# *CLINICAL PATHWAY:*
# Suspected Sexual Abuse

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

**Inclusion Criteria:** child of any age with concern for sexual assault/abuse (If clinically relevant, refer to the Suspected Physical Abuse Pathway)

**Obtain the history (*Important*: refer to Appendix A):**

- First with caretaker alone (leave child with staff)
- If the WHO, WHAT, WHEN is not clear, and child >3 yr old, interview child without caretaker (bring observer)

**Provider Notification Process:**

- DCF report: call Careline (860-550-6515) and fill out "136 form"(Appendix B). Document in EPIC that form was completed.
- Contact ED Social Worker.

**Indications for Forensic Evidence Collection (FEC):**

*The purpose of forensic evidence collection is to collect bodily secretions from the alleged perpetrator, which may still be present on the patient.*

- Alleged perpetrator ≥13 yo **AND** possible genital contact **AND** 1 of the following:
  - Post-menarcheal female with last contact <120 hours ago OR
  - Pre-menarcheal female with last contact <24 hours ago OR
  - Male patient with last contact <24 hours ago OR
  - Last contact with patient is unknown and alleged perpetrator has ongoing access to patient

**If FEC indicated (see Appendix C for FEC guidelines):**

- Call Hartford Sexual Abuse Crisis Services hotline 1-888-999-5545 to come to ED to support patient/family.
- *If child ≥13 years old:* call Sexual Assault Forensic Examiner (SAFE)
  - If FEC indicated, proceed to kit collection with legal guardian consent and child assent
- *If child <13 years old:* provider to perform limited FEC (see Appendix C)

**If FEC is not indicated:**

- Proceed directly to full physical examination

**ED provider to perform full physical examination even if SAFE completes FEC:**

- Include anogenital exam w/ labial traction, and photographs of non-genital injuries (*Important:* refer to Appendix D)
- Obtain SCAN consult if abnormal anogenital exam (e.g., acute injury, STI findings), or current anogenital symptoms.

**Labs:**

For all patients with concern of genital or anal involvement, and alleged perpetrator ≥13 years old.

- Refer to HIV PEP Pathway, if appropriate.
- Blood:
  - RPR
  - HIV screening antibody test
  - Hepatitis B surface antibody/surface antigen (if concern for incomplete vaccination)
  - Hepatitis C antibody (if direct blood exposure, or alleged perpetrator is high risk for Hepatitis C)
- Urine:
  - GC/Chlamydia - dirty sample (all females, or males with penile discharge or specific concern for GC/chlamydia)
  - HcG and trichomonas (if post-menarcheal female)
- Consider additional tests (obtain after FEC if done):
  - *If clear disclosure of alleged perpetrator's penis in patient's mouth:*
    - Throat culture for GC
  - *If clear disclosure of the alleged perpetrator's penis in patient's anus:*
    - Rectal culture for GC and chlamydia
  - *If vaginal discharge*
    - Affirm testing for trichomonas, BV, yeast (female of any age)
    - Pediatric genital culture of discharge in pre-menarcheal females; Do not touch the hymen or insert swab into the vagina.

**Do **not** treat any positive STI results; child will need confirmatory testing at SCAN.*

*Any patient with report of drug-facilitated sexual assault within 72 hours, or if child appears impaired or reported a period of time they cannot remember:*

- Use CT 400 KIT (separate kit from the FEC)
- Collect blood + urine if assault <48 hrs ago; urine only if 48-72 hrs ago

**Other Considerations:**

- ≥13 yrs old: Suspected Commercial Sexual Exploitation of Children (CSEC) of adolescent – Appendix E
- Consider Mental Health Screening and/or psychiatry consult if CSEC positive, or concern for self-harm

**Post-Exposure Prophylaxis (PEP):**

Offer an anti-emetic 30-60 minutes prior to starting any PEP.

All patients:

- If within 72 hours of vaginal, anal, oral, or percutaneous contact with blood or semen that is possibly or definitely HIV infected: offer **HIV PEP** (see HIV PEP Pathway)
- Hepatitis B prophylaxis, if indicated (refer to Appendix F – Hepatitis B Prophylaxis)
- Tetanus prophylaxis, if indicated (refer to Appendix G – Tetanus Prophylaxis)

Pre-menarcheal female or male of any age:

- No prophylaxis recommended for GC, chlamydia or trichomonas.
- If active signs or symptoms of STI, call SCAN.

