



SANE/SAFE
Forensic Learning Series

Child Sexual Abuse Assessment

SANE/SAFE Forensic Learning Series

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Leading Publisher of Scientific, Technical, and Medical Educational Resources

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Child Sexual Abuse Assessment

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**Patricia M. Speck, DNSc, APN, APRN,
FNP-BC, DF-IAFN, FAAFS, DF-AFN, FAAN**
Professor and Coordinator of Advanced Forensic Nursing
Department of Family, Community and Health Systems
University of Alabama at Birmingham (UAB) School of Nursing
Birmingham, Alabama

**Diana K. Faugno, MSN, RN, CPN,
SANE-A, SANE-P, DF-IAFN, DF-AFN**
Forensic Nurse Examiner
Board Director: End Violence Against Women International
President: Academy of Forensic Nursing
Eisenhower Medical Center
Barbara Sinatra Children's Center
Rancho Mirage, California

Angelia Clark Trujillo, DNP, MS, RN, WHNP-BC
Associate Professor
University of Alaska Anchorage
School of Nursing
Anchorage, Alaska

Tracey Wiese, DNP, FNP-BC, PMHNP-BC
Nurse Practitioner
Medical Director
Full Spectrum Health, LLC
Anchorage, Alaska

Christine Hallas, DNP, APRN, CPNP-AC
Pediatric Hospitalist,
Alaska Native Medical Center
Anchorage, Alaska

Colleen O. James, RN, BSN, BA, SANE-A, SANE-P
Forensic Registered Nurse
Clinical Forensic Services
South Peninsula Hospital
Homer, Alaska

**Jennifer L. Johnson, DNP, APRN,
WHNP-BC, AFN-BC, SANE-A, SANE-P, DF-AFN**
Assistant Manager
Forensic Assessment Consultation and Treatment
Shawnee Mission Medical Center
Mission, Kansas



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FOREWORD

Among other vital steps, medical forensic evaluations (MFEs) of sexually abused children involve assessment for injury, assessment for STIs and pregnancy, documentation, evidence collection, and most importantly, reassuring children that they are healthy. *Child Sexual Abuse Assessment* takes a thoughtful approach to the education of individuals who will evaluate children and adolescents in cases suspicious for sexual abuse. It begins with the evaluation of an infant and proceeds through the stages of male and female development up to age 16 years. The cases in this book are realistic examples of scenarios that play out every day in communities throughout the country and around the world. These include cases involving child pornography, drug abuse, absent parents, and abuse committed by trusted family members. These case histories will help readers attain the necessary skills for developmentally appropriate interventions in a vulnerable patient population. *Child Sexual Abuse Assessment* offers practical, evidence-informed recommendations for evaluating and documenting a wide range of child sex abuse cases. It is an ideal supplement for continuing education courses and individuals pursuing self-directed study, and it can serve as a resource of additional case histories for those examiners with limited access to a wide variety of cases.

Traumatic experiences in childhood and adolescence not only impact survivors in their adult lives, they can potentially impact survivors' children and their children's children. Due to the research, writing, and teaching of individuals who have dedicated their careers to improving the response to child sexual abuse, the examination of survivors has continued to evolve and improve. Exercises such as those in this book will help practitioners develop, refine, and maintain the skills needed to give children the care that they deserve and to better ensure their well-being in the future.

Kathy L. Bell, MS, RN

Forensic Nursing Administrator
Tulsa Police Department
Tulsa, Oklahoma



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and provide relevant information to
professionals and consumers.

FOREWORD

The health care response to child sexual abuse is evolving. In 2016, the Centers for Disease Control and Prevention (CDC) reported 676 000 cases of child maltreatment and neglect to Child Protective Services (CPS).¹ Sexual abuse is one form of child maltreatment. Forensic registered nurses, advanced practice nurses, and physicians care for children who present for medical forensic evaluations (MFEs) following sexual assault. Through application of the latest research and trauma-informed care principles, health care providers identify and therapeutically treat children who have experienced recent sexual trauma. While the histories given by these children are important, the ability to recognize physical findings is more important in formulating plans for care. *Child Sexual Abuse Assessment*, the newest addition to the *SANE/SAFE Forensic Learning Series*, will assist providers in mastering the knowledge necessary to meet the needs of a particularly vulnerable population.

The authors of this book are experienced in child sexual abuse response, and in this all-new title, they present valuable case studies that test the reader's knowledge of pediatric anatomy, medical conditions and normal variants that may be mistaken for abuse, evidence collection, and treatment options for children of various ages. Among other valuable exercises, readers are challenged to determine whether case histories warrant sampling for evidence and consider best courses of action for reporting abuse and referring for follow-up care. In each case, the authors present evidence-based rationale for identification of injury, documentation of evidence and physical findings, and treatment planning, including referral.

The *Child Sexual Abuse Assessment* is an excellent resource for providers of every level of experience seeking to maintain their skills in assessment, documentation, and treatment of typical presentations of children experiencing sexual abuse and assault. It will also make an excellent adjunct for pediatric SANE/SAFE courses. Its case histories and accompanying exercises will allow readers to refine critical thinking skills vital for delivering high-quality, evidence-based, and clinically reasoned care for children who have experienced sexual abuse. *Child Sexual Abuse Assessment* will be of use for continuing education courses, individuals studying for certification, or those in need of a refresher.

Stacey A. Mitchell, DNP, MBA, RN, SANE-A, SANE-P, FAAN

Clinical Associate Professor
Texas A&M University
College of Nursing
Bryan, Texas

1. Centers for Disease Control and Prevention. Child abuse and neglect prevention. Centers for Disease Control and Prevention Web site. <https://www.cdc.gov/violenceprevention/childabuseandneglect/index.html>. Updated April 10, 2018. Accessed August 20, 2018.

