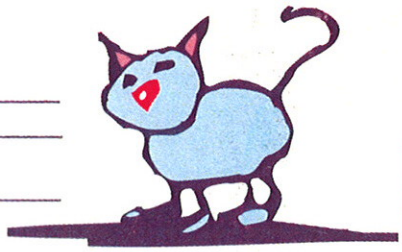
Training Kit

Massachusetts Pediatric Evidence Collection Kit

for Children under the age of 12



Incident Reported to Police? Yes No

If Yes, child's name:_____

Time and date DSS called: Time:_____ Date:_____

City/Town in which Incident occurred: _____

Hospital/ Clinic:_____

(Please Print)

Phone Numbers:_____

(Please Print)

Clinicians:_____

(Please Print)

Kit Sealed By:_____

(Please Print)

Please affix kit # label here

PLACE KIT IN LOCKED REFRIGERATED SAFE

Placed By: _____

Date:_____ Time:_____

AFFIX BIOHAZARD LABEL HERE

For Police Personnel
Chain of Possession

Received From:_____ Agency:_____

Date:_____ Time:_____

Received By:_____ Agency:_____

Date:_____ Time:_____

Received From:_____ Agency:_____

Date:_____ Time:_____

Received By:_____ Agency:_____

Date:_____ Time:_____

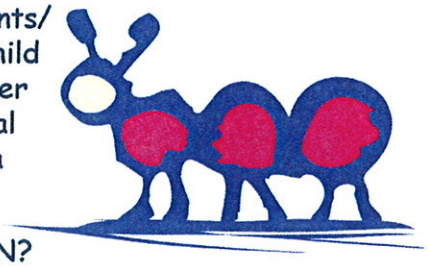
The Commonwealth of Massachusetts

The Commonwealth of Massachusetts

Massachusetts Pediatric Sexual Assault Evidence Collection Kit Indicators

BEFORE OPENING THIS EVIDENCE COLLECTION KIT, PLEASE READ THE INFORMATION BELOW TO DETERMINE WHETHER OR NOT EVIDENCE COLLECTION IS APPROPRIATE AND/OR NECESSARY.

Indicators for acute/emergency evidence collection should be based on guardian/caretaker report, physical complaints/ findings and, spontaneous remarks made by the child during interactions/examinations. Preteens and younger children should not be formally interviewed by medical clinicians. Interviews should only be conducted by a trained forensic interviewer.



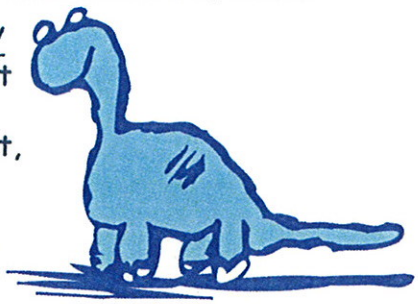
1. WHAT IS THE PURPOSE OF EVIDENCE COLLECTION?
   a. To contribute to the evaluation of a report of, or significant concern for sexual abuse/assault and, **or**
   b. To assist the investigation by law enforcement and DSS and, **or**
   c. Enhance the public safety by identifying the alleged perpetrator

2. WHEN SHOULD CLINICIANS CONSIDER EVIDENCE COLLECTION?

   (Circle all that apply)
   a. The child has told someone about the abuse/assault
   b. The abuse/assault was observed by a third party
   c. Existence of a videotape or photograph of abuse/assault involving the child
   d. Offender confesses to abuse/assault
   e. Anogenital injuries, anogenital bleeding or discharge with concern of abuse

3. WHAT ARE THE INDICATIONS FOR ACUTE/ EMERGENCY EVIDENCE COLLECTION? **(Circle all that apply)**
   a. Suspected vaginal or anal penetration, **however slight**, within 72 hours **or**
   b. Suspected oral penetration within 24 hours **or**
   c. Anogenital bleeding/discharge accompanying an obvious injury (History is inconsistent with injury **and** child presents within 72 hours of injury)
   d. Possibility of ejaculate or saliva on child's body

   If none of the above indicators circled, DO NOT OPEN KIT.



4. HOW SHOULD CLINICIANS GATHER INFORMATION REGARDING THE ABUSE/ ASSAULT INCIDENT?
   a. Obtain a brief history from the parent or caretaker accompanying the child. Whenever possible, verbal children should not be present during the parent/caretaker interview.

b. Formal interviewing of preteen and younger children by anyone other than a trained forensic interviewer is discouraged.
c. If the child provides spontaneous information regarding the assault/abuse during interactions/examination, clinicians should document this information in direct quotes on Form 2B contained in this kit. Follow-up questions should be focused only to Who, What, Where and When. Avoid asking leading questions. Ask clarifying questions in an open-ended manner such as "Can you tell me more about that", "Can you tell me or show me where he (using child's own words e.g. "poked", "kissed", "touched") you? .
d. **DO NOT** use anatomical dolls or props to elicit information.

5. **HOW MUCH CERTAINTY MUST CLINICIANS HAVE BEFORE COLLECTING EVIDENCE?**
   a. Rarely will clinicians be 100% certain that sexual abuse/assault has occurred.
   b. It is not the role of the clinician to determine if sexual abuse/assault occurred. Your role is to know when and how to collect certain types of evidence. Investigators and attorneys will determine the legal significance of the case and any evidence gathered.
   c. Each case is unique and clinical judgement must be used to determine the risks/ benefits of evidence collection.
   d. If there is a high level of uncertainty that penetration has occurred within the 72 hour time frame, but there is concern about possible sexual abuse, the evidence collection should NOT be obtained in the ED. The child should be referred to a multidisciplinary team of child abuse experts for further evaluation (See Enclosed list of Local Children's Advocacy Centers (CACs), Sexual Abuse Intervention Networks (SAINs), and Child Protection Teams (CPTs).
   e. DO NOT complete an evidence collection kit solely based on a history of behavioral changes such as bedwetting, masturbation or sexualized behaviors, which may have another etiology. Refer these patients to the resources listed above.

If any of the above indications for **ACUTE EMERGENCY EVIDENCE COLLECTION** have been circled, it is appropriate to collect evidence using this kit after obtaining parental or guardian consent.

UNDER NO CIRCUMSTANCES, SHOULD A CHILD BE RESTRAINED FOR EVIDENCE COLLECTION.

PLEASE SIGN BELOW BEFORE OPENING THE KIT, VERIFYING THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INDICATIONS FOR PERFORMING A PEDIATRIC FORENSIC EVIDENCE KIT.

PLEASE ENCLOSE THIS SIGNED FORM IN THE PEDIATRIC EVIDENCE COLLECTION KIT.

