# STEP-BY-STEP GUIDE
for the
 MANAGEMENT OF SEXUALLY ABUSED CHILDREN

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Dr NH McKerrow
Department of Paediatrics
Pietermaritzburg Metropolitan Hospitals Complex
KwaZulu-Natal

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JJ McCann & DL Kerns
BACKGROUND

DEFINITION

What is childhood sexual abuse?

1. The involvement of a child in sexual activity:
   a. To which he/she does not consent;
   b. That he/she does not understand on the basis of his/her developmental age;
   c. That violates the norms of society.

2. The involvement of a child in sexual activity where there is an imbalance of power on the basis of age, strength, assertiveness, wealth or status.

   Sexual abuse is defined by what the child says, compared with physical abuse which is defined by what one sees.

What is meant by sexual activity?

There are 4 classes of sexual activity:

1. Suspected abuse where the signs and symptoms suggest abuse but the child is unable or unwilling to confirm this.

2. Mild or non-contact abuse, i.e. verbal harassment, exhibitionism or exposure to pornography.

3. Moderate or contact abuse, i.e. fondling of the breast or genitalia of the child or perpetrator by the perpetrator or child.

4. Severe or penetrative abuse, i.e. penetration of the mouth, anus or vagina by any object. This may be the consequence of a process of seduction or one of rape.
EPIDEMIOLOGY

Gender
- one in three girls, and
- one in six boys
\{ \text{will be sexually abused before the age of 16 years.} \}

Age
- \text{Girls - two age peaks:}
  \begin{itemize}
  \item \text{< 6 years; and}
  \item \text{early teens.}
  \end{itemize}
- \text{Boys - a single peak:}
  \begin{itemize}
  \item \text{7 - 9 years of age.}
  \end{itemize}

Predisposing factors
\text{Children at particular risk are those:}
- \text{with behavioural or neurological disorders;}
- \text{from dysfunctional families;}
- \text{who have previously been abused.}

Disclosure
\text{Disclosure of sexual abuse is a complex process rather than a simple event and}
\text{invariable occurs days or weeks after the event. This is due to guilt, shame, coercion,}
\text{fear and other factors.}

\text{Partial disclosure is common as children don’t remember all the details, only disclose}
\text{what they think is relevant, may be scared or ashamed, may not appreciate the}
\text{relevance of certain events or actions and may anticipate a negative response.}

Forms of disclosure:
- \text{Spontaneous - infrequent.}
- \text{Prompted in response to hints from the child or the discovery of other}
  \text{problems - blood stained panties, a urinary tract infection, disclosure by a}
  \text{friend.}
- \text{Child abuse accommodation syndrome- the retraction of a disclosure following}
  \text{serious disruption of the child’s life or a negative response. This does not}
  \text{negate the initial story but requires appreciation of the broader context in}
  \text{which the child lives.}
PERPETRATOR

Who does the abuse?

Most instances of abuse involve a single perpetrator. Over 95% of perpetrators are male. Males of all age are capable of abuse and 20 - 40% of perpetrators are < 20 years of age. Female involvement occurs in one of three roles:

- By omission as they know what is going on and do nothing to stop it.
- As a facilitator, finding children for their partner to abuse.
- As the principle perpetrator.

There are four possible relationships between the child and the perpetrator:

- $\frac{1}{4}$ - unknown, as the child cannot or will not reveal this;
- $\frac{1}{2}$ - a stranger;
- $\frac{1}{4}$ - an acquaintance;
- $\frac{1}{4}$ - a family member.

NB in two out of three cases the perpetrator is known to the child.

How does the abuse happen?

It is important to understand the process of abuse so that one can assist the families of abused children to prevent a recurrence of the incident. Finkelhor has described four steps that a perpetrator engages in before abuse can happen:

1. Have a desire for a sexual relationship with a child - nothing a parent can do about this.
2. Overcome internal inhibitions - this happens when drinking or using drugs so parents need to more vigilant under these circumstances.
3. Overcome external inhibitions / Isolate the child - major point of prevention is adequate supervision of children.
4. Overcome the child by threats and force or bribery and seduction.
OVERALL CARE

MANAGEMENT ALGORITHM

SUSPECT
Who
How

INVESTIGATE
Social worker
SAPS
Healthcare worker

VALIDATE
Judicial process

TREATMENT & FOLLOW-UP
Investigations
Treatment (mental & physical)
Follow-up

ENSURE SAFETY
Empower family
Alternative placement

FAMILY RECONSTRUCTION
Maintain support system
SUSPECT

Spontaneous disclosure is uncommon and most cases of abuse come to light about a week after the event.

Who can suspect abuse?
Anyone interacting with children - a family member, neighbour, family friend, teacher, healthcare worker

In terms of the Child Care Act, Act 74 of 1983, anyone who suspects that a child may be being abused MUST report this to
- A social worker
- A member of the South African Police Services (SAPS)

Why would one suspect abuse?
This will be on the basis of what you:

- Hear:
  - Story of abuse from the child, a co-abused, the perpetrator, or a third party witness.
  - False allegations by children are uncommon.
  - Retraction of an initial allegation (the Child Abuse Accommodation Syndrome) is common and requires further intervention.

- Symptoms, including lower abdominal pain and genito-urinary tract problems (dysuria, frequency, discharge).

- See: Behavioural changes, deteriorating school work, truancy, sexualized language and behaviour.