PREFACE

Children who have experienced sexual abuse face a challenging path to physical and psychological recovery. The medical forensic evaluation of such children must, necessarily, be specifically tailored to their developmentally prescribed capacities, including developmentally normal verbal and physical limitations, and conducted with particular consideration for their immediate emotional reactions to trauma as well as their continued personal well-being long after the evaluation has ended. For the full and flourishing recovery of all their patients, forensic nurses involved in the evaluation of sexually abused children must regularly supplement their base of knowledge and experience with continuing education, training, and review of current best practices in their field. To that end, the authors are pleased to present this work for their current and future colleagues in pediatric forensic nursing and pediatric health care in general. This all-new assessment title provides readers with 16 case histories of child sexual abuse and accompanying full-color photographs taken during patient evaluations. The patients in these cases vary in age from infancy to adolescence, and their cases involve a variety of assaultive scenarios that practitioners might encounter in the field, including abuse by perpetrators both known and unknown to the victims, child-on-child sexual abuse, and drug-facilitated sexual assault. Readers are challenged to analyze the facts of each case, such as the facts are presented, and complete a series of related exercises intended to assess and enhance their knowledge of and competence in sexual abuse evaluation. These exercises include identifying visible anatomical structures, determining evidence collection required in each case, and listing treatments and referrals that should be offered to each given patient. It is the authors' intention that through repeated exercise in these fundamental skill sets, students and expert health care professionals alike will reinforce their capacity for reasoned, patient-centered, and evidence-based practice in medical forensic evaluation, such that all readers might grant the full benefit of their knowledge and expertise to their patients and, by extension, their communities as a whole.

Patricia M. Speck, DNSc, APN, APRN, FNP-BC, DF-IAFN, FAAFS, DF-AFN, FAAN

Diana K. Faugno, MSN, RN, CPN, SANE-A, SANE-P, DF-IAFN, DF-AFN

Angelia Clark Trujillo, DNP, MS, RN, WHNP-BC

Tracey Wiese, DNP, FNP-BC, PMHNP-BC

Christine Hallas, DNP, APRN, CPNP-AC

Colleen O. James, RN, BSN, BA, SANE-A, SANE-P

Jennifer L. Johnson, DNP, APRN, WHNP-BC, AFN-BC, SANE-A, SANE-P, DF-AFN

REVIEWS

The Child Sexual Abuse Assessment provides detailed information about assessment, photodocumentation, evidence collection, and treatment planning in cases of child sexual abuse, as well as information for the identification of normal anatomical features and normal variants that might be observed during a forensic evaluation. It is an excellent resource for health care personnel who frequently or infrequently encounter children and adolescents who are suspected or confirmed victims of sexual abuse. The case histories in this book address a variety of scenarios that forensic nurses and other medical professionals might encounter in practice, including abuse committed by strangers and by individuals known to their victims, child-on-child sexual abuse and peer sexual assault of adolescents, as well as cases of abuse involving strangulation. I recommend the Child Sexual Abuse Assessment both for students and for health care professionals involved in the response to child and adolescent sexual abuse.

Qiana A. Johnson, DNP, FNP-C
SANE Program Director
Day League (formerly DeKalb Rape
Crisis Center)
Decatur, Georgia

The Child Sexual Abuse Assessment will be a useful resource for nurse examiners who work with child abuse victims. The case histories and examination photos make each case come alive and challenge readers first to formulate their own opinions of a given case and then recommend a course for case management. The Case Supplements provided throughout include additional research to augment the case histories and accompanying exercises. Child Sexual Abuse Assessment will provide readers a clear understanding of the requirements and recommended practices for competent child sexual abuse evaluations. Having read this book and completed the exercises inside, readers will be better equipped to conduct holistic, comprehensive, and nonthreatening evaluations in order to promote resilient healing in child abuse victims.

Kim Martinez, MPH, RN, APRN,
CPNP, PSANE
Program Manager, Medical Academy
Midwest Regional Children's Advocacy
Center
Edina, Minnesota

The Child Sexual Abuse Assessment is an excellent resource for nursing classes as well as for personal study. Each chapter includes a case history and a set of full-color photographs, with exercises and supplemental information related to each given case that will help readers to enhance their knowledge of sexual abuse examinations and documentation and promote fruitful discussion among colleagues and students. Readers at every level of experience, from new forensic nurses to seasoned frontline practitioners, can benefit from the detailed cases and recommendations for evidence collection and treatment planning included in this book. I would gladly recommend the Child Sexual Abuse Assessment for guided learning in the classroom or for self-directed study at home.

Steadman McPeters, DNP, CPNP-AC,
CRNP, RNFA
Board-Certified Acute Care Pediatric
Nurse Practitioner
Assistant Professor, School of Nursing
Director of Graduate Clinical
Subspecialty Tracks
Dual Option Pediatric Nurse
Practitioner Specialty Track Coordinator
University of Alabama at Birmingham
Birmingham, Alabama

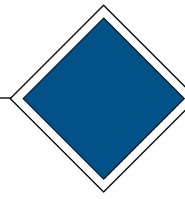
Forensic nurses must be prepared to review a wide variety of conditions, assess patients, and provide accurate conclusions regarding patients' conditions and likely contributing factors. Given the difficulty of mastering the full range of diagnoses that could apply to children and adolescents, I am pleased to find a current and comprehensive guide in the Child Sexual Abuse Assessment. This book illustrates both common and uncommon scenarios that medical professionals might encounter in the course of assessing child abuse and provides recommendations for approaching child and adolescent patients based on their developmental stages. The Child Sexual Abuse Assessment is a fantastic resource for both experienced practitioners and those new to assessing child maltreatment. I highly recommend

this book for any medical providers who care for children or adolescents involved in potential cases of abuse.

Sarah Pederson, BSN, RN,
SANE-A, SANE-P
SANE Coordinator
liveSAFE Resources
Marietta, Georgia

The Child Sexual Abuse Assessment is another excellent resource from STM Learning for health care professionals committed to providing excellent medical forensic health care responses to the population of children and adolescents impacted by abuse. The collection of complex, authentic case histories, exceptional digital images, and evidence-based references provides a valuable tool for clinicians as well as educators. The standardized format guides the reader through the phases of assessment, critical thinking, and interpretation and emphasizes the necessity of a team approach and interprofessional collaboration in cases of child abuse. The Child Sexual Abuse Assessment, authored by forensic nursing experts, is a much-needed resource for both novices and established professionals providing services to children, adolescents, and their families in the aftermath of abuse.

Valerie Sievers, MSN, RN, CNS,
SANE-A, SANE-P
Clinical Nurse Specialist, Forensic
Healthcare Consultant
Forensic Nurse Examiner, Safe Passage-
Child Advocacy Center
Colorado Springs, Colorado



INTRODUCTION

The *Child Sexual Abuse Assessment* is intended for students new to SANE/SAFE practice as well as longtime SANE/SAFE examiners seeking to hone their skills. Formatted for self-study and group instruction, the book allows for portable, straightforward learning. Each exercise and corresponding answer key is purposefully designed for a broad audience to reflect the diversity and scope of practice of sexual assault examiners. Medical professionals have the opportunity to earn continuing medical education (CME) credits or continuing education (CE) contact hours through successful completion of this book. Successful completion consists of reading the text in its entirety, including the case supplements included in each chapter, and completing the chapter activities, post-test, and evaluation form. The *Child Sexual Abuse Assessment* is a valuable resource for trainees, early-stage practitioners, and managers and supervisors responsible for the ongoing evaluation of examiners.