Post-menarcheal females:

- If urine HcG negative:
  - If exposure ≤72 hours: **Plan-B** (give in the ED)
  - If exposure >72 hours and ≤ 120 hours: **Ella** (outpatient Rx needed; Plan B not indicated)
  - Give anti-emetic 30 minutes prior.
- If alleged perpetrator ≥13 yo and possible genital contact within last 120 hours, offer PEP for GC, chlamydia and trichomonas:
  - GC:
    - If <150 kg: **ceftriaxone** IM 500 mg x1
    - If ≥150 kg: **ceftriaxone** IM 1 gram x1
    - *If PCN allergy*: Consult Infectious Disease
  - Chlamydia:
    - If >45 kg: **azithromycin** PO 1 g x1
    - If ≤45 kg: **azithromycin** PO 20 mg/kg (max 1 g) x1
    - *If azithromycin allergy and >45 kg*: doxycycline PO 100 mg BID x 7 days OR levofloxacin PO 500 mg daily x7 days
  - Trichomonas:
    - If >45 kg: **metronidazole** PO 2 g x1 [Contraindicated if pregnant in 1st trimester!]
    - If ≤45 kg: no prophylaxis recommended

**Inpatient Admission Criteria:**

Admit to Inpatient/Observation if mental health concerns or physical conditions requiring inpatient level of care. Place SCAN consult.

**Discharge Criteria:**

Stable with no injuries or mental health concerns requiring inpatient management; call/report made to DCF; chain of custody maintained on all forensic evidence; appropriate testing/treatment provided; safe discharge plan; place Epic order for urgent referral to SCAN, and provide number to SCAN 860-837-5890; if family declining SCAN referral – must be referred back to PCP; if on HIV PEP, place Epic referral to ID; if need vaccine completion – refer to PCP; ≥9 yrs old: refer to PCP to start HPV vaccine series)

**Discharge Instructions:**

Instruct family not to question child further; continue safety plan for child; follow up with appropriate appointments; begin medications as instructed; post-menarcheal females will need repeat pregnancy test every 2 weeks until menses

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Connecticut Children's

**Talk with caretaker alone first (leave child with staff), and ask:**

- Why is the caretaker concerned?
  - WHO?
  - WHAT (sexual contact)?
  - WHEN (last possible contact with alleged perpetrator)?
  - Symptoms?
  - Any disclosures by child?
- What words child/family uses for genital/anal area?

**If WHO, WHAT, WHEN are not clear, briefly interview child without caretaker. Have another hospital staff member observe the interview:**

**In all children**

- The following are recommendations about how to talk to children about possible child sexual abuse. Use the appropriate category for your patient's age or developmental ability.
- **AVOID**:
  - Coercing or bribing children to talk
  - Asking yes/no, multiple choice, or compound questions
  - Questions that name an action or a person (ie "Did Daddy put his pee-pee in your butt-butt?")
  - Showing shock or disapproval

**Pre-School Age Children**

- In very young children, often the only information that can be gathered is WHAT happened and WHO did something. Young children cannot reliably report WHEN or timeframes.
- Establish rapport with neutral, child-friendly topics.
- Ask child "what happened?" or "what happened to your _____ (child's name for genitals)."
- To gather more information, say "tell me more about that."
- Document clearly what child tells you in his/her own words.
- Thank child for talking with you.

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## School-aged Children

- School-aged children can often provide WHO, WHAT, and some information about WHEN or if there were repeated incidences.
- Establish rapport with neutral, child-friendly topics.
- Ask child "why did you come to the hospital?" or "what happened?" or "what happened to your _____ (child's name for genitals)."
- To gather more information, say "tell me more about that." Do not be afraid to repeat that statement multiple times.
- For timing:
  - Ask child "Did this happen one time or more than one time?"
  - Ask child "tell me about the last time something like this happened." Connect to age of child, or relevant major event (Halloween, birthday party) to determine approximate timing of last contact.
- Document clearly what child tells you in his/her own words.
- Thank the child for talking with you. Reassure child that you will check his/her body and address any concerns.

## Adolescents

- Teens can often provide WHO, WHAT, WHEN, and if multiple events occurred. Avoid "why" questions such as "why didn't you tell" or "why did he do that to you?"
- Establish rapport.
- Explain that as a medical provider, you need to know some details about what happened so that you can provide the best medical care for the teen.
- Ask "What happened?" Or "why did you come to the hospital?"
- To gather more information, say "tell me more about that." Do not be afraid to repeat that statement multiple times.
- For timing
  - Ask "Did this happen one time or more than one time?"
  - Ask "Tell me about the last time something like this happened."
- Document clearly what child tells you in his/her own words.
- Thank the teen for talking with you. Reassure teen that you will check his/her body and address any concerns.

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# REPORT OF SUSPECTED CHILD ABUSE OR NEGLECT

DCF-136
05/2015 (Rev.)

**Careline**
**1-800-842-2288**

**Within forty-eight hours of making an oral report, a mandated reporter shall submit this form (DCF-136) to the relevant Area Office listed below**
See the reverse side of this form for a summary of Connecticut law concerning the protection of children.