- Find: Anal or genital injuries, infections or structural changes.
INVESTIGATE

Three different investigations are required:

Social worker
A risk assessment to define the social circumstance of the child and his/her susceptibility to abuse.

South African Police Services (preferably a detective branch)
Investigation of a criminal offence.

Healthcare worker

| The investigation of suspected childhood sexual abuse should be performed by an experienced healthcare worker if available. |

There are two components to the healthcare worker's investigations:

- A medical examination, including history, examination and special investigations, to establish the most likely cause of the presenting complaint.

- A medico-legal examination to support the SAPS investigation.
  - Collect forensic evidence using the Sexual Assault Evidence Collection Kit (SAECK) in all cases where the child presents within 48 - 72 hours of the incident.
  - Record all clinical findings on a J88 irrespective of the interval between the abuse and the examination.
VALIDATE

This is really a judicial process and a decision as to whether to prosecute or not. This is based in part on evidence obtained during the above three investigations.

The decision is the responsibility of the prosecutor and NOT the family, SAPS, social worker or healthcare worker.

The decision must be in the best interests of the child.

It does not influence the medical management.

It does however require medical input:

- **J88:**
  - Must be completed in every case of suspected abuse irrespective of the interval between the incident and the examination.
  - Must be completed by the healthcare worker who first examined the child.
  - Must be handed to the SAPS investigating officer and not the family.

- **SAECK for all children presenting soon after the alleged incident:**
  - 48 hours for children < 6 years.
  - 72 hours for children > 6 years.
TREATMENT & FOLLOW-UP

Investigations

- Rapid test for HIV.
- Baseline bloods for syphilis and hepatitis.
- Pregnancy test in girls with Tanner stage 3 or more thelarche.

Treatment

Mental status

1. Prevent post-traumatic stress disorder (PTSD) by debriefing:
   - The earlier the better.
   - This is basically a process of allowing the child to talk about what has happened and how they feel about it.

2. Recognise PTSD. Warning signs include:
   - Disturbance in sleep patterns.
   - Change in appetite.
   - Development of separation anxiety.
   - Deteriorating school work.
   - General behavioural changes subsequent to the incident.

If any are present:
   - Consider an anxiolytic drug for somatic symptoms
     e.g. Diazepam 2 mg po nocte for 10 - 14 days.
   - Refer for ongoing counselling.

Physical status

1. Treatment:
   - Treat all acute injuries and infections evident on presentation.
   - Treat established complications - infections or pregnancy.
2. Prophylaxis:

2.1 Infections

Prescribe for all children presenting within 72 hours of the alleged incident.

- **ATT** ½ cc IMI if skin or mucosal barrier is breached.
- **Rocephin** < 6 years 125 mg IMI stat.  
  > 6 years 250mg IMI stat.
- **Flagyl** 7mg/kg/dose tds for 7 days.
- **Erythromycin** 50mg/kg/day qid for 14 days.

2.2 HIV prophylaxis (see Appendix 5)

All children presenting within 72 hours of the alleged penetrative abuse need to be offered post-exposure prophylaxis (PEP) for the prevention of HIV infection.

This entails:

- Counselling the parents and older child about the risk of HIV transmission which is significantly higher in children than in adults.
- A baseline HIV test (a rapid test is adequate).
  - HIV-positive: refer to appropriate HIV/AIDS service to assess eligibility for ART and to provide ongoing care.
  - HIV-negative: eligible for PEP.
    - Baseline bloods – LFT, U&E, FBC.
    - **AZT & 3TC** according to weight bd for 28 days
    - If the child has sustained a breech of the genital/anal skin or mucosa, add a protease inhibitor.  
      (see Appendix 6).

**HIV prophylaxis is prescribed on the allegation of penetrative abuse NOT on the basis of clinical findings.**
2.3 Pregnancy prophylaxis

- Based on pubertal development NOT a history of menarche.
- All girls with Tanner stage 3 or more thelarche.
- Do a pregnancy test before prescribing abortifacient.
- Prescribe up to 7 days after abuse.
- **Ovral 28** 2 tablets stat, and 2 after 12 hours.
  Give an extra 2 tablets in case the child vomits.

This dose of Ovral 28 makes children nauseous so they must also get Maxalon 10 mg po tds for at least 24 hours.

Follow-up

- Essential to assess medium-term consequences of the abuse.
- 48 hours:
  - HIV Elisa result if rapid tests were discordant.
- 1 - 2 weeks:
  - Assessment and follow-up of emotional wellbeing.
  - Check for physical complications of abuse:
    - Sexually transmitted infections.
    - Pregnancy.
  - Results of baseline blood tests.
- 3 months:
  - Repeat bloods to exclude syphilis, hepatitis or HIV infection.

Post-traumatic stress disorder or severe emotional sequelae require urgent referral to an appropriate psychologist.
ENSURE SAFETY

Ultimately this is the responsibility of the family, social workers and SAPS.

**DO NOT** admit children to hospital unless this is medically indicated.

It is preferable to explain the process of abuse to families to allow them to respond appropriately.

- Considering the process of abuse identified by Finkelhor the most important response is to create a constant external inhibiting environment, i.e. ensure adequate and appropriate supervision for the child.
- Review the daily routine of the child to identify risk periods.
- Provide safety in numbers.
- Ensure adequate and appropriate supervision (**NOT** male).

Only admit a child, if no alternative place of safety is available, under the conditions of a **FORM 4**.