_____ _____

Printed Name of Provider *Date*

_____

Signature of Provider

6. **SHOULD THE POLICE BE CONTACTED?**
   Early police involvement can be extremely helpful and should be done with **parental/ guardian consent.**
   a. Physical evidence often disappears quickly, a timely crime scene investigation helps to maximize evidence collection.
   b. Perpetrators will often flee or try to destroy evidence if they sense that the child has disclosed, early police reporting may help to minimize this risk.
   c. Police reports should be made in the town where the assault/abuse occurred.

7. **WHEN SHOULD CLINICIANS NOTIFY DSS?**
   a. DSS must be notified for all children < 18 years of age when it is suspected that sexual abuse or assault has occurred.
   b. Clinicians must file a 51A on all pediatric patients < 18 years of age, regardless of the relationship between the child and perpetrator.
   c. Call the DSS Hotline at 1-800-792-5200 to make a verbal report. Follow-up with a written report submitted to the appropriate DSS office.

8. **WHEN SHOULD CLINICIANS FILE A PROVIDER SEXUAL ASSAULT REPORT?**
   a. Clinicians must complete an anonymous Provider Sexual Assault Report whether or not evidence collection is indicated. Follow the instructions provided on the form for completion and faxing.

Massachusetts Pediatric Evidence Collection Kit Instructions for Victims of Sexual Assault under the age of 12

The Commonwealth of Massachusetts

The Commonwealth of Massachusetts

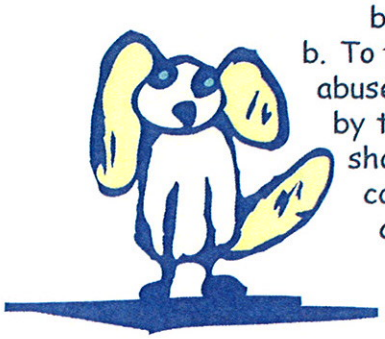
The Massachusetts Department of Public Health's Pediatric Sexual Assault Nurse Examiner Program in collaboration with it's many advisors and the Executive Office of Public Safety have designed the following kit and instructions to use in caring for acute pediatric sexual assault patients. This kit is designed for forensic evidence collection for patients under the age of 12 who present within 72 hours of the assault.

The Overarching Principle in the collection of evidence for child victims is to **"Do No Harm"**. Therefore under no circumstances should a child be restrained or forced to have evidence collected.

Timing and Order of Evidence is Critical: When performing evidence collection on young children, it is imperative to get the most important evidence first, while you have a cooperative child. The steps of evidence collection in this kit are organized to meet this goal. Evidence is available only if the child is compliant.

ACUTE PEDIATRIC EVIDENCE COLLECTION PROCEDURES/PROTOCOL

a. The 13 Steps for acute evidence collection are outlined on the following pages. The examiner may modify, omit or add to this protocol based on history, age of victim, physical findings and cooperation of the child. Any modifications should be documented and the rationale provided.



b. To further support optimal care for child victims of sexual assault/abuse, a Pediatric Sexual Abuse/Assault Protocol has been developed by the Massachusetts Department of Public Health. This protocol should be located in your Emergency Department and provides comprehensive guidelines for clinicians to use when caring for children with concerns of sexual abuse/assault. It is important that clinicians follow these "best practice guidelines" to provide the optimal standard of care.

EXAMINATION/EVIDENCE COLLECTION TIPS

a. Allow child to have control whenever possible (tell child to raise hand or tell you if they need a break).
b. Allow parent/caretaker to remain in the exam room if child desires.
c. Prioritize order of evidence collection based on the type of assault. It is critical to prioritize steps according to history, obtaining most important evidence (i.e. DNA) first.
d. Evidence collection should be stopped if the child becomes distressed or unable to cooperate.
e. Different positions can be used, including supine frog-leg, knee-chest, lateral and lithotomy.
f. Very young children can be held by an appropriate support person during the exam.

STEP 1: **Documentation**

Form 1: Consent For Forensic Exam

1. Consent must be obtained from the non-offending parent or legal guardian.
2. Each of the following requires itemized consent or non-consent:
   - History Taking/Documentation
   - Physical Examination
   - Forensic evidence collection and STD cultures as appropriate
   - Administration of appropriate medical treatment including medications, pregnancy screening/prophylaxis as appropriate
   - Photography and/or video documentation of physical findings
   - Toxicology testing when appropriate
   - Police notification
   - Follow-up phone call

Form 2A: Patient Information/Parent/Guardian's Report of the Incident
(Interview may be conducted in collaboration with DSS and police, **child should not be present)**

1. Document parent or caretaker's report of sexual abuse/ assault incident.
2. Include as much detail as possible.

Form 2B: Child's Spontaneous Report of Incident/Mandatory Reporting/Case Status

1. Formal interviewing of the child victim by anyone other than a trained forensic interviewer is discouraged. Use this form to document **spontaneous** remarks about the assault/abuse that the child may make during interactions/examination. Avoid asking leading questions. Ask clarifying questions in an open-ended manner such as "Can you tell me more about that", "Can you tell me or show me where he (using child's own words e.g. "poked", "kissed", "touched") you?
2. Document what mandatory reports were completed **(Mandated reporters should file a 51A on all pediatric patients for whom a kit is used or, when there is concern for abuse or neglect).**
3. Document information regarding police involvement, use of evidence collection kit and DSS as appropriate.

Form 3: Physical Assessment and Wound Documentation

1. Document physical examination findings.
2. Use diagrams to document location of injuries.
3. Record photographs taken.
4. Label body part photographed on body diagrams as Photo #1, Photo #2 etc.

Form 4: Physical Examination

1. Document specific findings of patient's examination.

Form 5: Medical Treatment and Discharge Instructions

1. Summarize care given to child regarding STD screening, medications and pregnancy screening as appropriate.
2. Document information regarding medical follow-up appointments.
3. Document information regarding follow-up appointments with CAC/SAIN/CPT as appropriate.
4. Document information regarding mental health follow-up as appropriate.
5. Provide parent/caretaker with names of clinicians involved in child's care.

STEP 2: **Clothing and Foreign Material Collection**

Considerable evidence such as semen, blood, dirt or foreign material **may be present, even if bedding/clothing has been washed.**

If the child's guardian, EMS or police present you with clothing worn at the time of the assault/abuse, follow the **General Guidelines** listed below:

GENERAL GUIDELINES

1. **Handling**: Avoid any unnecessary handling of items. Do not shake, fold, or spread items out.
2. **Storage**: Leave all clothing in the original bag if bag is made out of paper. Otherwise, carefully place the clothing/items in one paper bag to avoid losing any debris. Do not discard any original packaging, ie. a plastic bag. Simply place the original packaging into the new paper bag with the evidence. If items are presented to you in one bag, it is not necessary to separate them. A complete list of bagged items should be documented on the outside of bag.
3. **Sealing**: Use tape to seal open ends. Initial and date the tape. Do not use staples.
4. **Labeling**: Document the bag's content, your initials, the date, the kit number and whom evidence was received from clearly on the bag. Also document whom evidence was received from on Form 2A under "Patient Information".