*Please Print or Type*

| Child's Name | ☐ M ☐ F | Age Or DOB | Race: ☐ American Indian or Alaskan Native ☐ Asian/Pacific Islander ☐ Black/African American (not of Hispanic Origin) ☐ Hispanic ☐ White (not of Hispanic origin) ☐ Unknown ☐ Other _____ |
|---|---|---|---|

| Child's Address | | |
|---|---|---|
| Name Of Parents Or Other Person Responsible For Child's Care | Address | Phone Number |
| Name Of Careline Worker To Whom Oral Report Was Made | Date Of Oral Report | Date And Time Of Suspected Abuse/Neglect |
| Name Of Suspected Perpetrator, If Known | Address And Phone Number, If Known | Relationship To Child |

Nature And Extent Of Injury(ies), Maltreatment Or Neglect

Describe The Circumstances Under Which The Injury(ies), Maltreatment Or Neglect Came To Be Known

Describe the Reasons Such Persons(s) Are Suspected of Causing Such Injuries, Maltreatment of Neglect

Information Concerning Any Previous Injury(ies), Maltreatment Or Neglect Of The Child Or His/Her Siblings

Information Concerning Any Prior Cases(s) In Which The Person(s) Have Been Suspected Of Causing An Injury(ies), Maltreatment Or Neglect Of A Child

List Names And Ages Of Siblings, If Known

What Action, If Any, Has Been Taken To Treat, Provide Shelter Or Otherwise Assist The Child?

***REPORTER SECTION***

| Reporter's Name:<br>Agency Name:<br>Phone Number:<br>Agency Address:<br>City: | **Reporter's Race**<br>☐ American Indian or Alaskan Native<br>☐ Asian/Pacific Islander<br>☐ Black/African American (not of Hispanic Origin)<br>☐ Hispanic (any race)<br>☐ White (not of Hispanic origin)<br>☐ Prefer Not to Answer<br>☐ Other _____ |
|---|---|

| Reporter's Signature | Position | Date |
|---|---|---|

***WHITE COPY: TO DCF AREA OFFICE (see below)*** ***IF YOU NEED ADDITIONAL SPACE, YOU MAY ATTACH MORE DOCUMENTATION***

| | | | | |
|---|---|---|---|---|
| **Bridgeport**<br>100 Fairfield Avenue<br>Bridgeport, CT 06604<br>203-384-5300<br>TDD: 203-384-5399<br>Fax: 203-384-5306 | **Danbury**<br>131 West Street<br>Danbury, CT 06810<br>203-207-5100<br>TDD: 203-748-8325<br>Fax: 203-207-5169 | **Hartford**<br>250 Hamilton Street<br>Hartford, CT 06106<br>860-418-8000<br>TDD: 800-315-4082<br>Fax: 860-418-8325 | **Manchester**<br>364 West Middle Turnpike<br>Manchester, CT 06040<br>860-533-3600<br>TDD: 800-315-4415<br>Fax: 860-533-3734 | **Norwalk**<br>761 Main Avenue, I-Park Complex<br>Norwalk, CT 06851<br>203-899-1400<br>TDD: 203-899-1491<br>Fax: 203-899-1463, 203-899-1464 |
| **Meriden**<br>One West Main Street<br>Meriden CT 06451<br>203-238-8400<br>TDD: 203-238-8517<br>Fax: 203-238-6425 | **Middletown**<br>2081 South Main Street<br>Middletown, CT 06457<br>860-638-2100<br>TDD: 860-638-2195<br>Fax: 860-346-0098 | **Milford**<br>38 Wellington Road<br>Milford, CT 06461<br>203-306-5300<br>TDD: 203-306-5604<br>Fax: 203-306-5606 | **New Britain**<br>One Grove Street, 4th Floor<br>New Britain, CT 06053<br>860-832-5200<br>TDD: 860-832-5370<br>Fax: 860-832-5491 | **New Haven**<br>One Long Wharf Drive<br>New Haven, CT 06511<br>203-786-0500<br>TDD: 203-786-2599<br>Fax: 203-786-0660 |
| **Norwich**<br>Two Courthouse Square<br>Norwich, CT 06360<br>860-886-2641<br>TDD: 860-885-2438<br>Fax: 860-887- 3683 | **Torrington**<br>62 Commercial Blvd<br>Torrington, CT 06790<br>860-496-5700<br>TDD: 860-496-5798<br>Fax: 860-496-5834 | **Waterbury**<br>395 West Main Street<br>Waterbury, CT 06702<br>203-759-7000<br>TDD: 203-465-7329<br>Fax: 203-759-7295 | **Willimantic**<br>322 Main Street<br>Willimantic, CT 06226<br>860-450-2000<br>TDD: 860-456-6603<br>Fax: 860-450-1051 | **Special Investigations Unit**<br>505 Hudson Street, 7th Floor<br>Hartford, CT 06106<br>860-550-6696<br>FAX: 860-723-7237 |