- This is a form that declares a child to be “in need of care“ and authorises their removal from their parents/home.
- The form is available from a social worker or the local police station.
- It must be signed by a social worker or police officer.
- The Form 4 and child must be presented to a Commissioner of Child Welfare, in a Children's Court, at the soonest opportunity, i.e. the next working day.
- The court will oversee the appropriate placement of the child.
FAMILY RECONSTRUCTION

The family is the child’s primary support system.

The family needs to function effectively to minimise the sequelae experienced by the child and to ensure his/her ongoing wellbeing.

Provide adequate information and support to the mother and father of all abused children so that they can in turn inform and support their child.

Ensure that all affected families are referred for:

- Debriefing;
- Ongoing counselling; and
- Support.

Calm, empathetic parents can more readily support a traumatised child. It is therefore essential to ensure that both the abused child and his/her parents receive appropriate emotional support.
MEDICAL ASSESSMENT

REQUIREMENTS FOR THE ASSESSMENT

Time

- The examination of a child who has been sexually abused cannot be rushed or squeezed in in-between other responsibilities.
- The full assessment will take at least 90 minutes and this time must be set aside before starting the assessment.
- Early presentation (within 72 hours):
  - During the day or early evening -
    • Proceed with the assessment as soon as possible.
  - Late at night (after 22h00), provided the 72 hour window for the collection of forensic evidence will not expire -
    ▪ Take the necessary bloods.
    ▪ Start prophylactic treatment.
    ▪ Put the child to bed.
    ▪ Arrange for a full assessment first thing in the morning.
- Delayed presentation (after 72 hours):
  - Arrange for an assessment by a multidisciplinary team at the soonest appropriate time.

Privacy

- The setting for the assessment must ensure both visual and auditory privacy and must protect the child from further trauma.
- The casualty or general outpatient departments are therefore inappropriate.
- A quiet room in the children's ward or paediatric outpatient department is ideal.

Examination room

- Requires at least four chairs (one each for doctor, child, mother and nurse).
- Full examination couch with space at the foot for examiner to sit/stand.
- Bright angle-poise light source.
- Surface for preparation and storage of evidence collection items.
- Blood-taking materials and laboratory resources.
Consent

- The following consent is required before proceeding with the examination:
  - From the child, irrespective of age.
  - From the parent, although not strictly necessary this is preferable.
  - From the South African Police Service as a SAP 308 form:
    - Available from all police stations.
    - This provides permission to examine a person with/without other consent in the event of a suspected criminal matter.
    - Must be signed by the investigating officer.
- Additional consent is required:
  - To submit evidence and disclose information to the SAPS in the SAECK and J88.
  - To do an HIV test.
  - To prescribe anti-retroviral treatment for post-exposure prophylaxis as this is an off label use of these drugs.

Participation

- The co-operation of the abused child during the examination and collection of evidence is crucial. To achieve this it is essential that he/she:
  - Understands what is going to happen.
  - Agrees to the assessment.
  - Is kept informed of the process on an ongoing basis.

Support

- The child will require support during the assessment.
- Ideally this should be a family member selected by the child.
- If the child does not want a particular parent or person present this must be respected.
- The police have no role during this process and must leave the room.
COMMUNICATING WITH THE ABUSED CHILD

Whenever possible an abused child should see a social worker or counsellor before the medical assessment.

Speaking to the child

- Use the child’s home language.
- Use an interpreter if you do not speak the same language as the child. Make sure to record the name of the interpreter in your notes and in the J88.
- If possible get the history directly from the child.
- Clarify what terms the family uses to describe the genitalia, anus and other body parts and ensure that you and the child are talking the same “language”.

What to say

- Set the child at ease by chatting about everyday matters - school, home, friends, favorite activities etc
- Once you have established some rapport confirm the nature of his/her “problem”.
- Explain your role:
  - To check their bodies to make sure that everything is fine or to fix any problems that you find.
  - To let the police know that after examining them you know they are telling the truth.
- Explain the procedure:
  - Provide details on what you will be doing and how you will do it.
  - Let the child choose a chaperone to be present during the examination to make sure that no-one hurts them.
  - Discuss whether or not they wish to be covered with a sheet during the examination - younger children may not want to be covered as they cannot see what you are doing and may feel “threatened”.
  - Prepare them for the possibility of having to collect forensic specimens.
ASSESSMENT

What to do

• Counselling
  o Let the social worker or counsellor prepare the child for the medical assessment.
  o This entails debriefing, counselling and support.

• History
  o Introduce yourself, chat with the child and develop some rapport.
  o Confirm their "problem".
  o Take a detailed history
    ▪ Circumstance of the abuse so that you know what corroborating evidence to look for during the general examination.
    ▪ Details of extra-genital contact, i.e. kissing, biting etc
    ▪ Details of extra-genital trauma, i.e. beating, throttling, stabbing etc
    ▪ Details of any defensive actions, i.e. scratching, biting etc
    ▪ Details of the abuse, i.e. position (lying, standing, knee-chest); angle of penetration (from the front or back); what was used (finger, penis, stick); what was penetrated (mouth, anus, vagina); use of lubricants (spit, water, jelly); use of condom; and did the perpetrator ejaculate (if so, where).
    ▪ These details are required to guide the examination, the collection of forensic evidence and to aid the interpretation of clinical findings.
  o Explain your role and the procedure.

• Proceed with the examination.

• Investigations
  o Forensic.
  o Medical.