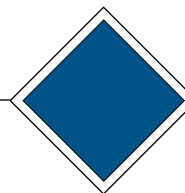
Upon completion of the *Child Sexual Abuse Assessment*, the student will have a basic understanding of anogenital anatomy, be familiar with proper terminology, and be able to accurately identify and document injury. The student will understand treatment plans based on recommendations made by the Centers for Disease Control and Prevention, the World Health Organization, and his or her local community protocols for treatment and discharge. Additionally, the student will have demonstrated understanding of evidence collection following a sexual assault.

SELF-STUDY USE

Using case studies and attendant color photographs, the *Child Sexual Abuse Assessment* simulates the environment of a clinic and provides continuing education to examiners who assess and treat patients reporting a history of sexual abuse or assault.

GROUP INSTRUCTIONAL USE

The *Child Sexual Abuse Assessment* provides instructors with the materials they need to share knowledge of sexual abuse or assault issues with interested participants. Students should purchase their own copies of the *Child Sexual Abuse Assessment* when learning in a classroom setting.



INSTRUCTIONS

OVERVIEW

— Title: *Child Sexual Abuse Assessment*

— Jointly provided by Postgraduate Institute for Medicine and STM Learning, Inc.

— Release date: October 31, 2018

— Expiration date: October 31, 2021

— Estimated time to complete activity: 3.75 hours

The application of clinical reasoning can be challenging. The authors of this book believe that repetition improves the clinical reasoning necessary for quality evidenced-based practice. In the *Child Sexual Abuse Assessment*, participants will analyze cases of sexual abuse and critically consider the most appropriate application of clinical reasoning based on patient histories and the identification of anatomical locations, physical injuries, and medical conditions. The basic premise of the *Child Sexual Abuse Assessment* is that through repeated practice in the use of accurate anatomical descriptions, injury identification, and treatment recommendation, health care providers will continually improve the knowledge, skills, abilities, and understanding required for quality practice.

TARGET AUDIENCE

This activity is intended for physicians, registered nurses, and other health care providers engaged in the care of patients who have been abused or sexually assaulted.

EDUCATIONAL OBJECTIVES

After completing this activity, the participant should be better able to:

- Identify and describe structures of the oral, anal, and genital anatomy for the child/adolescent patient who has experienced sexual abuse or assault.
- Recognize injuries to the oral, anal, and genital structures for the child/adolescent patient who has experienced sexual abuse or assault.
- Differentiate normal variants from injury or findings that may be related to specific medical conditions.
- List potential items to be collected for evidentiary purposes for the child/adolescent patient who has experienced sexual abuse or assault.
- Apply standard terminology for documenting the medical forensic evaluation, including photodocumentation.
- Utilize patient-specific interventions for the child/adolescent patient presenting with a history of sexual abuse or assault (eg, patient-specific resources, referrals)

FACULTY

Patricia M. Speck, DNSc, APN, APRN, FNP-BC, DF-IAFN, FAAFS, DF-AFN, FAAN
Professor and Coordinator of Advanced Forensic Nursing
Department of Family, Community and Health Systems
University of Alabama at Birmingham (UAB) School of Nursing
Birmingham, Alabama

Diana K. Faugno, MSN, RN, CPN, SANE-A, SANE-P, DF-IAFN, DF-AFN
Forensic Nurse Examiner
Board Director: End Violence Against Women International
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Medical Director
Full Spectrum Health, LLC
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Pediatric Hospitalist,
Alaska Native Medical Center
Anchorage, Alaska

Colleen O. James, RN, BSN, BA, SANE-A, SANE-P
Forensic Registered Nurse
Clinical Forensic Services
South Peninsula Hospital
Homer, Alaska

Jennifer L. Johnson, DNP, APRN, WHNP-BC, AFN-BC, SANE-A, SANE-P, DF-AFN
Assistant Manager
Forensic Assessment Consultation and Treatment
Shawnee Mission Medical Center
Mission, Kansas

COURSE FORMAT AND IMPLEMENTATION

For optimal results, the authors suggest you read the text in its entirety, including the case supplements included in each chapter, and complete the chapter activities, post-test, and evaluation form. Chapters and credits designated for this book are as follows:

Chapter 1: 6-month-old Female Infant of Parent in Possession of Child Pornography
Chapter 2: 26-month-old Female Patient Referred by Pediatrician
Chapter 3: 30-month-old Female Patient Assaulted by Mother's Boyfriend
Chapter 4: 4-year-old Male Patient With Possible Abuse by Teenage Male Relative
Chapter 5: 5-year-old Female Patient Assaulted by Adult Male Relative
Chapter 6: 6-year-old Female Patient Missing for 24 Hours
Chapter 7: 7-year-old Female Patient Assaulted by Child Next Door
Chapter 8: 8-year-old Male Patient Assaulted by Stepfather
Chapter 9: 9-year-old Female Patient Abused by Her Mother's Live-in Boyfriend
Chapter 10: 10-year-old Female Patient Assaulted by Male Cousin

-
- Chapter 11: 12-year-old Female Patient Assaulted by Adult Male Cousin
 - Chapter 12: 13-year-old Female Patient Assaulted by Adult Male Stranger
 - Chapter 13: 13-year-old Female Patient Assaulted by Friend's Older Brother
 - Chapter 14: 14-year-old Female Patient Assaulted by Trainer
 - Chapter 15: 15-year-old Male Patient Assaulted at a Party
 - Chapter 16: 16-year-old Female Patient Assaulted by a Teammate
 - Chapter 17: Documenting a History and Reviewing a Case

AMA PRA Category 1 Credits™: 3.75

OR

CE contact hours: 3.7



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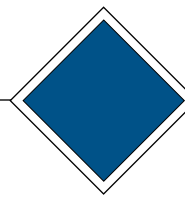
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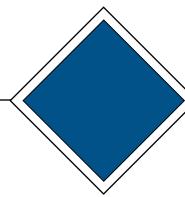
DISCLAIMER

Participants have an implied responsibility to use the newly acquired information to enhance patient outcomes and their own professional development. The information presented in this activity is not meant to serve as a guideline for patient management. Any procedures, medications, or other courses of diagnosis or treatment discussed or suggested in this activity should not be used by clinicians without evaluation of their patient's conditions and possible contraindications and/or dangers in use, review of any applicable manufacturer's product information, and comparison with recommendations of other authorities.



