

**Wisconsin Chapter – International Association of Forensic Nurses**

**FORENSIC NURSE EXAMINER (FNE)  
EVALUATION OF THE PREPUBERTAL PATIENT  
SUSPECTED OF BEING SEXUALLY ABUSED**

This guideline was reviewed/revised by the WI-IAFN  
Protocol / Documentation Committee on 4/21/2022

**FORENSIC NURSE EXAMINER (FNE)  
EVALUATION OF THE PEDIATRIC PATIENT SUSPECTED OF BEING SEXUALLY ABUSED**

This guideline was developed by the Wisconsin Chapter of the International Association of Forensic Nurses to outline the steps in the assessment and care of the prepubescent child when there is a history or concern of sexual abuse or assault. The U. S. Department of Justice Office on Violence Against Women (2016) National Protocol for Sexual Abuse Medical Forensic Examinations Pediatric defines prepubescent as those children having sexual characteristic development of Sexual Maturity Rating (SMR) 1 or 2. Adolescents are children who are SMR stage 3 and above who have potential reproductive capability. (Please refer to the Forensic Nurse Examiner Evaluation of the Adult/Adolescent Victim of Sexual Assault). Protocols for the care of adolescents is similar to adults, but with particular sensitivity to their neurodevelopmental and emotional needs. The guideline is not intended to include all the triage issues, medical evaluations, tests, and follow-up that may be necessary for appropriate care for an individual patient, and some steps may not be appropriate for every patient. The goal is to provide compassionate and sensitive services and care in a non-judgmental manner. The physical and psychological well-being of the sexual assault patient is given precedence over forensic needs. A review of this guideline by the members of the Wisconsin Chapter of the International Association of Forensic Nurses Protocol / Documentation Committee will be conducted periodically.

**I. GENERAL INFORMATION**

**Purpose of Exam**

**Medical/Forensic**

1. Identify and treat injuries. Injuries that require intervention beyond scope of practice of FNE should be referred to the physician for treatment
2. Assess risk of sexually transmitted infections
3. Offer prophylaxis for sexually transmitted infections and pregnancy, when indicated (Late SMR 2 and SMR 3 or higher)– note presumptive treatment for prepubertal children who have been sexually assaulted or abused is not recommended
4. Document medical history
5. Document physical findings
6. Assess for other forms of abuse/neglect (including but not limited to: Drug Endangered Children (DEC), trafficking, and family violence). Follow agency/organization protocol regarding referral to expert advanced practice provider for continued and follow up care
7. Identify, collect, document forensic evidence

**Social/Psychological**

1. Respond to patient's and family's immediate emotional needs and concerns
2. Assess patient safety and immediate mental health needs
3. Explain limits to confidentiality, mandatory reporting process, Crime Victims Compensation, resources for advocacy, counseling, and follow-up

**Consult/Report/Refer**

1. A FNE Program and a Child Advocacy Program / child abuse pediatrician / expert nurse practitioner should have a relationship and agreement in place for the care of the child and consultation as needed. It is recommended that peer review of photographs with a child abuse pediatrician / expert advanced practice provider (nurse practitioner or physician assistant) occur with all children with a physical finding related to possible abuse / assault. Referral to the child abuse pediatrician / expert advanced practice provider (nurse practitioner or physician assistant) for a follow-up medical evaluation may also be indicated.
  - a. Indications for a follow-up medical evaluation include
    - i. Findings on the initial examination are unclear
    - ii. Further testing, prophylaxis, treatment for sexually transmitted infections if needed
    - iii. Pregnancy testing
    - iv. Documentation of healing/resolution of acute findings
    - v. Confirmation of initial findings (schedule as soon as possible)
2. Refer for follow-up medical care needs unrelated to the abuse/assault
3. Refer for advocacy and counseling

4. Report to Child Protective Services (CPS) and/or law enforcement as soon as possible (ASAP); dual reporting is best practice

### **Mandated Reporting**

1. Nursing and medical providers are mandated to report suspected child maltreatment and risk of maltreatment to CPS and/or law enforcement immediately (WI Statute 48.981 Abused or Neglected Children and Abused Unborn Children). Dual reporting to both CPS and law enforcement is recommended and best practice.
2. Report to law enforcement in the jurisdiction where crime occurred. Contact CPS in the county in which child resides
3. Advise patient/parent/caregiver of mandated reporting to CPS and/or law enforcement unless doing so would jeopardize the safety of the patient or other children.
4. All mandated reporting must be documented within the medical record

### **Consent**

1. No parental consent is needed to conduct a child sexual abuse medical evaluation including examination, evidence collection, photographs, and laboratory tests.
2. Wisconsin law specifically exempts need for consent when photographs are taken for child abuse medical evaluation (WI Statute 48.981(4) Abused or Neglected Children and Abused Unborn Children – Immunity From Liability)
3. Assent from the child is needed when the child is verbal.
4. Follow hospital/agency policy regarding consent, however this should not delay medical treatment or immediate mandatory reporting

## II. TRIAGE DECISIONS

*Medical stabilization always precedes forensic examination*

### **Triage**

1. The following history or conditions should be evaluated medically prior to the sexual abuse evaluation:
  - History of loss of consciousness
  - Head injury
  - Altered consciousness or mental status
  - Abnormal vital signs
  - Respiratory distress
  - Significant facial injury
  - Possible fractures
  - Blunt or penetrating injury to chest, abdomen or back
  - Active bleeding
  - Strangulation
  - Acute pain
  - Any other injury or condition which may endanger life or health of patient
2. Psychiatric illness
  - If apparent psychiatric illness complicates assessment of reported sexual assault, both psychiatric assessment and medical exam may be necessary. Proceed according to patient tolerance and needs.

### **Medical/Forensic Examination**

*The Wisconsin State Crime Laboratory allows for the collection of evidence up to 120 hours post assault. Forensic samples are usually collected to a maximum of 72 hours in the prepubescent child. The most recent known contact with the perpetrator can be used if the child is unable to verbalize a clear timeframe for the assault.*

### **Urgent**

Patients who present with the following should have an examination as soon as possible:

1. Patients with suspected injury, bleeding, pain, suspicion of internal injury, and/or medical complaints (discharge).

2. Recent physical contact with suspect
3. Concerning social issues, investigative urgency or placement issues

Advise patient or parent/caregiver, if possible:

- Do not bathe, brush teeth, douche, eat, or drink before exam
- Bring in clothing worn at time of assault and immediately after assault, especially undergarments or diapers, in a paper bag

### **Non-urgent**

Patients who are asymptomatic, last physical contact with suspect was remote/distant and who have an active safety plan can be seen when it is best for the patient.