COLLECTING CLOTHING CHILD IS CURRENTLY WEARING

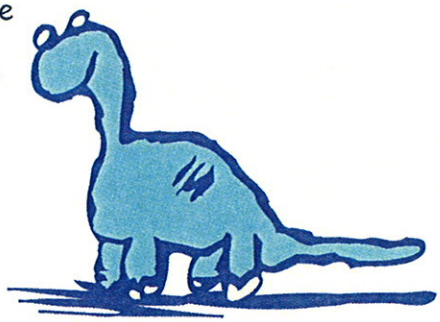
Is child wearing the clothing they had on when the abuse/assault took place?

IF YES:

1. Clothing should be collected even if it has been washed.
2. Do not cut through any existing holes, rips or stains in clothing.
3. Place hospital sheet on floor or in the case of very young child, on the exam table.
4. Remove and unfold paper sheet from Step 2A envelope and place on top of hospital sheet.
5. Child should undress, or be assisted to undress over paper sheet, to collect any foreign materials that may fall off of clothing.
6. Place each item of clothing in a separate clothing bag. Seal each bag with tape, complete requested information on each bag, and attach a kit # label.
7. Use "underpants" bag for underpants or diapers.
8. Refold paper sheet and return to Step 2A envelope. Seal envelope, complete requested information and affix kit label.
9. Diapers and clothing should be air-dried before placing in bag.
10. Inspect all body surfaces for foreign material, fibers, hairs, etc. Using sterile gloves, collect and place any foreign material in the paper bindles provided in the Step 2B envelope. Note the location from which each sample was taken on the anatomical drawing sheet located in the Step 2B envelope. Seal envelope(s), completing requested information and affix kit # label.

IF NO:

1. Collect only underwear, diaper or clothing in contact with genital area. Avoid cutting through existing holes, rips or stain in clothing.
2. Allow diapers and underpants to air dry.
3. Place item in underpants bag. Seal bag with tape, complete requested information on bag, and attach a kit # label.
4. With parent/guardian permission, notify law enforcement of other crime scene evidence that would be significant (bedding, clothing, pornography, objects).



STEP 3: **Oral Swabs and Smears**

As a guideline, collect a sample within 24 hours of an oral assault. If time of the assault has not been accurately determined, use your discretion, based on results of the physical exam, in deciding whether or not to collect a sample.

1. Inspect the oral cavity for injuries to palate, gums, teeth and pharynx. Document findings on anatomical drawing located on Form 3.
2. Using 2 dry swabs, simultaneously swab the upper and lower areas between the lips and gum, and along the tooth and gum lines.
3. Using both swabs together prepare 2 smears. Confine the smear to a rectangular area in the center of slide approximately $\frac{1}{2}$" x $\frac{1}{2}$". Allow the swabs and smears to air dry.
4. Affix the Oral 1A and 1B labels on the shafts of each swab.
5. Using the 2 additional swabs provided, repeat the same swabbing procedure of the mouth and gums. Allow the swabs to air dry.
6. Affix swab labels "Oral 2A and 2B" to second set of swabs collected.
7. Any STD testing of pharynx should be performed at this point using appropriate culture swabs.
8. Place swabs and smears inside STEP 3 Envelope.
9. Seal the envelope, complete the requested information and affix a kit number label.

STEP 4: **External Genital/Vaginal Swabbings**

(Collect if Assault/Abuse reported within 72 hours of presentation)

- Intravaginal speculum exams are NEVER indicated unless there is:
  a. Vaginal Bleeding
  b. Report of a foreign body
- Intravaginal exams usually require evaluation, under anesthesia, preferably by a pediatric gynecologist. Mature **post**menarcheal females may tolerate the procedure without sedation.
- Document anal or vaginal tears on Form 3 and consult the gynecologist on call.
- If the child goes to the OR, and there is a high suspicion of ejaculation, evidence can be collected in the Operation Room. General evidence collection guidelines should be followed, ie. swabs taken should be dried, appropriately labeled, and retained in kit. Operating Room staff should follow the chain of custody and possession instructions found at the end of these guidelines.

Females

1. Do a general visual inspection of the pubic area and inner thighs, noting injuries and subtle contusions.
2. Using appropriate lighting, handheld magnifier and/or videocolposcope, carefully separate labia and thoroughly assess external genitalia (hymen, posterior commissure, labia, urethra, clitoris, perineum). Posterior hymen and posterior commissure should be carefully visualized. Note tears, bleeding, bruising, etc. and document on appropriate anatomical drawing located on Form 3, at a later time.
3. Remove swabs from the paper sleeve. Open a fresh bottle of sterile water and lightly moisten swabs.
4. While gently separating labia, use 2 cotton swabs to simultaneously swab the **external** genitalia, focusing on the posterior perihymenal area. Avoid touching hymen in prepubertal girls, as it is very sensitive/painful.
5. Affix the Genital 1A and 1B labels on the shafts of each swab.
6. Intravaginal swabs may be obtained **only** on **postmenarcheal females without use of a speculum**. Using Vaginal Swabs provided in the Step 4A Vaginal Swabs envelope, simultaneously and gently swab the proximity of cervical and posterior vaginal pool. Affix the Vaginal Swab 1A and 1B labels to the shafts of each swab. If the patient does not tolerate this procedure, STOP immediately and complete only external genital swabs.
7. Any STD testing should be performed at this point repeating the above technique with fresh, appropriate culture swabs.
8. Allow evidence swabs to air dry.
9. Return evidence swabs to their original paper sleeve(s) and return the sleeve(s) to the Step 4 and Step 4A envelopes.

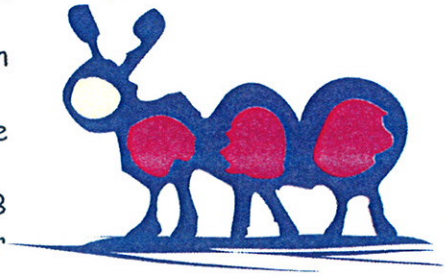
Males

1. Do a general inspection of the pubic area and inner thighs, noting injuries, and subtle contusions. Document findings on appropriate anatomical drawing located on Form 3, at a later time.
2. Remove genital swabs from paper sleeve. Lightly moisten with sterile water.
3. Using the 2 swabs, simultaneously, gently swab the penis and genital area for saliva and foreign semen. Swab across the penile tip, shaft and scrotal area.
4. Affix the Genital 1A and 1B on the shafts of each swab.
5. Using the additional set of swabs provided, repeat steps 2, 3 and 4 and label swabs genital 2A and 2B.
6. Allow swabs to air dry.
7. Return swabs to their paper sleeve and return the sleeve to the Step 4 envelope.
8. Seal the envelope, complete the requested information and affix a kit number label.

STEP 5: **Perianal Swabbing**

- If external genital swabbings are being collected, then perianal swabbings should be obtained.
- Collect even if bowel movement has occurred since assault.

