Child Sexual Abuse/Assault Medical Response Protocol[1]

All children who are suspected victims of child sexual abuse should be offered a timely medical evaluation by a provider skilled in performing such evaluations. The primary purpose of the medical evaluation is to identify, document, diagnose, prevent, and treat medical conditions and/or trauma (resulting from abuse and unrelated to abuse), as well as to assess issues related to patient safety and wellbeing. An additional purpose of the medical evaluation is to determine the appropriateness of trace evidence collection and, if indicated, to ensure that biologic trace materials are properly collected and preserved.

A medically-based screening process can guide medical professionals and community partners in determining whether a child requires an immediate medical examination by an emergency medical provider, mental health provider, or social worker. A child who does not require emergency services will be more effectively served by contacting the nearest Children's Advocacy Center (CAC) so that the child may be referred to a medical provider skilled in addressing non-acute child sexual abuse.

While most child abuse victims of sexual abuse/assault do not require emergency medical evaluations, reasons for emergency medical examinations include, but are not limited to:

- The alleged assault may have resulted in the transfer of trace biological material and occurred within the previous 96 hours (4 days).
- The reported assault may have placed the child at risk for pregnancy and occurred in the previous 5 days.
- The child complains of pain in the genital or anal area.
- There is evidence or complaint of anogenital bleeding or injury.

Reasons for emergency medical health or social interventions include, but are not limited to:

- Intervention is needed emergently to assure the safety of the child.
- The child is experiencing significant behavioral or emotional problems that could make the child a danger to themselves or others.

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The flowchart on the next page is meant to support medical professionals and facilities in their decision-making when a child presents to them with allegations, suspicions, or signs of child sexual abuse. The place where you, your institution, or community refers a child for acute sexual assault exams may vary depending on when the child presents to you. There is a place on the flowchart to fill in your local business-hours contact and the after-hours/weekend contact to whom you may refer a child for an acute sexual assault exam. For non-acute sexual abuse exams, your local Children's Advocacy Center will be able to point you to the nearest provider or facility with specially-trained medical professionals and support specific to these children's needs.

[1] **This protocol has been a project of the West Virginia Child Advocacy Network (WVCAN) funded by the Claude Worthington Benedum Foundation and the Bernard McDonough Foundation. It has been endorsed by the West Virginia Chapter of the American Academy of Pediatrics and the West Virginia Chapter of the American College of Emergency Physicians.**

Child Sexual Abuse/Assault Screening Protocol Flowchart

*** Refer to Additional Information**

CPS: Hotline 800-352-6513
State Police Detachment: _____
Local CAC: _____

A child has disclosed sexual abuse, abuse was witnessed, or there is other credible concern that a child was sexually abused. **1***

↓

MANDATED REPORTING—Make a child abuse/neglect report to CPS and law enforcement. **2***

↓

Could the contact have resulted in transfer of biologic evidence? **3**

YES → Is it possible that the contact occurred in the 96 hours? Refer to additional info on trace evidence collection. **4***

YES → Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact your local Children's Advocacy Center (CAC) to determine appropriate follow-up care. **5***

NO ↓

Is the child at risk of pregnancy?
- Female with signs of pubertal development (such as breast development) AND
- Penile-vaginal contact is suspected **6***

YES → Emergency medical care, to include possible offer of pregnancy prophylaxis, should be provided in the nearest appropriate facility. Then contact your local Children's Advocacy Center (CAC) to determine appropriate follow-up care. **8***

NO ↓

Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days? **7**

YES → Emergency medical care should be provided in the nearest appropriate facility. Contact your local Children's Advocacy Center (CAC) to determine appropriate follow-up care. **10***

NO ↓

Is the child experiencing symptoms of pain or bleeding? **9***

YES → Emergency mental health care should be provided in the nearest appropriate facility. Then contact your local Children's Advocacy Center (CAC) to determine appropriate follow-up care. **12***

NO ↓

Is the child displaying behavioral or emotional problems that put themselves or others in danger? **11***

YES → Emergency social intervention should be provided in the nearest appropriate facility, which may be a medical facility. Then contact your local Children's Advocacy Center (CAC) to schedule a comprehensive sexual abuse medical evaluation. **14***

NO ↓

Is an emergent intervention needed to assure the safety of the child? **13***

NO ↓

Contact your local CAC to determine if and/or when a scheduled comprehensive sexual abuse medical evaluation is recommended. **15***

Additional Information

Figure 1: A child has disclosed sexual abuse, abuse was witnessed, or there is other credible concern that a child was sexually abused.

Victims of child sexual abuse present for medical care in many different ways. Some children will tell someone they trust about the abuse. A child does not have to repeat the disclosure to a medical provider to be offered appropriate medical care. A provider must remember that children frequently do not disclose all aspects of the abuse immediately. Some children do not disclose sexual abuse but other credible evidence is obtained or found, such as a witness disclosure or photographs of abuse are found. Providers should use the best and most complete information available in determining the need for emergency medical services.

Frequently, a concerned adult will request a medical evaluation for sexual abuse because of non-specific indications (such as a behavior change) or a strong distrust of a specific person or people in the child's life. These medically-based screening guidelines will still apply for this patient population, but decisions to perform acute medical interventions should be based on more specific indications that an abusive event has occurred.

Figure 2: Make a Child Abuse/Neglect Report.

