



**Q: What does the term *contact children* mean?**

*The term "contact children", within the protocol, refers to any other children beyond the presenting victim(s) who may have had contact with, and possibly been abused by, the perpetrator. This protocol encourages a multidisciplinary, collaborative approach, jurisdictional and multijurisdictional as applicable, to identify and sensitively address the needs of contact children.*

**Q: What is the timing for forensic evidence collection for the post pubescent population?**

The [National Protocol for Sexual Abuse Medical Forensic Exams Adolescent/ Adult](#) does not provide a specific number of hours as a recommendation, it does recommend the following:

*Make decisions about timeliness issues for evidence collection on a **case-by-case basis**, guided by the knowledge that outside time limits for obtaining evidence vary due to factors such as the location of the evidence or type of sample collected.*

*Examiners and law enforcement representatives, in particular, should be aware of the standard cutoff time for evidence collection in their jurisdictions, which is typically indicated in instructions in evidence collection kits. But it is important to remember that evidence collection beyond the cutoff point is conceivable and may be warranted in particular cases. In any case where the utility of evidence collection is in question, encourage dialogue between law enforcement representatives (if involved), examiners, and forensic scientists regarding potential benefits or limitations.*

*Medical care, which is the ultimate need for the exam, has treatment that can be delivered up to 5 days post assault including STD prevention, emergency contraception AND also DFSA specimens are specifically mentioned. For more information on the Timing Considerations for Evidence Collection for the adult/adolescent population of patients check out the [www.SAFETA.org](http://www.SAFETA.org) website.*

**Q: What do you mean by the term chaperone?**

*The protocol recommends a chaperone during the medical forensic examination as a safeguard for children, due to their vulnerability to abuse. The chaperone may be a*



*caregiver, a health care provider other than the examiner, or another supportive person not suspected of involvement in the abuse.*

**Q: Why take pictures of normal findings?**

**In regards to the question about photo-documentation** of injury and or normal findings, the protocol states the following:

*Photo-documentation during the medical forensic examination is the standard of care in prepubescent child sexual abuse cases. In every case, examiners should take the diagnostic quality still images or videos of **detected injuries as well as normal, apparently uninjured anatomy.***

*Video or still photography is going to depend on the availability of the equipment. Many imaging systems have the ability to video and also capture still images. [See Chapter B6 Photo-Documentation](#) for additional information.*

**Q: What is the recommendation for the following common scenario: when the child is brought in by a parent who states that “child is red down there” or that “things don’t look right”, yet there is no disclosure from the child, or the child is preverbal?**

*The suspicion of child sexual abuse should be all that is needed to trigger community interventions, which may include medical forensic care, child protection, criminal investigation victim services and mental health care. The protocol affirms that a medical forensic examination should be accessible to all prepubescent sexual abuse victims, regardless of their background, circumstances or geographical location. And, that it is imperative that children who disclose or are suspected of being sexually abused receive timely health assessments, treatment and interventions regardless of the probability of evidence on their bodies.*

*The protocol recognizes that states, territories and the District of Columbia, all require certain persons to report suspected child abuse and neglect to an appropriate agency or agencies, such as child protective services, a law enforcement agency, and/or a state toll-free child abuse reporting hotline. Mandatory reporters vary across jurisdictions,*



*but typically include individuals who have frequent contact with children. In all states, the District of Columbia, and territories, any person is permitted to report. Child abuse reporting systems function to ensure children's safety if any question exists that abuse or neglect has occurred. Suspicion of sexual abuse may be based on a disclosure by the child or another person, or observations of a pattern of indicators associated with sexual abuse.*

*When sexual abuse is a concern, children should be promptly assessed to determine the urgency of the medical forensic care needed. Urgency is determined by the child's presentation, the presence of injuries, and the nature and timing of the abuse. While the protocol recommends a collaborative community response to a report of or suspicion of child sexual abuse, a health care provider, rather than law enforcement or child protective service representative, should determine the urgency of care appropriate for a child.*

**Q: Will peer reviews be more fully discussed in future documents?**

This is a great topic for further technical assistance discussion as the protocol does recommend that:

*Pediatric examiners need to be supported in their ongoing education as well as their access to experts in the child sexual abuse field who can participate in examiner training, mentoring, and peer review of medical forensic examinations and quality assurance. In peer review, medical experts in child sexual abuse have the opportunity to review written and photographic documentation of a child's examination. They may discuss interpretation of medical findings, particularly those thought to be abnormal or indicative of sexual abuse and give the provider input on his/her care and documentation. Peer review has been demonstrated to improve diagnostic accuracy, assist with confirmation and verification of exam findings and strengthen the examiners' skills to not overcall a normal variant finding. **Each program should have a peer review process that is clearly defined, including a rationale for conducting the review.***

**Additionally, the protocol differentiates between peer review and obtaining an expert opinion in the following statement:**

Pediatric SAFE Protocol Webinar  
Thursday, June 16, 2016  
Attendee Chat Questions and Discussion



*Peer review should not be confused with obtaining an expert second opinion. Obtaining a second opinion is one aspect of the overall care of the patient. For example, an examiner may reach out to an expert to obtain another opinion or confirm findings in a given case. The consulted expert reviews the medical report and photo-documentation and subsequently should provide formal written documentation of her/his review and conclusions. The second opinion report is then included in the patient's medical record, which will be released for legal proceedings upon request. Jurisdictional protocols should be clear in what situations a second opinion may be helpful and the process for obtaining one, and clarify how a second opinion and formal report differs from a program clinical peer review.*

The Kidsta project is always looking for information on current practice challenges and evolving topics of interest so that we can highlight them on the website, and/or offer educational resources or webinars on the topics related to the medical forensic response to children who have been sexually abused.

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