1. Gently separate buttocks and carefully assess anus. Note symmetry, tone, dilation, fissures, bleeding, and presence of stool.
2. Remove the swabs from their paper sleeve. Lightly moisten the 2 swabs with sterile water.
3. Using the 2 swabs simultaneously, carefully swab the perianal area.
4. Allow all swabs to air dry and affix the Perianal 1A and 1B labels on the shafts of each swab. Return swabs to their paper sleeves.
5. Any anal STD testing can be collected at this point if indicated.
6. Seal the envelope, complete the requested information and affix a kit number label.



STEP 6: **Anorectal Swabs and Smears**

As a guideline, collect a sample within 24 hours of an anal assault. If the time of the assault has not been accurately determined, use your discretion, based on physical exam findings, in deciding whether or not to collect a sample.

- Collect even if a bowel movement has occurred since the time of assault.

1. Open the first packet of swabs. Do not moisten swabs prior to sample collection. Gently swab the rectal canal using both swabs simultaneously, if possible. If not use swabs separately. If collected separately, document this on envelope.
2. Prepare two smears.
3. Affix the Anorectal 1A and 1B labels on the shafts of each swab. Label smears and swabs as Set #1.
4. Using the 2 additional swabs provided, obtain swabs as instructed above.
5. Affix labels "Anorectal 2A and 2B."
6. Allow the 4 swabs to air dry.
7. Return both sets of swabs to their original paper sleeve, then return swabs and slides to Step 6 Envelope.
8. Seal the envelope, complete the requested information, and affix a kit number label.

STEP 7: **Additional Swabs**

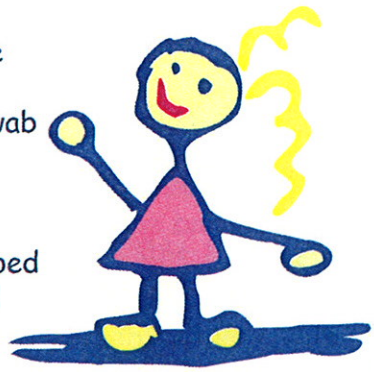
- All areas of suspected saliva, semen, or blood should be swabbed.
- A Wood's lamp may be used to fluoresce body fluids such as seminal fluid that may not be evident to the naked eye.
- Collect a sample of fluorescing areas or other stains following the steps below. NEVER document findings as "seminal fluid". Instead, "suspected stain" should be used to describe collection.

1. Moisten two swabs with sterile water.
2. Using both swabs simultaneously, collect the specimen.
3. Note the location(s) from which the sample(s) was taken on the anatomical drawing sheet located in the Step 7 envelope.
4. Allow swabs to air dry.
5. If more than one specimen is required, use hospital provided sterile cotton-tipped applicators. Repeat Steps 1 - 4 for each location.
6. Label each swab sleeve with the appropriate location and note location on anatomical drawing.
7. Return swabs to their original paper sleeves and place in Step 7 envelope.
8. Seal the envelope, complete any requested information and affix a kit number label.

STEP 8: **Bite Marks**

- All visible bite marks should be video-documented or photodocumented.
- Document bite marks on anatomical drawings located on Form 3.

1. Use 2 sets of swabs for bite marks.
2. Moisten 1st swab set with sterile water. Swab the area of the bite mark with both swabs simultaneously.
3. Moisten 2nd set of swabs, using both swabs simultaneously, swab outer area of bite mark.
4. Allow the swabs to air dry.
5. Place the swabs into their original paper sleeve.
6. If more than one bite mark is present, use sterile cotton-tipped applicators available from the hospital, follow Steps 1 - 5 and label swabs as bite mark #1, #2 etc.
7. Place the sleeve(s) into the Step 8 envelope.
8. Seal the envelope, complete any requested information, and affix a kit number label.
9. Note on the location from which the sample(s) was taken on the anatomical drawings on Form 3. Label sites as bite mark #1, #2 etc.
10. If possible, measure the wounds with a ruler and note on Form 3.
11. Place the photographs into a clean, unused legal sized envelope for placement in the patient's medical record according to institutional policies. **DO NOT INCLUDE PHOTOGRAPHS WITH EVIDENCE KIT.** Document kit number and MR# on envelope.



STEP 9: **Fingernail Scrapings**

- Complete only if the history indicates.

1. Unfold the paper sheet labeled "Left Hand" and place it on a flat surface.
2. Place the patient's left hand over paper. Using the fingernail scraper provided, gently scrape under all five fingernails, allowing any debris to fall onto the paper.
3. Place the used scraper in the center of the paper. Fold, so as to retain contents.
4. Repeat this procedure with the patient's right hand using the paper labeled "Right Hand."
5. Return both folded papers to the Step 9 envelope.
6. Seal the envelope, complete the requested information, and affix a kit number label.

STEP 10: **Control Swabs**

1. Lightly moisten both swabs with sterile water used throughout the examination.
2. Allow both swabs to air dry.
3. Return the swabs to their original paper sleeve; place the sleeve in the Step 10 envelope.
4. Seal the envelope, complete any requested information, and affix a kit number label.

STEP 11: **Toxicology Testing**

- Awake and alert patients **should not** be catheterized for urine.
- **Only complete this step if there are indications from the case history/narrative and/ or the patient's symptoms that testing is warranted to determine if the sexual assault was facilitated by drugs:**
  - Periods of unconsciousness or lack of motor control or
  - Amnesia or confused state with suspicions of a sexual assault having occurred or
  - Parent's/guardian's suspicion or belief the patient was drugged prior to or during sexual assault and
  - The suspected ingestion of drugs having occurred within 72 hours of the exam
- Consent must be obtained from patient's parent/guardian on Form 1.

Step 11 A. Collection of the urine specimen: Urine should be obtained within 72 hours of suspected ingestion.

- Alert, awake children should not be catherized. Children with altered mental status may require catherization to obtain this important evidence.
- If collecting specimen of urine for toxicology test before evidence has been collected, please instruct the patient not to wipe to minimize loss of evidence. Have the patient void directly into the urine specimen bottle. A minimum of 30 ml is preferred. Replace cap and tighten down to prevent leakage.
- Affix a Sexual Assault Evidence Collection Kit number label to the specimen bottle.
- Return specimen (bottle with urine) to cardboard specimen holder.
- If a blood specimen is <u>not</u> being collected, complete the requested information on bag label, then return specimen holder to the ziplock bag. Squeeze out excess air and close bag. Do not remove liquid absorbing sheet from ziplock bag. Affix a kit number label.

Step 11B. Collection of the blood specimens: Blood should be collected within 24 hours of suspected ingestion or if time of the suspected ingestion is uncertain, collect if history indicates possible drug assisted assault. Coordinate blood draw with other labs as appropriate.

