one of the following:**<br>• Cabinet – Child Protective Services,<br>• Local law enforcement,<br>• Kentucky State Police,<br>County or Commonwealth Attorney |
| **Vulnerable Adult Abuse or Neglect** | Everyone.<br><br>(All healthcare providers are mandated to report). | If any person harms/neglects an individual who is **18 y.o. or older who has a mental or physical disability that limits ability to care and/or protect themselves.** | Must report to: Cabinet – Adult Protective Services |
| Ky. Rev. Stat. §600.020 and §620<br>Ky. Rev. Stat. §532.045<br>Ky. Rev. Stat. §508.125 | | | |

Statewide Abuse Reporting Hotline, 1-877-KYSAFE1 or 1-877-597-2331
Ky. Rev. Stat. §209

- The law requires reporting when "any person knows or has reasonable cause to believe that a child is dependent, neglected, or abused…" and "any person…having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation…"
- "Failure to report" is a crime. Therefore, reporting is the safest thing to do if abuse or neglect is suspected.
- If the report was made "in good faith," the person who reported is immune from legal liability.

**Fulfilling the Duty to Report:**

- When reporting is required, it should be done immediately.
  - Document the intake reference number provided when a report is made.
  - If known, document the names of investigators.
- The law requires that the source of a report of abuse, neglect or exploitation be kept confidential unless court ordered to be released.
- Since the duty to report applies to individuals, a healthcare provider should make a report directly to the appropriate government officials, even if a report has already been made.
- Although institutions' policies/procedures may require individuals to tell someone inside the organization, internal reporting does not fulfill an individual's legal duty to report.
- If there are new unreported concerns for abuse or neglect, a new report should be made to the appropriate officials, even if a Child Protective Agency is already investigating.
- If there are ongoing concerns and a report is not accepted, a request may be made to speak directly with a Child Protective Agency Intake supervisor and/or the Office of Ombudsman (1-800-372-2973).
- Not all sexual assaults need to be reported, refer to the chart above. Reporting without consent, except where the law requires, is a violation of Kentucky state law as well as federal laws such as HIPAA and VAWA. Where it may be unclear, refer to facility policy.
- When a patient consents to contacting law enforcement outside of a mandated reporting situation, it is prudent to document the patient's consent to do so.
- Contact local advocacy agency to request victim advocate as mandated by law. Refer to http://cackentucky.org/medical and/or http://kasap.org for victim advocacy agencies by region.
- Medical needs ALWAYS take priority over evidence collection.
- Do NOT delay medical care while waiting for a SANE Examiner.
- Medical clearance evaluation should be provided according to facility protocol.
- Address immediate physical or mental health needs.
- Limit the number of persons obtaining the history from the child.

## Identifying a Qualified Healthcare Provider to Perform the Evaluation:

- A physician, SANE, APRN, or physician's assistant can evaluate a child who presents for concern for sexual assault/abuse.
- Physician, APRN, or physician's assistant shall provide medical clearance. If a child is prepubertal (see "Definitions" section), then a SANE-P/A can evaluate the child for sexual assault/abuse in collaboration with a physician, nurse practitioner or physician's assistant.
- Physician, APRN, or physician's assistant shall provide medical clearance. If a child has reached puberty (see "Definitions" section), then a SANE-A/A or SANE-P/A can evaluate the child for sexual assault/abuse.
- If a SANE is unavailable, the most qualified healthcare provider at the facility should proceed with the evaluation.
- In order to meet statutory requirements for the care of the sexual assault patient, the exam should be completed at the request of the patient without delay.

## Obtaining Initial and Ongoing Consent and Providing a Detailed Explanation of the Evaluation:

- Provide a clear explanation to the caregiver and child of the evaluation process and continue to do so as the evaluation progresses.
- When feasible, options/choices during the examination should be provided to the child, so that the child feels a sense of control over the process.
- Obtain initial consent from caregiver if the child is not able to give consent.
- Typically a minor can consent to their own medical evaluation and treatment if the provider feels that the child understands the benefits and risks of the evaluation well enough to make an informed decision.
- A child who cannot consent should still provide assent to the evaluation after consent has been obtained from the caregiver. Assent means that the child agrees to the evaluation even if they cannot necessarily understand the risks and benefits inherit in the evaluation.
- Explain to the child and caregiver that consent/assent is an ongoing process and that the consenting individual may withdraw consent at any point during the medical evaluation.
- If a child consents to evaluation, only they can withdraw consent and stop the evaluation.
    - The caregiver cannot rescind consent and stop the evaluation if the child continues to provide consent for examination. The provider should explore the reason why the caregiver would like to stop the evaluation and explain why the child has rights to consent.
- Consult the facility's legal department if there are questions about consent.

## Key considerations regarding consent for a medical/forensic evaluation:

- Identification of bodily injury is always a component of evidence collection. A full head to toe examination is crucial to the medical/forensic evaluation.
- For all patients, evidence collection should be deferred until medically stable.
- For unconscious pubertal patients, evidence collection MUST be deferred until the patient is medically stable and able to provide consent.
- For unconscious prepubertal patients, a legal custodian can provide informed consent.
- In the event the caregiver is unable, unwilling, or not available to provide consent for a child who cannot otherwise consent themselves for the exam, consult the facility legal department (Refer to KRS 620.050).
- If a child does not consent or assent to the collection of evidence, an evidence collection kit should not be obtained. A child should not be physically restrained for the sole purpose of evidence collection. When injury, infection, or other medical condition is suspected, sedation or anxiolytic may be considered. If there are questions regarding whether collection should be attempted, consultation with an expert is recommended.
- If the patient's capacity to consent/assent changes (e.g. change in mental status, level of consciousness, or ability to give ongoing consent), stop evidence collection and address medical concerns. Reassess proceeding with evidence collection when appropriate.
- If parent consents to the exam but the patient does not assent for evidence collection, then explore with the patient the reason for not proceeding and attempt to reconcile the issue. If reconciliation is unsuccessful, do not proceed with evidence collection.

## Obtaining a History:

**Investigative History:**
Investigators (child protective agency worker and/or law enforcement agent) may be able to provide additional history that would be beneficial in guiding the medical/forensic examination. This information should be obtained away from the patient and/or caregivers.

**With the Caregiver and/or Adolescent Child:**

- If the child is the consenting individual for the examination, the child should be asked for consent for you to speak with a caregiver alone.
- Obtain a history from the caregiver without the child present.
- Ask open-ended, non-leading questions when eliciting a history of the presenting concerns.
- Clarify dates, times, and types of contact.
- Discuss any medical or behavioral concerns related to the presenting complaint.
- Obtain a complete past medical history. The past medical history includes immunizations, allergies, medications, past diagnoses, past surgeries, and past traumas (including past concerns for sexual assault/abuse).

**With the child:**

It is important to try to talk to the child alone without the caregiver or investigators in the room unless the child specifically requests that they remain.

- Start by building rapport and briefly talking about unrelated topics to allow the patient to become comfortable with talking to you.
- Ask very general, open-ended, and non-leading questions.
- Limit information gathering to what is relevant for medical management and for forensic evidentiary examination.

The following are examples of open-ended questions that are recommended for use with children:

- Can you tell me why you are here today?
- Do you know what this place is?
- What does a doctor do?
- Do you need the doctor to check anything?
- Do you have "anything that hurts?" (or if age appropriate "any ouchie's or boo-boo's?")

If the child uses specific words with their descriptions, clarify what those words mean. For example, if the child said, "he touched my private," then clarify who touched, how the touch occurred and where the "private" is.

Disclosures should be documented in the patient's own words in quotes as much as possible. Do not paraphrase or interpret the disclosures in your documentation.

The medical history should include questions to screen for acute mental health issues. Screen for self-injurious behaviors like cutting, suicidal ideation, as well as homicidal ideation and substance/alcohol use. Ask follow-up questions for clarification.

Here are some sample questions that could be used:

- My job is to make sure children are safe and healthy. How are you feeling today?
- Have you ever had any thoughts about trying to hurt yourself?
- Do you know what cutting is? Have you ever done that?
- Have you had any thoughts about death or dying?
- Have you had any thoughts about trying to hurt other people?

## Strangulation Assessment:

An assessment for history or evidence of strangulation should be performed. See additional strangulation information at http://cackentucky.org/medical. Refer to Appendix B for information related to strangulation.

Providers should be aware that:

- Children sometimes refer to being strangled as being "choked."
- Strangulation most often does not leave externally visible or readily apparent findings.
- Symptoms of strangulation can be present or may be delayed.
- When there is potential for internal injury and/or if a patient exhibits signs or symptoms (even if mild) related to strangulation, consider patient transfer to a medical facility with clinicians experienced in evaluating pediatric blunt force trauma to the neck.

For a child who reports strangulation or strangulation is suspected based on physical examination findings (regardless of when they present for care), the following should be addressed:

- Was an object or body part used in the strangulation, and if so, how?
- Was there a change in level of consciousness?
- Were there visual disturbances?
- Was there neck pain during or after the event? What was the duration of the neck pain?
- Was there difficulty speaking or voice hoarseness following the event? (Remember, onset may be delayed) What was the duration of the difficulty speaking or voice hoarseness?
- Was there loss of bladder or bowel continence?
- Was there difficulty breathing or inability to breathe during or after the event? What was the duration?
- What did the patient think was going to happen during or after the event?

# Determining a need to use a sexual assault evidence collection kit:

**Prepubertal Child - (see "Definitions" section)**

According to "502 KAR 12-010": "If the sexual assault occurred within ninety-six (96) hours prior to the forensic-medical examination, a Kentucky State Police Sexual Assault Evidence Collection Kit shall be used." See chart below.

- At a minimum, forms contained in the kit and reference standards (buccal, blood, and when indicated the hair standards [Most current kit instructions available on http://cackentucky.org/medical] should be completed, since other evidence (outside of the kit) could be collected by investigators. Other components of the kit can be completed on a case-by-case basis.
- Physical assessment for injury and documentation may still be indicated beyond 96 hours.
- Discuss with investigators that items such as clothing, bedding, and/or objects (condoms, sex toys, etc.) used during or after the assault may provide biologic forensic evidence that can be recovered and should be considered for collection.

## EVIDENCE COLLECTION GUIDELINES

**Prepubertal patient**

- Discuss the exam and evidence collection process with the caregiver and patient. Proceed with caregiver's consent and patient's assent.
- Speculum exam should NOT be performed unless there is concern for intravaginal injury or foreign body. (In this situation, an exam should be performed with sedation/anesthesia).
- The current timeframes recommended for evidence collection in this document may be altered by advances in DNA methodology in the future**.**

| **Patient reports** | **Time since assault** | **Recommended action regarding collection in addition to the standards (as discussed above). Additional collection may be considered as clinically indicated.** |
|---|---|---|
| Vaginal or anal penetration with penis or object | Less than or equal to 72 hours | Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), the perianal area and the anus.<br><br>If hymenal injury, collection of intravaginal swabs for the kit would be indicated and can be considered up to 96 hours. This collection should occur with sedation or anesthesia. |

| **Patient reports** | **Time since assault** | **Recommended action regarding collection in addition to the standards (as discussed above). Additional collection may be considered as clinically indicated.** |
|---|---|---|
| Vaginal or anal penetration with penis or object | 72-96 hours | Consider selected evidence collection including: Undergarments worn at the time of or immediately after the assault. Patient genital swabs can also be considered, especially if patient has not bathed.<br><br>If hymenal injury, collection of intravaginal swabs for the kit would be indicated and can be considered up to 96 hours. This collection should occur with sedation or anesthesia. |
| Oral penetration with penis | Less than or equal to 24 hours | Collect evidence within the oral cavity.<br><br>Consider additional evidence collection if there are concerns that the disclosure of assault/abuse is incomplete. |
| Oral penetration with penis | 24-96 hours | Assess oral cavity for mucosal injury, petechiae, injury to frenula.<br><br>Consider additional evidence collection if there are concerns that the disclosure of assault/abuse is incomplete. |
| Digital penetration of vagina or anus or hand to genital contact | Less than or equal to 24 hours | Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), the perianal area and the anus. |
| Digital penetration of vagina or anus or hand to genital contact | 24-96 hours | Swabs in addition to the standards are not generally recommended unless patient has **not** bathed or urinated or defecated and there is a potential of bodily fluid transfer.<br><br>Consider additional evidence collection if there are concerns that the disclosure of assault/abuse is incomplete. |
| Transfer of bodily fluids to extragenital body areas such as breast, neck, abdomen, thighs, etc. | Less than or equal to 96 hours | Recovery may be diminished with bathing, but additional evidence collection (by swabbing the identified areas) should still be strongly considered. |

| **Patient reports** | **Time since assault** | **Recommended action regarding collection in addition to the standards (as discussed above). Additional collection may be considered as clinically indicated.** |
|---|---|---|
| No history of sexual contact but acute unexplained anogenital injury that is not consistent with accidental trauma and/or raises concern for sexual abuse or inflicted injury | Timeframe unclear but likely less than or equal to 96 hours | Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), the perianal area and the anus.<br><br>If hymenal injury, collection of intravaginal swabs for the kit would be indicated and can be considered up to 96 hours. This collection should occur with sedation or anesthesia. |
| No known sexual contact but suspicious circumstances (abduction, concern for trafficking, etc.) | Timeframe unclear but likely less than or equal to 96 hours | Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), the perianal area and the anus. |
| No clear history of sexual contact but child presents with symptoms (vaginal discharge, dysuria) and there is a nonspecific concern for sexual abuse based on history. | Timeframe is unclear | Evidence collection including standards is not typically indicated in this circumstance.<br><br>Consider expert consultation. |
| No history of sexual contact, no concern for abuse by caretaker and child presents with anogenital complaints/symptoms or concerning or sexualized behaviors that could have another etiology. | Timeframe is unclear or unknown | Evidence collection including standards is not typically indicated.<br><br>Recommend CAC referral/consultation for services. |
| No history of sexual contact, no symptoms, but caretaker is concerned about sexual abuse. | Timeframe is unclear or unknown | Evidence collection including standards not typically indicated.<br><br>Recommend CAC referral/consultation for services. |
| Patient reports sexual contact. | Timeframe greater than 96 hours. | Evidence collection including standards not typically indicated acutely.<br><br>Recommend CAC referral/consultation for services. |

**Pubertal Child (see "Definitions" section)**

According to "502 KAR 12-010": "If the sexual assault occurred within ninety-six (96) hours prior to the forensic-medical examination, a Kentucky State Police Sexual Assault Evidence Collection Kit shall be used." See chart below.