**SUMMARY OF LEGAL REQUIREMENTS CONCERNING CHILD ABUSE/ NEGLECT**

**PUBLIC POLICY OF THE STATE OF CONNECTICUT (C.G.S. §17a-101)**

To protect children whose health and welfare may be adversely affected through injury and neglect; to strengthen the family and to make the home safe for children by enhancing the parental capacity for good child care; to provide a temporary or permanent nurturing and safe environment for children when necessary; and for these purposes to require the reporting of suspected child abuse or neglect, investigation of such reports by a social agency, and provision of services, where needed, to such child and family.

**WHO IS MANDATED TO REPORT CHILD ABUSE/NEGLECT?**

Child Advocate and OCA Employees
Chiropractors
Coaches and Directors of a Private Youth Sports, Organization or Team
Coaches and Athletic Directors of Youth Athletics
Dental Hygienists
Dentists
Department of Children and Families Employees
Domestic Violence Counselors
Office of Early Childhood Employees and Department of Public health Employees who are Responsible for Licensing Day Cares and Camps
Family Relations Counselors (Judicial Dept.)
Family Rel. Counselor Trainees (Judicial Dept.)
Family Services Supervisors (Judicial Dept.)
Licensed Foster Parents
Licensed Marital and Family Therapists
Licensed or Unlicensed Interns at Any Hospital
Licensed or Unlicensed Resident Physicians
Licensed Physicians
Licensed Practical Nurses
Licensed Professional Counselors
Licensed Surgeons
Licensed/Certified Alcohol and Drug Counselors
Licensed/Certified Emergency Medical Services Providers
Medical Examiners
Members of the Clergy
Mental Health Professionals
Optometrists
Persons Paid to Care for Children
Persons who Provide Services to and have Regular Contact with Students
Pharmacists
Physical Therapists
Physician Assistants
Podiatrists
Police Officers
Probation Officers (Juvenile or Adult)
Psychologists
Public or Private Institution of Higher Education Administrators, Faculty, Staff, Athletic Directors, Athletic Coaches and Athletic Trainers
Registered Nurses
School Administrators
School Coaches
School Guidance Counselors
School Paraprofessionals
School Superintendents
School Teachers
Sexual Assault Counselors
Social Workers
Substitute Teachers

**DO THOSE MANDATED TO REPORT INCUR LIABILITY?**

**No.** Any person, institution or agency which, in good faith, makes or does not make a report, shall be immune from any civil or criminal liability provided such person did not perpetrate or cause such abuse or neglect.

**IS THERE A PENALTY FOR NOT REPORTING?**

**Yes.** Any person required to report who fails to do so may be prosecuted for a Class A misdemeanor and may be required to participate in an educational and training program. Any person who intentionally and unreasonably interferes with or prevents a report may be prosecuted for a Class D felony.

**IS THERE A PENALTY FOR MAKING A FALSE REPORT?**

**Yes.** Any person who knowingly makes a false report of child abuse or neglect may be fined not more than $2,000 or imprisoned for not more than one year or both. The identity of such person shall be disclosed to the appropriate law enforcement agency and to the alleged perpetrator of the abuse.

**WHAT ARE THE REPORTING REQUIREMENTS?**

- An oral report shall be made by a mandated reporter by telephone or in person to the DCF Careline or to a law enforcement agency as soon as practicable, but not later than 12 hours after the mandated reporter has reasonable cause to suspect or believe that a child has been abused or neglected or placed in imminent risk of serious harm. If a law enforcement agency receives an oral report, it shall immediately notify Careline. Oral reports to the Careline shall be recorded.

- Within 48 hours of making an oral report, a mandated reporter shall submit a written report to the DCF Careline on the DCF-136, "Report of Suspected Child Abuse or Neglect."

- When a mandated reporter is a member of the staff of a public or private institution or facility that provides care for children or a public or private school, the reporter shall also submit a copy of the written report to the person in charge of such institution, school or facility or the person's designee.

**DCF CHILD ABUSE AND NEGLECT CARELINE: 1-800-842-2288**

**STATUTORY REFERENCES: C.G.S.17a-28, §17a-101 *et seq.;* §46b-120**

**DEFINITIONS OF ABUSE AND NEGLECT**

**Abused Child:** Any child who has a non-accidental physical injury, or injuries which are at variance with the history given of such injuries, or is in a condition which is the result of maltreatment such as, but not limited to, malnutrition, sexual molestation, deprivation of necessities, emotional maltreatment or cruel punishment.