• Records
  o Brief conclusions and record of investigations in routine file.
  o Detailed report in confidential record.
  o J88.
EXAMINATION

- The examination must occur in a setting with visual and auditory privacy.
- The child must consent to the presence of any third party during the examination.
- The child must strip completely, in privacy, and then be covered with a sheet unless he/she indicates otherwise.
- The genital examination must accommodate the needs and age of the child and recognize the process of the sexual assault.
  - Infants and toddlers can be examined on their mother’s lap or an examination couch. They usually do not need to be covered by a sheet.
  - Children and adolescents must be examined on an examination couch and must be covered with a sheet.
  - Avoid any position that was used by the perpetrator during the abuse eg knee-chest position.
- Reveal only the part of the body that is being examined.

What to look at

- The whole child
  - A general examination is essential to identify any features that corroborate the child’s story or provide a rational alternative explanation for the presenting complaint.
  - Document:
    - The mental state and child’s affect during the examination. This may help with the interpretation of clinical findings.
    - The state of the child’s clothing.
    - The presence of any foreign matter, such as grass, soil, blood semen, saliva etc.
    - The child’s growth parameters, i.e. height and weight, to provide some indication of his/her physical maturity.
    - All extra-genital injuries.
• **Stage of puberty**
  o Assess the pubertal development of the child, both pubarche and thelarche, using Tanner stages (see Appendix 1).
  o This gives some indication of the oestrogenisation of the genital tract.
  o Oestrogen has a major influence on the anatomy and physiology of the hymen and may prevent or mask injuries and structural changes.

• **The genitalia**
  o The genital examination must be done in two positions:
    ▪ Supine frog position;
    ▪ Knee-chest or left lateral position; and

  Should include at least two examination techniques:
  ▪ Labial separation;
  ▪ Labial traction

  o The external genitalia (labia majora and minor, clitoris, vestibule, posterior fourchette, fossa navicularis and perineum) need to be assessed for signs of acute trauma.
  o The “internal” genitalia (hymen and vagina) need to be examined for signs of acute trauma as well as for any structural changes suggesting penetration.
  o Complications of sexual intercourse also need to be excluded.

• **The anus**
  o An anal examination must always be included as part of the assessment of a sexually abused child.
  o It is best done with the child in the knee-chest or left lateral position. In infants and toddlers it can still be done on the mother’s lap.
  o It is unnecessary to do a rectal examination.
Examination positions:

1. Supine frog position

Child lies on her back with her heels touching each other in the midline and drawn up towards her buttocks. Keeping the heels in the midline she needs to relax her adductor muscles, open her legs and allow her knees to fall outwards towards the couch.

This is an ideal position for examining the lower abdomen, thighs and external genitalia.

The hymenal membrane and orifice are also well exposed.

2. Knee-chest position

The child lies prone with her face to one side and her arms next to her head or hanging over the edge of the couch. Keeping her chest on the bed she must lift her pelvis and draw her legs up until her knees are in line with her hips. The knees are then placed 15 cm apart and the pelvis tilted towards the ceiling.

This is an ideal position to examine the anus, the posterior rim of the hymen and fossa navicularis as well as the vagina. With good positioning and a bright light, it is possible to see the cervix in two out of three young girls.

It is therefore never necessary to do an internal pelvic examination in a child.
Examination techniques:

1. **Labial separation**
   Place index and middle fingers on the lateral surface of the labia majora at the junction of the middle and posterior thirds. Apply lateral pressure to separate the labia.

   This allows good visualization of external genitalia, posterior fourchette and perineum.

![Labial separation](image1)

2. **Labial traction**
   Grasp the labia majora between thumb and index fingers at the junction of the middle and posterior thirds and pull firmly toward the bed, the thighs and the feet. This places a lot of tension on the posterior fourchette and may

![Labial traction](image2)
occasionally cause a superficial tear. It is important to note whether this tear is due to the examination or sexual assault. The tear can be easily treated by protecting it with vaseline.

This technique allows a good view of the hymenal membrane and margin. Measurements of the hymenal orifice diameter and posterior rim should be made using this technique with the child in the supine frog position.

3. **Knee-chest position with labial separation**

In the knee-chest position place the thumbs on either side of the anus and apply firm lateral pressure. This will allow easy examination of the anus.

Note: most children will feel the urge to pass flatus. They must be warned about this and encouraged not to prevent it because if they do they will distort the clinical findings.

![Knee-chest with labial separation](image)

**Knee-chest with labial separation**

Bring the thumbs forward to the junction of the middle and posterior third of the labia majora and apply firm lateral pressure. This will provide an excellent view of the posterior rim of the hymen and the fossa navicularis and allows one to see into the vagina.
What to look for

1. Normal anatomy
   There are numerous variations in normal genital anatomy especially with respect to the hymen and interior of the vagina.

   Oestrogen profiles have a further impact on normal anatomy of the genitalia resulting in continuous changes from birth through childhood and adolescence to adulthood. The basics are illustrated below.

   ![](image)

   **Genital anatomy of the pre-pubertal girl**

2. Features of sexual assault
   - On average only one in three girls subject to penetrative abuse will have any physical evidence on genital examination.
   
     - Signs of trauma on the thighs, external or internal genitalia:
       - T Tears or tenderness.
       - E Ecchymosis, i.e. small petechial haemorrhages to large haematomas and bruises.
       - A Abrasions.
       - R Redness, secondary to trauma or infection.
       - S Swelling or scars.
• Signs of trauma to the genitalia heal very rapidly within 7 – 10 days so depending on the interval between the incident and the examination, they may no longer be present.