- At a minimum, forms contained in the kit and reference standards (buccal, blood, and hair) should be completed, since other evidence (outside of the kit) could be collected by investigators.
- Evidence collection is indicated up to 96 hours. However, physical assessment, documentation of injury, STI prophylaxis and emergency contraception could still be indicated beyond this time frame. It is still prudent to discuss with investigators that items such as clothing, bedding, and/or objects (condoms, tampons, sex toys, etc.) used during or after the assault may still provide biologic forensic evidence that can be recovered and should be considered for collection.

**Pubertal Child**

- Discuss the exam and evidence collection process with the patient. Proceed with patient consent.
- Decision to perform speculum exam should be made on a case-by-case basis, taking child's age, sexual history, and informed consent for this exam component into consideration. Extreme care should be taken when deciding whether a speculum exam will be performed for a young postmenarchal adolescent, to prevent further injury, pain, or trauma. Speculum exam is indicated if there is concern for intravaginal injury or foreign body. It should be noted that injury and/or foreign body, as well as trace evidence may be identified on exam of the vagina and cervix even in the absence of a patient history that raises concerns.
- The current timeframes recommended for evidence collection in this document may be altered by advances in DNA methodology in the future**.**

| **Patient reports** | **Time since assault** | **Recommended action regarding evidence collection in addition to the standards (as discussed above). Additional collection may be considered as clinically indicated.** |
|---|---|---|
| Vaginal or anal penetration with penis or object | Less than or equal to 96 hours | Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), intravaginal swabs, and swabs of the perianal area and the anus. |
| Oral penetration with penis | Less than or equal to 24 hours | Collect evidence within oral cavity.<br><br>Consider additional evidence collection if there are concerns that the disclosure of assault/abuse is incomplete. |

| **Patient reports** | **Time since assault** | **Recommended action regarding evidence collection in addition to the standards (as discussed above). Additional collection may be considered as clinically indicated.** |
|---|---|---|
| Oral penetration with penis | 24-96 hours | Assess oral cavity for mucosal injury, petechiae, injury to frenula.<br><br>Consider additional evidence collection if there are concerns that the disclosure of assault/abuse is incomplete. |
| Digital penetration of vagina or anus or hand to genital contact | Less than or equal to 24 hours | Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), intravaginal swabs, and swabs of the perianal area and the anus. |
| Digital penetration of vagina or anus or hand to genital contact. | 24-96 hours | Swabs in addition to the standards are not generally recommended unless patient has **not** bathed or urinated or defecated and there is a potential of bodily fluid transfer.<br>Consider additional evidence collection if there are concerns that the disclosure of assault/abuse is incomplete. |
| Transfer of bodily fluids to extragenital body areas such as breast, neck, abdomen, thighs, etc. | Less than or equal to 96 hours | Recovery may be diminished with bathing, but additional evidence collection (by swabbing the identified areas) should still be considered. |
| No history of contact but acute unexplained anogenital injury that is not consistent with accidental trauma and/or raises concern for sexual abuse or inflicted injury | Timeframe unclear but likely less than or equal to 96 hours. | Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), intravaginal swabs, and swabs of the perianal area and the anus. |
| No history of contact but patient presents with history of impairment AND there are concerns that a sexual assault occurred (patient was found in a state of undress, patient perceives possible unwanted sexual contact, or has anogenital symptoms related to possible sexual assault or abuse) | Less than or equal to 96 hours | Patient must be conscious and provide consent.<br><br>Collection should include swabs of the external labia, the vaginal vestibule (area between the labia in front of the hymen), intravaginal swabs, and swabs of the perianal area and the anus. |

| **Patient reports** | **Time since assault** | **Recommended action regarding evidence collection in addition to the standards (as discussed above). Additional collection may be considered as clinically indicated.** |
|---|---|---|
| No history of sexual contact, no symptoms, but caretaker is concerned about sexual assault/abuse. | Timeframe unknown or unclear. | Any exam should be performed with patient consent.<br><br>Evidence collection including standards not typically indicated.<br><br>Consider CAC referral/consultation for services. |
| Patient reports sexual contact. | Greater than 96 hours. | Evidence collection including standards not typically indicated.<br><br>Recommend CAC referral/consultation for services. |

## Physical Examination:

- Ensure that the examination room has adequate lighting and privacy.
- The order of the exam may need to be modified to meet the needs of the patient.
- A patient should not be physically restrained for an examination. If an emergent evaluation is essential for the child's well-being (bleeding, concern for severe injury), then a sedated exam should be considered.
- The exam can be performed with a caregiver or support person present if the patient desires one. Examiner should have a nurse or healthcare personnel present to both assist and chaperone.
- Children who experience sexual assault/abuse may have experienced other forms of maltreatment. A complete head-to-toe physical exam should be performed for every child, with child undressed and in a hospital gown with appropriate draping. If possible, use clinical photography to document any injuries identified.
- Examine for and document any areas of tenderness. For each injury or area of tenderness, assess pain duration, quality (aching, stabbing, sharp, etc.), and severity. Providers can consider using a pain scale.
- Refer to chart below for additional details.

| **Body Surface** | **Assess** |
|---|---|
| For all body surfaces | Examine and document any abnormal findings including abrasions, lacerations, contusions, hematomas, petechiae, pattern injuries (bite, pinch, slap marks, etc.), edema, bruising in clusters, thermal injury. Describe size, location, color, and tenderness |
| Head, Scalp, Hair Line | Hair loss, bogginess under the scalp, injury underlying hair |
| Ears and behind the ears | Hematomas, petechiae, bleeding, perforated tympanic membrane, hemotympanum |
| Eyes | Periorbital petechiae, periorbital edema, subconjunctival hemorrhages, hyphema |
| Face | Pattern injuries (bite, pinch, slap marks, etc.) |
| Oropharynx | Tenderness, abrasions to buccal mucosa, lacerations, contusions, hematomas, palatal petechiae, torn frenula (upper lip, lower lip, sublingual), damage to teeth, difficulty swallowing, pain on swallowing, lip injury/edema |
| Neck | Tenderness to palpation, petechiae, pattern injuries (bite, pinch, slap marks, etc.), edema/swelling, suction injuries ("hickey"), pain on swallowing, hoarseness, aphonia, stridor |
| Breast | Pattern injuries (bite, pinch, slap marks, etc.), suction injuries ("hickey") |
| Abdomen | Pattern injuries (bite, pinch, slap marks, etc.), suction injuries |
| Torso | Pattern injuries (bite, pinch, slap marks, etc.), suction injuries |
| Inner Thighs | Pattern injuries (bite, pinch, slap marks, etc.), suction injuries |
| Extremities | Pattern injuries (bite, pinch, slap marks, etc.), suction injuries, ligature marks, injuries related to self-harm |

## Anogenital Examination:

**General Considerations:**

- Coordinate physical exam/anogenital exam, STI testing, evidence collection (if necessary), and photographs all at the same time to avoid multiple exams.
- The anogenital examination encompasses the external genitalia of boys, the labia and contents of the vestibule of girls, and the anal area of both.
- Assess the Tanner Stage of sexual maturation. (Tanner Stage Diagram Appendix A)
- Photographic documentation is recommended. Refer to http://cackentucky.org/medical for information regarding clinical photography.
- If considering application of toluidine blue dye, refer to the section regarding indications and procedures for toluidine blue dye for additional information. Dye application should be performed after swabs for evidence collection and other testing are obtained.
- Rectovaginal bimanual, speculum or anoscopic assessment of internal structures in prepubertal children **are not routinely indicated**.
- Speculum exams are NOT typically indicated in prepubertal girls. If a speculum exam is needed in a prepubertal girl, sedation or anesthesia would most likely be required. Indications for a speculum exam include:
    - Concern for a laceration
    - The source of vaginal bleeding or pain is unknown
    - The presence of a foreign body is suspected
- Extreme care should be taken when deciding whether a speculum exam will be performed for a young postmenarchal adolescent, to prevent further injury, pain, or trauma.
    - A speculum exam can help determine the source of unexplained bleeding or pain, concern for intravaginal/cervical injury or abnormality, and can help determine the presence of a foreign body (tampon, condom, etc.) in the vagina.
    - Note that sperm may be recovered from the cervical os even after showering.
- Anoscopic exams are not typically indicated. If an anoscopic exam is needed, sedation or anesthesia would most likely be required. Indications for anoscopy include:
    - Concern for a laceration.
    - The source of rectal bleeding or pain is unknown.
    - The presence of a foreign body is suspected.

**Female Examination Techniques:**

- Examination of the prepubertal girl (vaginal vestibule and anus) is usually accomplished with the child in the supine frog leg position or supine lithotomy position. The prone knee chest position can be used to better visualize the posterior rim of the hymen, and vagina if needed, as well as the anus.
- If necessary, young children can be examined on an appropriate caregiver's lap during the exam.
- Separation and traction of the labia allows visualization of the vaginal vestibular structures, the hymen and the vagina.
    - Labial separation is accomplished by placing 2 to 3 fingers on the labia majora and moving the labia gently laterally.
    - Labial traction is accomplished by gently grasping the left and right labia with the thumb medially and the curved index finger laterally and applying downward and lateral traction on the labia majora. Traction will allow visualization of the vaginal vestibule. Traction should be performed carefully to avoid iatrogenic injury to the posterior commissure/fourchette.
    - See Appendix C Labial Separation, Traction, and Prone Knee Chest Positioning Diagram and Clinical Photography Techniques
- Carefully examine the mons pubis, labia majora, the labia minora, the clitoris, urethra, the vaginal vestibule, hymen, posterior fossa, posterior commissure /posterior fourchette (See Appendix D Labeled Diagrams of Genital Anatomy).
- Note any injuries or findings of concern. If possible, note the configuration of the hymen (See Appendix E Common Hymenal Configurations).
- The hymen in prepubertal girls is very sensitive and touching of the hymen should be avoided. A difficult to visualize hymen can also be assessed by "floating the hymen" or squirting water or saline on the hymen.
- In pubertal girls, the contour of the hymen can be further assessed by tracing the rim of the hymen with a moistened cotton swab. Alternatively, placing a foley catheter behind the hymen, inflating the catheter balloon and then providing gentle traction on the balloon can provide better visualization of the hymenal rim.
- Examine the perineum, the gluteal fold and cleft, the perianal skin, the perianal folds and rugae, and the anal tone (by observation only). If injury to the anal sphincter is suspected, consultation with a specialist should be considered.
- The anus can be examined in the supine position with the child's knees pulled up to the chest, in the lateral decubitus position, or the prone knee chest position.

**Male Examination Techniques:**

- The penis and scrotum can be examined in the supine or standing position.
- If necessary, young children can be examined on an appropriate caregiver's lap during the exam.
- Identify any injury to the penile shaft, the glans, the foreskin, the urethral meatus, the testes (Appendix D Labeled Diagrams of Genital Anatomy).
- Examine the perineum, the gluteal fold and cleft, the perianal skin, the perianal folds and rugae, and the anal tone (by observation only). If injury to the anal sphincter is suspected, consultation with a specialist should be considered.
- The anus can be examined in the supine position with the child's knees pulled up to the chest, in the lateral decubitus position, or the prone knee chest position.

**Genital Examination Findings:**
*****The majority of all children and adolescents who report sexual assault/abuse have normal examinations. Reasons for a normal exam may include:**

- The nature of the assault/abuse may not leave injury, such as if the penetration is beyond the labia but not past the hymen.
- Disclosures of sexual assault/abuse are often delayed.
- There may be discordance between what a child perceives has happened and the actual event.
- Peer reviewed medical literature supports that injuries typically heal rapidly.
- Medical literature supports that exams are normal even in cases where assailants have confessed to sexual assault/abuse.
- Children who have been assaulted/abused in pornographic videos also have had normal examinations.