**Neglected Child:** Any child who has been abandoned or is being denied proper care and attention, physically, educationally, emotionally, or morally or is being permitted to live under conditions, circumstances or associations injurious to his or her well-being.

**Exception:** The treatment of any child by an accredited Christian Science practitioner shall not by itself constitute neglect or maltreatment.

**CHILD UNDER AGE 13 WITH VENEREAL DISEASE:** A physician or facility must report to Careline upon the consultation, examination or treatment for venereal disease of any child who has not reached his or her 13th birthday.

**DO PRIVATE CITIZENS HAVE A RESPONSIBILITY FOR REPORTING?**

**Yes.** Any person having reasonable cause to suspect or believe that any child under the age of 18 is in danger of being abused or has been abused or neglected may cause a written or oral report to be made to the Careline or a law enforcement agency. Any person making the report in good faith is immune from any liability, civil or criminal. However, the person is subject to the penalty for making a false claim.

**WHAT IS THE AUTHORITY AND RESPONSIBILITY OF THE DEPARTMENT OF CHILDREN AND FAMILIES (DCF)?**

All child protective services in Connecticut are the responsibility of the Department of Children and Families.

Upon the receipt of a report of child abuse or neglect, the Careline shall cause the report to be classified, evaluated immediately and forwarded to the appropriate Area Office for the commencement of an investigation or for the provision of services within timelines specified by statute and policy.

If an investigation produces evidence of child abuse or neglect, DCF shall take such measures as it deems necessary to protect the child, and any other children similarly situated, including, but not limited to, immediate notification to the appropriate law enforcement agency, and the removal of the child from his or her home with or without the parents' consent consistent with state law.

If DCF has probable cause to believe that the child or any other child in the household is at imminent risk of physical harm from the surroundings, and that immediate removal from such surroundings is necessary to ensure the child's safety, the Commissioner or designee shall authorize any employee of DCF or any law enforcement officer to remove the child and any other child similarly situated from such surroundings without the consent of the child's parent or guardian. The removal of a child shall not exceed 96 hours. If the child is not returned home within such 96-hour period, with or without protective services, DCF shall file a motion for temporary custody with the Superior Court for Juvenile Matters.

**WHAT MEANS ARE AVAILABLE FOR REMOVING A CHILD FROM HIS OR HER HOME?**

- 96-Hour hold by the Commissioner of DCF or designee (see above).

- 96-Hour hold by a physician – Any physician examining a child with respect to whom abuse or neglect is suspected shall have the right to keep such child in the custody of a hospital for no longer than 96 hours in order to perform diagnostic tests and procedures necessary to the detection of child abuse or neglect and to provide necessary medical care with or without the consent of such child's parents or guardian or other person responsible for the child's care, provided the physician has made reasonable attempts to (1) advise such child's parents or guardian or other person responsible for the child's care that the physician suspects the child has been abused or neglected, and (2) obtain consent of such child's parents or guardian or other person responsible for the child's care. In addition, such physician may take or cause to be taken photographs of the area of trauma visible on a child who is the subject of such report without the consent of such child's parent's or guardian or other person responsible for the child's care. All such photographs or copies thereof shall be sent to the local police department and the Department of Children and Families.

- Bench order of temporary custody – Whenever any person is arrested and charged with an offense under Section 53-20 or 53-21 or under Part V, VI, or VII of Chapter 952, as amended, the victim of which offense was a minor residing with the defendant, any judge of the Superior Court may, if it appears that the child's condition or circumstances surrounding the case so require, issue an order to the Commissioner of the Department of Children and Families to assume immediate custody of such child and, if the circumstances so require, any other children residing with the defendant and to proceed thereon as in other cases.

**WHAT IS THE CENTRAL REGISTRY OF PERPETRATORS OF ABUSE OR NEGLECT?**

The Department of Children and Families maintains a registry of persons who have been substantiated as responsible for child abuse or neglect and pose a risk to the health safety or well-being of children. The Central Registry is available on a 24-hour daily basis to prevent or discover child abuse of children.