1. Forensic Exam
  - Forensic exam is generally NOT indicated on emergency basis. Consider community protocol regarding order of forensic interview and examination.
  - Individual case circumstances may warrant urgent evidence collection beyond 120 hours after an assault (i.e., little or no post assault hygiene, held captive, etc.) or when requested by law enforcement
2. Medical Evaluation
  - Medical evaluation is indicated for all patients at any time following sexual assault
  - Patients may be evaluated by the FNE or referred to a Child Advocacy Center or other appropriate clinic for medical care.
    - Refer to sexual assault center, advocacy organization or mental health counselor for psychological support for patient and/or parent/caregiver/family.

### **Advocacy**

FNE Programs will contact advocacy when the FNE is called and together will respond as a team (2015 Wisconsin Act 351 – Victim Accompaniment Law).

## III. HISTORY AND INITIAL EVALUATION

See the WI-IAFN Forensic Nurse Examiner (FNE) Pediatric Documentation Form

### **Patient Information**

Document the following information if it is available and pertinent:

1. Routine demographic data: patient name, gender assigned at birth, gender identity, ethnicity/race, age, birth date, medical record number, home address, phone number/contact information
2. Parent/caregiver name, home address, phone number/contact information, custody status
3. Date and time of arrival
4. Who accompanied patient, and their relationship
5. Interpreter name, if used, and language
6. Name of advocate and agency
7. Name of law enforcement personnel and agency
8. Law enforcement case number, if available
9. Name of CPS worker and agency

### **Medical History**

1. Review of systems to include significant medical problems, surgery, major injuries, chronic diseases, immune problems, developmental, cognitive, mental health and/or physical disabilities, and immediate familial history.
2. Current medications including over-the-counter drugs and herbal supplements
3. Recent ingestion of other drugs, including over-the-counter drugs, legal and illegal substances, and/or alcohol
4. Allergies
5. Immunization status
6. Primary care provider

7. Prior sexual abuse/assault
8. Screen for abuse, suicidal ideations per agency protocols
9. Current complaints/symptoms including vaginal, urethral, anal discharge, anogenital itching, bleeding, pain, odor, dysuria, encopresis.
10. Items which may affect physical findings – toilet training, bowel / bladder history, recent UTIs, hygiene, enuresis, constipation, bubble baths, diarrhea, recent antibiotics, any prior surgery/injury to anogenital area

### **History of Assault**

Obtain information from the child at the time of the acute FNE exam using minimal facts interviewing guidelines, obtaining only the information needed for medical decision-making unless the child offers the information spontaneously. Recommend comprehensive interviews of children be completed by those trained in forensic interviewing of children (referrals for forensic interviews need to come from Law Enforcement and/or Child Protective Services). The forensic interview of the child is investigative, performed to gather facts regarding suspicions, allegations, or specific incidents. Forensic interviewing is conducted only by those specifically trained in the forensic interviewing of children. Forensic interviewing is NOT included in the education of the pediatric FNE. Whenever possible follow community protocol regarding the timing of the forensic interview and FNE exam. Interviewing of the parent/guardian or other adult who accompanies the child should not be performed in front of the child. Be clear about who is providing the history when documenting. Document the following if information provided by parent/caregiver, CPS, law enforcement, et cetera or if spontaneously disclosed by patient:

### **Facts about assault**

1. Source of information (patient, CPS, CAC provider, family, police, or another person)
2. Nature of assault
3. Date, time, place of assault, and jurisdiction/location if known
4. Time since assault
5. Multiple assaults by suspect
6. Number of suspects and identity of suspect(s), if known
7. Any concerns for sex trafficking (See Appendix A)
8. Relationship of suspect(s), if known
9. Photographs taken by suspect
10. Record narrative history of assault

### **Methods used for control**

1. Patient had impaired consciousness
2. Known or suspected alcohol/drug ingestion
3. Verbal threats
4. Use of physical force
5. Use of restraints, including body weight
6. Use of weapon
7. Use of coercion, manipulation, grooming
8. Strangulation and/or suffocation

### **Physical facts of sexual assault**

1. Location of physical contact on patient by suspect
2. Body parts or objects used by suspect
3. Whether condom was used
4. Whether lubrication was used
5. Physical injuries
6. Whether bleeding or pain was reported
7. Physical contact made by patient on suspect

### **Post assault activity of the patient**

1. Showered or bathed
2. Rinsed mouth, urinated, defecated

3. Changed clothes, gave clothes to police at scene, or brought clothes worn at time of assault to hospital/agency

#### **Plan of Care**

1. Discuss medical and forensic examination with patient and parent /caregiver
2. Consider child's developmental stage
3. Rapport building
4. Inform patient that written information and educational literature will be provided
5. Discuss use of medical photography for documentation.

#### IV. MEDICAL EXAMINATION

##### **General Information**

1. All patients should receive a complete head-to-toe physical examination.
  - Document mental status, general appearance, any physical or cognitive disability.
  - Document objective observations
  - Vital signs, height, weight, pain (age-appropriate scale) per hospital/agency protocol
  - Document Sexual Maturity Rating (SMR)
2. Assent of the patient is needed. It is the patient's right to consent or refuse any aspect of the examination or evidence collection.
3. The patient may have a support person(s) (relative, friend, and/or advocate) present during the exam. Document who was in the room during the examination.
4. Explain all procedures in age and developmental level appropriate language prior to performing them.

##### **Documentation of Injury**

1. Define injury i.e., abrasion, bite mark, laceration, bruise, petechiae, suction ecchymosis, et cetera.
2. Document size, shape, color, and how acquired, if known.
3. Document sites of pain even if no injury is noted. Document how pain acquired, if known.
4. Utilize a body map or anatomical diagram for documentation of injury, lesions, or irregularities.
5. The patient should be informed that injury may take hours or days to become visible. If the patient notes injury that becomes visible after the FNE exam, he/she should contact the FNE or law enforcement to document the injury.