Medical providers who commonly evaluate children that give a history of sexual assault/abuse have developed criteria for assessment of the significance of a variety of anogenital findings and injuries in relation to child sexual assault/abuse, which is available in the medical literature and can be useful in the interpretation of findings. (Reference provided on http://cackentucky.org/medical)

While there are injuries that can be non-specific (lysed adhesions, abrasions from scratching, chemical irritation, anal fissure from constipation, etc.), acute injuries, especially in the absence of a clear and convincing history of accidental trauma (straddle injury, impalement injury or crush injury) are highly concerning for assault/abuse. Healed transections of the hymen are indicative of previous penetrative injury. The specificity and interpretation of the findings should be discussed with an expert.

## Evidence Collection:

*****See section "Determining the need to use a Sexual Assault Evidence Collection Kit" prior to Evidence Collection.**

**Recommendations for Evidence Collection:**

- To facilitate the exam process, prepare the room before the child's arrival. Have all exam supplies and equipment in room and ready for use. The evidence kit, however, must remain sealed until the exam is ready to begin.
- Exam and evidence collection should be patient sensitive, trauma informed, and minimally invasive.
- A child should never be forced, restrained, or sedated to have forensic evidence collected.
- Because children frequently do not disclose the full extent of what happened, examiners are encouraged to complete as many steps as possible when indicated.
- Maintain ongoing consent/assent throughout exam.
- Allow child to have control whenever possible and proceed at the child's pace.
- Caregiver can remain in the exam room when it is appropriate and the child gives permission.
- Suspend evidence collection if the child becomes distressed. Reassess how to proceed and how to collect evidence if possible.
- Evidence may be collected in a manner that meets the needs of the child. If appropriate, perform the more invasive collection steps, such as blood and hair collection, towards the end of the examination.
- Collection from a deceased individual should only occur under the direction of the Medical Examiner's Office or local coroner.
- Toxicology testing should be prioritized when drug facilitated sexual assault is suspected as delays in collection may affect results.
- Before swabs are obtained, a visual inspection of the area should be performed.
- Injury should be documented on appropriate anatomical drawings and whenever possible, should be documented with clinical photography. The clinical photographs are for the medical record and should not be included in the evidence collection kit.
- A Forensic Alternate Light Source (general body fluids range is 350-500nm, semen and saliva 415-490 nm with forensic goggles) may be used by trained collectors to fluoresce body fluids that may not be evident to the naked eye. Ultimately, the patient's history should determine areas for evidence collection. Even if there is no fluorescence, all areas of suspected saliva, semen, blood, or prolonged touching should be swabbed.
- Verify expiration date of collection kit. If collection kit is expired, examiner should substitute original expired swabs with equivalent hospital swabs. Envelopes can still be used regardless of expiration date.
- Hospital personnel are not required or encouraged to forensically analyze any of the evidence collected in this kit or other items collected during the exam. Use hospital supplies to collect required medical specimens.
- If additional evidence collection is needed beyond what is included in the kit, use additional swabs from hospital stock and plain envelopes marked similarly to envelopes provided in the kit. Do not put swabs from different sources in the same envelope.

## Principles for Evidence Collection

### Ensure security of specimens.

- Limit the number of persons who handle forensic evidence. Whenever possible, the examiner should be the only person handling the evidence. If anyone else handles any of the evidence, it must be documented on the chain of custody form. A sample form for use is attached to this document.
- Once the kit is opened, the individuals documenting the chain of custody must maintain visual contact with the kit and any evidence collected. The examiner must be able to account for the kit's integrity until it has been sealed and secured onsite according to facility protocol or turned over for police transport with a chain of custody form completed.
- Store nonreporting kits per facility protocol. (KRS 216B.400(10)).

### Collect forensic specimens appropriately.

- Wear gloves throughout the forensic evidence collection process.
- Change gloves with each individual collection site.
- Collect all swabs in a manner which will distribute concentrated staining over the entire surface of the swab head by rolling the swabs in the stain, if possible.
- The number of swabs collected for each item should not be less than the number in the kit instructions.
- Only use swabs provided in the kit or equivalent hospital stock swabs.

### Dry forensic specimens.

- Dry any wet forensic evidence at room temperature in a clean environment and manner that prevents contamination.
- Do not allow swabs from different locations to touch when drying or packaging.
- A swab dryer may be used to facilitate drying. Only place samples from one patient at a time in the swab drying box. Wipe or spray the swab drying box with a 10% bleach solution before each use.
- Follow proper procedures for packaging specimens that cannot be dried thoroughly at the exam facility to prevent leakage and contamination of other evidence.

### Package and label forensic specimens appropriately.

- After drying specimens, package each different type in paper envelopes.
- Package dry clothing evidence individually in paper bags.
- Clean, unused legal-sized envelopes may be used if additional envelopes are required. Clean white paper, such as is used for printers or copiers, may be used if additional paper is needed. Clean PAPER grocery-type bags may be used if additional clothing bags are required.
- Seal envelopes with tape. Do not contaminate specimens with saliva by licking a flap to seal the envelope. Do not use staples.
- Label all specimens clearly, including patient's name, the source of the specimen, date and time of collection, and examiner's name. Tape and initial across the taped seal.
- Write on the specimen envelope any variations or modifications in the collection.
- To avoid mislabeling, label bag/envelope immediately after the collection.

**Store forensic specimens correctly.**

- Complete chain of custody documentation.
- Maintain chain of custody of toxicology samples. Do not put toxicology samples in Sexual Assault Evidence Collection Kit. Use Drug Facilitated Sexual Assault Urine Specimen Collection Kit or Kentucky State Police Blood Collection Kit for toxicology and/or blood alcohol analysis.
- Store forensic specimens at the exam facility until released to law enforcement personnel.
- Per KRS 216B.400(10), nonreported kits must be stored per jurisdictional policy for at least one year.

**Keep medical specimens separate from forensic specimens.**

- It is not necessary to maintain a chain of custody of medical specimens. Label these specimens according to facility protocol.
- When collecting specimens for both medical testing and forensic samples, collect forensic samples first. Coordinate forensic collection with medical exam to avoid examining body areas multiple times.

## Guidelines and Procedures for Evidence Collection

**Victim's Medical History and Sexual Assault Information Form**

- This form must be completed in addition to any other paperwork required by the hospital. The laboratory utilizes the specific case history information provided on this form for analysis. Other hospital forms vary by facility and may not include all necessary information.
- Fill out all information requested on the form and have collector sign and date where indicated.
- Use an additional sheet of paper to complete the patient's description of the reported assault as necessary; include a copy in the kit and provide a copy to the investigating officer if it is a reported case.
- Once completed, if it is a reported case, the pink copy of this form should be provided to the officer for their record, and the yellow copy should be returned to the kit for the laboratory.
- White copy of the form should be submitted to the facility medical records.

**Anatomical Drawings**

- Using the appropriate set of anatomical drawings, note findings the appropriate page of the triplicate form (Victim Medical History and Sexual Assault) as you progress through the exam, then sign and date form where indicated. Do not document findings on the diagrams in the instructions, these are only for reference.

**Blood Standard and Toxicology**

- Blood Stain Collection Card should be prepared in all cases, when possible.
- Depending on the case history and/or the patient's symptoms, toxicology testing may be warranted to determine if the sexual assault was facilitated by drugs/alcohol. Time since assault determines if collection is indicated; therefore, toxicology testing requires prioritization.
- If toxicology and/or blood alcohol analysis is needed, collect additional blood and urine samples in additional Kentucky State Police Blood Collection Kit (with a hospital stock sterile urine specimen cup) or Drug Facilitated Sexual Assault Urine Specimen Collection Kit. On the blood collection kit label, indicate this is "sexual assault" case. Note any information regarding specific drug suspected, especially date rape drugs on toxicology kit forms. Do not put a toxicology kit inside the sexual assault kit.
- Refer to http://cackentucky.org/medical for a list of substances tested for by the state toxicology kit.
- If toxicology results are needed for clinical management, additional separate testing should be obtained, since the kit results will not be available in a timeframe to be clinically helpful.
- If the patient has experienced a loss of consciousness or cannot remember and it is suspected that this is due to drug and/or alcohol impairment, then samples for toxicology and/or blood alcohol analysis should be collected. Note patient symptoms (lethargy, slurred speech, somnolence, altered mental status, obtunded, gait disturbance, etc.) on the "Victim's Medical History of Sexual Assault Information" Form.
- Prior to blood sample collection, determine all necessary testing to minimize the number of collections required. (DFSA, STI baseline studies, Toxicology, etc.)
- If patient received a blood transfusion, collect the sample as advised, but note "transfusion" on the Blood Stain Collection envelope. A Buccal Standard must also be collected.
- If obtaining a Blood Standard is too traumatic for the patient, alternative collection of reference standards may be appropriate.
    - Use an EDTA microtube in conjunction with a finger stick for the Blood Standard.
    - If no patient oral-to-assailant genital contact has been reported, a Buccal Standard is sufficient.
- Change gloves. Obtain consent/assent. When there is a concern for DFSA, cleanse the collection site using an alcohol-free prep pad or betadine swab, otherwise an alcohol pad is acceptable. Using a 7 ml lavender top EDTA collection tube, draw specimen from patient, filling to maximum volume allowable by weight of child per blood draw.
- Using the Blood Standard Collection Card provided, place one to two drops of blood on each of the four (4) printed circles.
- Allow blood stains to thoroughly air dry. Fill out all requested information on the Blood Stain Collection Cards and return cards to the Blood Standard Envelope. Seal and fill out all information requested on the specimen envelope. Do not place blood tube in the envelope or kit.

**Collection of Clothing**

General considerations:

- Frequently, clothing contains important evidence in a case of sexual assault/abuse.
- Clothing provides a surface upon which traces of foreign matter may be found, such as the assailant's semen, saliva, blood, hairs and fibers, as well as debris from the crime scene.
- While foreign matter can be washed or worn off the body of the patient, the same substances often can be found intact on clothing for a considerable length of time following the assault.
- Any moist or wet items should be dried prior to packaging.
- Follow jurisdictional policy for handling and transporting wet clothing that cannot be dried thoroughly at the exam site.
    - Ensure that it is packaged in leak-proof containers and separated from other evidence when being transported.
    - It is critical to alert involved law enforcement representatives and crime lab personnel about the presence of wet evidence and the need for its immediate analysis or further drying.
- Carefully evaluate the need to take coats and shoes, as loss of these items may represent a financial burden to the child's family. Offer replacement clothing in coordination with victim advocacy program.
- Obtain consent to collect relevant clothing. Spread a bed sheet from hospital supply on the floor as a barrier. Spread another additional sheet or large paper sheet over the bed sheet. While the patient stands in the center of the sheet, have patient remove shoes and disrobe. Wearing gloves, assist the patient as requested and drape them appropriately.
- If the patient has been transported to the treatment facility in an emergency vehicle and has been wrapped in or was resting on a sheet, it may be necessary to collect that sheet also.
- Only new PAPER (grocery-type) bags should be used to collect clothing and other forensic specimens.
- Paper bags should be numbered (e.g. #1 of 4, #2 of 4) and documented on the chain of custody form.
- Seal bag and initial over seal. On the front of the paper bag, list patient's full name, date of collection, brief description of the item, and signature or initials of the person who collected and placed the item in the paper bag.
- The examiner should inquire as to the location of the original clothing. If reported, inform the investigating officer so the officer can plan to retrieve the clothing before any potential evidence is destroyed. If appropriate, instruct the family to save unlaundered bedding and clothing for law enforcement, and provide paper bags for items to be collected at home.

**Collection Guidelines for Underpants**

- Drainage of ejaculate from the vaginal or anal cavities may collect on the underpants.
- Evidence identified in underpants may include semen, saliva, hair, and other trace evidence.
- Underwear worn at time of medical/forensic exam should be collected even if it is not the underwear worn at the time of the assault.
- Do not shake out underpants or microscopic evidence will be lost. Do not cut through any existing holes, rips or stains in patient's underpants. Place underwear in the "Underpants Bag," seal, initial over taped seal, and fill out all information requested.
- If the underwear is saturated with liquid, package the underwear separately from the kit in a brown paper bag, and include patient's name, date of collection, description of item and collector's name. Note on the Underpants Bag that the underwear has been packaged separately from the kit.
- If the patient is not wearing any underpants after the assault, it is then recommended to collect the clothing item that was in contact with the anogenital area. This clothing should not be placed in the kit and should be placed in a paper bag. Seal and initial over seal. On the front of the paper bag, list patient's full name, date of collection, brief description of the item, and signature/initials of person who collected and placed item in the paper bag.
- If the patient is not wearing the underpants worn during and/or immediately after the reported assault, inform the investigating officer in charge so those underpants can be collected by law enforcement personnel.
- If law enforcement needs to take custody of the kit before drying of the evidence is complete, the underpants should not be included in the kit and packaged separately.

**Other Evidence Collection:**

- **Diapers, Pull-Ups, or Padding of Any Kind**
  If the patient was wearing an absorbent item at the time of the assault/abuse or immediately following, then collect, dry, and package the item in a paper bag. Seal, initial over seal, and write the patient's full name, date of collection, description of the item, and signature of examiner collecting the item on the front of the bag.