- Cleanse collection site with alcohol-free prep pad supplied.
- Check the date of the blood tube; if it has expired, replace it.
- Fill the gray stoppered blood tube with 5ml of blood.
- Immediately after blood collection, assure proper mixing of anticoagulant powder by slowly and completely inverting the blood tube at least five times. **Do <u>not</u> shake vigorously!**
- Affix a Sexual Assault Evidence Collection Kit number label to tube.
- Return filled blood tube to the cardboard specimen holder.
- Complete the requested information on bag label, then return specimen holder to the ziplock bag. Squeeze out excess air and close bag. Do not remove liquid absorbing sheet from ziplock bag. Affix a kit number label.
- Blood and urine specimens should be returned to the kit box, sealed, labeled and then placed in a locked refrigerator immediately after collection.

STEP 12: **Buccal Swabs**

1. Buccal Swabs are a non-invasive way to collect the patient's DNA profile.
2. The Pediatric Sexual Assault Evidence Collection Kit contains the Massachusetts Pediatric Sexual Assault Nurse Examiner DNA Saliva Collection Kit in the Step 12 envelope.
3. Do not use the kit if the seal has been tampered with or is missing.
4. Follow the kit instructions contained within the envelope for proper sample collection.
5. Reseal the kit, following the instructions on the envelope flap.
6. Return the DNA Saliva Collection Kit to the Step 12 envelope.

STEP 13: **Foreign Head Hair**

- Visual inspection is necessary before performing head hair combings. A fine tooth comb is necessary to extract foreign fibers. The examiner should slowly comb hair from bottom up so as to avoid unnecessary pulling on the child's hair.

1. Remove paper towel and comb from the Step 13 envelope.
2. Place the paper towel under the patient's head.
3. Comb the head hair so that any loose foreign hair and debris will fall onto paper towel.
4. Remove the paper towel, place the comb in the center of the towel, and fold the paper towel ***without*** *following the old fold lines (to prevent items from slipping out). Comb is not meant to fit within the existing fold lines. Folding appropriately will retain both the comb and any evidence.*
5. Return the folded paper to the Step 13 envelope.
6. Seal the envelope, complete the requested information, and affix a kit number label.

RE0MA(P): INS3.1 6/04

Completion and Disposition of Documentation Forms
Final Instructions

1. Complete forms 1 through 5. (Found in Step 1 envelope.)
2. Review all documentation on the forms and envelopes for completeness and accuracy, particularly the documentation of injuries that may have been revealed during the course of the exam.
3. Print your name and sign your name on each of the forms.
4. Ensure that the printed name of any other examiner, nurse or physician who has participated in the exam and/or evidence collection is included on the appropriate form. Also make sure that a kit number label is affixed to each form.
5. Provide the patient's parent or legal guardian with the yellow copy of Form 5 only.
6. Place yellow copies of Forms 1, 2A (Part A & B), 2B and 3 in kit box.
7. Retain all original forms for the hospital's records.

Completion and Disposition of Evidence
Final Instructions

1. Complete the "Provider Sexual Crime Report for Pediatric Assaults < 12 Years of Age" which is mandated by Massachusetts General Law C. 112 12 1/2. Return or fax the completed report to: Executive Office of Public Safety, Programs Division, One Ashburton Place, 21st Floor, Suite 2110, Boston, MA 02108. Fax: (617) 727-5356 and to the local police in the city or town in which the assault occurred.
2. Return all evidence collection envelopes, used or unused, to the kit box.
3. Return signed and dated Indicators Form to the kit box.
4. Fill out all the information requested under "**For Hospital Personnel**."
5. Initial and affix police evidence seals where indicated on the sides of the box, and affix a Biohazard Label in the area indicated.
6. When at all possible, if collecting underwear/diapers worn at time of assault, include in the evidence collection kit box.
7. Place all other Clothing into the **Evidence Transport Bag** and seal with tape. Retain the sealed kit box.
8. The label on the Evidence Transport Bag should identify the city/town of the assault and whether the case is reported to police or unreported to police.
9. Make the first entry on the Chain of Possession label on Evidence Transport Bag. Do the same on the sealed kit box. Immediately transfer the bag and the kit box to the appropriate police officer. If the officer is not immediately available, store the evidence in a secured, locked refrigerator.
10. Police from the town/city in which the assault occurred are required by law to transport all kits to the State Police or Boston Crime Labs in a timely manner, regardless of whether the assault has been reported to law enforcements.

Notes _____

_____

_____

_____

_____

_____

FDA INSERT
Important Information Regarding
RE-0MA(P)

This product information sheet is included to comply with FDA Regulations.

PLEASE RETURN THIS FORM TO INSIDE OF KIT

Expiration Date Information:
The expiration date on this product pertains only to specific components. Please check the expiration date on the following components. If any are beyond the expiration date, please replace with similar components from hospital stock.

12 pkgs. sterile, cotton-tipped swabs (2/pkg.)*
1 ea. 10ml grey stoppered blood collection tube

***Make sure all replacement swabs have the same lot number.**

Intended Use:
Evidence collection from the victims of sexual assault

Contents:
kit instruction booklet
forms
envelopes
plastic slide holders
microscope slides
sterile, cotton-tipped swabs
swab labels
fingernail scrapers
paper bindles
ziplock bag
right hand and left hand folded paper sheets
MA pediatric DNA saliva collection kit
paper sheet
bags
paper towel
plastic comb
10ml grey stoppered blood collection tube
kit number labels
evidence transport bag
police evidence seals
biohazard label
cardboard specimen holder
liquid absorbing sheet
100ml urine specimen bottle
prep pad

Warnings and Precautions:
Blood and other biological fluids should be handled and processed as if they are potentially infectious.

Waste Disposal Instructions:
- **Needles:**
  Dispose of any needles in an approved Sharp's container.
- **Blood Tube:**
  Dispose of all tubes using safe laboratory procedures as outlined in bio-safety and microbiological and bio-medical laboratories as HH Publication CDC 84-8395.

Form 1 - Consent for Forensic Examination
Commonwealth of Massachusetts
Pediatric Sexual Assault Evidence Collection Kit

Please affix kit # label here

Consent for Pediatric Sexual Assault/Abuse Forensic Examination

USE **BLUE INK ONLY** ON ALL DOCUMENTATION FORMS

Patient's Name: _____

Patient's Address: _____

Date of Birth: _____ Phone #: _____

I _____ (Parent or guardian), Consent and authorize _____ (Pediatric Sexual Assault Examiner/Clinician) of _____ Hospital to perform the following on _____ (child's name).

Procedure	Consent	Decline	Guardian Initials
• Obtain and document history of abuse			
• Perform physical examination			
• Collect evidence including clothing, STD testing, swabs for DNA			
• Administer appropriate medical treatment			
• Screen for pregnancy if indicated			
• Administer medications for STD prophylaxis if indicated			
• Administer medications for pregnancy prophylaxis if indicated			
• Photograph/videotape physical injuries, portions of the examination			
• Follow-up telephone call			
• Toxicology testing as indicated (≤ 72 hr of suspected ingestion)			
• Police notification			
• Other (please specify)			

I understand that the medical information contained in this record is confidential and private and protected under state law. In most circumstances, the medical record will be released only with my written permission. However, I understand the medical information must be released if subpoenaed by court.