##### **Alternate Light Source**

1. Using alternate light source with room lights dimmed, scan patient's skin surface, including breasts, abdomen, perineum, hair, face, buttocks, thighs, and ankles, if applicable:
  - Document presence/absence and location of fluorescence.
  - Collect forensic swabs from area(s) of fluorescence.
  - If history indicates presence of evidence, collect blind swab from an area even if no fluorescence is noted.

##### **Injury Photo Documentation**

*The use of photo documentation to supplement standard documentation during the examination of the prepubertal child is the standard of care in pediatric sexual abuse evaluations for the purpose of peer review, case review, and consultation (U.S. Department of Justice Office on Violence Against Women, 2016). Prior to obtaining high quality images, an agency should have policies that align with obtaining consent, and a best practice procedure of how photographs will be taken, stored, and released. FNE should take photographs regardless if law enforcement has taken photographs. Written description and documentation with drawings is necessary even when photographs are taken.*

##### **Exam Procedure**

The following sections outline the steps for the examination and collection of evidence. The order of these steps may vary by examiner preference or patient need.

### **Oral Exam**

1. Document lacerations, abrasions, petechiae, and bruises and how injury acquired, if known.
2. Check mucosa, palate, upper/lower frenula, tongue, teeth, and oropharynx.
3. Document sites of pain even if no injury is noted. Document how pain acquired, if known.
4. Collect forensic swabs (*See section V. Evidence Collection & Storage*)

### **Skin Exam**

1. Document bruises, petechiae, abrasions, lacerations, bite marks, suction ecchymosis, and other findings and how injury acquired, if known.
2. Assess areas of the skin that are easily missed including behind the ears, soles of the feet, palms of the hands, scalp.
3. Collect forensic swabs (*See section V. Evidence Collection & Storage*)

### **Vulvular Genital Exam**

The child will be examined in two different positions, if tolerated. The use of magnification is recommended to aid in the identification of injury.

1. Document sexual development using Sexual Maturation Rating (SMR) Scale
2. Document hymen shape including estrogenation of hymen and normal variants.
3. Document genital lacerations, abrasions, bruises, petechiae, erythema, inflammation, bleeding, edema, discharge, etc.
4. Document sites of pain even if no injury is noted. Document how pain acquired, if known.
5. Collect forensic swabs (*See section V. Evidence Collection & Storage*)
  - Swabs of the external genitals (vulvar and vestibular) should be obtained.
  - Do not touch the unestrogenized hymen with anything as it is very sensitive and may cause the child pain.

A speculum examination is NOT recommended with prepubertal children. However, an examination under anesthesia (consultation with physician) may be necessary in cases in which there are significant lacerations, bleeding, hematoma, presence of foreign body is suspected, or it is considered medically necessary.

Factors to consider prior to performing speculum examination without anesthesia:

- Estrogenization of hymen (may be premenarchal but fully estrogenized)
- Sexual Maturity Rating (SMR)
- Patient's ability to tolerate, cooperate

### **Penile Genital Exam**

1. Document sexual development using Sexual Maturation Rating (SMR) Scale
2. Document if circumcised or not.
3. Retract foreskin to examine glans penis, if tolerated.
4. Document normal variants.
5. Document penile, scrotal, or perineal abrasions, bruises, lacerations, petechiae, bleeding, edema, discharge, erythema, inflammation, tenderness.
6. Document sites of pain even if no injury is noted. Document how pain acquired, if known.
7. Collect forensic swabs (*See section V. Evidence Collection & Storage*)
8. The use of magnification is recommended to aid in the identification of injury

### **Perianal and Anal Exam**

1. Document normal variants
2. Document perianal bruising, petechiae, edema, discharge, bleeding, tenderness, abrasions, lacerations, erythema, inflammation.
3. Document sites of pain even if no injury is noted. Document how pain acquired, if known.
4. Collect forensic swabs (*See section V. Evidence Collection & Storage*)

Exam Techniques

- Use a good light source.
- Separate anal folds to effectively visualize anal area.
- The use of magnification is recommended to aid in the identification of injury.
- Anoscopy is NOT routine in the assessment of the prepubertal child. Anoscopy may be indicated if there is a report of anal assault and active rectal bleeding, suspected foreign body or rectal pain. This procedure should be done under anesthesia and by a physician.

Anogenital findings may be interpreted using guidelines published by Adams et.al (2017). Reference of the WI-IAFN Forensic Nurse Examiner (FNE) Prepubertal Patient Suspected of Being Sexually Abused Documentation Form is recommended as a foundation for the comprehensive documentation of the examination.

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V.

## EVIDENCE COLLECTION & STORAGE

### Forensic Evidence Collection

Wisconsin Crime Laboratory Sexual Assault Evidence Collection Kit is used for evidence collection.

- Obtained at no cost from the Wisconsin State Crime Laboratory
- Someone is available at the Crime Lab 24/7 to answer questions
  - Madison: (608) 266-2031
  - Milwaukee: (414) 382-7500

### Chain of Custody of Forensic Specimens

One staff member must be responsible for always maintaining chain of evidence. That staff member:

1. Safeguards specimens
2. Stores specimens in secured refrigerator, cabinet, or specific area (per hospital/agency policy) until they are picked up by law enforcement personnel.

### Evidence Collection

#### General Information

1. It is the patient's right to consent or refuse any aspect of the exam and evidence collection.
2. The physical and psychological well-being of the sexual assault patient is given precedence over forensic needs.
3. Masks are recommended during the evidence collection process.
4. Change gloves frequently during all phases of evidence collection and processing.
5. The proper collection of evidence is dependent upon the history of the assault and examiner discretion. Children often do not report the full extent of the abuse on initial disclosure.
6. Envelopes may be relabeled when used to obtain swabs from sites other than those outlined in the kit.
7. The kit does not include everything that one needs to collect evidence. Materials such as scissors, tape, et cetera will need to be collected from hospital stock.
8. Drying of collected materials is very important as moisture enhances the proliferation of bacteria and mold which will destroy biological and trace evidence. Drying may be accomplished by air drying or using a drying box. Use of a drying box requires the development of policy which addresses the cleaning of the box between patients and samples as well as methods used to prevent cross contamination of the swabs. Law enforcement should be informed of items which require further drying.
9. Collect evidence which may be compromised by time or examination FIRST such as oral swabs (in cases of an oral assault) and fingernail debris/swabbing.
10. NEVER LICK evidence envelopes to seal.
11. NEVER store evidence in plastic bags or airtight containers.