- **Baby Wipes, Body Wipes, or Tissues**
  If the patient or caregiver wiped the patient's mouth, genitals, and/or body with tissues or wipes after the assault, collect, dry, and package items in paper bag. Seal, initial over seal, and write patient's full name, date of collection, description of the item, and signature of examiner collecting the item on the front of the bag.

- **Sanitary Pad or Tampon**
  If a sanitary pad or tampon was in use during the assault/abuse or during the 96-hour collection period following the assault/abuse, retain it. Dry and place the item in Other Collection Envelope, paper envelope, or small paper bag. Seal, initial over seal, and write patient's full name, date of collection, description of item, and signature of examiner collecting the item on the front of the bag.
  If item has not fully dried by the completion of the exam, indicate to law enforcement that drying needs to be completed at the crime lab. Consider placing the item in a sterile specimen cup. Poke holes in the lid with a blunt tip needle prior to placing the specimen in the cup for further drying of contents.

- **Condom or Pieces of a Condom**
  If a condom is collected from a patient's body or is brought in, allow the condom to dry as much as possible before packaging.
    - A condom be difficult to dry completely.
    - Dry the condom as much as possible and place in a paper bag or double paper bags and seal and label accordingly.
    - As an alternative, place the condom in a sterile urine cup (poke holes in the lid with a blunt tip needle prior to placing the condom in the cup), then place in a paper bag, and seal and label accordingly.
    - Inform the detective that there is an undried item included in the evidence being handed over.

**Oral Swabs**

- This is not a buccal standard; a buccal standard should still be collected.
- Collect if patient oral- assailant genital assault occurred.
- Examine the entire oral cavity and the upper and lower lips for injury prior to collecting swabs.
- Photograph if indicated and document on the corresponding chart.
- Using two swabs simultaneously, carefully swab under the tongue and along the gum line. Using two additional swabs provided, repeat the swabbing procedure. Attention should be paid to those areas of the mouth, such as between the upper lip and gum and lower lip and gum, where seminal fluid might remain for the longest amount of time.
- Allow (4) swabs to dry. Return dried swabs to the Other Evidence Envelope. Seal, initial over seal, and fill out all information requested on the envelope. Check off "Oral Swabs" on the envelope.

**Known (Patient) Buccal Standard**

- The Known Buccal Standard in NOT an Oral Swab (which is collected for evidentiary purposes).
- The patient should not have anything to drink, eat, chew, or smoke for a minimum of 15 minutes prior to Known Buccal Standard collection.
- If oral penetration is reported, have the patient rinse with water two times prior to collection.
- If the patient reported oral contact with the assailant's genitals, a Blood Standard should be collected in addition to the Buccal Standard.
- Obtain consent/assent. Change gloves. Using two swabs simultaneously, vigorously swab the right and left side of the patient's cheek for 5 to 10 seconds. Using the two other swabs, repeat the same procedure. Allow swabs to dry.
- Return (4) swabs to Known Buccal Standard Envelope. Seal, initial over seal, and fill out all information requested on envelope.

**Pubic Hair Combings**

- Do not collect if greater than 24 hours since assault unless the patient was physically incapacitated or had limited mobility.
- Collect regardless of timeframe when a coroner or medical examiner requests for a deceased individual.
- If no hair, vellus hair, or early Tanner Stage, Pubic Hair Combings may not be necessary. Document on the envelope the reason why collection did not occur.
- Obvious foreign hair and/or fibers should still be collected.
- The comb provided in the sexual assault evidence kit should be used to collect any loose hairs or fibers from the pubic area.
- If a foreign hair is visualized, it should be collected no matter the time frame and whether or not the child has pubic hair. Visible hair may be collected with a gloved hand or using a new roll of paper tape. Use a section of tape to collect the hair and enclose in a zip lock bag. Adhere tape to the inside of the bag.
- Document on the bag the location of the item collected (For example, "hair from inner thigh," patient's name, date, time collected and collector's name).
- Obtain consent/assent. Change gloves. Remove the paper towel and comb provided in the Pubic Hair Combings envelope. Place the towel under patient's buttocks. Using the comb provided, comb pubic hair in downward strokes so that any loose hairs and/or debris will fall onto the paper towel. Fold towel in manner to retain both comb and any evidence present. Return to Pubic Hair Combings envelope. Seal, initial over taped seal, and fill out all information requested on the envelope.
- Patients may prefer to do the combing themselves to reduce embarrassment and increase their sense of control. If the paper towel is dropped on the floor or otherwise contaminated, a clean sheet of white paper may be substituted.

**Pulled Pubic Hair Standard**

- If no hair, vellus hair, or early Tanner Stage, do not collect Pubic Hair Standard and document on the envelope the reason why no standard was collected.
- Collection may not be indicated if the suspected assailant resides in the same environment as the patient **unless** hairs are found in the patient's body cavity.
- Collection of less than 30 hairs is an insufficient sample.
- Consider deferring this step to the latter part of the examination. Pulled hair samples are used to compare hairs found on the patient's/suspect's clothing, at the crime scene, or in hair combings taken from the patient.
- Collect Pulled Pubic Hairs as a patient hair standard even if the Pubic Hair Combings are not collected. As hairs can change over time, it is important to preserve this evidence near the time of the assault.
- Patient should be informed that this portion of the exam is voluntary.
- If topical anesthetic is used to facilitate hair collection, then it should be applied after all anogenital samples have been collected so as not to contaminate evidence samples.
- Try to collect hairs first by gently applying traction to a large section of the hair.
- Collecting a matted hair sample does not suffice as a pubic hair standard.
- Obtain consent/assent. Change gloves. Pull, do not cut, a minimum of 30 full-length hairs from various locations of the pubic region. It is imperative that the root be attached to each hair. To assist in the transfer of the sample hairs to the envelope, place the hairs on a

piece of paper and fold and place in the Pulled Pubic Hair Standard envelope. Seal and fill out all information requested on envelope.
- Attempt to collect even if the patient partially shaves or waxes.

**Female External Genitalia Swabs**
- Use "Other Evidence" envelope and mark accordingly.
- Collect when patient reports genital to genital contact or when there is a suspicion for bodily fluids on the patient's external genitals (See EVIDENCE COLLECTION GUIDELINES CHART).
- Collection when hand to genital contact without suspicion of body fluid deposition is recommended if the contact occurred within the last 24 hours.
- Obtain consent/assent. Change gloves. Examine external genitalia and for injury or foreign material. Photograph prior to collecting samples. If available, an Alternate Light Source (450 nm) is recommended to examine the patient in the lithotomy or frog-leg supine position in the event secretions were missed during the inspection of the body.
- Lightly moisten two swabs with sterile water, then simultaneously swab the external genitalia, beginning with the most external structures and working inward: the mons pubis, clitoral hood, labia majora, and perineum. Using the two remaining swabs provided, repeat the swabbing procedure. Collect all swabs in a manner which will distribute concentrated staining over the entire surface of the swab head by rolling the swabs in the stain, if possible.
- Allow (4) swabs to air dry, then return them to the Other Evidence Envelope. Seal, initial over seal, and fill out all information requested on envelope. Check off "Female External Genitalia" on the envelope.

**Vaginal or Vaginal/Cervical Swabs**
- Collect if vaginal assault occurred.
- If indicated, cultures for sexually transmitted infections may be taken immediately after evidence collection. To avoid multiple exams, coordinate STI testing, evidence collection, photographs, and the anogenital exam.
- See Appendix D for Labeled Anogenital Diagrams.

- **PREPUBERTAL Females**
  - **Speculum exams should NEVER be done on pre-pubertal children without sedation or anesthesia.** Care should be taken when deciding to do a speculum exam in order to prevent further injury, pain or trauma. Indications include:
    - Concern for a laceration
    - The source of vaginal bleeding or pain is unknown
    - The presence of a foreign body is suspected
  - Lightly moisten two swabs with sterile water. While gently separating the labia, simultaneously swab the outer and inner aspects of the labia minora, the posterior commissure/fourchette, and the fossa navicularis. Avoid touching the hymen or inserting the swab beyond the hymen in pre-pubertal girls, since this may be painful. Lightly moisten the two remaining swabs and swab the same areas again.

  - Allow the four swabs to dry. Return dried swabs to collection envelope, seal, initial over seal, and fill out all information requested. Mark as "Vaginal Vestibule."
  - If penetrative injury of the hymen is identified, consider collection of vaginal swabs in the setting of a sedated exam. Do not moisten swabs. Using two swabs simultaneously, carefully swab the vaginal walls and cervix. Repeat with two additional swabs. Place all (4) swabs in an "Other Evidence" envelope and mark as "Vaginal/Cervical." Do not put them in the same envelope with the vaginal vestibule. Allow the four swabs to dry. Return dried swabs to envelope, seal, and fill out all information requested.

- **PUBERTAL Females**
  - Care should be taken when deciding to do a speculum exam in order to prevent further injury, pain or trauma. Indications include:
    - Concern for a laceration
    - The source of vaginal bleeding or pain is unknown
    - The presence of a foreign body is suspected
  - Obtain consent. Change gloves. Examine the vaginal area for injury or foreign material. Photograph injuries prior to collecting samples.
  - Do not moisten swabs. Using two swabs simultaneously, carefully swab the vaginal walls and cervix. Using the additional swabs provided, repeat the swabbing procedure.
  - Allow the (4) swabs to dry. Return dried swabs to envelope, seal, and fill out all information requested. Mark as "Vaginal Swabs."

**Penile Swabs**

- If indicated, cultures for sexually transmitted infections may be taken immediately after evidence collection. To avoid multiple exams, coordinate STI testing, evidence collection, photographs, and the anogenital exam.
- Swabs for evidence collection should NOT be inserted into the urethra.
- Obtain consent/assent. Change gloves. Slightly moisten two swabs, and thoroughly swab the glans, shaft of the patient's penis and all outer areas of the penis and scrotum where contact is suspected. If the patient is not circumcised, gently retract the foreskin and swab the glans. Do not force retraction as this can be painful and cause injury. Slightly moisten the two remaining swabs, and simultaneously swab the same area.
- Allow the four swabs to dry. Return dried swabs to envelope, seal, initial over seal, fill out all information requested on envelope. Mark as "Penile Swabs."

**Perianal Swabs**

- If necessary, the swabs may be moistened slightly with water. Using two swabs, simultaneously swab over perianal area/folds. Using the two remaining swabs provided, repeat the swabbing procedure
- Allow the (4) swabs to dry. Return dried swabs to envelope, seal, initial over seal, and fill out all information requested on envelope. Check off "Perianal Swabs" on the envelope.
- Utilize "Other Evidence" envelope and mark the evidence envelope accordingly (Example: Perianal swabs, Patient's Name, Date and Time Collected, and Collected By). Do not put swabs from different sources in the same envelope.

**Anal Swabs**

- Swabs may be collected for suspected penetration or bodily fluids.
- For reported digital penetration without suspicion of bodily fluid deposition, collect 4 swabs only up to 24 hours.
- Obtain consent/assent. Change gloves. Examine the anus prior to collecting swabs. Photograph injuries as indicated.
- If necessary, the swabs may be moistened slightly with water. Using two swabs, swab the anal canal. Using the two remaining swabs provided, repeat the swabbing procedure. Using another two swabs, repeat the same procedure for the anal canal.
- Allow the (4) swabs to dry. Return dried swabs to envelope, seal, and initial over seal.
- Utilize "Other Evidence" envelope and mark the evidence envelope accordingly (Example: Anal swabs, Patient's Name, Date and Time Collected, and Collected By). Do not put swabs from different sources in the same envelope.

**Dried Secretion Swabs**

- Can be collected for
    - dried blood, semen, or saliva found on the patient's body
    - may also include swabs of bite mark
    - "hickey"/suction injury or licking of a body surface
    - neck for manual strangulation
- Four swabs should be used for each location of suspected secretions on the body. Collect all swabs in a manner which will distribute concentrated staining over the entire surface of the swab head by rolling the swabs in the stain, if possible.
- Dried secretions are collected by moistening the two (2) swabs slightly with sterile water, then thoroughly swabbing the suspected area on the patient's body. Using the two (2) additional swabs provided, repeat the swabbing procedure. Allow swabs to dry then return them to the Other Evidence envelope. Seal, initial over tape, and fill out all information requested on the envelope. Check off "Dried Secretions" on the envelope, and note location of collection on the envelope and on the anatomical drawings.
- Include history if applicable.
- When details of assault are unknown, swabbing of neck and breasts in pubescent females for dried secretions is recommended.

**Fingernail Swabs**

- Collect when the patient advises that the patient scratched or injured the assailant.
- Fingernail swabs should be collected in lieu of fingernail clippings for living patients.
- Patients should be asked whether or not they scratched the assailant's face, body or clothing or surrounding objects. If skin or other materials are observed under the patient's fingernails, the nails should be swabbed. **DO NOT SCRAPE.**
- Prior to taking fingernail specimens, photograph fingernail damage that may have been related to the assault/abuse. If a patient has an artificial nail that has fallen off during the assault, it is important photograph, document, and notify the law enforcement investigator so that it may be collected. Document missing or torn nails and collect those separately from other intact nails.
- Moisten two swabs with distilled water, then thoroughly swab under the fingernails of one hand. Using the two additional swabs provided, repeat the swabbing procedure for the other hand. Allow swabs to air dry. Return these swabs in the wrapper paper, writing

the specific hand on the wrapper from which each set of 2 swabs was collected (right hand/left hand), then return both sets of swabs to the Other Evidence envelope. Also note specific information about scratches or injury on the envelope.