All medical providers are mandated reporters (West Virginia Code §49-2-803). Any mandated reporter "who has reasonable cause to suspect that a child is neglected or abused or observes the child being subjected to conditions that are likely to result in abuse or neglect shall immediately, and not more than forty-eight hours after suspecting this abuse or neglect, report the circumstances or cause a report to be made to the Department of Health and Human Resources: Provided, That in any case where the reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter shall also immediately report, or cause a report to be made, to the State Police and any law-enforcement agency having jurisdiction to investigate the complaint."

It is the responsibility of the medical provider(s) evaluating the child to follow the mandated reporting statute. It is not the reporter's responsibility to prove that abuse has occurred prior to making a report. In fact, delaying a mandated report to perform an independent investigation may result in criminal charges and civil liability. Use the chart below to fill in your local information. **There is space on the flowchart above to document this information for quick access.**

Figure 4: Could the contact have resulted in transfer of biologic evidence? Is it possible that the contact occurred in the last 96 hours?

Indications that trace evidence collection may provide forensically valuable information include:

1. Debris or body fluid is visible on child's body or clothing, -or-
2. The contact included possible body fluid (semen, blood, saliva) or debris transfer,
    a. This includes (but is not limited to) a perpetrator licking, biting, or using genitals to touch a child anywhere on their body.

b. Remember that a child may not disclose or have knowledge of all details of an abusive act; therefore, do not use an assumption of "no ejaculation" or "no penetration" as a reason to defer trace evidence collection –or-

3. Acute genital injury indicating an abusive event is detected during physical examination, regardless of history provided.

Local Child Abuse multidisciplinary investigative teams (MDITs) composed of local representatives from law enforcement, Child Protective Services (CPS), Children's Advocacy Centers (CACs), prosecutors, mental health providers, and medical providers will determine how long after a reported sexual abuse event trace evidence collection will be recommended. MDITs will use information from the West Virginia State Police Forensic Laboratory to assist in determining how likely it is that trace evidence collection may lead to a forensically relevant positive result.

When determining how long after a reported abusive act trace evidence should be collected, use your local MDIT agreed upon interval, which may range from 1-5 days, depending on the age of the child and the nature of the contact.

1. After 24 hours, the likelihood of obtaining trace evidence from a young child's body is low.
2. It is well established that trace evidence collection from anywhere on or in a child is never indicated past 7 days.
3. Clothing and bedding from a scene may yield positive results even years after the crime has occurred. Encourage law enforcement investigators to collect evidence from the scene or clothing as soon as possible.

Figure 5: **See pg. 5**

Figure 6: Is the child at risk of pregnancy? Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?

Pregnancy prophylaxis is available and should be offered to females who meet the following criteria:

1. History of menarche or has a Sexual Maturity rating (breast or pubic hair) of 3 or greater; and
2. Suspected penile-vaginal contact, with or without a history of penetration, condom use, or ejaculation; and
3. Contact occurred in the previous 5 days.

Figure 8: **See pg. 5**

Figure 9: Is the child experiencing symptoms of pain or bleeding?

Current anogenital pain or bleeding may represent a traumatic injury from sexual abuse/assault or other medical condition which requires emergency medical intervention. A history of distant anogenital pain or bleeding, now resolved, typically does not require emergency medical care, but that historical

information should be communicated to the medical provider responsible for the scheduled comprehensive medical evaluation.

Figure 10: **See pg. 5**

Figure 11: Is the child displaying behavioral or emotional problems that put themselves or others in danger?

An appropriate medical or mental health provider should evaluate any concern that a child's behavior or emotional state represents a danger to themselves or others (including but not limited to suicidal/homicidal thoughts). Emergency care may include crisis counseling, mental health evaluation, and/or treatment plan.

Figure 13: Is an emergent intervention needed to assure the safety of the child?

A child victim of sexual abuse should be protected from possible perpetrators during the investigation. If a child remains at risk for sexual abuse, Child Protective Services and your state police attachment should be notified to evaluate the circumstances and establish a safety plan.

Figures 5, 8, 10, 12, 14, 15: Locating a medical provider with specialized training in identifying and treating child abuse.

NOTE*: Always make sure to make a mandated report to CPS and law enforcement as soon as a child presents.*

Normal Business Hours (Monday-Friday, 9am-5pm): Your local Children's Advocacy Center (CAC) can assist you in referring to a medical provider with specialized training in identifying and treating child abuse in emergency and non-emergency situations. If your county falls outside of an official CAC service area, a child may still be able to receive courtesy services. Please call the CAC in your nearest neighboring county. If you need additional assistance in locating a provider, please call the West Virginia Child Advocacy Network at 304-414-4455 during normal business hours.

After Business Hours: Follow your facility's protocols, make a mandated report to CPS and law enforcement, and follow up with your local CAC as soon as possible.

Background

The West Virginia Child Advocacy Network (WVCAN) and a multidisciplinary committee it has convened have adapted these guidelines from "A Medically-Based Screening Protocol for the Medical Response to Child Abuse/Assault" with permission from Missouri's Sexual Assault Forensic Exam-Child Abuse Resource and Education (SAFE-CARE) Network. http://health.mo.gov/living/families/injuries/safecare/

The SAFE-CARE Advisory Council provides guidance regarding services, education, networking, quality assurance, and consultation. Advisory Council members include professionals from nursing, medicine, social work, and child advocacy centers.

The SAFE-CARE Advisory Council developed these recommendations to comply with Missouri Revised Statutes Section 334.950.4: "The SAFE CARE network shall develop recommendations concerning medically based screening processes and forensic evidence collection for children who may be in need of an emergency examination following an alleged sexual assault. Such recommendations shall be provided to the SAFE CARE providers, child advocacy centers, hospitals and licensed practitioners that provide emergency examinations for children suspected of being victims of abuse."

References

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