#### **WI Crime Lab Information Sheet** (included in WI State Crime Lab kit)

1. Fill out all information requested on form.
2. This form is placed in the completed kit

#### **Oral Swabs**

Collect ASAP when:



1. Abuse/assault occurred or visible oral injury or history of oral/genital contact.
2. Collect 2 swabs, thoroughly swab the oral cavity, especially between the cheeks and gums
3. Allow swabs to thoroughly air dry.
4. Place swabs in original swab package.
5. Place swab package in envelope labeled Oral Swabs.
6. Seal and fill out all information requested on the envelope.

#### **Floss**

1. Unwaxed dental floss can be used for areas between the teeth.
  2. Have the patient or FNE floss the teeth *using a minimal amount of floss.*
  3. Place the floss in the envelope labeled Floss.
  4. Seal and fill out all information requested on the envelope.
- \*An HIV risk assessment is standard procedure in a SANE examination. If this risk assessment determines that the patient is at risk for the possible transmission of HIV, the use of dental floss should be omitted.  
Reference – *IAFN Position Statement on DNA Evidence Collection from the Oral Cavity*, September 2013

#### **Buccal Cell Standard (DNA)**

Collect reference oral standard swabs to establish patient DNA. The buccal cell standard should be collected if any other samples have been collected in the kit.

1. Rinse mouth with water prior to collecting sample.
2. Using one swab, place the swab in solid contact with the inner cheek and gum surface.
3. Gently move the swab up and down, back, and forth five or six times, rotating the swab while rubbing.
4. Repeat process with the second swab on the other inner cheek and gum surface.
5. Do not collect from the teeth or along the edges of the teeth.
6. Return the dry swabs to their original swab package and place in the envelope labeled Buccal Cell Standard (DNA).
7. Seal the envelope and fill out all information requested on envelope.

#### **Fingernail Evidence**

Collect if patient reports scratching assailant or examiner believes nail debris may be related to assault. Obtain when visible debris or blood under nails, nails broken during assault and/or history suggests patient scratched assailant.

1. Evidence from each hand should be collected individually.
2. Place small paper sheet on flat surface.
3. Using moistened tapered/fine-tipped swab to swab under all five fingernails of left hand (or right), allowing any debris to fall onto paper. Repeat swabbing under the fingernails with a second lightly moistened swab.
4. If fingernails are short, swab the tips of the fingers.
5. Bindle paper (fold all edges inward so that there are no open edges) to retain debris.
6. The swabs should be air dried, placed back in the original swab package, and then placed in the appropriate envelope, along with the folded collection paper.
7. Place paper and swab from each hand in a separate labeled envelope.
8. Seal the envelope and fill out all information requested on envelope.

#### **Crime Lab Toxicology**

If drug facilitated sexual assault is suspected, specimens for analysis should be collected as soon as possible.

1. Collect when drugs are suspected of being ingested (i.e., victim lost consciousness or had a significant period of memory loss that is not explainable, unexplained lethargy noted by parent / caregiver).
2. Use Wisconsin State Crime Laboratory Medical-Forensic Drug Facilitated Sexual Assault (DFSA) Blood and Urine Specimen Collection Kit
3. Blood and urine should be collected within 24 hours of suspected drugging. If greater than 24 hours since drugging ONLY urine should be collected. Urine should be collected up to 96 hours.
4. Blood sample – Fill two 10ml gray-top tubes. The minimum amount of blood needed is 5ml.
5. Urine sample – Obtain urine as soon as possible. Collect the urine from the patient according to hospital/agency protocol. Fill two 10ml gray-top tubes.

6. Place the patient's name, or patient label, to the side of each tube.
7. The tubes are then placed in the bubble pack pouches provided.
8. Place the sealed, bubble-pouched blood and urine samples inside the larger plastic evidence bag provided and seal. Do not complete the information blanks on the plastic evidence bag. Place the bagged samples back into the cardboard DFSA box.
9. Complete and place the information sheet into the DFSA box.
10. Affix the biohazard label provided in the kit onto the box top.
11. Seal the cardboard DFSA kit with the integrity seal provided.
12. Blood and urine samples must be kept refrigerated if not taken to the Crime Lab immediately.
13. Crime Lab toxicology results are not reported to healthcare and do not become a part of the medical record.

### **Trace Evidence/Collection Paper**

To collect foreign material that may fall when patient undresses:

1. Place bed sheet or large paper sheet on floor. This is to prevent floor debris from adhering to evidence collection paper.
2. Place evidence collection paper sheet over the bottom sheet (sheet on floor).
3. Instruct patient to stand in the center of paper and remove clothing.
4. Bindle paper (fold all edges inward so that there are no open edges) where patient stood, retaining any foreign material, and place in paper bag as forensic evidence
5. Place in paper bag and label with content and patient identifying information.

### **Clothing Collection**

If assault occurred out of doors, or clothing was stained or damaged during assault, collection is particularly important.

1. Collect the clothes the patient was wearing during or immediately after the assault.
2. Always collect patient's underwear even if changed after assault.
3. Do not cut through any existing holes, rips, or stains on clothing.
4. Do not shake out victim's clothing or trace evidence may be lost.
5. Do not fold wet or bloody clothing in a way which will transfer the blood or fluid to another site on the clothing – layer paper and/or linen prior to folding to prevent transfer
6. Consider taking photographs of clothing if any unusual findings are present i.e., rips, tears, body fluids, debris, etc.
7. Place each item of clothing in a separate paper bag labeled with contents
8. Place patient identifying information on each bag, fold top of bag multiple times, tape bag closed securely to avoid tampering, and sign over tape.
9. Document all clothing collected and document anything unusual about clothing i.e., rips, stains, bites which occurred through clothing, etc.
10. Maintain chain of evidence for clothing bags. Place in secured area when not directly observed.