• Structural changes to the hymen:
  o Effacement of the hymenal membrane with hymenal remnants.
  o Acute tearing of the hymenal membrane.
    ▪ In the acute stage this presents as tears.
    ▪ Tears heal to form notches or clefts.
    ▪ Notches are always significant when they occur in a posterior position (between 3 and 9 o’clock).
  o Enlargement of the hymenal orifice.
    ▪ Measure the transverse diameter of the hymenal orifice.
    ▪ The vertical diameter is influenced by the size of the child so cannot be compared with norms for age and is of little value.
    ▪ Narrowing of the posterior rim of the hymen.

• Complications of sexual intercourse:
  o Sexually transmitted infections.
    ▪ Must be interpreted with respect to the age of the child.
  o Pregnancy.

**It is NORMAL to be NORMAL.**

A normal genital examination does not exclude sexual assault or penetration.

3. **Features of anal assault**
   • Signs of anal or peri-anal trauma (TEARS).

   • Muco-cutaneous changes in and around the anus:
     o Flattening, thickening or distortion of anal folds.
     o Thickening of peri-anal skin.

   • Venous engorgement:
     o Engorgement, diffuse or localised, of peri-anal skin within 30 seconds of applying pressure to either side of the anus.
• Dilatation of the anus:
  o Within 30 seconds of applying pressure to either side of the anus.
  o To a diameter of > 2.5 cm.
  o With no visible stool in the rectum.

Making sense of it all

The interpretation of the medical assessment must occur at three levels:

1. Immediate management
   • This is based on the story told by the child irrespective of other findings.
   • This must result in:
     o Appropriate prophylactic therapy;
     o Psychological support; and
     o Ensuring the ongoing safety of the child.

2. Interpretation of ano-genital findings
   • This is crucial for medico-legal purposes.
   • It is an assessment of the compatibility of the clinical findings with the allegation made by the child and the likelihood of vaginal and/or anal penetration.
   • For consistency, interpretation should be according to the classification of ano-genital findings presented in Appendix 2.

Remember: A normal examination does not exclude sexual assault or vaginal and/or anal penetration.

3. Likelihood of sexual abuse
   • This is important for the ongoing care of the child.
   • It is based on a full evaluation of the history, clinical examination and special investigations.
   • The interpretation should be according to the classification presented in Appendix 3.
COMPLETION OF THE J88

This is a legal document found in the Sexual Assault Evidence Collection Kit (SAECK).

It must be completed by the first medical practitioner to examine the child.

Do:

- Complete the whole report in your own handwriting.
- Make sure you record the date and time of the examination.
- Complete all your personal details.
- Record the history and source.
- Sign every page.
- Be legible and comprehensive - it may reduce the chance of you having to appear in court.
- Complete the form in duplicate - hand the original to the investigating officer and keep the copy with patient's confidential record.

Don’t:

- Complete a J88 for a patient you have not seen or based on information obtained by a colleague.
- Use medical abbreviations unknown to legal colleagues.
- Leave blank spaces or cross out sections. If a section is not relevant indicate - “Not relevant” or “Not examined”.
- Make legal conclusions.

Rape/indecent assault are legal conclusions reached by the court. Describe your findings and their compatibility with the story told by the child.

DO NOT make a legal finding.
Available from SAP 308 or any accompanying police officer.

Your details.

Essential to establish interval between incident & examination so as to interpret findings.

Full name as on ID/birth certificate.

Indicate source of story.

Any medical problems that may explain clinical findings.

Details of sexual assault - who did what, when & how - include use of condom, lubricants, witnesses, co-abused etc.

Indicate tears, missing buttons, stains etc.

This is all important to corroborate that the abused was a child at the time of the abuse.

Record details of all extra-genital injuries and other abnormalities.

Comment on mental competence. Also crucial to indicate degree of relaxation as this can influence genital findings & their interpretation. Record any suggestions that child may have been drugged.

Brief summary of the general state of the child.

Don’t forget.
Post-menarchal girls only.

Sexually active teenagers - ask after examination.

TEARS:
- Tears/tenderness
- Ecchymoses
- Abrasions
- Redness
- Swelling/scars

- Fimbriated
- Annual
- Crescentic
- Thick with redundant

NEVER do an internal examination in children.

Requires a speculum so NOT done in children.

Crucial area for injuries in sexual assault.

Beware of tears caused by the examination.

Ask in every case.

Presents SAECK specimens.

Provides insight into oestrogenisation which is important in the interpretation of findings.

Describe rashes, ulcers, discolouration.

Old & new lesions. Indicate age of lesions, if possible.

Don’t forget.

T/V diam important & relates to age:
- 5 mm in girls ≤ 5 years
- 1mm/year for girls > 5 yrs
- Vertical diam unreliable so don’t use.
- Posterior rim must be ≥ 2 mm.
Important for chain of evidence. Can also record any specimens sent to hospital lab - for MC&S, WR, HIV.

Conclusion based on clinical examination using "Classification of ano-genital findings":
- Look at likelihood of sexual assault OR vaginal penetration, and compatibility with history.
- Indicate any evidence of acute genital trauma.
- NEVER be negative (e.g. "No signs of sexual assault") or mention rape. "Normal genital examination which does not exclude sexual assault".