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Child Sexual Abuse Assessment

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ANATOMICAL REVIEW

OBJECTIVES

After reviewing the figures presented in this section, the student will be able to:

1. Correctly identify oral, genital, and anal anatomy.
2. Accurately define structures of the oral, genital, and anal anatomy.

INSTRUCTIONS

Anatomical diagrams and photographs have been provided to assist the student with correctly identifying anatomical landmarks. These diagrams and photos should be used when documenting normal anatomy, injuries, and any other variant conditions or findings throughout the *Child Sexual Abuse Assessment*.

ADDITIONAL DEFINITIONS

The student may find reviewing the following definitions useful in completing the activities within this book. Terminology for indicators of direction when documenting findings during a medical forensic examination include *anterior, posterior, inferior, superior, medial, lateral, proximal, and distal*.

- **Abrasions:** Superficial injuries representing the removal of the outermost layers of the skin; usually caused by lateral rubbing, sliding, or compressive forces.
- **Avulsion:** A forceful separation or detachment that may occur traumatically or surgically; tearing away of a body part or structure.
- **Bruises (contusions):** Injuries that lie below the intact epidermis and result from extravascular collection of blood that has leaked from ruptured capillaries or blood vessels after sufficient force has been applied to distort the soft tissues and tear 1 or more vessels.
- **Cut:** An opening in the skin that occurs when a sharp object comes into contact with skin or tissue with enough pressure to divide it; cuts have even, regular edges.
- **Drug-facilitated sexual assault (DFSA):** Generic term for all types of sexual assault when drugs, alcohol, or other intoxicants are deliberately given to the victim by the perpetrator.
- **Hymen Estrogen Response Scale (HERS):** Tool for evaluating changes to the hymen and surrounding structures related to developmental and cyclical changes throughout the life span (**Table AR-1**). HERS scores (rated 0, 1, or 2) describe 5 variables: color, thickness, lubrication, distensibility, and sensitivity. The 5 variable scores are added up, and the total score determines the level of estrogen effect. A total score of 0 reflects characteristics expected when estrogen is low or absent. A total score of 10 reflects characteristics expected when estrogen levels are high (eg, during pregnancy). Scores between 0 and 10 reflect varying levels of estrogen and other unknown variables (eg, genital changes throughout the life span, cyclic variability, medications, activities that impact the appearance of the hymen and surrounding tissues).
- **Lacerations:** Injuries that occur when the continuity of the skin is broken and disrupted, such as by tearing, ripping, crushing, overstretching, pulling apart, over-bending, or shearing of tissue.

Table AR-1. Hymen Estrogen Response Scale and Scoring

VARIABLE	0	1	2	SCORE
Color	Red	Pink	White	
Lubrication	None/scant clear	Scant white caked	Clear to white mucous	
Distensibility	None/flat	Some folds/scallops	Redundancy/layers	
Sensitivity	Painful to touch	Sensitive to touch	No pain to touch	
Thickness	Thin, translucent flat	Areas of thickening, some translucent margins	Thick, without translucency	

HERS SCORE TOTAL

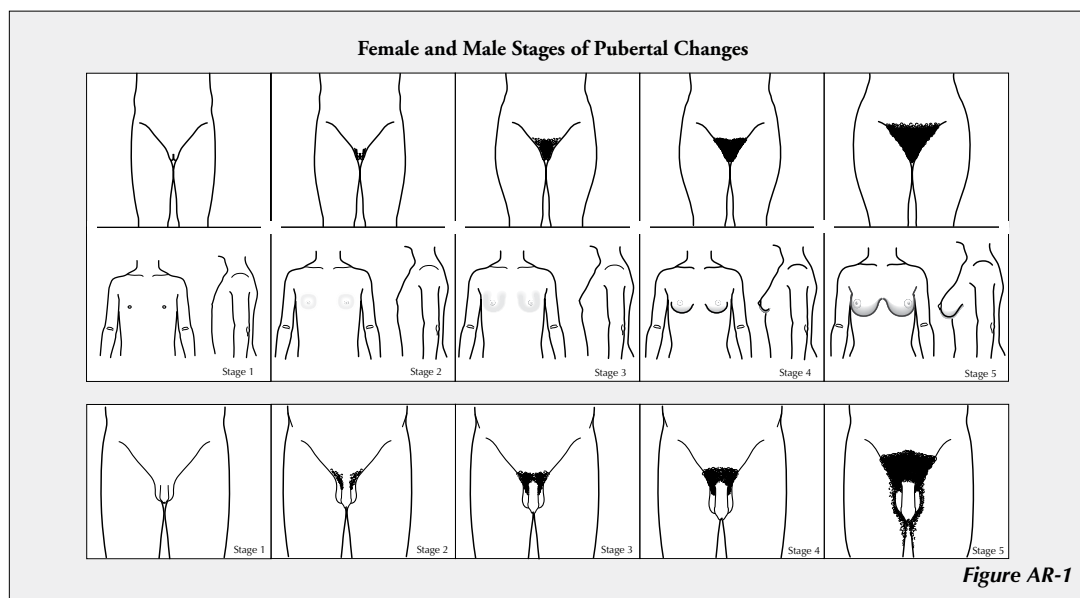
Variable	HERS Interpretation
0-1	No estrogen effect (NEE)
2-4	Early transition (ET)
5-7	Late transition (LT)
8-10	Full estrogen effect (FEE)