### **Other Items**

Collect items which may contain forensic evidence, such as diaper, wet wipes, condom, etc. These should be collected on a case-by-case basis. Contact Crime Lab for further drying and storage instructions if needed.

1. Air dry the item if possible. If unable to air dry, package the item in a non-airtight container, such as a urine cup with holes in the lid to allow the item to dry. Contact law enforcement for transport as soon as possible.
2. Place patient identifying information on container / envelope and store with kit or in separate paper bag.

### **Debris**

Collect when foreign material is visible on patient's skin or hair and patient reports, or examiner believes, debris is related to the assault.

1. Collect any foreign debris (dirt, leaves, fiber, hair, etc.).
2. Separate debris – DO NOT collect unlike debris from one site or like debris from different sites in the same envelope.

3. Note site from which debris is obtained on the envelope.
4. Seal the envelope and fill out all information requested on envelope.

### **Dried Secretions**

Examples of dried secretions may be vaginal secretions on a penis, saliva on a bite mark, penis or external genital area and dried blood. Consider collecting swabs from the abdomen/umbilicus and thighs in children as an assailant performing vulvar coitus may ejaculate onto the abdomen/thighs of the child.

1. To obtain swabs from dry areas (i.e., skin, fingertips, rectum, and any areas that may contain DNA):
  - Lightly moisten swabs with distilled water (soaking in water will prolong drying time and increase likelihood of specimen molding) and swab area of interest.
  - Collect both swabs.
2. When collecting a penile swab (there is a separate envelope labeled Penis Swab), the entire external area of the penis should be swabbed. Care should be taken to avoid the area around the urethral opening.

*As each swab is obtained*

- a. Place swab in drying rack or drying box
- b. Allow swab to thoroughly air dry

*When swabs are dry*

- a. Place swab into original swab package and then into the Dried Secretions envelope.
- b. Document on envelope site from which specimen is obtained.
- c. Seal the envelope and fill out all information requested on envelope.

**Pubic Hair Collection** (Presence of pubic hair is not usual in the prepubertal child. Omit if not present or has been shaved)

#### *Pubic Hair Combing*

To collect foreign hairs and debris:

Patient should be sitting, or lying, in the dorsal lithotomy position.

1. Place paper sheet under the victim's buttocks.
2. Using disposable comb, comb pubic hair in downward strokes so that any loose hairs and/or debris will fall onto paper.
3. Bindle paper to retain both comb and any evidence present and place in appropriate envelope.
4. Seal the envelope and fill out all information requested on envelope.

#### *Pubic Hair Collection Male and Female*

### **DO NOT PLUCK PUBIC HAIR!**

1. Obtain by cutting them at the skin surface. The hairs should be collected from various areas within the pubic region.
2. Place the hairs in the Pubic Hair Standards envelope.
3. Seal the envelope and fill out all information requested on envelope.

### **Mons Pubis Swabs**

If the patient does not have pubic hair, swab the mons pubis. The sample should be collected by gently swabbing the area with 2 lightly moistened swabs. The swabs should be air dried, returned to the original swab package, and placed in the envelope labeled Pubic Hair Standards or Mons Pubis Swabs. Seal and fill out all information requested on the envelope. The goal is to maximize the potential evidence on as few swabs as possible.

### **External Genital Swabs**

Swabs of the external genitals (vulvar and vestibular) should be obtained. Vulvar swabs are collected by swabbing (see dried secretion swabbing method) the external female genitalia (mons and labia majora). Vestibular swabs are collected by swabbing (see dried secretion swabbing method) the interior part of the vulva avoiding the hymen and urethral opening. Use 2 swabs – the goal is to maximize the potential evidence on as few swabs as possible.

### **Speculum Exam**

A speculum exam is NOT recommended with prepubertal children. However, an examination under anesthesia (consultation with physician) may be necessary in cases in which there are significant lacerations, bleeding, hematoma, presence of foreign body is suspected, or it is considered medically necessary. A speculum exam should NOT be done solely for the purpose of evidence collection.

### **Vaginal Swabs**

*Swabs of the vagina should only be considered if such evidence is likely/essential, and this swabbing is tolerated by the child. Consider anesthesia – see Speculum Exam.*

Collect when:

1. Assault occurred within prior 120 hours AND
2. History of penile-vaginal penetration OR
3. Visible acute genital injury associated with penetration

Procedure:

1. See **Speculum Exam** above.
2. Never touch the unestrogenized hymen with a swab.
3. Four swabs are requested.
4. Lightly moisten one swab with distilled water.
5. Using 1 swab, swab the vaginal canal. Repeat with 3 more swabs.
6. Allow swabs to thoroughly air dry.

When swabs are dry:

1. Return to original swab packages.
2. Place in appropriate envelope and affix patient label to front of envelope.
3. Seal the envelope and fill out all information requested on envelope

**Cervical Swabs** are NOT recommended in the prepubertal child.

**Penis Swab** – see *Dried Secretions*

### **Anoscope Exam**

An anoscope exam is NOT recommended with prepubertal children. However, an examination under anesthesia (consultation with physician) may be necessary in cases in which there are significant lacerations, bleeding, hematoma, presence of foreign body is suspected, or it is considered medically necessary. An anoscope exam should NOT be done solely for the purpose of evidence collection.

**Anal Swabs** (*Collection of this specimen is from the anal area without using an anoscope.*)

Collect when:

1. Assault occurred within prior 120 hours AND
2. Report of contact to anus by any part of assailant's body OR
3. Ejaculation occurred near anogenital area OR
4. Visible acute anal injury OR
5. Alternative light source scan is positive

Procedure:

1. Lightly moisten swabs with distilled water if area is dry.
2. Using two swabs, thoroughly swab the anal area.
3. Allow swabs to thoroughly air dry.

When swabs are dry:

1. Place swab in original swab package and then into Anal Swabs envelope.
2. Affix patient label to front of envelope.
3. Seal the envelope and fill out all information requested on envelope.