_____

Signature of parent or guardian Relationship to patient

_____

Examiner's Signature Print Name Date

white copy - medical record yellow copy - return to kit box

Form 2A - Patient Information/Parent/Guardian's Report of Incident
Commonwealth of Massachusetts
MA Pediatric Sexual Assault Evidence Collection Kit

Affix kit number label here on both white and yellow copies.

A. PATIENT INFORMATION

1. **Date of Birth:** ____/____/____ 2. **Gender:** ☐ Female ☐ Male
3. **Race:** ☐ White (non-Hisp) ☐ Black (non-Hisp) ☐ Hispanic ☐ Asian/Pacific Islander ☐ Other: _____
4. **Date of assault:** ____/____/____ 5. **Approximate time of assault:** _____ ☐AM ☐PM
6. **City/Town of assault:** _____ **State:** _____ **Neighborhood:** _____
7. **Date of hospital exam:** ____/____/____ 8. **Time of hospital exam:** _____ ☐ AM ☐ PM
9. **Hospital providing service:** _____ 10. **Toxicology kit used?** ☐ YES ☐ NO
11. **Interpreter used?** ☐ YES ☐ NO **Language:** _____ **Name of Interpreter:** _____
12. **Bedding/Clothing presented to clinician by guardian/EMS/police?** ☐ YES ☐ NO
If Yes, document name of person and relationship to child, or name, agency, and ID/Badge #:
_____

B. PARENT/GUARDIAN'S OR CARETAKER REPORT OF INCIDENT

Please record any information that the parent/guardian or caretaker offers regarding the assault/abuse. Document how abuse/assault was discovered and what was reported as having occurred in this section. Document information related to alleged assailant(s), child's terminology for genitalia, and specific known details of the abuse/assault in sections C, D, E, F & G.

Name of Historian:	Abuse Reported to Historian by: ☐ Child ☐ Other:	History Obtained by:
Relationship to Patient:		

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ ____/_____/____

Clinician/P-SANE (Print) Clinician/P-SANE Signature Date

C. REPORTED ASSAILANT(S) RELATIONSHIP TO CHILD AND GENDER OF ASSAILANT(S) IF KNOWN (if > 1, designate relationship of each)

Total # of assailants: _____ #M #F

	#M	#F		#M	#F		#M	#F
☐ Parent/Step-parent/Adoptive	____	____	☐ Sibling	____	____	☐ Neighbor	____	____
☐ Foster Parent	____	____	☐ Uncle	____	____	☐ Stranger	____	____
☐ Grandparent	____	____	☐ Relative	____	____	☐ Other	____	____
☐ Parent's live-in partner	____	____	☐ Teacher	____	____			
☐ Parent's partner's child	____	____	☐ Coach	____	____			

Does perpetrator(s) have current access to child? ☐ YES ☐ NO

D. ASCERTAIN FROM HISTORIAN (if known) - CHILD'S TERMINOLOGY FOR:

Female genitalia _____ Male genitalia _____

Breasts _____ Anus _____

E. ACTS DESCRIBED BY HISTORIAN

Use this area to document information provided by the historian about known details of the abuse/assault. Interviewers may ask appropriate follow-up questions using the prompts as a guide. Explain to the historian that it is not expected that they will know all the information. Encourage the historian to refrain from further questioning the child about known and unknown details of the abuse/assault.

☐ Information Unknown

Was there penetration, however slight, of:

Vagina? ☐ no ☐ unsure ☐ attempt ☐ yes ⇒ by ☐ penis ☐ finger ☐ tongue ☐ object/other: _____

Anus? ☐ no ☐ unsure ☐ attempt ☐ yes ⇒ by ☐ penis ☐ finger ☐ tongue ☐ object/other: _____

Mouth? ☐ no ☐ unsure ☐ attempt ☐ yes ⇒ by ☐ penis ☐ finger ☐ tongue ☐ object/other: _____

During the assault, were acts performed by the patient upon the assailant? ☐ YES ☐ NO ☐ UNSURE

If yes, specify: _____

Did ejaculation occur? ☐ YES ☐ NO ☐ UNSURE

If yes, list location on the patient's body, i.e. hip, outer thigh, forearm: _____

If yes, list location: ☐ Bedding ☐ Clothing ☐ Other _____

Did assailant(s) use a condom? ☐ YES ☐ NO ☐ UNSURE

Did assailant(s) use any substance as lubrication (saliva is considered lubrication)? ☐ YES ☐ NO ☐ UNSURE

If yes, specify: _____

Did assailant(s) kiss, lick, spit, or make oral contact with the patient? ☐ YES ☐ NO ☐ UNSURE

If yes, describe location: _____

Were photographs or videotapes of the child made? ☐ YES ☐ NO ☐ UNSURE

Was the child made to view pornographic pictures/videos? ☐ YES ☐ NO ☐ UNSURE

Was the Internet used as a vehicle of abuse? ☐ YES ☐ NO ☐ UNSURE

Any injuries to patient resulting in bleeding? ☐ YES ☐ NO ☐ UNSURE

If yes, describe: _____

Any injuries to assailant resulting in bleeding? ☐ YES ☐ NO ☐ UNSURE

If yes, describe: _____

F. Force/Weapons Used: Document per report of Child's Guardian/Historian

☐ Unknown	☐ Bites	☐ Gun	☐ Restraints	☐ Coercion (e.g. bribes, rewards)
☐ Verbal threats	☐ Burns	☐ Hitting	☐ Chemical(s)	☐ Abduction/Kidnapping
☐ Choking	☐ Knife	☐ Blunt object	☐ Other physical force	

Affix kit number label here on both white and yellow copies.

G. Since the Time of the Assault, Has the Patient

a. Changed clothes? ☐ YES ☐ NO ☐ UNKNOWN

b. Bathed or showered? ☐ YES ☐ NO ☐ UNKNOWN

c. Washed off? ☐ YES ☐ NO ☐ UNKNOWN

d. Brushed teeth? ☐ YES ☐ NO ☐ UNKNOWN

e. Used mouthwash? ☐ YES ☐ NO ☐ UNKNOWN

f. Fluid intake? ☐ YES ☐ NO ☐ UNKNOWN

g. Washed or brushed hair? ☐ YES ☐ NO ☐ UNKNOWN

h. Vomited? ☐ YES ☐ NO ☐ UNKNOWN

i. Defecated? ☐ YES ☐ NO ☐ UNKNOWN

j. Urinated? ☐ YES ☐ NO ☐ UNKNOWN

H. Medical/Behavioral History:

a. Has child had any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures or medical treatments that may affect the physical findings? ☐ YES ☐ NO if yes, list _____

b. Any pre-existing medical conditions or injuries that may affect physical findings? ☐ YES ☐ NO if yes, list _____

c. Changes in behavior? ☐ YES ☐ NO if yes, list _____

_____

_____

_____ ___/___/___

Clinician/P-SANE (Print) Clinician/P-SANE Signature Date

Form 2B - Child's Spontaneous Report of Incident/Mandatory Reporting/Case Status
Commonwealth of Massachusetts
Pediatric Sexual Assault Evidence Collection Kit

Affix kit number label here on both white and yellow copies.