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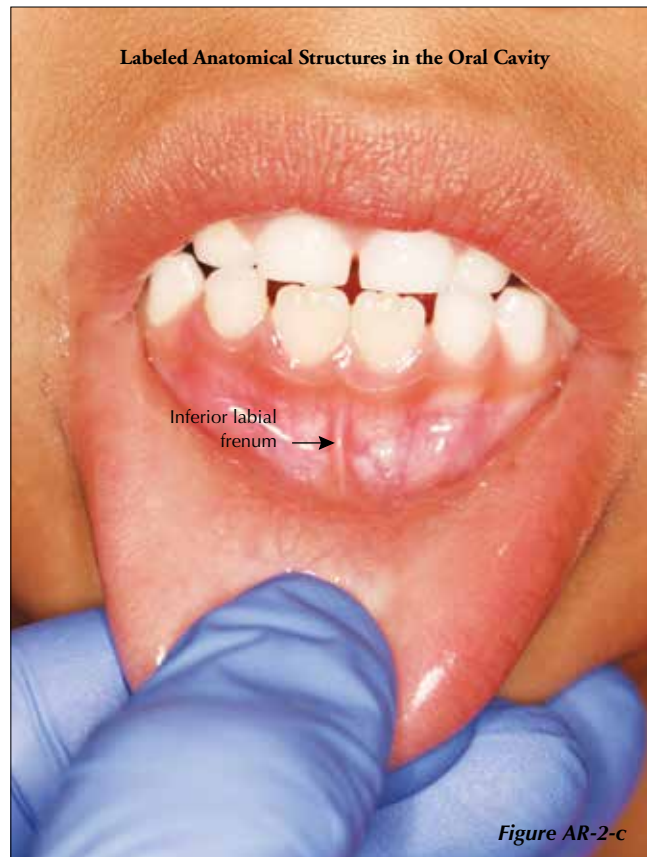
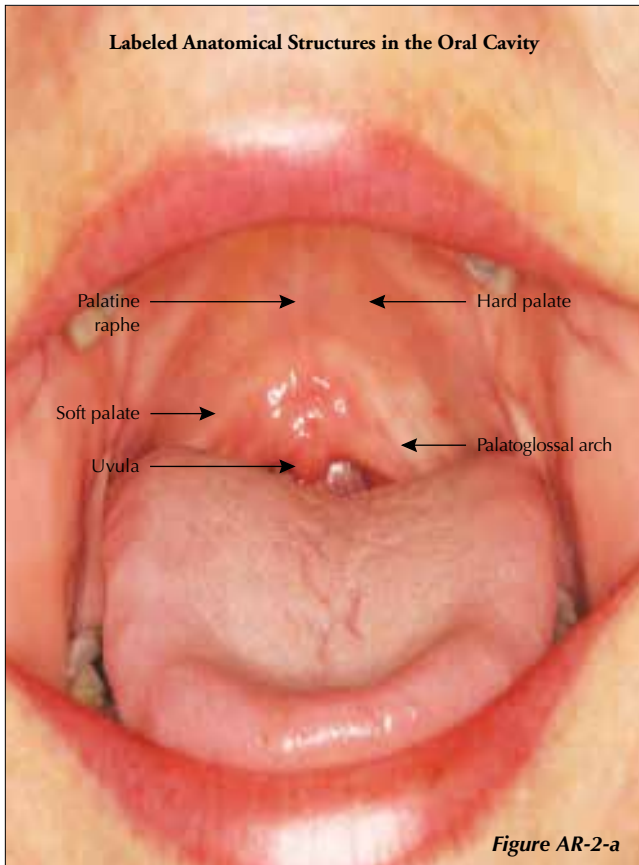
- **Nursing diagnosis:** A nursing diagnosis is a clinical judgment about individual, family, or community experiences or responses to actual or potential health problems or life processes. A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable. (As defined by NANDA International.)
- **Petechiae:** Multiple hemorrhagic spots, pinpoint to pinhead in size.
- **Sexual Maturity Rating (“Tanner Scale/Stages”):** A widely used model for assessing sexual maturity that classifies sexual maturation into 5 stages, with Stage 1 referring to children without any evidence of pubertal development, Stages 2 through 4 referencing intermediate stages of growth, and Stage 5 referring to adolescents with completed physical maturation. Breast and pubic hair development is evaluated in girls, and genital and pubic hair development is evaluated in boys (**Table AR-2** and **Figure AR-1**).

Table AR-2. Tanner Stages of Maturity

BREAST SEXUAL MATURITY RATING (SMR)	
Stage 1 (prepubertal)	Elevation of the papilla
Stage 2	Breast budding with areolar enlargement and later tenderness
Stage 3	Enlargement with no separation of breast/nipple contour
Stage 4	Projection of the areola and papilla to form a clear mound (nipple)
Stage 5	The mature stage with areolar recession
PUBIC MATURITY RATING	
Stage 1 (preadolescent)	Only vellus over the pubes, no pubic hair
Stage 2 (pubarche)	Sparse growth, downy hair, straight, little curl, hairs easily counted
Stage 3	Hair darker, coarser, curlier, mainly over the pubis, still countable
Stage 4	Adult type hair over the mons and labia, counting now requires compulsive behavior
Stage 5	Mature stage spreads to medial thighs and forms the female escutcheon (inverted triangle)
BOYS SMR	
Stage G1 (preadolescent)	Infantile, no enlargement of penis, testicular volume 1.5 mL
Stage G2	Testes enlarge (volume 1.6 mL), early sparse pubic hair
Stage G3	Hair increases, both testes (volume 6-12 mL) and penis grow
Stage G4	Hair now thickened, scrotum more rugated, volume of testes 12-20 mL
Stage G5	Adult male hair on the thighs; penis and testes (volume > 20 mL) full size; male escutcheon is triangular



ORAL CAVITY



DEFINITIONS

- *Fordyce spots*: Enlarged ectopic sebaceous glands in the mucosa of the mouth and genitals, appearing as small yellow spots.
- *Frenum (original term: frenulum)*: A small fold of mucous membrane that limits the movements of an organ or anatomical structure (eg, lingual frenum, maxillary labial frenum, mandibular labial frenum).
- *Gingiva*: The soft tissue overlying the crowns of unerupted teeth and encircling the necks of those that have erupted. Wisdom teeth are the last set of molars to erupt, usually at age 18 to 25 years.
- *Hard palate*: The anterior part of the palate, covered above by the mucous membrane of the nose and below by the mucoperiosteum of the roof of the mouth.
- *Lips*: The soft external structures that form the boundaries of the mouth, the opening to the oral cavity.

Section



CASE HISTORIES

6-MONTH-OLD FEMALE INFANT OF PARENT IN POSSES- SION OF CHILD PORNOGRAPHY

OBJECTIVES

After completing the exercises presented in this chapter, the student will be able to:

1. Correctly identify the anogenital anatomy of an 6-month-old female patient.
2. Identify and document injuries, normal variants, or medical conditions based on review of case photographs.
3. Determine whether or not the case history warrants evidence collection. If so, list 3 items of evidence that should be collected.
4. Discuss and provide treatment options based on the patient's history.