**Completing Evidence Collection Kit**

1. Complete WI Crime Lab Evidence Collection Sheet / Inventory Form and place in kit.
2. Once all evidence has been placed inside the kit:
  - a. Open desiccant pouch per instructions inside kit.
  - b. Complete information requested on the front of the kit.
  - c. Place a patient label on the kit, seal and initial.
  - d. Give the kit to the law enforcement representative and have him/her sign the front of the kit.
3. If no law enforcement representative is available:
  - a. Follow hospital/agency policy in place.
  - b. Store the kit in a secure area.
  - c. Contact law enforcement immediately and give them the location of the completed kit so they can pick it up as soon as possible.
4. Enter Sexual Assault Forensic Examination Kits into the Wisconsin Sexual Assault Kit Tracking System (2021 Wisconsin Act 117).

**Evidence Storage**

**Temperature**

1. Dry evidence may be kept at room temperature.
2. Damp or wet evidence specimens should be thoroughly air dried. If this is not possible, these specimens must be given to law enforcement with instructions for further drying.
3. Blood tubes and/or urine samples (toxicology) must be kept refrigerated and secured if not taken to Crime Lab immediately.

VI. **DIAGNOSTIC TESTS**

**Pregnancy Test**

Obtain urine or serum pregnancy test on all patients at risk of pregnancy (Late SMR 2 and SMR 3 or higher)

**Urinalysis**

Request that lab check and report presence of sperm

**Hospital Toxicology Tests**

If toxicology and/or alcohol results are needed for patient care, hospital/agency toxicology tests should be done:

1. Patient appears impaired, intoxicated, or has altered mental state
2. Patient reports unexplained blackout, memory lapse, or partial or total amnesia for event
3. Patient or other is concerned that he or she may have been drugged
4. Samples for toxicology should be obtained as soon as possible, consider collecting specimen for Crime Lab toxicology at this time as well.

**Genital Culture**

1. May be done to assess for Group A Beta-hemolytic Streptococcus infection if signs and/or symptoms are present. This swab may be collected from the peri-anal area as well.

**Vaginal Wet Mount**

1. May be used to assess vaginitis if signs and symptoms are present
2. Request that lab check and report presence of sperm and / or Trichomoniasis
3. See **Speculum Exam** above

**Sexually Transmitted Infection (STI) Tests for Gonorrhea and Chlamydia**

1. STI testing, if done at time of acute assault, should be repeated at follow-up visit. It is best to wait 2 weeks from the time of the assault for STI testing to allow for adequate incubation time.
2. Specimens for STI testing go to hospital /agency lab NOT to Crime Lab
3. Inform patient these tests are related to health issues and are not exclusively for forensic purposes
4. Positive tests may indicate pre-existing infection
5. If nature of assault is uncertain, test / culture all orifices.
6. For vaginal or penile infection
  - Urine, vaginal or penile/urethral swabs for NAAT (Nucleic Acid Amplification Test) or vaginal or penile culture for Gonorrhea and Chlamydia
  - If results to be used for forensic purposes a positive NAAT must be confirmed (prior to treatment) by culture or by a different NAAT method which detects a different DNA/RNA sequence.
7. For anal infection
  - Culture for Gonorrhea and Chlamydia
  - Only Clinical Laboratory Improvement Amendments (CLIA)-validated, Food Drug Administration (FDA)-cleared NAATs should be used for extra-genital specimens.
8. For pharyngeal infection
  - Culture for Gonorrhea and Chlamydia
  - Only CLIA-validated, FDA-cleared NAATs should be used for extra-genital specimens.

#### **STI Tests for Syphilis and Syphilis Serology**

*The decision to test for syphilis should be made on a case-by-case basis and should be referred to primary care provider. Consider the incident rate in your community.*

#### **HIV Testing**

Serologic testing for HIV should be considered. The decision to test for HIV should be made on a case-by-case basis, depending on the likelihood of infection of the suspect(s). Diagnosis of HIV-1 infection relies primarily on HIV antibody and antigen/antibody test.

1. Review community epidemiology
2. Assess risk of suspect
3. Evaluate circumstances for HIV transmission
4. Follow hospital/agency policy regarding HIV testing and HIV PEP
5. Consult with specialist who treats HIV in children if HIV PEP is considered

#### **Hepatitis Serology**

The decision to test for HBV, HCV or HIV should be made on a case-by-case basis and should be referred to primary care provider.

## VII. TREATMENT

*Medication administration should only be considered after consultation with medical provider and/or hospital/agency protocol*

#### **Pregnancy Prevention**

1. Every patient who is at risk for pregnancy will be offered prophylactic treatment for pregnancy prevention.
2. Late SMR stage 2 and SMR stage 3 and above have potential reproductive capability.
3. Document on the medical record if the patient declines pregnancy prophylaxis, if appropriate.

#### **Offer emergency pregnancy prophylaxis when:**

1. Patient is at risk for pregnancy and pregnancy test is negative
2. Emergency contraception (EC) must be given within 120 hours of a sexual assault to be effective

#### **STI Prophylaxis**

Presumptive treatment for prepubertal children who have been sexually assaulted or abused is not recommended. See CDC guidelines (2021). A positive STI test requires confirmation prior to treatment in the prepubertal child. Pubertal children / adolescents are treated as adults.

### **Hepatitis B Vaccine**

Vaccination status should be assessed at time of exam. Hospital/agency policy should be in place if vaccination is needed.

### **Tetanus Prophylaxis**

Vaccination status should be assessed at time of exam. Hospital/agency policy should be in place if vaccination is needed.

### **HPV Prophylaxis**

Vaccination status should be assessed at time of exam. If needed, referral to patient's PCP should be made.

### **HIV Prophylaxis**

Complete HIV risk assessment should be done at time of exam. When indicated, HIV Post Exposure Prophylaxis (PEP) must be started within 72 hours of assault. Consult with a specialist in treating HIV infected children if PEP is considered. Follow hospital/agency policy regarding HIV testing and HIV PEP.