NB: Rape/indecent assault are legal NOT medical conclusions - avoid.

Need to document:
- Muco-cutaneous changes
- Venous engorgement
- Complete/partial dilatation

Do NOT do PR - this does not aid the assessment.

Conclusion based on clinical examination using "Classification of ano-genital findings".
Look at likelihood of sexual assault or anal trauma.

More commonly involved in physical abuse.
Indicate signs of poor hygiene, acute trauma (paraphimosis) or infections.

Signature of medical practitioner.
Comment on hymenal configuration, variations & abnormalities

Always indicate width of posterior rim in "mm" especially if absent.

Always document transverse diameter of hymenal orifice in "mm".

Good idea to comment on the fossa navicularis, posterior fourchette & perineum:

- The dynamics of abuse frequently result in trauma in this area.
- Look for petechial haemorrhages, abrasions & tears.

* TEARS
Describe rashes, ulcers, discoloration.
Old & new lesions.
Indicate age of lesions, if possible.

Don’t forget.
The Sexual Assault Evidence Collection Kit (SAECK) is specific for survivors of sexual assault and serves two purposes:

- Enables the collection of foreign matter that can corroborate the story told by the child; and
- Facilitates the collection of biological samples for DNA analysis to identify the perpetrator.

Samples are not used for medical testing therefore separate specimens must be taken for these and sent to the local hospital laboratory.

A Clothing Collection Kit must be requested from the police if the child's clothing is thought to contain relevant physical or biological evidence.

The collection of forensic evidence:
- Is only possible if the child presents to hospital within 72 hours of the sexual assault:
  - NB: Only do vaginal swabs in children < 6 years of age if they present within 48 hours. All other specimens can still be taken in these children up to 72 hours.
  - Requires the knowledge and consent of the parent and the child (> 10 years).
  - Requires the integrity of the specimens be maintained.
  - Requires maintenance of the chain of evidence.

### Contents

1. Forms
   - Duplicate J88
     - Complete after examination completed.
     - Keep the copy.
     - Hand the original to the investigating officer who must sign for both the J88 and the SAECK in section “F2. Specimens handed to.....” on the J88.
   - Triplicate form (orange)
     - Complete Parts A, B, C and D before the examination and collection of evidence.
Complete Part E as evidence is collected:
- Mark the appropriate block for each specimen that is collected.
- Barcodes are only required if separate kits are used for the collection of clothing specimens and body fluids.
- Return original to SAECK.
- Keep 2nd copy with patient’s confidential record.
- Hand 3rd copy to investigating officer with J88.

- Collection of evidence form
  - Used to document:
    - The source of evidence on the child’s body.
    - The swab guard box in which the evidence was collected.
    - The suspected nature of the evidence.
  - Barcodes are only required if separate kits are used for the collection of clothing specimens and body fluids.
  - Place the completed form in the SAECK.

2. Seven sealed pouches

- Collection of clothing
  - Collect panties and possibly tampon or sanitary pad.

- Oral cavity
  - Swabs should be taken from all children in case they are too shy to indicate oral penetration.

- Reference blood sample
  - Take this last, after the examination, with other blood samples to maintain the cooperation of younger children.

- Evidence on the body
  - Physical evidence such as sand in the hair.
  - Biological specimens in the hair, under the nails and on the skin - saliva, semen or blood.
  - Get your assistant to document the source, disposal and suspected nature of each specimen on the "Collection of Evidence" form as you take them.
• Pubic hair
  o Not relevant for pre-pubertal children.
  o Note if pubic hair shaven and treat as for body fluids.

• Ano-rectal specimens
  o If indicated the anal or rectal swabs must be done last after the genital swabs.

• Genital specimens
  o Do not use a speculum or do an internal examination.
  o Do not take a cervical swab.
  o Take the vaginal swab first without touching the hymen which is exquisitely sensitive in pre-pubertal girls.
  o Swab the vestibule after taking the vaginal swab before the anal swab.

Tips
• When taking the history start establishing what specimens will need to be collected.
• Some specimens are always needed:
  o Oral swabs.
  o Reference bloods.
  o External genital or anal swabs.
• Prepare the evidence collection implements and assemble the swab guard boxes before you start your examination.
• Do not moisten the swabs excessively - one drop of water is adequate.
• Each swab must be placed in its own swab guard box in perforation B.
• Make sure all specimens are dry before sealing the swab guard and SAECK - moist specimens allow fungi to grow which destroys the DNA.
• NEVER blow on specimens to dry them - you may contaminate them with your saliva (and DNA).
• REMEMBER to include the Triplicate form and Collection of evidence forms in the SAECK before sealing it.
• DON’T put the J88 in the SAECK.
• Discard all unused evidence collection items in the dustbin. They are all labeled with a barcode which is specific for each SAECK and therefore for each child.
• DO NOT mix items from different SAECKs.
APPENDIX 1

Tanner staging for sexual development of girls

Breast development
Stage 1: Pre-pubertal elevation of the papilla only.
Stage 2: Breast bud stage: elevation of the breast and papilla as a small mound; and enlargement of the areola diameter.
Stage 3: Further enlargement and elevation of the breast and areola, with no separation of their contours.
Stage 4: Projection of the areola and papilla above the level of the breast.
Stage 5: Mature stage: projection of the papilla alone due to recession of the areola.