**Additional Sites**

- Carefully inspect the body, including head, hair, and scalp for foreign material and debris such as fibers, loose hairs, paint, grass or other vegetation, soil/debris, sand, glass, and matted hair cuttings.

**Foreign Material and Debris Collection**

- Obtain consent. Change gloves. Collect foreign material and place in envelope. Seal, initial over taped seal, and fill out all information requested on the envelope. Note on the anatomical drawings the location where the sample was taken.
- Debris-containing evidence may be found on equipment, such as wheelchairs, scooters, canes, wheelchair pads, assistive communication devices, catheters, and service animals, used by some patients with physical impairments. With the patient's permission, swab equipment and/or animals for evidence, if appropriate.

**Pulled Head Hairs**

- As hairs can change over time, it is important to preserve the evidence near the time of the assault.
- Collection of less than 30 hairs is an insufficient sampling.
- Obtain consent/assent. Change gloves. **Pull,** (or have patient pull) **do not cut**, a minimum of 30 full-length head hairs, 6 from each of the following scalp locations: center, front, back, left side and right side and place in Pulled Head hairs envelope. Try to collect hairs first by gently pulling at large sections of hair. Collect regardless of length of hair, even if the patient has a "buzz cut" or is balding. Seal, initial over seal, and fill out all information requested on envelope.
- If the patient has dreadlocks, run hands through hair to obtain any hairs ready to shed. Then, if possible, pull and collect new hairs not entwined in the dreadlock from each of the 5 areas listed above. If locks are small, cut a lock from each of the 5 areas; however if locks are larger, cut at least 1 lock. Collect samples in a similar manner for patients with a weave. Seal and fill out all information requested on envelope.

**Maintaining Evidence Integrity for Completed Kit**

- Prior to sealing, ensure forms are completed, and legible.
- Ensure all specimen envelopes and containers are labeled legibly.
- Seal kit box with the Kit Box Seal provided.
- Fill out all information requested on the seal and the examiner should initial where sealed.
- For reported cases, provide the kit and the pink copies of the forms to the investigating officer.
- If the officer is unable to immediately assume responsibility of the kit, store evidence in a designated secure area.
- Store non-reporting kits (kits collected without law enforcement report) per facility protocol (KRS 216B.400(10)).
- Add the kit information to the Kit Tracking Portal.
- If consensual activity occurred within one week, the investigator should be advised to pursue standards from those contacts.
- Advise the officer if a toxicology kit or any other items were collected.

**Completion and Transfer of Evidence**

- Complete Chain of Custody documentation, noting all forensic specimens collected during the exam. Forensic specimens may include:
    - Clothing evidence
    - KSP Sexual Assault Evidence Collection Kit
    - KSP Blood/Urine Collection Kit for toxicology testing
    - Other evidence
- Log KSP Sexual Assault Evidence Collection kit into the KSP SAFE Kit Tracking system. If you need a login code contact the KSP Forensic Lab.
- Release forensic specimens to investigating officer or secure on site per jurisdictional policy.

## HIV Risk Assessment, Testing, and Prophylaxis:

**General Considerations:**

- When determining if HIV prophylaxis is indicated, it is not appropriate to await assailant testing to make a decision.
  - Assailant testing can be challenging to arrange and may take a prolonged period of time.
  - HIV prophylaxis is only beneficial if started within 72 hours and should be started as close to the time of sexual contact as possible.
- Be clear with the family when HIV post-exposure prophylaxis is:
  - "Medically recommended" due to a clear medical indication

  VERSUS
  - "Offered" without a clear/definitive medical indication
- Recommendation for HIV post-exposure prophylaxis should take into consideration the following:
  - The likelihood that the source of exposure is infected or contaminated with HIV.
  - The likelihood of transmission of HIV as a result of the nature of the exposure.
  - The timeframe.
  - Possible adverse effects.
  - Likelihood of adherence to the medication regimen.
- HIV nPEP is “medically recommended” if the sexual assault occurred within 72 hours of presentation to medical care **and** there is potential for exposure to bodily fluids that may carry the Human Immunodeficiency Virus as described below. (Based on CDC HIV nPEP Guidelines, References at http://cackentucky.org/medical).

## HIV nPEP RECOMMENDATIONS

| **Patient Exposure: vagina, rectum, eye, mouth or other mucous membrane, non-intact skin (As indicated by a history or physical findings)** | | |
|---|---|---|
| **Type of Exposure within 72 Hours** | **Assailant HIV status** | **Recommendation** |
| Assailant's:<br>• Blood,<br>• Semen,<br>• Vaginal secretions,<br>• Rectal secretions,<br>• Breast milk,<br>• Body fluid that is visibly contaminated with blood (for example saliva with blood) | Known positive | Initiate nPEP |
| Assailant's:<br>• Blood,<br>• Semen,<br>• Vaginal secretions,<br>• Rectal secretions,<br>• Breast milk,<br>• Body fluid that is visibly contaminated with blood (for example saliva with blood) | Unknown | Consider on case-by-case basis (See below)<br>Consideration includes:<br>• Type of assault/abuse described<br>• Age of the assailant<br>• Presence of anogenital injury<br>• Presence of genital ulcer or STI<br>• Whether assault/abuse was ongoing by the SAME individual<br>• Other high-risk factors for assailant and patient (drug involvement, history of sex trafficking, STI's, or incarceration)<br>• More than one exposure (for example multiple penetrative acts or multiple assailants) |
| Assailant's secretions not visibly contaminated with blood:<br>• Urine<br>• Nasal secretions<br>• Saliva<br>• Sweat<br>• Tears | Regardless of assailant's HIV status | nPEP NOT recommended |

The following information may assist when counseling patients/families about the risk of acquiring HIV and the need for nPEP:

- Note that the CDC (https://www.cdc.gov/hiv/risk/estimates/riskbehaviors.html) states that the likelihood of HIV acquisition from an **infected source** varies depending on the type of a **single exposure**.
    - The highest risk of acquisition is associated with receptive anal penetration.
    - The lowest risk of acquisition is associated with receptive oral and insertive oral intercourse.
    - The risk of HIV acquisition as a result of a **single** act of biting, spitting, sex toy sharing or having body fluids thrown at a person is negligible.
- Factors that may increase the risk of HIV transmission include:
    - More than one exposure (for example multiple penetrative acts or multiple assailants)
    - The presence of concomitant sexually transmitted diseases (like herpes lesions creating a portal for easy entry of infection)
    - The presence of acute anogenital injury (broken skin) in the patient
    - Assailant with acute or late-stage HIV infection or high viral load
    - Patient exposed to contaminated needles relative to the time of the assault
    - Assailants engaging in ongoing high risk behaviors (males having sex with males, intravenous drug use, history of incarceration, or prostitution/trafficking)
- Factors that may decrease the risk include:
    - Condom use by assailant
    - Male circumcision of assailant
    - Assailant taking antiretroviral treatment
    - Assailant is a minor or child
- Testing for HIV rather than provision of HIV nPEP may be considered/indicated in situations in which assault/abuse has been ongoing by the same assailant, as the likelihood of HIV acquisition as a result of a single recent event might be considered low if the child has not already acquired HIV as a result of the ongoing assault/abuse.
    - *** Note that this may not be the case in some situations where the assailant engaging in ongoing high-risk behaviors (males having sex with males, intravenous drug use, history of incarceration, or prostitution/trafficking).
- Provision of nPEP may not be necessary in situations where the reported assailant is an adolescent or preadolescent child, as the likelihood of the reported assailant having HIV in this situation is low.
- Adherence to the completion of the full 28 course of nPEP is crucial. If there are concerns for potential non-adherence, it may not be appropriate to initiate HIV nPEP.

**If HIV nPEP is being considered:**

- Discuss risks and benefits, including prescription cost, symptoms (nausea and emesis), the rare potential for pancytopenia, hepatic enzyme elevation, kidney dysfunction, and the need to take the medication twice daily for one month.
- Consider consultation with an infectious disease specialist if guidance regarding current medication regimen, baseline labs, and/or follow-up is needed.
- Consider referring to your Hospital Protocol if one has been established.
- Refer to Child Advocacy Center Kentucky website for additional resources (cackentucky.org/medical). These include resources regarding:
    - Medication Management
    - Financial Support for Medications
    - Hotline Numbers
    - Provider Guidance

**If HIV nPEP is initiated:**

- Perform baseline complete blood count (CBC) and comprehensive metabolic panel (CMP). Also perform HIV Ag/Ab testing as well as testing for Syphilis, Hepatitis B, and Hepatitis C. Refer to STI testing chart for additional information.
- Emphasize the importance of follow-up to monitor for side effects.
- Provide anti-nausea medications to be taken 30 minutes prior to HIV nPEP administration.
- If possible, provide a minimum of 7-day supply in hand to the patient/caregiver to help ensure there will be no lapses in medication regimen administration.
- If the crime occurred in Kentucky, complete the appropriate compensation forms located at the Kentucky Office of Claims and Appeals website (http://kycc.ky.gov) under the Sexual Assault Exam Program page.
- If the crime occurred outside of Kentucky, fill out state specific compensation forms/vouchers (if available) for the patient/caregiver for follow-up medical care.
- Coordinate a follow-up appointment with a provider, ideally within 3-7 days of initial presentation, to allow ample time to obtain the remaining medication needed to complete a 28-day HIV nPEP course.
- Inform the patient/caregiver that follow-up will be needed at 2 weeks as well as at 4-6 weeks, 3 months, and possibly 6 months.

- **Resources for HIV nPEP**:
    - HIV nPEP Consultation Services for Clinicians (1-888-448-4911)

- **Additional Resources for HIV nPEP**:
    - Children's Medical Centers of Kentucky (https://cackentucky.org/medical)

## Sexually Transmitted Infection (STI) Assessment and Prophylaxis (OTHER THAN FOR HIV):

Inquire about anal, penile, or vaginal symptoms including lesions, pruritus (itching), pain, bleeding, discharge, dysuria, or hematuria.

It is not mandated by Kentucky regulation to automatically test for STI's during the sexual assault examination, unless medically indicated or per patient's request. However, public health officials and medical professional organizations recommend STI testing when contact by sexual assault/abuse and/or prior consensual sexual activity could result in acquisition of an STI.

### Prepubertal STI Testing

STI testing is recommended for the following situations regardless of when the contact occurred:

- Patient has experienced penetration, however so slight, or there is evidence of acute or healed penetrative injury of the genitals, anus, or oropharynx.
- Patient exhibits signs and/or symptoms of an STI (e.g., vaginal discharge or pain, genital itching or odor, urinary symptoms, and genital lesions or ulcers).
- A sibling or relative or adult in the environment has an STI.
- The assailant has a known STI or is at high risk for STIs (e.g., IV drug use, multiple sex partners, men who have sex with men, history of incarceration, and history of STIs).
- The assailant is a stranger.
- Patient lives in an area with a high rate of STIs in the community.
- The family is requesting testing.
- Patient has already been diagnosed with one STI.
- Unclear history and there are reasons to believe patient is at risk for acquiring an STI.
- Follow up is difficult or unlikely.

### Pubertal STI Testing

Other factors that may indicate need for STI testing, whether sexual contact is acute or remote:

- Patient has experienced penetration, however slight, or there is evidence of acute or healed penetrative injury to the genitals, anus, or oropharynx.
- Patient exhibits signs and/or symptoms of an STI (e.g., vaginal discharge or pain, genital itching or odor, urinary symptoms, abdominal pain, and genital lesions or ulcers).
- A sibling or relative or adult in the patient's environment has an STI.
- The assailant has a known STI or is at high risk for STIs (e.g., IV drug use, multiple sex partners, men who have sex with men, history of incarceration, or history of STIs).
- The assailant is a stranger.
- Patient lives in an area with a high rate of STIs in the community.
- The patient is requesting testing.
- Patient has already been diagnosed with one STI.
- Unclear history and there are reasons to believe patient is at risk for acquiring an STI.
- Follow up is difficult or unlikely.
- Patient is sexually active.

# Kentucky Medical Protocol for Child Sexual Assault/Abuse Evaluation

If testing is indicated and with patient's permission, follow CDC guidelines. See table below for testing guidelines.

## Testing Sites, Methods, and Intervals in Child Sexual Assault/Abuse

*****If a sexually transmitted infection is identified in a child:**

- Recommendations may evolve over time. The most up-to-date information can be found at the http://cackentucky.org/medical.
- Medical consultation with a children's advocacy center or hospital-based child protection program is advised.
- Consider hospital admission if there are safety and/or adherence to treatment regimen concerns.
- A report should be made to the appropriate child protection agency, when indicated below.
- If using NAAT, only FDA-cleared NAAT assays should be used.
- Confirmation of initial positive test results may be necessary before a final diagnosis is made. Preferably, all positive specimens should be retained at the lab, should additional testing be necessary.
- The primary medical provider should be contacted to conduct the evaluation if consultation is not available.