CASE HISTORY*

Claire, a 6-month-old female, presents to the local child advocacy center (CAC) accompanied by a Child Protective Services (CPS) social worker. The social worker picked up Claire from daycare earlier today after law enforcement found child pornography on a home computer belonging to Claire's father. The uncovered pornography includes many photographs of unidentifiable infants and very young children positioned in explicit sex acts, including photographs of adult men fondling infants. The local police department is assisting the Federal Bureau of Investigation (FBI) in investigating the case.

After finding the child pornography, law enforcement picked up Claire's mother from work and took her to the police station for questioning, before she had the chance to speak with Claire's father. With permission from law enforcement, Claire's mother calls the CAC and gives verbal consent for a medical forensic examination to the forensic nurse, with the CPS social worker on hand to witness the verbal consent. Claire's mother provides the forensic nurse with her identifying social security information and birthdate as well as a brief medical history of her child. Both the forensic nurse and social worker sign a consent form, testifying to the provision of verbal consent and identifying information. The social worker informs Claire's mother that she will contact her after the medical forensic evaluation to answer questions.

Claire's health history is negative for recent illness or injury, hospitalization, or surgery. According to her mother, she had an ear infection at "somewhere between 4 and 5 months old" and received treatment, which she completed. Claire is up to date on her immunizations schedule and had a well-child visit when she turned 6 months old. Her next visit is planned for her 9-month checkup. Claire's mother relates that neither she nor Claire's pediatrician has any concerns related to Claire's growth and development. She reports that she bathed Claire last night and "only rinses [her] privates." The mother also reports that she is currently under treatment for severe depression and posttraumatic stress disorder (PTSD), which manifested after she delivered Claire. When asked if she ever leaves Claire unattended, she says, "Only with her father, especially when I feel sad." It should be noted that Claire's mother and father are teenagers. After speaking with the forensic nurse at the CAC, law enforcement requests a kit collection from the patient's mouth, anus, and vulva.

**After completing the following exercises, refer to Case Supplement on page 22 for additional information.*

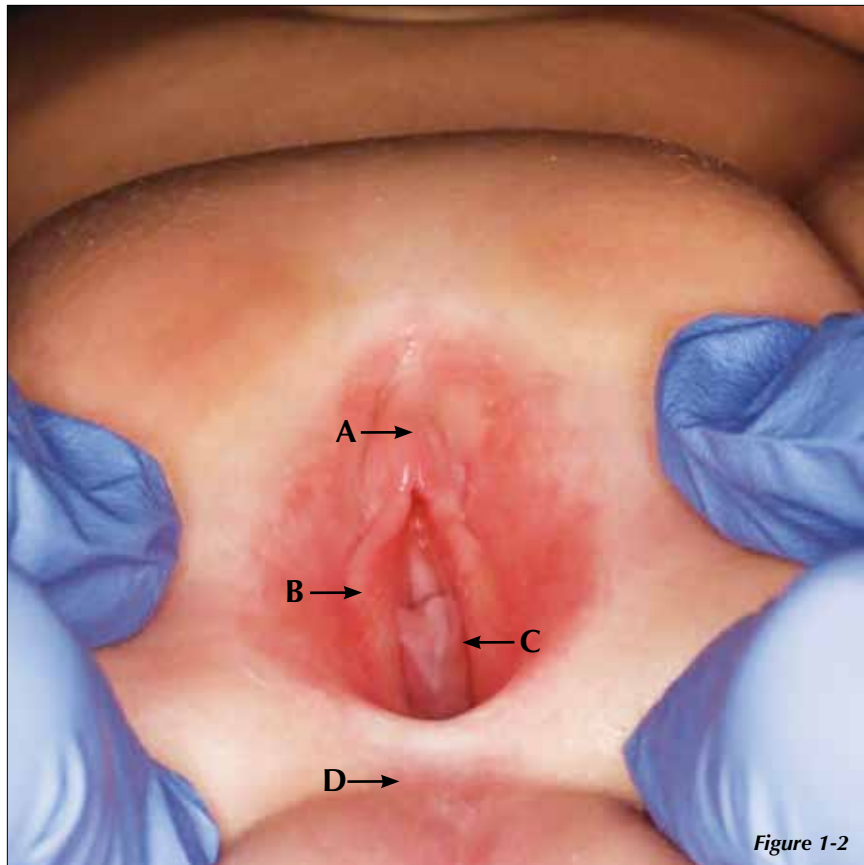
ANATOMICAL SKILLS 1-1

Refer to **Figure 1-1**. Name the corresponding anatomical locations.

Arrow A: _____

Arrow B: _____

Arrow C: _____



ANATOMICAL SKILLS 1-2

Refer to **Figure 1-2**. Name the corresponding anatomical locations.

Arrow A: _____

Arrow B: _____

Arrow C: _____

Arrow D: _____



Figure 1-3

ACTIVITIES

ACTIVITY 1-1. INJURY, NORMAL VARIANT, OR MEDICAL CONDITION IDENTIFICATION

Refer to **Figure 1-3**. Identify injuries, normal variants, or medical conditions based on an analysis of the case photograph. Give objective descriptions when documenting findings.

ACTIVITY 1-2. EVIDENCE COLLECTION

Using the history and photographs provided, list the evidence you will collect from the patient. List evidence in the order it will be collected.

ACTIVITY 1-3. TREATMENT

Describe the treatment you will offer the patient based on her history and your findings.

CASE SUPPLEMENT

Child pornography is a form of child exploitation and maltreatment. Children who live with adults in possession of child pornography are at risk for exposure to explicit images long before they are developmentally ready to process the experience. During the 1990s, it was thought that exposure to pornography in the home contributes to sexual abuse among same-age siblings and children.¹ Recent work suggests that adolescents who sexually offend, as in this case, tend to experience earlier and more frequent exposure to sex, either by viewing others engaged in sexual activity or by viewing pornography.^{2,3} Studies have found that exposure to sexually explicit magazines during youth and exposure to sexually explicit materials at younger ages (between 5 and 8 years) is common among both adolescent males and females who commit sex offences.^{4,6} Other evidence suggests that arrested online sex offenders often admit to satisfying sexual fantasies and curiosity using child pornography and other paraphilias, but they rarely admit to actually abusing children.⁷