A. CHILD'S SPONTANEOUS REPORT/REMARKS REGARDING ABUSE/ASSAULT
Interviewing of the pediatric patient is discouraged however, this area should be used to document any spontaneous remarks about the abuse/assault that ***may*** be made by the child to the clinician/Pediatric SANE during an examination. Clinicians should document the child's exact words using quotes. Follow-up questions should be focused only to Who, What, Where and When. Avoid asking leading questions. Ask clarifying questions in an open-ended manner such as "Can you tell me more about that", "Can you tell me or show me where (s)he (using child's own words e.g. "poked", "kissed", "touched") you?

Information disclosed by patient to: ☐ Pediatric SANE ☐ Social Worker
☐ Physician ☐ RN ☐ Other: _____

Print Name/Credentials Signature Time/Date

B. MANDATORY REPORTING (check all that apply)
a. Pediatric Provider Sexual Crime Report ☐ YES (anonymous report must be completed on all patients)
b. 51A Child Abuse Report ☐ YES (report mandated on all children < 18 years of age)
c. Weapon Report ☐ YES ☐ NO

C. CASE STATUS AT THE TIME OF THE EXAM:
Evidence collection kit used? ☐ YES ☐ NO if no, why not: _____
Assault reported to police? ☐ YES ☐ NO if yes, specify police department: _____

/ /

Clinician/P-SANE (Print) Clinician/P-SANE Signature Date

RECORD OF PHOTOGRAPHS COMPLETED

Enclose photographs in hospital record. Do **not** include photographs in Pediatric Evidence Collection Kit.

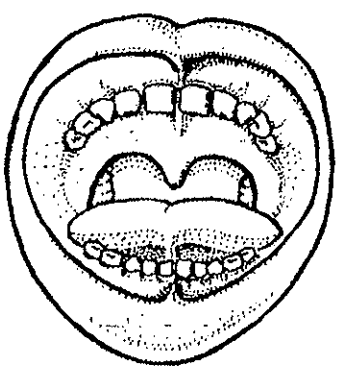
- Label body part photographed on body diagrams as photo #1, photo #2, etc.

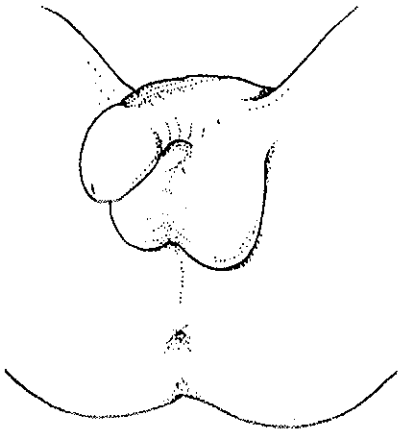
Photo Documentation Methods:

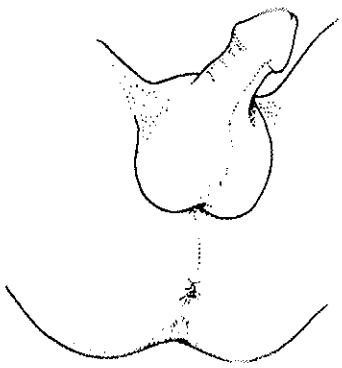
☐ Medscope ☐ Colposcope/35mm ☐ Macrolens/35mm ☐ Other Optics: _____

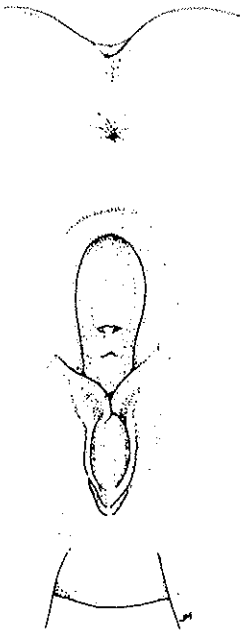
Total # of pictures taken during evidence collection _____

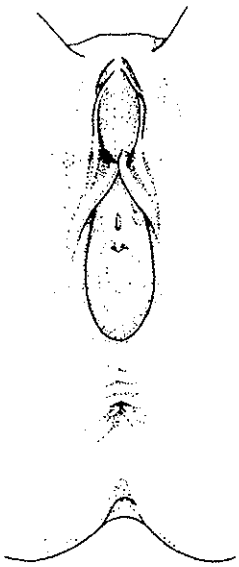
# of Photos Taken	Numbered area	Body Part	# of Photos Taken	Numbered Area	Body Part











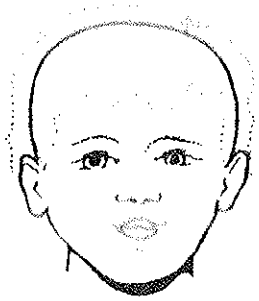
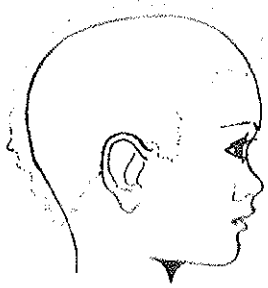
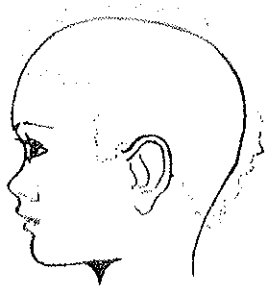
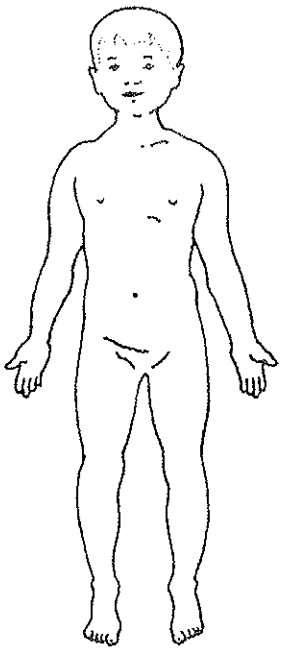
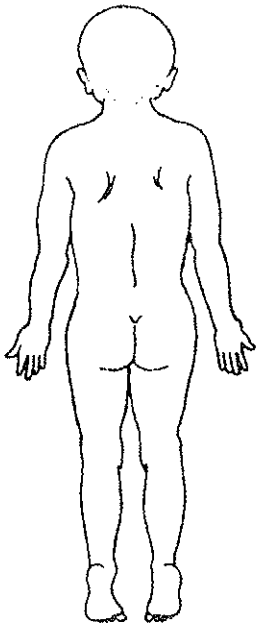
Form 3 - Physical Assessment and Wound Documentation
Commonwealth of Massachusetts
Pediatric Sexual Assault Evidence Collection Kit

Affix kit number label here on both white and yellow copies.