## VIII. DISCHARGE AND FOLLOW-UP CONTACT

### **Discharge**

1. Consider appropriateness of sharing information with parent/caregiver:
  - Parent/caregiver is suspect
  - Parent/caregiver is complacent with suspect
2. Discuss safety issues / plan
3. Appropriate medical follow-up will be identified for the patient with respect to the evaluation of possible sexually transmitted infections, pregnancy and any physical injuries sustained during the assault
4. Explain follow-up for test results
5. Confirm plans for medical and counseling follow-up
6. Give phone number for sexual assault victim advocate and other support services
7. Give written discharge instructions for all treatment and follow-up
8. Provide patient educational materials as needed.
9. Provide information on area resources including medical follow-up, crisis intervention phone numbers, sexual assault crisis centers, shelters, CPS, child advocacy center, Crime Victims Compensation Program, law enforcement and the district attorney's office as needed.

### **Follow-Up**

Recommended within two weeks of the initial exam

#### **Review with patient or parent/caregiver:**

1. Exam findings as appropriate
2. Lab results
3. Current physical symptoms
4. Emotional reactions (sleep disorders, anxiety, depressive symptoms, flashbacks, other)
5. Concerns for safety
6. Concerns regarding STIs and HIV
7. Additional history or any new information regarding the assault
8. Report any new information to law enforcement and/or CPS as appropriate
9. Assess need for referral for further services
10. Document follow-up contact and additional referral(s) made within the medical record

### **Review / Expert Consultation**

It is best practice that all agencies have a policy for the review of all prepubertal child examinations. A child examination with a finding that is suspicious or diagnostic for sexual abuse must be reviewed by an expert in child sexual abuse. An agency should have a policy regarding obtaining a second opinion. If child maltreatment beyond sexual abuse is suspected, the child must be referred to a CAC or expert in child maltreatment.

**Reviewed and revised in 2022 by the members of the Wisconsin Chapter of the International Association of Forensic Nurses Protocol/Documentation Committee:**

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Appendix A



Wisconsin Child Sex Trafficking and Exploitation Indicator and Response Guide



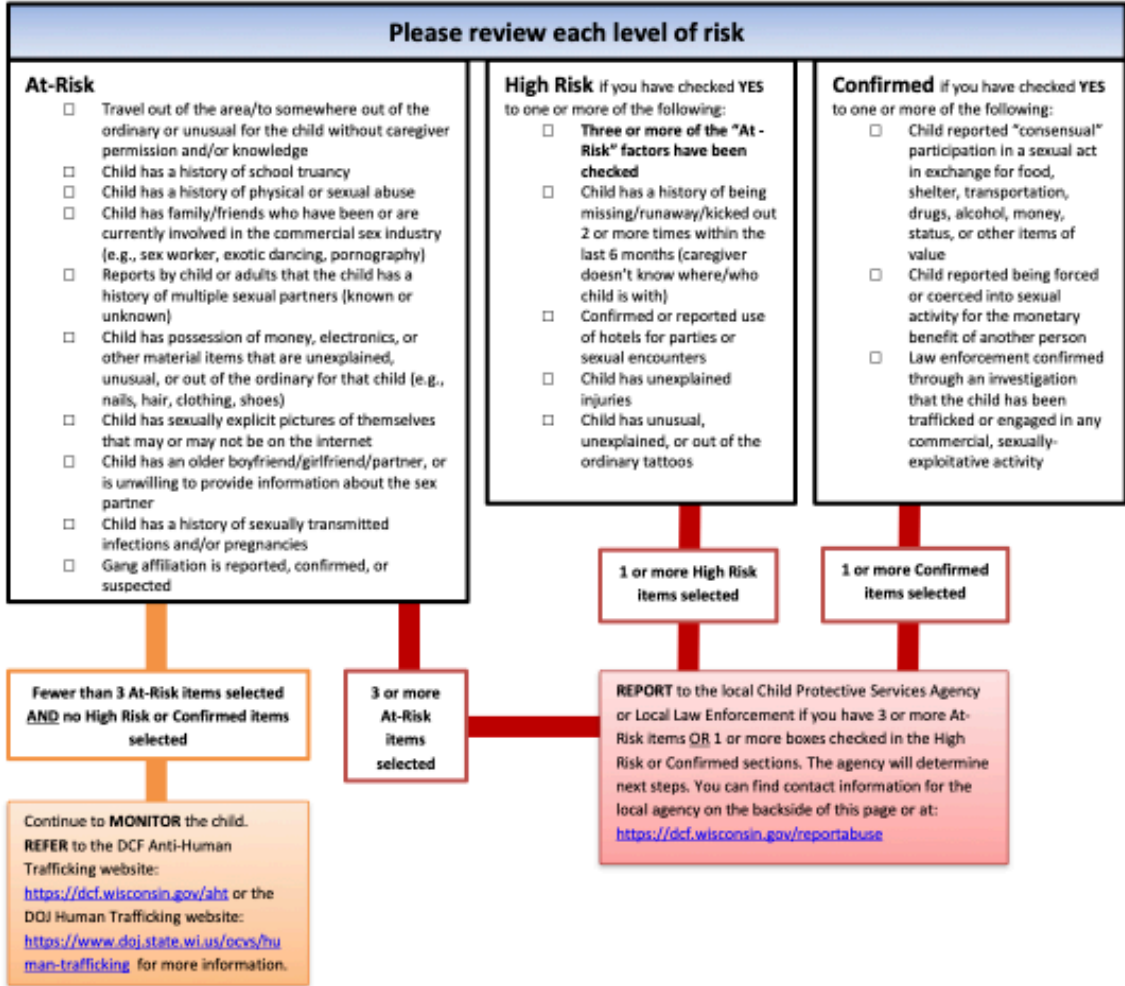
The Wisconsin Child Sex Trafficking and Exploitation Indicator and Response Guide should be consulted if you have concerns that a child or youth you have contact with is being sexually trafficked or exploited. Review the indicators in this guide and follow the directions for the appropriate response. This indicator and response guide also alerts the reader to indicators or potential red flags that should continue to be monitored.

**Mandated Reporters** are required to report suspected abuse or neglect of any child, including those that you may learn about through discussions with the child of concern ([s.48.981\(2\) Wis. Stat.](#)).

Sex trafficking and sexual exploitation are both forms of child abuse, even if the perpetrator is unrelated to the child. Although sex trafficking and sexual exploitation share similar elements, they have distinct differences, as noted below:

**Sex Trafficking of a Child** involves another person benefitting from forcing, defrauding, or coercing a child into a commercial sex act with another person ([s.948.051 Wis. Stat.](#)).