- This chart was REVISED September 1, 2021 to reflect updated CDC MMWR 2021 STI Treatment Guidelines.

| STI | Reporting & Diagnostic Considerations | | Testing | Follow-up Testing Interval Following Acute Assault |
|---|---|---|---|---|
| | **Pre**pubertal | Pubertal | | |
| *Neisseria gonorrhea* | REPORT<br>to Child Protective Agency<br><br>DIAGNOSTIC for child sexual assault/abuse, once other rare modes of transmission are excluded. | CONSIDER REPORT<br>to Child Protective Agency<br><br>SUSPICIOUS for child sexual assault/abuse. Other modes of transmission should be excluded. | NAAT (swab or urine)<br>• Female Genital<br><br>NAAT (urine)<br>• Male Genital<br><br>For boys with genital discharge, urine NAAT or meatal swab NAAT or culture.<br><br>Culture or NAAT<br>• Pharyngeal<br>• Anal | 2 Weeks<br><br>*** Positive NAAT results and any presumptive culture isolates should be confirmed if forensically significant |

# Kentucky Medical Protocol for Child Sexual Assault/Abuse Evaluation

| STI | Reporting & Diagnostic Considerations | | Testing | Follow-up Testing Interval Following Acute Assault |
|---|---|---|---|---|
| | **Pre**pubertal | Pubertal | | |
| ***Chlamydia trachomatis*** | REPORT to Child Protective Agency<br><br>DIAGNOSTIC for child sexual assault/abuse, once other rare modes of transmission are excluded. | CONSIDER REPORT to Child Protective Agency<br><br>SUSPICIOUS for child sexual assault/abuse. Other modes of transmission should be excluded. | NAAT (swab or urine)<br>• Female Genital<br><br>NAAT (urine)<br>• Male Genital<br><br>For boys with genital discharge, urine NAAT or meatal swab NAAT or culture.<br><br>Culture or NAAT<br>• Pharyngeal<br>• Anal | 2 Weeks<br><br>*** Positive NAAT results and any presumptive culture isolates should be confirmed if forensically significant |
| | **Pre**pubertal | Pubertal | | |
| ***Trichomonas vaginalis*** | REPORT to Child Protective Agency<br><br>DIAGNOSTIC for child sexual assault/abuse, once other rare modes of transmission are excluded. | CONSIDER REPORT to Child Protective Agency<br><br>SUSPICIOUS for child sexual assault/abuse. Other modes of transmission should be excluded. | NAAT<br>• Genital<br>• Urine<br>OR<br>OR<br><br>Culture with wet mountGenital<br>• Genital | 2 Weeks<br><br>*** Expert consultation is recommended for interpretation of non-culture positive results. |

# Kentucky Medical Protocol for Child Sexual Assault/Abuse Evaluation

| STI | Reporting & Diagnostic Considerations | | Testing | Follow-up Testing Interval Following Acute Assault |
|---|---|---|---|---|
| ***Human Immunodeficiency Virus*** | **Pre**pubertal | Pubertal | HIV-1 and HIV-2 antigen/antibody screening assay | 6 weeks<br>and<br>3 months |
| | REPORT to Child Protective Agency<br><br>DIAGNOSTIC for sexual assault/abuse if not likely to be acquired perinatally and non-sexual transmission has been excluded. | REPORT to Child Protective Agency<br><br>HIGHLY SUSPICIOUS for child sexual assault/abuse. Consider perinatal, non-sexual, or consensual sexual transmission. | | |
| ***Hepatitis B*** | **Pre**pubertal | Pubertal | Blood for: (all 3)<br>• Hepatitis B surface antigen<br>• Hepatitis B surface antibody<br>• Hepatitis B surface core antibody | 6 weeks<br>and<br>3 months<br><br>If hepatitis B immune, no further testing is necessary after baseline testing. |
| | CONSIDER REPORT to Child Protective Agency if possibly related to sexual assault/abuse.<br><br>Could be the result of sexual assault/abuse, although there are other modes of transmission. | CONSIDER REPORT to Child Protective Agency if possibly related to sexual assault/abuse.<br><br>Could be the result of sexual assault/abuse, although there are other modes of transmission. | | |
| ***Syphilis*** | **Pre**pubertal | Pubertal | Blood for:<br>• RPR<br>OR<br>• VDRL<br>OR<br>• Total Syphilis Antibody | 6 weeks<br>and<br>3 months |
| | REPORT to Child Protective Agency<br><br>DIAGNOSTIC for child sexual assault/abuse, once other modes of transmission are excluded. | CONSIDER REPORT to Child Protective Agency<br><br>HIGHLY SUSPICIOUS for child sexual assault/abuse. Consider non-sexual or consensual sexual transmission. | | |

# Kentucky Medical Protocol for Child Sexual Assault/Abuse Evaluation

| STI | Reporting & Diagnostic Considerations | | Testing | Follow-up Testing Interval Following Acute Assault |
|---|---|---|---|---|
| | **Pre**pubertal | Pubertal | | |
| ***Hepatitis C*** | CONSIDER REPORT to Child Protective Agency if possibly related to sexual assault/abuse.<br><br>Although sexual transmission can occur, there are other more common modes of transmission. | CONSIDER REPORT to Child Protective Agency if possibly related to sexual assault/abuse.<br><br>Although sexual transmission can occur, there are other more common modes of transmission. | Blood:<br>• Hepatitis C antibody | 6 months if indicated |
| | **Pre**pubertal | Pubertal | | |
| ***Human papilloma virus (HPV)*** | REPORT to Child Protective Agency (unless clear history of autoinoculation). Assess for other abuse indicators (history, exam, other STIs).<br><br>SUSPICIOUS for child sexual assault/abuse, once other modes of transmission are excluded. | CONSIDER REPORT to Child Protective Agency<br><br>MAY BE SUSPICIOUS for child sexual assault/abuse, once other modes of transmission are excluded. | Typically diagnosis is by visual inspection of lesion on skin or mucous membrane. | Vaccine series can be initiated for children age 9 years or older. Check immunization status when appropriate. |

| STI | Reporting & Diagnostic Considerations | | Testing | Follow-up Testing Interval Following Acute Assault |
|---|---|---|---|---|
| | **Pre**pubertal | Pubertal | | |
| ***Herpes simplex virus (HSV 1 and HSV 2)*** | REPORT to Child Protective Agency<br><br>SUSPICIOUS for child sexual assault/abuse once other modes of transmission are excluded. | CONSIDER REPORT to Child Protective Agency<br><br>MAY BE SUSPICIOUS for child sexual assault/abuse. Exclude other modes of transmission. | NAAT or culture from unroofed vesicle or base of ulcerated lesion. | If active lesions are noted, arrange follow-up to assess resolution. |

## Prophylaxis of Sexually Transmitted Infections

**STI Prophylaxis**

- Assess **all** patients for risk of Hepatitis B exposure and the need for prophylaxis. See http://cackentucky.org/medical for prophylaxis guidelines.
- For **prepubertal** children, prophylaxis for gonorrhea, chlamydia, and trichomonas is not recommended when follow-up can be ensured.
    - This is due to the low risk of STI acquisition and spread to the upper genital tract.
    - Retesting is indicated at 2 weeks following last sexual contact to assess for possibility of incubating infection that would not have been detected on initial testing.
    - If a patient or caregiver requests prophylaxis OR if appropriate follow-up cannot be assured, consider providing prophylaxis for gonorrhea, chlamydia, and trichomonas.
- For **pubertal** children, **provide prophylaxis for gonorrhea, chlamydia, and trichomonas, if sexual assault with known or possible exchange of bodily fluids**.
- The CDC recommends STI prophylaxis for acute **pubertal** assault. Consider prophylaxis when the assault occurred within 2 weeks of presentation and involved potential exchange of bodily fluids. If presentation is after 2 weeks, consider testing first and treating based on results or on clinical presentation. See http://cackentucky.org/medical for prophylaxis and treatment guidelines.
- **The doses for treatment of a positive infection may vary from prophylaxis and doses should be checked prior to treating a positive result.** See http://cackentucky.org/medical for treatment guidelines.

**If Hepatitis B prophylaxis or treatment is provided, refer to follow-up recommendations section.**

## Pregnancy Assessment, Testing, and Emergency Contraception:

- Inquire about patient's age of menarche, last menstrual cycle, and last consensual sexual contact (when developmentally appropriate to ask about consensual sexual contact).
- If within 120 hours (5 days) of sexual assault with known or possible exchange of penile secretions to the vagina of a menstruating female patient:
    - Test for pregnancy with Urine Qualitative hCG and/or Serum Quantitative hCG
    - Educate the patient/caregiver that the medication can help prevent pregnancy by delaying ovulation. Emergency contraception will NOT affect an existing pregnancy (i.e. is NOT an abortion pill) and will not affect future fertility.
    - Offer emergency contraception.
        - If possible, request that the hospital pharmacy provide single dose emergency contraception.
        - If the hospital formulary carries 2-dose emergency contraception, instead of separating the doses, whenever possible, provide both doses at the same time to help ensure efficacy and adherence.

## Toluidine Blue:

**General Considerations:**

- Providers should recognize this may be uncomfortable, especially for prepubertal children and should prioritize other components of evaluation and evidence collection prior to dye use.
- Toluidine blue can be used on the vulva (labia majora, labia minora, posterior fourchette/commissure), perineum, or external anal ring. Toluidine blue **should not be** used on mucous membranes (peri-hymenal area, urethra, or fossa navicularis) or hymen.
    - Toluidine Blue dye is a nuclear stain that binds to nucleated squamous cells.
    - Normal intact vulvar skin cells will not bind the dye.
    - When superficial vulvar tissue is injured, dermis cells that contain nuclei are exposed, exposed areas will bind dye allowing visualization of anogenital injury.
- Toluidine blue dye should be used to enhance photographic documentation of previously identified findings.
- Toluidine blue dye should not be used to identify acute injury not visible prior to dye.
- **Should only be done by a provider with training in how to use and assess toluidine blue.**
- Important considerations for use of toluidine blue:
    - DO NOT use with patients who have diagnosis of G6PD (Glucose 6 Phosphate Dehydrogenase) Deficiency.
    - Additional time may be needed for this procedure.
    - Inform the patient this may cause discomfort.
    - Can dye clothing.
    - Can pose risk of over interpretation of findings if performed by an inexperienced examiner.
    - Recognize trauma, infection, irritation, or malignancy may all result in dye uptake.

**Procedure:**

- **Obtain any needed swabs for evidence collection and other testing prior to using dye.**
- Visually inspect the area.
- Assess any areas of pain. Ask patient to describe the pain (burning, throbbing, sharp, dull, etc.).
- Photograph area before placing dye.
- Inform the patient that procedures related to dye use may cause discomfort.
- Apply the dye to the area with cotton tip swabs and allow dye to remain for a minimum of 1 minute before removal.
- Remove the dye using one of the following:
    - A 1% vinegar solution (1% acetic acid) in a spray bottle and flush area until excess dye is removed.
    - A lubricant gel.
- Use gauze to blot, not rub the area and remove dye.
- Photograph area again once dye is removed.

## Discharge Planning:

- Consult a pediatrician or pediatric child abuse specialist (refer to the https://cackentucky.org/medical) to discuss patient management if there are questions.
- Validate the child's feelings by acknowledging that sexual assault/abuse disclosures are difficult to make and take courage. Remind the child that they may need to share their story with individuals responsible for keeping them safe at a later date.
- Review what was done during the evaluation (exam findings, tests ordered, and what follow up care is needed) with the patient and caregiver. Sample form available at https://cackentucky.org/medical.
- Ensure that all immediate medical and mental health needs are addressed.
- Consider providing an antiemetic if emergency contraception and/or STI prophylaxis/treatment is provided. Educate patients/caregivers that if medications are vomited following facility discharge, the facility should be contacted for further guidance.
- In reported cases, tell the caretaker that investigators request that the caregiver avoid questioning the child about the assault/abuse. The investigators should schedule the child to be interviewed by a trained child forensic interviewer at a Children's Advocacy Center. This provides the child the opportunity to tell what happened. If a child spontaneously discusses the sexual assault/abuse with a caregiver, it is okay to listen.
- Ensure that the child will be discharged to a safe environment.
    - Await safe disposition/DCBS recommendations prior to discharging the patient if applicable
    - KRS 620.040(5) (b) provides authority to physicians and hospital administrators to place a child under a 72-hour hold if necessary for protection of the child.
- Provide the caretaker and patient with the contact information for the Children's Advocacy Center in their region (https://cackentucky.org/local-centers). The Children's Advocacy Center can provide victim advocacy, counseling, and/or serve as a resource for where to obtain these services.