Clinician/P-SANE (Print) _____
Clinician/P-SANE Signature _____
Date: _____

Using legend below, document findings of exam on body diagrams.

AB Abrasion	**DF** Deformity	**FB** Foreign Body	**MS** Moist Secretion	**PS** Potential Saliva	**TB** Toluidine Blue
BI Bite	**DS** Dry secretion	**IN** Induration	**OF** Other foreign matter	**SHx** Sample per hx	**TE** Tenderness
BU Burn	**EC** Ecchymosis	**IW** Incised Wound	**OI** Other injury (describe)	**SI** Suction Injury	**V/S** Vegetation/Soil
DE Debris	**ER** Erythema	**LA** Laceration	**PE** Petechiae	**SW** Swelling	**WL** Woods Lamp

white copy - medical record

yellow copy - return to kit box

Form 4 - PHYSICAL EXAMINATION
Commonwealth of Massachusetts
Pediatric Sexual Assault Evidence Collection Kit

Affix kit number label here

Tanner Stage: Breast 1☐ 2☐ 3☐ 4☐ 5☐ **Genitals** 1☐ 2☐ 3☐ 4☐ 5☐

FEMALE GENITALIA	WNL	ABN	DESCRIBE
Labia majora			
Labia minora			
Clitoral hood			
Female Circumcision ☐ Yes ☐ No			
Perineum			
Periurethral tissue/ urethral meatus			
Perihymenal tissue (vestibule)			
Hymen			
Posterior commisure/ fourchette			
Fossa navicularis			
Vaginal discharge ☐ Yes ☐ No			

Positions used for female genital exam
☐ Supine frog-leg ☐ Lithotomy ☐ Knee-Chest
☐ Other (specify): _____

Is the patient pregnant? ☐ YES ☐ NO
LMP: _____

MALE GENITALIA	WNL	ABN	DESCRIBE
Penis			
Circumcised ☐ Yes ☐ No			
Urethral meatus			
Urethral discharge ☐ Yes ☐ No			
Scrotum			
Testes			
FEMALE/MALE ANO-RECTAL			
Buttocks			
Perianal skin			
Anal verge/folds/rugae			
Tone			

Anal dilation > 20 mm ☐ Yes ☐ No
Anal laxity ☐ Yes ☐ No

Note presence of stool in rectal ampulla ☐ Yes ☐ No ☐ Undetermined

Method of exam for anal tone: (discretion of examiner) ☐ Observation ☐ Digital Exam

Positions used for anal exam ☐ Supine ☐ Knee-Chest ☐ Lateral-recumbant ☐ Lithotomy ☐ Other (specify):

EXAM DONE WITH	YES	NO
Direct visualization		
Colposcope/Medscope exam		
Hand-held magnification		

Speculum Exam is indicated only in pubescent females or if child requires an exam under general anesthesia.

	WNL	ABN	Describe
Vagina			
Cervix			

Adam's Classification	
☐ Class 1	☐ Class 2
☐ Class 3	☐ Class 4
☐ Undetermined	

Clinician/Pedi SANE (Print) **Clinician/Pedi SANE Signature** **Date** / /

Retain this form for Hospital Record

Form 5 - Medical Treatment and Discharge Instructions
Commonwealth of Massachusetts
Pediatric Sexual Assault Evidence Collection Kit

Please affix kit # label here

Your child has been examined and is ready to leave. We know that this may be a very stressful time for you and your child. This form will review what tests were done on your child and help remind you of things to do in the next few days and weeks. You may find it helpful to share this form with your child's primary care clinician.

STD Screening ☐ Not Indicated
Gonorrhea Culture ☐ Vagina ☐ Pharynx ☐ Rectum ☐ External Genitalia
Chlamydia Culture ☐ Vagina ☐ Urethra ☐ Rectum
Hepatitis B Testing ☐ HBsAG ☐ anti-HBsAG
Other Testing: _____

Antibiotic/Antiviral Medications (document administration on appropriate ED record)

- **Antibiotic given or prescribed:** ☐ Not Indicated

a. Drug and Dose _____
b. Drug and Dose _____

- **Antiviral (HIV PEP) given or prescribed:** ☐ Not Indicated

a. Drug and Dose _____
b. Drug and Dose _____

- **Hepatitis B Vaccine:** ☐ Not Indicated

Brand Name and dose given _____

- **Tetanus Toxoid:** ☐ Not Indicated ☐ UTD per caretaker

DPT DT Td (circle one) and dose _____

Pregnancy Testing ☐ Not Indicated ☐ Urine HCG ☐ Serum HCG Result: _____
Pregnancy Prevention Medication
(**ONLY** if within 120 hours of possible penile-vaginal penetration)
☐ Not Indicated
☐ Pregnancy prevention medication given or prescribed:
Drug and Dose _____

AFTERCARE INSTRUCTIONS
☐ Yellow copy of Form 5 and printed ***Aftercare Instructions*** given to parent/guardian
Follow-up Appointments (if appropriate)
_____
_____

Name of Pediatric SANE clinician: _____
Name of ED Physician: _____
Name of ED Primary Nurse: _____
Name of ED Social Worker: _____

☐ I have received a written copy of discharge instructions and have had any questions answered.
Parent/Guardian Signature _____ Time: _____ Date: _____

white copy - medical record

yellow copy - parent/guardian

STEP 2: **Clothing**

AFFIX PEDI Kit Number
Label Here

Was Clothing Collected? Yes No

Collect underpants or diapers in all acute assaults (≤ 72 hours)

If No, Why Not?

- ❑ Not Indicated
- ❑ Unable to collect

Clothing Article Enclosed:_____

STEP 2A: **Foreign Material Collection** (Paper Sheet)

AFFIX PEDI Kit Number Label Here

Collector's Initials:_____

Was Paper Sheet Used/Collected? Yes No

If No, Why Not?

❑ Not Indicated ❑ Unable to collect

REOMA(P): STEP2A.1 6/04

STEP 2: **Clothing-Underpants/Diapers**

AFFIX PEDI Kit Number Label Here

Was Clothing Collected? Yes No

Collect underpants or diapers in all acute assaults (≤ 72 hours)

If No, Why Not?

❑ Not Indicated

❑ Unable to collect

Clothing Article Enclosed:_____

STEP 11: Toxicology Testing

AFFIX PEDI Kit Number
Label Here

Collector's Initials: _____

Was Sample Collected? Yes No

If No, Why Not?

- ❑ Not Indicated
- ❑ Unable to collect