**Sexual Exploitation of a Child** involves forcing, defrauding, or coercing a child to engage in a sexually explicit way for the purposes of recording, displaying, and/or distributing the recording ([s.948.05 Wis. Stat.](#)).



The Wisconsin Sex Trafficking and Exploitation Indicator and Response Guide was adapted from the 2015 Minnesota Safe Harbor Sexual Exploitation/Trafficking Flowchart. Questions about this tool can be sent to [DCFAHT@wisconsin.gov](mailto:DCFAHT@wisconsin.gov)

Effective May 2017  
Updated September 2019

Available at <https://dcf.wisconsin.gov/files/aht/pdf/indicatorguide.pdf>

## **Appendix B**

### **Suggested Baseline Serology Testing for HBV, HCV, HIV and Syphilis**

If referring for advanced evaluation, baseline testing of blood may include:

- HIV Ab/Ag
- Consider HIV RNA if high risk as this can detect infection earlier (See Appendix C)
- Hepatitis B
- Hepatitis C (if HIV PEP started or known exposure)

\*Guardian consent is preferred but not required. The treatment of a minor infected with a sexually transmitted disease or examine and diagnose of a minor for the presence of such a disease without obtaining the consent of the minor's parents or guardian may occur (WI Statute 252.1 (1m) Communicable Diseases- Sexually Transmitted Disease).

**Appendix C**

**HIV High Risk Indicator Tool for the Sexually Assaulted Patient**

*If concern for multiple sexual exposures in the recent past, consider HIV RNA testing*

Did patient have exposure of vagina, rectum, eye, mouth or other mucous membrane, non-intact skin, or percutaneous contact with blood, semen, vaginal secretions, rectal secretions, breast milk, or any body fluid that is visibly contaminated with blood?

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Unknown

**If the answer is YES or Unknown to one of above question, proceed with Risk Assessment below**

**Suspect Risk Assessment:**

1. Unknown suspect
2. Multiple suspects
3. Known HIV positive suspect
4. Suspect is sex partner of known HIV + person
5. Known IV drug use by suspect
6. Suspect is sex partner of known IV drug user
7. Male who engages in sex with other men
8. Assault occurred in area of high prevalence of HIV
9. Suspect had blood transfusion before 1992
10. Other factor(s) of high risk

**Patient Risk Assessment:**

*This would include youth at risk for sex trafficking*

1. Recurrent runaway behaviors
2. Homeless/living in shelters/group homes
3. Prior history of child maltreatment
4. Pregnant adolescents or adolescents with STI's, multiple sex partners, frequent requests for STI testing
5. Signs of physical or sexual abuse, medical neglect, and slash or torture
6. Youth who have money or gifts with no legal source
7. Youth familiar with language commonly used in the sex trade or branding/tattoos
8. Youth with peers or family members involved in sex trade
9. Polysubstance abuse (ex: Heroin, Percocet, Xanax)
10. Multiple psychiatric diagnoses (esp. PTSD, ADHD, depression, anxiety, bipolar)
11. Evidence of self-harm and/or suicide attempts or re-occurring SI

Describe other factor(s) of high risk \_\_\_\_\_  
\_\_\_\_\_

**If answered YES or Unknown to any of the Risk Assessment questions:**

Did ejaculation occur? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Unknown

Did suspect use a condom during assault? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Unknown

***Does the patient have a Risk for HIV Exposure?***  
\_\_\_\_\_ ***Yes*** \_\_\_\_\_ ***No***

**If HIV PEP is deemed necessary, Follow your facility's protocol for HIV PEP treatment policies/ referral PEP Hotline (888) HIV-4911**

**Referred to \_\_\_\_\_ for further care.**

## Resources

- Adams, J.A. (2020). Sexual abuse in children: What the general practice OB/Gyn needs to know. *Clinical Obstetrics and Gynecology*. 63(3) DOI: <https://doi.org/10.1097/GRF.0000000000000539>
- Adams, J.A., Farst, K., and Kellogg, N. (2017). Interpretation of medical findings in suspected child sexual abuse: An update for 2018. *Journal of Pediatric and Adolescent Gynecology*. 31(3). DOI: <https://doi.org/10.1016/j.jpag.2017.12.011>
- Centers for Disease Control and Prevention. (2021). Sexually transmitted infections treatment guidelines, 2021. Available at <https://www.cdc.gov/std/treatment-guidelines/toc.htm>
- IAFN. (2013). Position statement: DNA evidence collection from the oral cavity. Available at [https://forensicnurses.org/wp-content/uploads/2021/11/dna\\_evidence\\_collection\\_from.pdf](https://forensicnurses.org/wp-content/uploads/2021/11/dna_evidence_collection_from.pdf)
- Wisconsin Department of Children and Families. (2021). Wisconsin child sex trafficking and exploitation indicator and response guide. Available at <https://dcf.wisconsin.gov/files/aht/pdf/indicatorguide.pdf>
- Wisconsin Legislative Counsel. (2016). 2015 Wisconsin act 351: Right to accompaniment by a victim advocate and the victim advocate privilege. Available at <https://docs.legis.wisconsin.gov/2015/related/lcactmemo/act351>
- Wisconsin State Legislature. (2021). 2021 Wisconsin Act 117. Available at <https://docs.legis.wisconsin.gov/2021/related/acts/117>
- Wisconsin State Legislature. (2022). Communicable diseases: Sexually transmitted diseases. Available at <https://docs.legis.wisconsin.gov/statutes/statutes/252/11>
- Wisconsin State Legislature. (2022). Subchapter XXI miscellaneous provisions: Abused or neglected children and abused unborn children. Available at <https://docs.legis.wisconsin.gov/statutes/statutes/48/xxi/981>
- U.S. Department of Justice Office on Violence Against Women. (2016). A national protocol for sexual abuse medical forensic examinations pediatric. Available at [https://cdn.ymaws.com/www.safeta.org/resource/resmgr/protocol\\_documents/national\\_pediatric\\_protocol\\_.pdf](https://cdn.ymaws.com/www.safeta.org/resource/resmgr/protocol_documents/national_pediatric_protocol_.pdf)