Pubic hair
Stage 1: Pre-pubertal, no hair.
Stage 2: Sparse growth of slightly pigmented, downy hair, chiefly along the labia.
Stage 3: Hair darker, coarser and more curled, spreading sparsely over the junction of the pubes.
Stage 4: Hair adult in type, but covering smaller area without spread to the medial surface of the thighs.
Stage 5: Adult quantity and type, with distribution of a horizontal pattern and spread to the medial surface of the thighs.
APPENDIX 2

Classification of ano-genital findings

Pediatrics 1994; 94: 311

Class 1 - Normal

- Periurethral bands
- Intravaginal ridges or columns
- Erythema in sulcus
- Hymenal tags, mounds or bumps
- Elongated hymenal orifice in obese child
- Ample posterior hymenal rim (1 - 2 mm)
- Oestrogenic changes
- Diastasis ani / smooth area in perianal midline
- Anal tag / thickened fold in perianal midline

Class 2 - Nonspecific

- Erythema of vestibule
- Increased vascularity of vestibule / hymen
- Labial adhesions
- Rolled hymenal edges
- Narrow hymenal edge, at least 1 mm
- Vaginal discharge
- Anal fissure
- Flattened / thickened anal folds
- Anal dilatation with visible stool
- Venous congestion of perianal tissue (delayed)

Class 3 - Suspicious

- Enlarged hymenal orifice
- Posterior hymenal rim < 1 mm
- Acute abrasion or laceration of labia or vestibule
- Condylomata accuminata
- Immediate anal dilatation with no visible stool
- Immediate perianal venous congestion
- Distorted, irregular anal folds
Class 4 - Suggestive

- Two or more suspicious anal or genital findings
- Scar or laceration of posterior fourchette with sparing of hymen
- Scar in perianal area

Class 5 - Clear evidence of penetrating injury

- Hymenal notch - between 3 and 9 o’clock
- Hymenal transection or laceration
- Laceration of posterior fourchette extending to involve hymen
- Scar of posterior fourchette with loss of hymenal tissue - between 5 and 7 o’clock
- Perianal laceration extending deep to external anal sphincter
APPENDIX 3

Overall assessment of the likelihood of sexual abuse

Class 1 - No evidence of abuse

- Normal examination, no history, no behavioural changes, no witness.
- Nonspecific findings with another aetiology and no history or behavioural change.
- Child considered at risk for sexual abuse, but gives no history and has nonspecific behavioural changes.

Class 2 - Possible abuse

- Class 1, 2 or 3 findings in combination with significant behavioural changes but child unable to give history of abuse.
- Condylomata or genital herpes in absence of a history of abuse and otherwise normal examination.
- Child has made a statement but this not consistent or detailed.
- Class 1, 2 or 3 findings in combination with significant behavioural changes but child unable to give history of abuse.
- Condylomata or genital herpes in absence of a history of abuse and otherwise normal examination.
- Child has made a statement but this not consistent or detailed.

Class 3 - Probable abuse

- Child gives clear, consistent and detailed story.
- Class 4 or 5 findings with no convincing history of accidental penetrating injury.
- Culture proven infection with Chlamydia trachomatis in a prepubertal child over two years of age.

Class 4 - Definite evidence of sexual abuse

- Finding sperm of seminal fluid in or on a child’s body.
- Witnessed episode of sexual molestation.
- Non-accidental, blunt penetrating injury to the vaginal or anal orifice.
- Confirmed infection with Neisseria gonorrhoea or syphilis.
APPENDIX 4

Dimensions of the hymenal orifice

1. For the pragmatist – a rule of thumb...

   Transverse/horizontal diameter with labial traction:
   
<table>
<thead>
<tr>
<th>&lt; 6 years</th>
<th>&gt; 6 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 mm</td>
<td>1 mm per year</td>
</tr>
</tbody>
</table>

2. For the purist – consideration of plane and technique...

   Inferior rim and transhymenal diameters of annular and crescentic hymens in prepubertal girls (in mm).

   Pediatrics 1992; 89: 393

<table>
<thead>
<tr>
<th>&lt; 12 months</th>
<th>13 - 24 months</th>
<th>25 - 48 months</th>
<th>49 - 81 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horizontal</td>
<td>Vertical</td>
<td>Inferior rim</td>
<td>Vertical</td>
</tr>
<tr>
<td>Mean Range</td>
<td>Mean Range</td>
<td>Mean Range</td>
<td>Mean Range</td>
</tr>
<tr>
<td>2.5 1.0 - 3.5</td>
<td>2.9 1.5 - 6.5</td>
<td>2.9 1.0 - 6.5</td>
<td>3.6 2.0 - 4.8</td>
</tr>
<tr>
<td>3.4 1.8 - 6.0</td>
<td>2.8 1.0 - 4.3</td>
<td>3.6 1.0 - 6.0</td>
<td>3.9 1.0 - 8.8</td>
</tr>
<tr>
<td>2.8 1.5 - 4.5</td>
<td>2.7 0.9 - 5.0</td>
<td>2.7 0.9 - 5.0</td>
<td>2.7 1.0 - 3.8</td>
</tr>
</tbody>
</table>

   Transhymenal diameter by age and examination method.