## CONSENT

- Per 2017 State of CT Technical Guidelines for Health Care Response to Victims of Sexual Assault (http://www.ct.gov/csao/lib/csao/2017-Technical-Guidelines.pdf), a minor **victim who is 13-17 may present with or without a parent or guardian – one is not required to be present. Staff should attempt to obtain consent from parent or guardian when possible and adolescent agrees to parent notification.** Whether or not such a parent or guardian is present when the minor victim presents - the additional consent of the parent or guardian to the exam and evidence collection is not required and does not need to be obtained in order for the medical/forensic exam and evidence collection to go forward.
- **For child victim age 12 or younger, consent from a parent or guardian should be sought, unless it is suspected that the sole parent/guardian may be the perpetrator, in which case assent from the child (who is capable of doing so) will suffice and parent/guardian consent is not required.**
- Assent should always be obtained from every child who is capable of doing so (verbal will suffice). No child should be forced against his or her will to undergo a sexual assault examination and evidence collection.
- Forensic evidence collection should not be performed on a patient with altered mental status; once mental status returns to normal forensic evidence collection can be performed.
- If parent/guardian refuses to consent and child is believed to be in danger from parent/guardian/other caretaker, DCF should be immediately involved. Attending physician may take the child into custody at the hospital for a period of 96 hours (order must be placed in the medical record indicating a 96 hour hold was placed for medical evaluation of an abuse concern), which allows health care personnel to provide immediate assessment, diagnosis, and treatment. If a 96 hour hold is placed by attending physician, the on-call administrator should be notified.

## FULL KIT EVIDENCE COLLECTION:

**For post-pubertal/post-menarcheal children, complete full evidence collection kit per kit instructions**

- Sexual Assault Forensic Examiners available for ≥ 13 yrs old
- If SAFE not available, ED providers will perform evidence collection.

## LIMITED EVIDENCE COLLECTION:

**For pre-pubertal/pre-menarcheal children, use the Full Forensic Evidence Collection Kit but only perform the following steps:**

First open kit and be sure to **wear gloves**.

- Complete paperwork included in kit*
- **DO NOT** pluck head or pubic hair; this can be done later if necessary
- Collect clothing – Collect outer clothing if it is the same clothing worn during the assault. Collect underpants even if not the same pair worn during the assault.
    a. Use 1 large bag labeled ***Clothing***, small bags labeled ***Outer Clothing*** (if indicated) and 1 small bag labeled ***Underpants***. Follow directions on the large

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bag labeled ***Clothing*** for direction on how to properly collect each article of clothing.

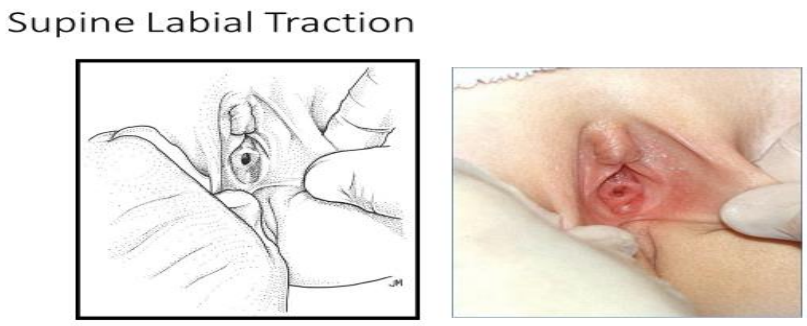
- Collect debris if present – Use envelope labeled ***Debris Collection***.
- Collect oral swabs – Use envelope labeled ***Oral Swabs and Smear.***
- Collect swabs of areas that fluoresce with alternate light source – Use envelope labeled ***Dried Secretion Specimen.***
- Collect "Touch DNA" swabs if indicated (Touch DNA can be collected if child was strangled or forcefully grabbed) – Once swabs are collected, seal and label envelope in accordance with instructions of ***Evidence Integrity***
- FEMALES:
    a. Collect 2 ***genital swabs*** from outer surface of the entire labial area.
    b. Collect 2 ***genital swabs*** between the labia.
    c. **DO NOT SWAB ON THE HYMEN OR INTO THE VAGINA AS THIS CAN BE PAINFUL. DO NOT USE A SPECULUM**. Use envelope labeled ***Genital Swab***, and use all four swabs if possible.
    d. Collect anal swabs from the anal cavity/rectum - Use envelope labeled ***Anal Swabs and Smear***.
- MALES:
    a. Collect 4 ***genital swabs*** from penis, scrotum, and perineum
    b. Collect anal swabs from the anal cavity/rectum - Use envelope labeled ***Anal Swabs and Smear***.