- Follow up with a medical provider is recommended 1-2 weeks or sooner after the emergency department evaluation:
    - As soon as possible:
        - Photographically document an injury identified but not photographed
        - Clarify a finding with unclear significance
        - Prescribe additional HIV nPEP to complete a full 28 day course
    - In 1 to 2 weeks:
        - Assess healing of injury that was previously photographically documented
        - Monitor adherence with treatment recommendations
    - In 2 weeks:
        - Identify infection
    - At every follow-up:
        - Address mental health concerns
        - Assess continued safety of the patient
    - In 1-2 months:
        - Obtain follow up titer to assess whether patient has responded to the vaccine if patient receives Hepatitis vaccine due to a low antibody titer (less than 10 mIU/mL).
        - Complete Hepatitis immunization (follow up doses are indicated 1-2 months and 4-6 months after the first dose).
- Additional Guidance for Adolescent Patients:
    - Patients are generally counseled to avoid sexual activity until seven days following prophylaxis/treatment initiation.
    - Patients should only resume having sex after symptoms have resolved and partners have been treated.
    - Patients prescribed metronidazole should avoid alcohol or products containing propylene glycol for at least three days after therapy.

# Appendix A

Tanner Stages Diagram

**Tanner Staging Ranges from 1 (Prepubertal) to 5 (Adult Development)[1]**

| Stages | Girls—Breast Development | Girls and Boys—Pubic hair | Boys—External Genitalia Development |
|---|---|---|---|
| *Tonner Stage 1* | *Prepubertol*<br>*Only the papilla is elevoted above the level of the chest woll* | *Prepubertol (velus hair similor to abdominol hair)* | *Prepubertol (velus hair similor to abdominol hair)*<br>*Testes, scrotol sac, and penis have size similar to early childhood* |
| *Tonner Stage 2* | *Breost budding, elevation of breosts as small mounds, enlargement and widening of areoloe. May be tender and not symmetricol biloterolly* | *Sporse growth of long, slightly pigmented, downy, straight or curled hair on labia majoro or ot the base of the penis* | *Enlorgement of scrotum and testes; scrotum skin will thin and may be redden* |
| *Tonner Stage 3* | *Breost enlorges, elevoting beyond the areoloe* | *Pubic hair becomes curly, coorser, extends outward over junction of pubes* | *Penis lengthening, testicles continue to grow* |
| *Tonner Stage 4* | *Breost enlorges and areoloe and papillo form secondory mounds* | *Hair odult in type, but covers smoller areo, no spreod to the medial surface of thighs* | *Penis and testicles grow, scrotum darker in color* |
| *Tonner Stage 5* | *Breost ochieves odult contour* | *Hair odult in type and quontity extends onto medial thigh* | *Adult genitalia* |

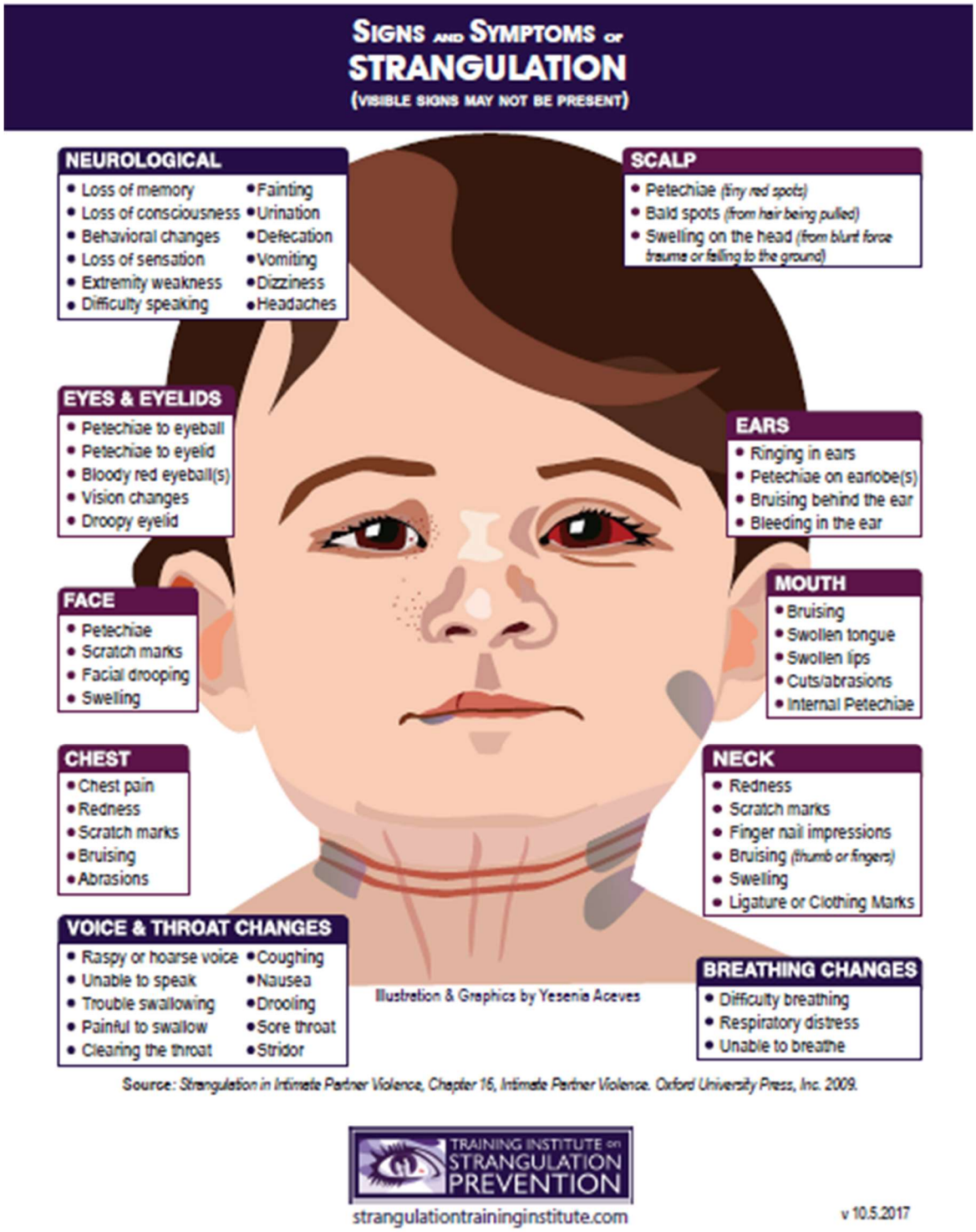
**Changes in Girls and Boys at Various Stages of Sexual Maturation**

*(Original illustration from Johnson, Moore, & Jefferies. (1978). Permission to use obtained from Abbott Laboratories, Nutrition Research and Development.)*

The Medical Protocol Subcommittee of the Sexual Assault Advisory Committee greatly acknowledges the National Protocol for Sexual Assault Forensic Exams- Pediatric for allowing us to reproduce, in part or in whole, the resources provided on their website.

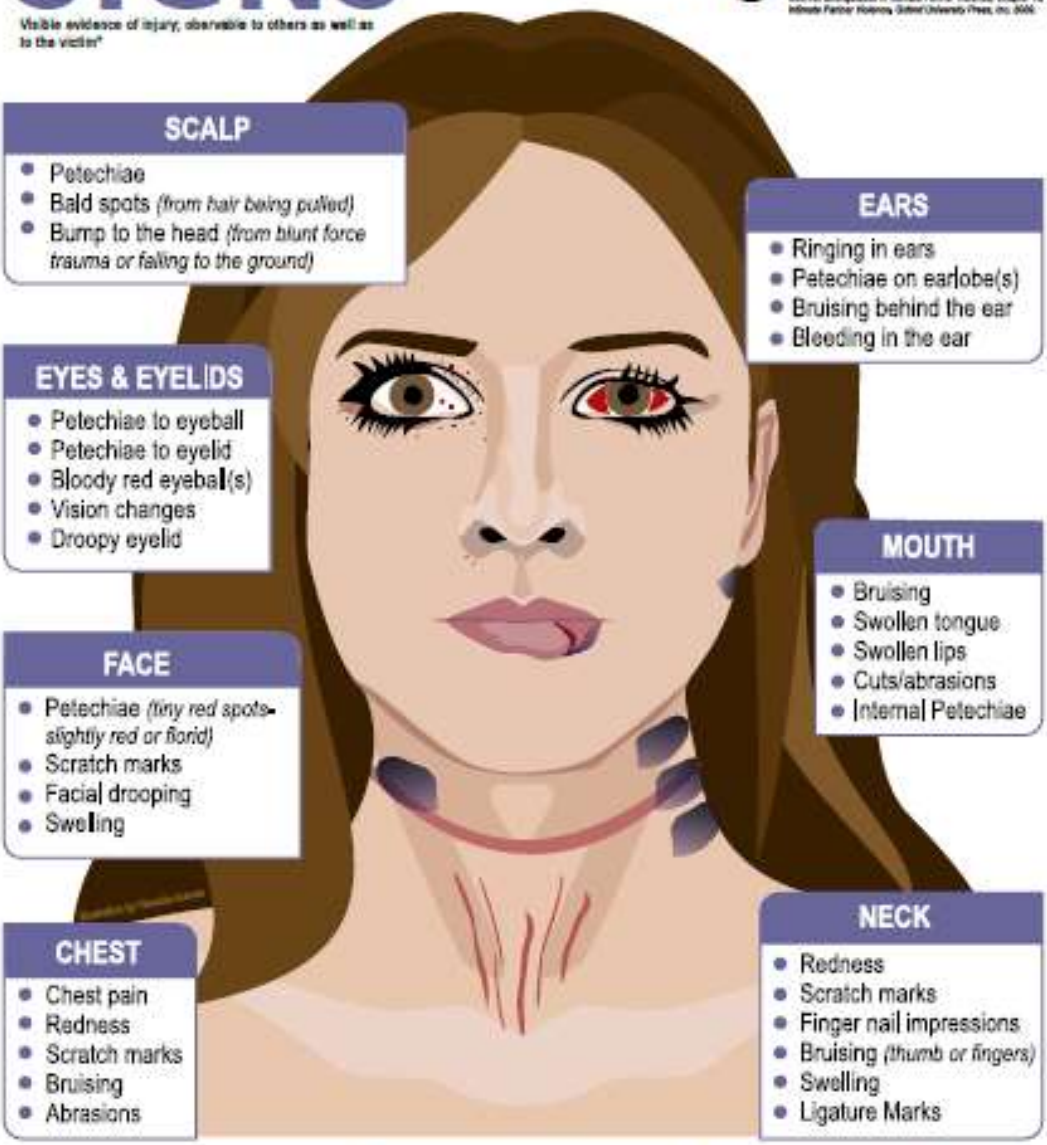
# Appendix B

Strangulation Resources



# SIGNS of Strangulation

Visible evidence of injury, observable to others as well as to the victim*



## SCALP

- Petechiae
- Bald spots *(from hair being pulled)*
- Bump to the head *(from blunt force trauma or falling to the ground)*

## EARS

- Ringing in ears
- Petechiae on earlobe(s)
- Bruising behind the ear
- Bleeding in the ear

## EYES & EYELIDS

- Petechiae to eyeball
- Petechiae to eyelid
- Bloody red eyeball(s)
- Vision changes
- Droopy eyelid

## MOUTH

- Bruising
- Swollen tongue
- Swollen lips
- Cuts/abrasions
- Internal Petechiae

## FACE

- Petechiae *(tiny red spots- slightly red or florid)*
- Scratch marks
- Facial drooping
- Swelling

## CHEST

- Chest pain
- Redness
- Scratch marks
- Bruising
- Abrasions

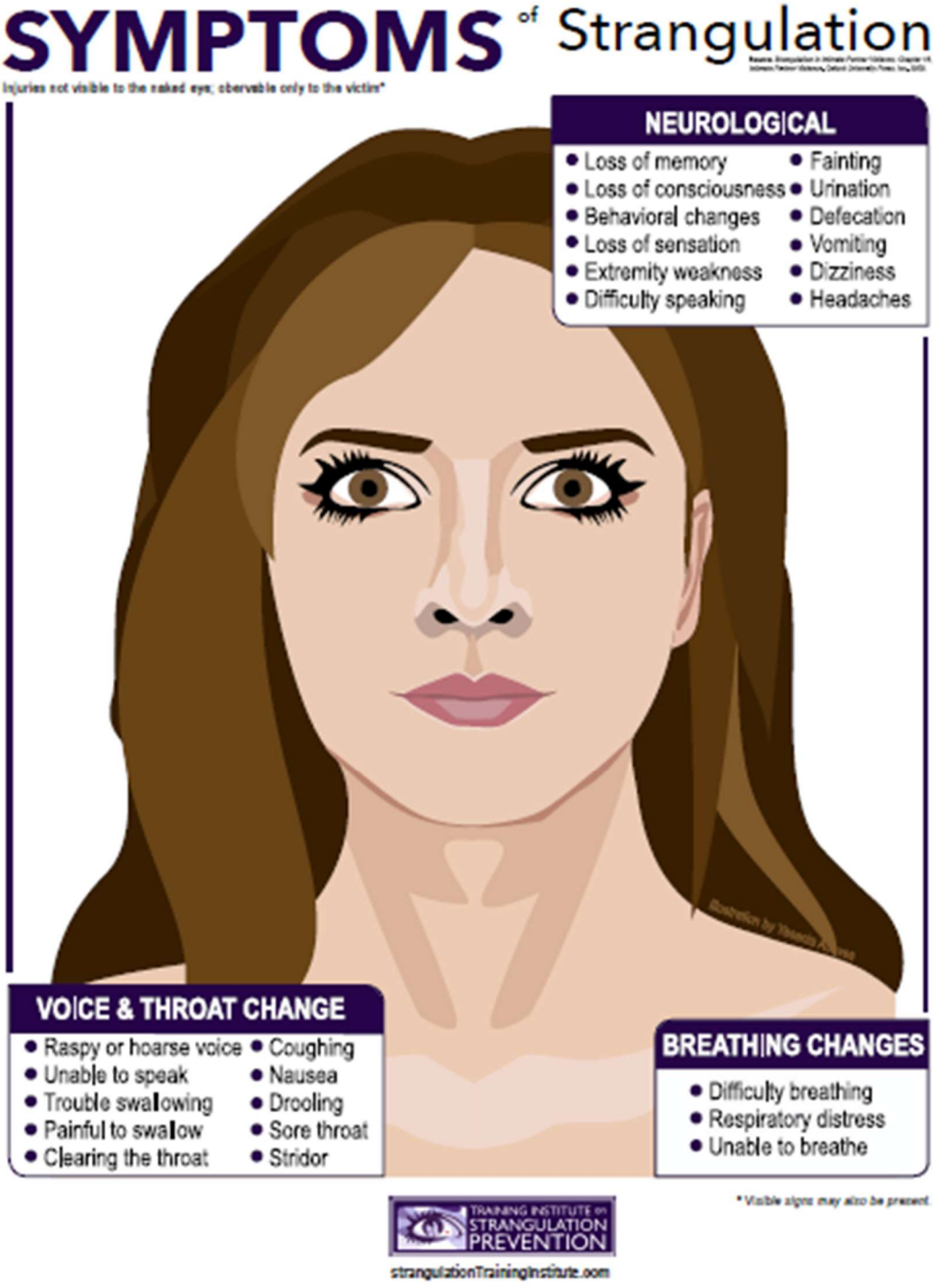
## NECK

- Redness
- Scratch marks
- Finger nail impressions
- Bruising *(thumb or fingers)*
- Swelling
- Ligature Marks