   Pediatrics 1990; 86: 436

<table>
<thead>
<tr>
<th>Examination technique</th>
<th>Diameter</th>
<th>2 - 4 years</th>
<th>5 - 8 years</th>
<th>&gt; 8 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labial separation</td>
<td>Vertical</td>
<td>5.5 mm</td>
<td>5.6 mm</td>
<td>8.4 mm</td>
</tr>
<tr>
<td></td>
<td>Horizontal</td>
<td>3.9 mm</td>
<td>4.2 mm</td>
<td>5.7 mm</td>
</tr>
<tr>
<td>Labial traction</td>
<td>Vertical</td>
<td>5.5 mm</td>
<td>6.1 mm</td>
<td>8.3 mm</td>
</tr>
<tr>
<td></td>
<td>Horizontal</td>
<td>5.2 mm</td>
<td>5.6 mm</td>
<td>6.9 mm</td>
</tr>
<tr>
<td>Knee-chest</td>
<td>Vertical</td>
<td>6.3 mm</td>
<td>7.0 mm</td>
<td>8.7 mm</td>
</tr>
<tr>
<td></td>
<td>Horizontal</td>
<td>4.6 mm</td>
<td>5.6 mm</td>
<td>7.3 mm</td>
</tr>
</tbody>
</table>
APPENDIX 5

Childhood sexual assault HIV PEP algorithm

- Children are presumed to have been sexually assaulted on the basis of what they report, not on the basis of clinical features identified on examination.
- Therefore all children claiming to have been sexually assaulted should be managed according to the following algorithm.
- All children should be assessed at a centre with staff experienced in the examination of sexually abused children.
- Children with a history of recent (< 72 hours) sexual assault need to be taken to an appropriate centre immediately for further management.
APPENDIX 6

ART doses for HIV PEP in childhood sexual assault

Basic regimen

AZT and 3TC for 28 days.
Dose to be calculated according to body surface area (BSA) or weight, although a simplified table according to age may be used in most cases.

\[ BSA = \sqrt{\frac{Ht(cm) \times Wt(kg)}{3600}} \text{ m}^2 \]

AZT
160mg/m²/dose
12 hourly dosing

<table>
<thead>
<tr>
<th>Age</th>
<th>AZT (12 hrly)</th>
<th>3TC (12 hrly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 3 months</td>
<td>4.0 ml</td>
<td>1.0 ml</td>
</tr>
<tr>
<td>3 months</td>
<td>5.0 ml</td>
<td>2.0 ml</td>
</tr>
<tr>
<td>6 months</td>
<td>5.0 ml</td>
<td>3.0 ml</td>
</tr>
<tr>
<td>9 months</td>
<td>5.0 ml</td>
<td>3.5 ml</td>
</tr>
<tr>
<td>12 months</td>
<td>7.5 ml</td>
<td>4.0 ml</td>
</tr>
<tr>
<td>18 months</td>
<td>7.5 ml</td>
<td>4.5 ml</td>
</tr>
<tr>
<td>2 years</td>
<td>10.0 ml</td>
<td>5.0 ml</td>
</tr>
<tr>
<td>3 years</td>
<td>10.0 ml</td>
<td>5.5 ml</td>
</tr>
<tr>
<td>4 years</td>
<td>1 capsule</td>
<td>6.5 ml</td>
</tr>
<tr>
<td>5 years</td>
<td>1 capsule</td>
<td>7.0 ml</td>
</tr>
<tr>
<td>6 years</td>
<td>1 capsule</td>
<td>8.0 ml</td>
</tr>
<tr>
<td>7 years</td>
<td>½ tablet</td>
<td>9.0 ml</td>
</tr>
<tr>
<td>8 years</td>
<td>½ tablet</td>
<td>10.0 ml</td>
</tr>
<tr>
<td>9 years</td>
<td>½ tablet</td>
<td>11.0 ml</td>
</tr>
<tr>
<td>10 years</td>
<td>½ tablet</td>
<td>12.5 ml</td>
</tr>
<tr>
<td>11 years</td>
<td>2 capsules</td>
<td>14.0 ml</td>
</tr>
<tr>
<td>12 years</td>
<td>2 capsules</td>
<td>1 tablet</td>
</tr>
<tr>
<td>13 years</td>
<td>2 capsules</td>
<td>1 tablet</td>
</tr>
</tbody>
</table>

3TC
4 mg/kg/dose
12 hourly dosing

<table>
<thead>
<tr>
<th>Age</th>
<th>Kaletra</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 – 6.9</td>
<td>1.5 ml</td>
</tr>
<tr>
<td>7 – 9.9</td>
<td>2 ml</td>
</tr>
<tr>
<td>10 – 11.9</td>
<td>2 ml</td>
</tr>
<tr>
<td>12 – 14.9</td>
<td>2 ml</td>
</tr>
<tr>
<td>15 – 16.9</td>
<td>2 ml</td>
</tr>
<tr>
<td>17 – 19.9</td>
<td>2.5 ml</td>
</tr>
<tr>
<td>20 – 24.9</td>
<td>3 ml</td>
</tr>
<tr>
<td>25 – 29.9</td>
<td>3.5 ml</td>
</tr>
<tr>
<td>30 – 34.9</td>
<td>4 ml</td>
</tr>
<tr>
<td>35 – 40</td>
<td>5 ml</td>
</tr>
</tbody>
</table>

Expanded regimen

If the sexual assault has been associated with breeches of any mucosal or cutaneous surfaces, a protease inhibitor e.g. Kaletra, must be added to the basic regimen (see simplified table below).

Kaletra (Lopinavir/Ritonivir)
4 mg/kg/dose
12 hourly dosing

Syrup 10mg/ml