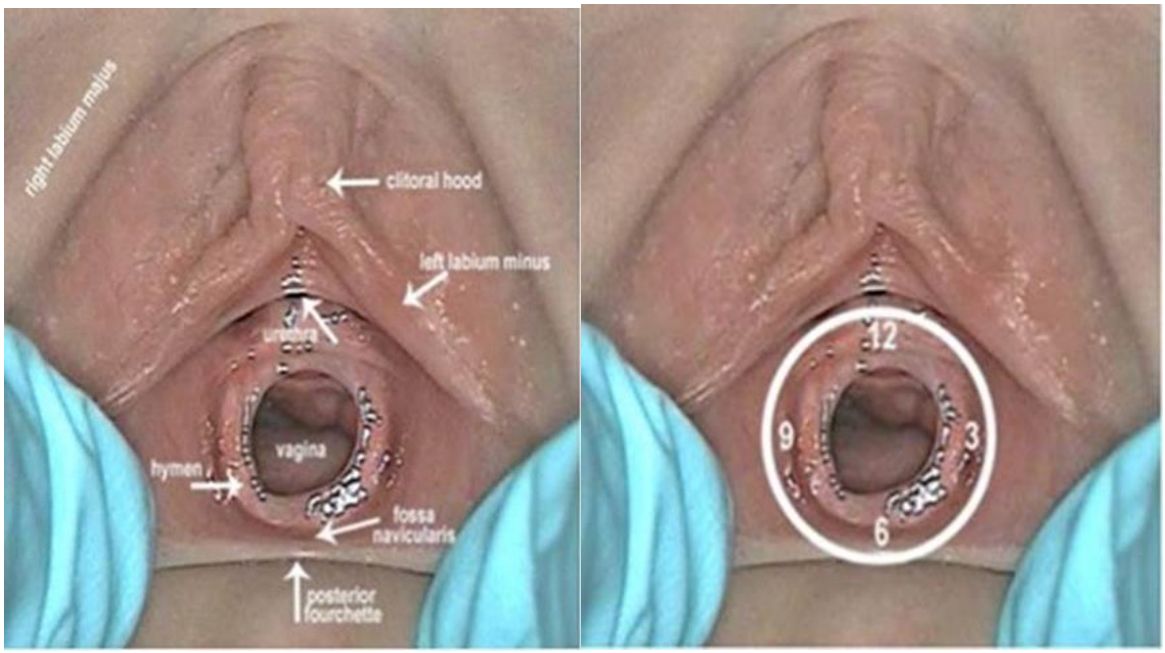
*** Be sure to put the yellow copy of the completed "State of CT Sexual Assault Medical Report" in the envelope glued to the underside of the forensic kit box.**

## FEMALES:

- Do NOT use a speculum!
- Pre-pubertal girls:
  - Involve Child Life Specialists.
  - Can be examined supine in frog leg position or on caretaker's lap.
  - Use gentle labial traction *(gently pull outward and lateral on the labia minora)* to expose structures of interest in females.
  - As the child relaxes, the hymen will relax and the opening should be visible.
  - Do not document "hymen intact" (even though this is a check box option in Epic) as this terminology is incorrect.

### Normal Female Prepubertal Anatomy in Labial Traction

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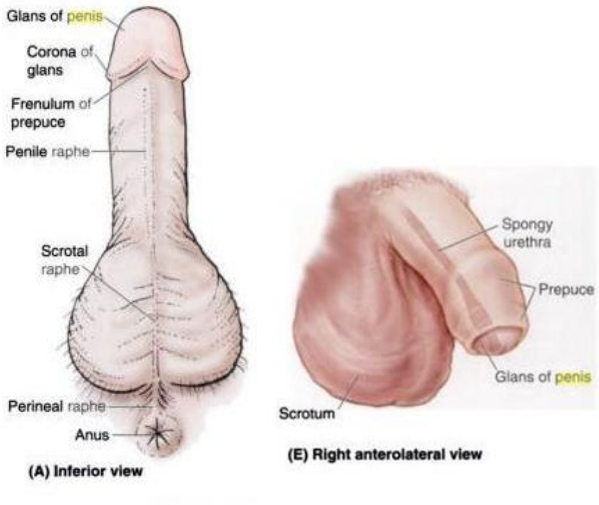
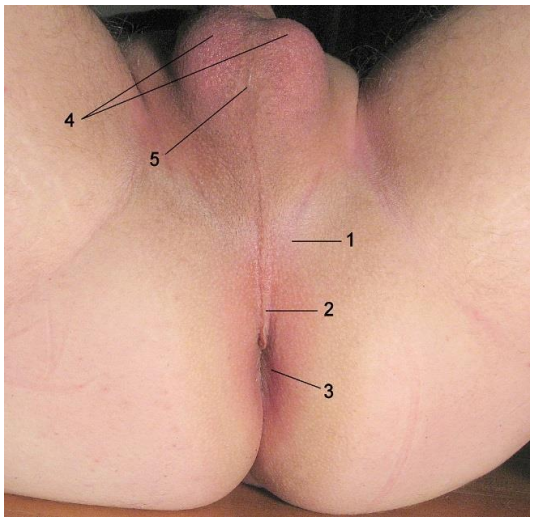
## MALES:

- Involve Child Life Specialists.
- Can be examined supine on table, then with knees to chest, or on caregiver's lap.