TRAINING INSTITUTE on STRANGULATION PREVENTION

strangulationtraininginstitute.com

* The lack of visible signs does not eliminate the possibility of strangulation; invisible symptoms may also be present.

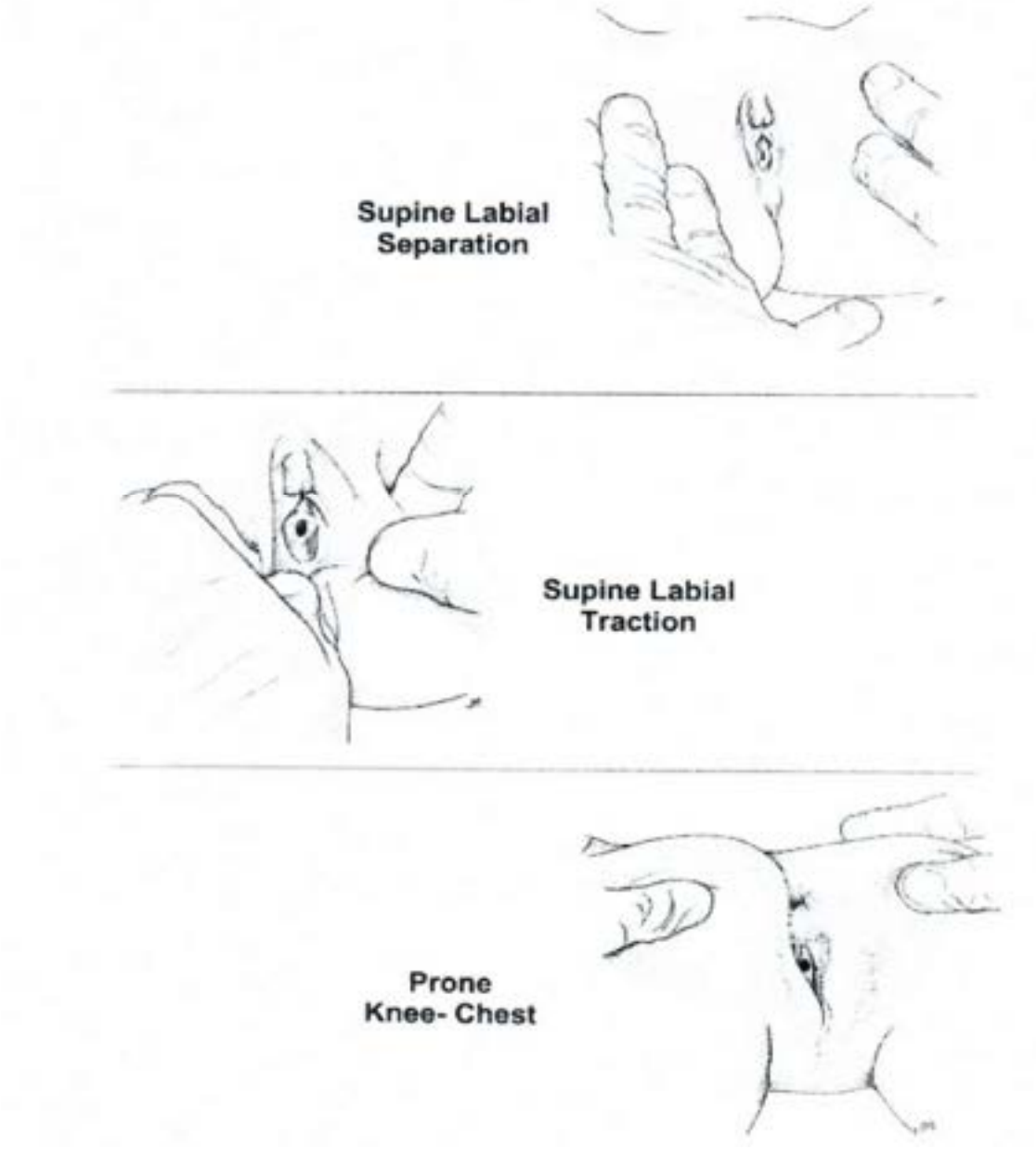



The Medical Protocol Subcommittee of the Sexual Assault Advisory Committee greatly acknowledges Alliance for Hope International for allowing us to reproduce, in part or in whole, the resources provided on their website.

# Appendix C

Examination Techniques

## Appendix 2. Illustrations of Exam Positions and Techniques

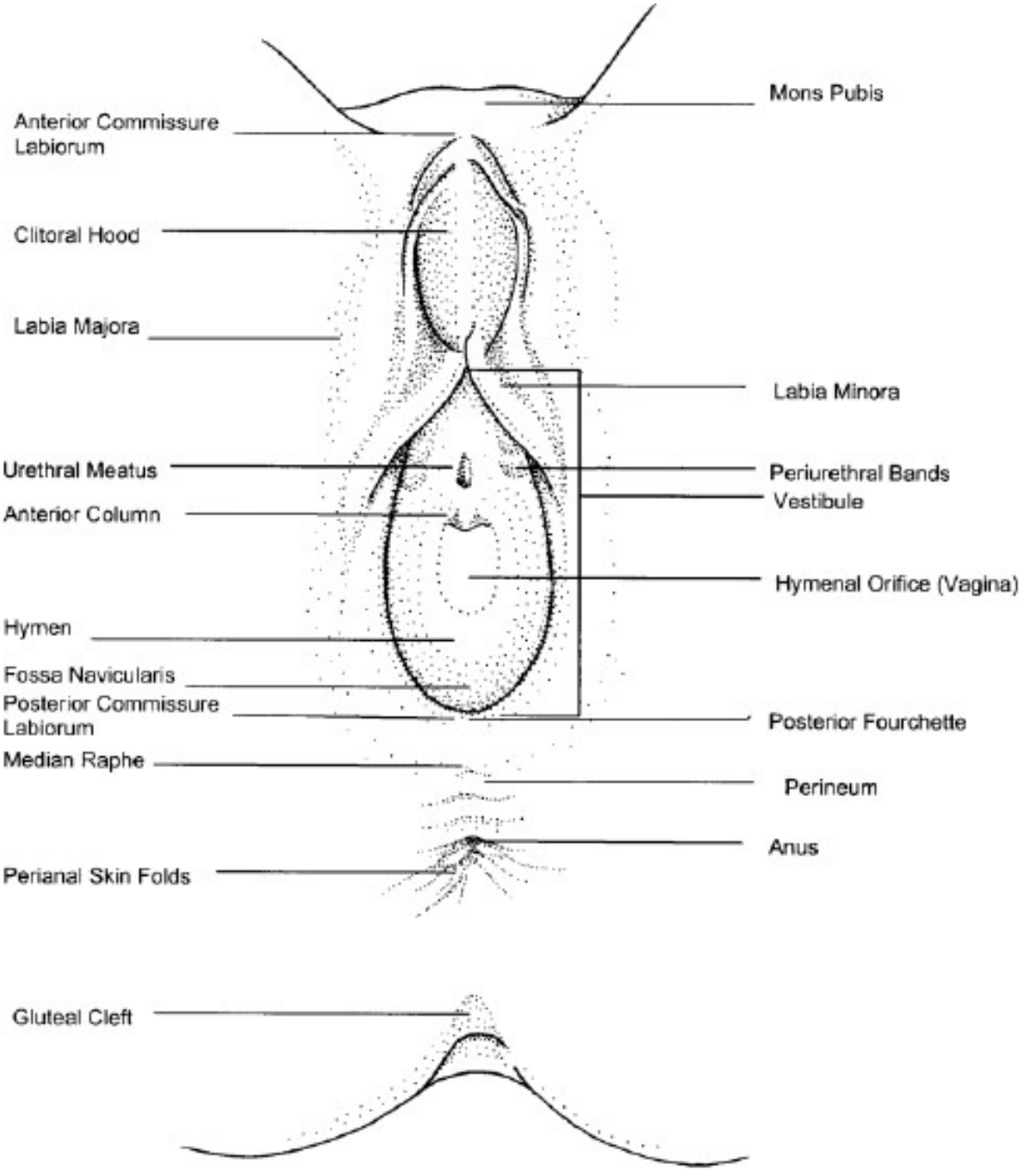



The Medical Protocol Subcommittee of the Sexual Assault Advisory Committee greatly acknowledges the National Protocol for Sexual Assault Forensic Exams- Pediatric for allowing us to reproduce, in part or in whole, the resources provided on their website.

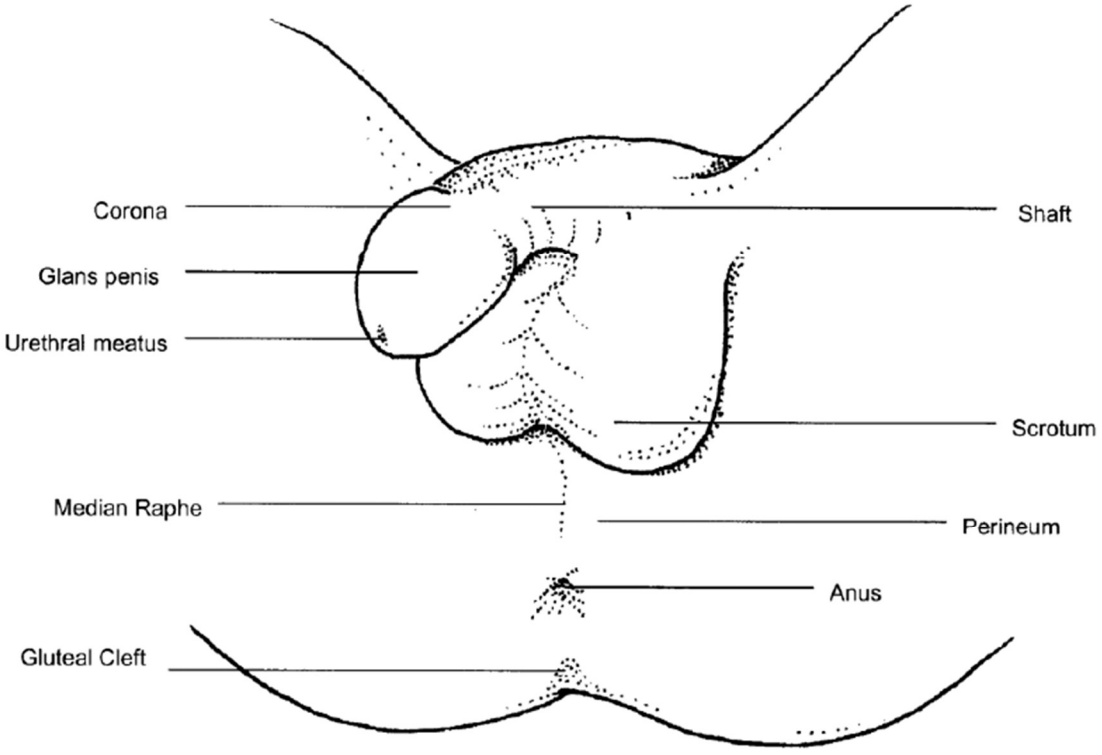
Clinical Photography of Genital Findings Techniques

# Appendix D

Female Genital Anatomy



Male Genital Anatomy

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## Appendix E

Types of Hymens

A. Crescent B. Annular C. Redundant

D. Septate E. Cribriform F. Imperforate