When there is suspicion for but no disclosure of sexual abuse (ie, in the case of a preverbal infant), and when there is no witness to an abusive act, the developmental and physical medical forensic evaluation may prove challenging (see the Health Care Provider Child Sexual Abuse Evidence Collection Algorithm in Section III: Appendix for more information). In this case, the forensic nurse received witnessed permission (by phone, with a third party listening to the verbal permission process) from the patient's mother to evaluate her infant child. The mother also provided the infant's medical history and some of her own medical history, disclosing experiences with depression and PTSD. After speaking with the forensic nurse, law enforcement requested a kit collection from the patient's mouth, anus, and vulva. If there is reason to believe that an abusive act occurred within 72 to 120 hours prior to presentation, an evaluation with evidence collection is prudent, particularly if the evaluation is atraumatic and routine (eg, a head-to-toe well-child examination). Given the sensitivity of DNA testing and the suspect's role as father and caregiver to the child, any sampling of the patient's anogenital orifices and mouth is likely to find potentially immaterial male DNA. The suspect may make regular, innocuous physical contact with or around those areas in the course of conducting parental responsibilities and given the lack of disclosure and physical injury to the patient, investigators should carefully consider the potential for trauma to the child and family, and the relative likelihood of collecting probative evidence before proceeding with evidence collection. However, given that the patient's father is in possession of child pornography (for which the patient should be considered at risk for abuse), the unknown potential for abusive contact, and law enforcement's request for evidence collection, collection of evidence would still be prudent.

In the event of conducting a medical forensic evaluation, the approaches toward infants are designed to reduce fear of strangers. It is common for infants to experience well-child examinations in the course of regular visits to their primary health care providers; therefore, the forensic nurse performing the medical forensic evaluation of an infant should use the skills of the well-child evaluation to gain access first to the patient's oral area and second to the patient's anogenital area. Age-appropriate distractions (ie, small toys) are helpful, as is a safe, infant-friendly room. Engaging the infant in play helps the forensic nurse assess development and prepares the infant for familiar activities, such as a diaper change. Common activities, familiar to the infant, assist evaluation of the anogenital region without restraining the infant. It is prudent to perform all necessary evaluations *before* collecting samples, because infants will often resist after being subjected to such collections.

For parts of the examination in which the child must be still (eg, photodocumentation), it may be helpful to (1) position the child in the supine frog-leg position, (2) have support personnel distract the child, and (3) employ rapid image capture methods. When working with children of any age, it is important to be patient

and assume a calming voice and affect. All sampling should be collected gently, allowing the cotton-tipped wooden applicator to wick fluids from the fossa navicularis. Gentle anal fold separation followed by gentle pressure of the cotton-tipped applicator helps pick up residue from vulvovaginal drainage and fecal matter. With respect to the fetal genesis and the impact of maternal estrogen on the infant genitourinary system, expected changes related to reduction in maternal estrogen should be described and documented. Concerns of abuse can be neither confirmed nor negated by physical assessment. Nonspecific findings external to the hymen and anal pectinate line (eg, fissures) raise suspicion of abuse and neglect, but such findings may have other causes.⁸ Other evidence, such as the presence of sexually transmitted infection (STI), more specifically supports contact and penetration of an orifice, and routine STI testing in children considered at risk for sexual abuse is standard in many communities.^{9,10} However, for most STIs, maternal transmission is likely in children under 3 years of age.⁸

In this case, reassurance and intervention for the nonoffending parent(s) requires the multidisciplinary efforts of local team members, although the forensic team assessment of family function is limited in capacity and science for correct decision-making in that regard is flawed.¹¹ Such decision-making is best handled by CPS. With regard to the mother's mental health, evidence suggests that when maternal adverse childhood experiences (ACEs) compromise mental health, pregnancy and subsequent delivery may result in maternal perinatal PTSD.¹²⁻¹⁴ The forensic nurse should consider a history of maternal mental health problems a risk factor for child abuse (physical and sexual), particularly during the perinatal period.¹³ Fathers with a history of ACEs may also experience negative mental health outcomes (eg, depression) during a partner's pregnancy.¹⁵ For all families experiencing forensic medical assessments and intersections with legal investigations, reassurance from the forensic nurse and anticipatory guidance to community services for case management are standard.¹⁶

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ANSWER KEY

NOTE TO STUDENTS

STUDENTS SHOULD READ AND CONSIDER THE FOLLOWING ITEMS BEFORE REVIEWING THE ANSWER KEY.

Community standards and agency protocols for sexually transmitted infection (STI) screening, prophylactic treatment, follow-up, patient referral, and specimen collection for evidence kits vary across the United States and internationally. It is the forensic nurse's responsibility to know his or her community standards and agency protocol *and* the rationale surrounding any variations where national or international standards or recommendations exist. It should also be noted that failure to identify any variance in the health of a child that results in adverse outcomes may result in tort, regardless of protocol or standards of practice.

Although specimen collection occurs throughout the forensic medical encounter, it is assumed for the purpose of these case studies that all urgent or emergent needs of the patient have been met, informed consent has been obtained, and a medical forensic history has been fully documented. All of these items, coupled with the physical evaluation, assist in guiding the forensic medical examination, treatment, referrals, recommended follow-up, photodocumentation, and specimen collection for the evidence kit.

When documenting findings in the medical forensic record, documentation should include the approximate length, width, shape, and color of each injury. This level of documentation is not possible when reviewing photodocumentation such as that presented in these case studies. Limitations to the assessment of injury through photodocumentation are related to several variables, including scale, angle, lighting, equipment settings, picture quality, and provider technique (eg, separation, traction).

The case studies in the *Child Sexual Abuse Assessment* are brief summaries of complex patient encounters. The figures provided with each case study represent a sample of the photodocumentation collected during the medical forensic examination. Please note the detail and extent of evidence collection, prophylactic treatment, referrals, and recommended follow-up are based on the information in these brief summaries, not on the additional details that would be available during an actual patient examination.

CHAPTER 1: 6-MONTH-OLD FEMALE INFANT OF PARENT IN POSSESSION OF CHILD PORNOGRAPHY

ANATOMICAL SKILLS 1-1

- A. Upper gum line
- B. Lower gum line
- C. Tongue

ANATOMICAL SKILLS 1-2

- A. Clitoral hood
- B. Right labium minus
- C. Thick, pale hymen with white margins
- D. Perineum

ACTIVITY 1-1. INJURY, NORMAL VARIANT, OR MEDICAL CONDITION IDENTIFICATION

- Nonspecific redness to the vulvar area.
- Redness noted in fold between labia majora and minora and on labia minora and clitoral hood.

ACTIVITY 1-2. EVIDENCE COLLECTION

NOTE: Despite the lack of patient history and detectible injury, it would be prudent to proceed as if this were an acute case, given law enforcement's request for evidence collection and the possibility of abusive contact.