### Normal Male Anatomy




1. Perineum. 2. Raphe perinealis. 3. Anus. 4. Testicles, Scrotum. 5. Raphe scrotalis

## FEMALES AND MALES:

- Anus best examined with child on back with knees held to chest (like a "cannonball"). Document any irregularities or lesions by superimposing a clock face with 12 anterior (similar to hymen diagram).
- Documentation:
  - Use Epic diagram under GU exam to help document.

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  - Only use words for structures you can identify. Otherwise, use drawing tools or numbers in Epic to indicate areas of injury or concern. For example, do not document “vaginal laceration” if the area is on the labia.
  - If injury present, document location using a clock face (see hyman diagram above).
- If patient refuses or is not cooperative with genital examination:
  - Defer examination and refer the child to SCAN for follow-up.
- If physical is urgent (e.g., there is pain or bleeding):
  - Involve Child Life Specialists.
  - In rare cases, sedation or anesthesia may be necessary.
  - Consult gynecology and/or trauma surgical team if blood coming from vagina/anus, or if exam under anesthesia is being considered.
- If abnormal genital findings are felt to be related to abuse/assault:
  - Notify SCAN team:
    - 860-837-5890 during weekday hours.
    - Or page SCAN provider on-call via Intellidesk.

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## For patients ≥13 years old:
## Greenbaum Screening Tool

- Is there a previous history of drug and/or alcohol use?
- Has the youth ever run away from home?
- Has the youth ever been involved with law enforcement?
- Has the youth ever broken a bone, had traumatic loss of consciousness, or sustained a significant wound?
- Has the youth ever had a sexually transmitted infection?
- Does the youth have a history of sexual activity with more than 5 partners?

**Results:**

- 2 or more positive answers is a positive screen.
- If positive, inform DCF and arrange a formal mental health evaluation. Consider child a possible flight risk.

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## Hepatitis B: Post-exposure Immunoprophylaxis

*Immunoprophylaxis should be administered as soon as possible (preferably within 24 hours) or within 7 days of percutaneous exposure.*

| Exposure | Hepatitis B Prophylaxis Management | |
|---|---|---|
| | Unvaccinated Person | Previously Vaccinated Person |
| HBsAg-positive source | Hep B vaccine series[1] and HBIG | Hep B vaccine dose[1] |
| HBsAg status unknown for source | Hep B vaccine series[1] | No management |

Abbreviations: Hep B = hepatitis B; HBsAg = hepatitis B surface antigen; HBIG = hepatitis B immune globulin.

[1]Hepatitis B lifetime vaccination maximum is 6 doses.

Schillie S, Vellozzi C, Reingold A, et al. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices. MMWR Recomm Rep 2018; 67(No. RR-1):1-31. DOI: http://dx.doi.org/10.15585/mmwr.rr6701a1.



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Guide to Tetanus Prophylaxis in Routine Wound Management

| History of Adsorbed Tetanus Toxoid (Doses) | Clean, Minor Wounds | | All Other Wounds [a] | |
|---|---|---|---|---|
| | DTaP, Tdap, or Td [b] | TIG [c] | DTaP, Tdap, or Td [b] | TIG [c] |
| Fewer than 3 or unknown | Yes | No | Yes | Yes |
| 3 or more | No if <10 y since last tetanus-containing vaccine dose | No | No [d] if <5 y since last tetanus-containing vaccine dose | No |
| | Yes if ≥10 y since last tetanus-containing vaccine dose | No | Yes if ≥5 y since last tetanus-containing vaccine dose | No |

Tdap indicates booster tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine; DTaP, diphtheria and tetanus toxoids and acellular pertussis vaccine; Td, adult-type diphtheria and tetanus toxoids vaccine; TIG, Tetanus Immune Globulin (human).

[a]Such as, but not limited to, wounds contaminated with dirt, feces, soil, and saliva (eg, following animal bites); puncture wounds; avulsions; and wounds resulting from missiles, crushing, burns, and frostbite.

[b]DTaP is used for children younger than 7 years. Tdap is preferred over Td for underimmunized children 7 years and older who have not received Tdap previously.

[c]Immune Globulin Intravenous should be used when TIG is not available.

[d]More frequent boosters are not needed and can accentuate adverse effects.

American Academy of Pediatrics. Wound Care and Tetanus Prophylaxis. In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2018 Report of the Committee on Infectious Diseases.* American Academy of Pediatrics; 2018; 186

## TETANUS IMMUNE GLOBULIN (TIG)[c]

- When TIG is required for wound prophylaxis, it is administered intramuscularly in a dose of 250 U (regardless of age or weight).
- If tetanus toxoid vaccine and TIG are administered concurrently, separate syringes and sites should be used.

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