1. Photodocumentation: Used as evidence in the investigative and judicial processes as well as in case review and consultation with other medical providers. It occurs throughout the medical forensic examination/evaluation and may include the following:
 - Patient upon initial presentation
 - Anterior and posterior hands
 - Oral cavity and lip frenula
 - Foreign debris or substances on patient or clothing
 - Injuries (genital and nongenital)
 - Anogenital structures (injured or uninjured)
 - Normal variants and/or medical conditions
2. Clothing: Collect clothing if applicable.
 - If clothing changed prior to arrival and law enforcement is involved, notify law enforcement that original items of clothing are not with patient.
3. Alternate light source (ALS): If community standard, examine patient with Wood's lamp or another ALS.
 - Regardless of negative or positive fluorescence, collect specimens from all areas relevant to the history. Examine any areas of positive fluorescence, even if unsupported by the patient's history.
4. Anogenital specimens:
 - NOTE: Order of specimen collection varies depending upon community standards and agency protocols.
 - Inspect and photograph the anogenital tissue. As the patient was recently bathed, no specimens are indicated for collection unless discharge is present.
 - If discharge from any anogenital orifice is observed, collect a specimen for medical testing as indicated.
 - NOTE: A speculum examination is rarely indicated in the prepubertal or peripubertal child. When indicated, a qualified physician or nurse practitioner conducts the examination of internal structures under conscious sedation or anesthesia, documenting iatrogenic changes in the pre- and postexamination appearance of genitourinary structures (eg, vagina, hymen, fossa navicularis, posterior fourchette, clitoral crura [triangular space connecting clitoris and urethra], labial folds, spaces and connections, urethra, perineum).
 - If practice includes use of toluidine blue dye, apply and assess for injury; however, toluidine blue dye is not often used on prepubertal females, because it can be uncomfortable on application. Follow community protocol.

5. Collect additional specimens, including foreign debris, loose hairs, or samples of dried substances, where observed.
6. Collect blood and toxicology screens per community standard or agency protocol.
 - NOTE: Because most children do not like blood draws, urine specimens should be considered as an alternative. If blood must be drawn, collect samples at the end of the examination.
7. DNA standard:
 - NOTE: Method and time of collection will vary based on community standards and agency protocols.
 - If community practice is to collect buccal specimens for DNA standard, collect buccal specimens following oral assessment or at the end of the examination if history does not warrant assessment of the oral cavity.
 - If community practice is to collect blood specimens for DNA standard (eg, blood standard card, tube of blood), collect blood specimens when other lab specimens are collected or at the end of the examination if other lab specimens are not collected.

ACTIVITY 1-3. TREATMENT

- No treatment required at this time. Child is afebrile and is not symptomatic for genital infection.
- Provide written discharge instructions, including a reminder of the presence of toluidine blue dye, if used. Provide anticipatory guidance as needed based on patient history, verbal/nonverbal communication during examination, and parent questions.
- Follow-up examinations may or may not be part of community standard or agency protocol. If they are not, provide appropriate referrals for all follow-up needs.
- Refer the patient's mother for counseling services via child advocacy center, rape crisis center, advocacy program, or another local service provider or counseling center.
- Refer to Victim Witness Assistance Program for assistance with expenses not related to the medical forensic examination. All children are eligible for medical insurance, and when injury requires treatment, hospitals implement enrollment as needed.
- Offer screening for sexually transmitted infections (STIs) based on Centers for Disease Control and Prevention (CDC) guidelines or local/community protocol. Consider:
 - Nucleic acid amplification tests (NAATs) for *Chlamydia trachomatis* and *Neisseria gonorrhoeae*
 - Wet mount for presence of bacterial vaginosis (BV) and candidiasis
 - Point-of-care testing of a vaginal swab specimen for *Trichomonas vaginalis* infection
 - A serum sample for evaluation for HIV infection, hepatitis B, and syphilis

CHAPTER 2: 26-MONTH-OLD FEMALE PATIENT REFERRED BY PEDIATRICIAN

ANATOMICAL SKILLS 2-1

- A. Clitoral hood
- B. Labia minora with posterior labial adhesion
- C. Left labium majus

ANATOMICAL SKILLS 2-2

- A. Clitoral hood
- B. Left labium minus
- C. Posterior fourchette

ACTIVITY 2-1. INJURY, NORMAL VARIANT, OR MEDICAL CONDITION IDENTIFICATION

— Red rash with open lesions and glistening discharge on bilateral surfaces of inner labia majora and crusty discharge on the margins of the mons, labia majora, and perineum (**Figure 2-3**).

— Note presence of white, raised, fleshy tissue on anal verge from approximately 7 o'clock to 9 o'clock and at 12 o'clock on the peritoneum (**Figure 2-4**).

ACTIVITY 2-2. EVIDENCE COLLECTION

NOTE: As this case is *unknown for last contact*, it would be prudent to proceed as if it were acute.

1. Photodocumentation: Used as evidence in the investigative and judicial processes as well as in case review and consultation with other medical providers. It occurs throughout the medical forensic examination/evaluation and may include the following:
 - Patient upon initial presentation
 - Anterior and posterior hands
 - Oral cavity and lip frenula
 - Foreign debris or substances on patient or clothing
 - Injuries (genital and nongenital)
 - Anogenital structures (injured or uninjured)
 - Normal variants and/or medical conditions
2. Clothing: Collect clothing if applicable.
 - If clothing changed prior to arrival and law enforcement is involved, notify law enforcement that original items of clothing are not with patient.
3. Alternate light source (ALS): If community standard, examine patient with Wood's lamp or another ALS.
 - Regardless of negative or positive fluorescence, collect specimens from all areas relevant to the history. Examine any areas of positive fluorescence, even if unsupported by the patient's history.
4. Anogenital specimens:
 - NOTE: Order of specimen collection varies depending upon community standards and agency protocols.
 - Inspect and photograph the anogenital tissue.
 - If discharge from any anogenital orifice is observed, collect a specimen for medical testing as indicated.
 - NOTE: A speculum examination is rarely indicated in the prepubertal or peripubertal child. When indicated, a qualified physician or nurse practitioner conducts the examination of internal structures under conscious sedation or anesthesia, documenting iatrogenic changes in the pre- and postexamination appearance of genitourinary structures (eg, vagina, hymen, fossa navicularis, posterior fourchette, clitoral crura [triangular space connecting clitoris and urethra], labial folds, spaces and connections, urethra, perineum).