

State of California
Governor's Office of Emergency Services
(www.caloes.ca.gov)

**FORENSIC MEDICAL REPORT: NON-ACUTE
CHILD/ADOLESCENT SEXUAL ABUSE
EVIDENTIARY EXAMINATION**

**ADOLESCENTS AGES 12–17 > 120 HOURS
CHILDREN UNDER 12: FOLLOW
LOCAL SART GUIDELINES**

INSTRUCTIONS

CAL OES 2-925

July 2020



For copies of this form or assistance in completing
the Cal OES 2-925, please contact

California Clinical Forensic Medical Training Center
www.ccfmtc.org

Cal OES 2-925 INSTRUCTIONS

Forensic Medical Report: Non-Acute Sexual Abuse Evidentiary Examination Adolescents Ages 12–17 (> 120 Hours) & Children Under Age 12 (Follow Local SART Guidelines)

REQUIRED USE OF STANDARD FORM

Penal Code section 13823.5(c) requires that every health care practitioner who conducts a medical examination of a sexual assault or child sexual abuse victim for evidence of sexual assault or abuse use a standard form to record findings. This form is intended to document medical/evidentiary examination findings and, as such, is not a complete medical treatment record.

USE OF THE STANDARD STATE FORMS: FOLLOW SEXUAL ASSAULT RESPONSE TEAM (SART) GUIDELINES.

Cal OES 2-923	<ul style="list-style-type: none"> History of acute sexual assault (< 120 hours) Examination of adults (age 18 and over) and adolescents (ages 12–17) 	Key Terms for Sexual Assault or Sexual Abuse Exams	
Cal OES 2-925	<ul style="list-style-type: none"> History of non-acute sexual abuse: Follow local SART guidelines due to jurisdictional variations Examination of children and adolescents under age 18 	Acute	Less than 120 hours have passed since the incident (< 120 hours)
Cal OES 2-930	<ul style="list-style-type: none"> History of acute sexual abuse or sexual assault Examination of adolescents ages 12-17 (< 120 hours) Examination of children under age 12: Follow local SART guidelines due to jurisdictional variations 	Non-acute	More than 120 hours have passed since the incident (> 120 hours)
Cal OES 2-930	<ul style="list-style-type: none"> History of chronic sexual abuse (incest) and recent incident Examination of adolescents ages 12-17 (< 120 hours) Examination of children under age 12: Follow local SART guidelines due to jurisdictional variations 		
Cal OES 2-950	<ul style="list-style-type: none"> Examination of person(s) suspected of sexual assault or sexual abuse 		

INSTRUCTIONS FOR Cal OES 2-925: These instructions contain the recommended methods for meeting the minimum legal standards established by Penal Code section 13823.11 for performing medical evidentiary examinations. These terms are used to describe time frames, not rigid standards. This is not to suggest that after 120 hours a complete exam should not be done. It is not unusual to detect injuries or possible trace and biological evidence after 120 hours. For infants, young children, and adolescents, there are many variables to consider. Use clinical judgment and/or follow local SART policy.

LIABILITY AND RELEASE OF INFORMATION: This medical evidentiary exam report is subject to the confidentiality requirements of the Child Abuse and Neglect Reporting Act (Pen. Code § 11164 or privilege), the Medical Information Act (Civ. Code § 56 et seq.), the Physician-Patient Privilege (Evid. Code § 990), and the Official Information Privilege (Evid. Code § 1040). It can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, city attorney, crime laboratory, child protective services worker, a child abuse and neglect team member, county licensing agency, and coroner. Records may be released to the defense counsel only through discovery of documents in the possession of a prosecuting agency or after the appropriate court process (i.e., judicial review and a court order).

Complete this report in its entirety. Use N/A (not applicable) when appropriate to show that the examiner attended to the question.	Patient Identification: This space is provided for hospitals and clinics using labels or plastic plates for stamping identification information.
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A. GENERAL INFORMATION: Print or type the name of the facility where the examination was conducted.

1. Enter the patient's name and identification number (if applicable); date/time of arrival; and date/time of discharge.
2. Enter the patient's age, date of birth (DOB), biological gender, identified gender, preferred pronouns, and ethnicity.
3. Enter the patient's address, city, county, state, and telephone number.
4. Enter the name of parent, stepparent, guardian, address, city, county, state, and telephone numbers.
5. Enter the name of parent, stepparent, guardian, address, city, county, state, and telephone numbers.
6. Enter the name(s) of siblings, gender, age, and date of birth (DOB).

B. REPORTING AND AUTHORIZATION: Indicate jurisdiction where the incident(s) occurred. Penal Code section 11166 requires all professional medical personnel to report suspected child abuse, defined by Penal Code section 11166, immediately by telephone and to submit a written report (DOJ SS 8572 also called the 11166) within 36 hours to the local law enforcement or Child Protective Services.

1. Check the appropriate box to indicate whether a telephone report was made to a law enforcement agency and/or to Child Protective Services. Identify the person who took the report by name, agency, identification number, and telephone number.
2. If the patient was accompanied to the medical facility by law enforcement or Child Protective Services, enter the person's name and identifying information.
3. If known, identify the law enforcement and/or Child Protective Services investigator assigned to this case.
4. Obtain the name of a law enforcement and/or Child Protective Services investigator to authorize payment for the evidentiary exam at public expense, the name of the agency, telephone number, date, time, and case number. If telephone authorization was obtained, enter the name of the authorizing party, identification number, and the date and time in the Telephone Authorization box.

Note: Medical facilities with contracts or memorandums of understanding may not require individual patient authorizations.

C. CONSENT FOR EXAMINATION BY PATIENT/PARENT/GUARDIAN

- Parental consent is not required for suspected sexual abuse examinations. Some jurisdictions require warrants for exigent and non-exigent circumstances.
- Family Code section 6927 permits minors (12–17 years of age) to consent to medical examination, treatment, and evidence collection related to a sexual assault without parental consent. Family Code section 6928 requires health care professionals to attempt to contact the minor's parent or legal guardian, and to note in the minor's treatment record the date and time the attempted contact was made, including whether the attempt was successful or unsuccessful. This provision is not applicable when the health professional reasonably believes the parent(s) or guardian committed the sexual assault on the minor.

D. PATIENT HISTORY

1. **Record the time or time frame of the incident(s) and date(s).**
 - For children, use familiar dates and time frames (holidays, birthdays, weekday or weekend, nighttime, or daytime).
 - Check the box if there were multiple incidents over time.
2. **Describe the location of the most recent incident(s).**
3. **Record the terms the patient uses for the female and male genitalia, breasts, and anus.**
4. **Record the identity of the alleged perpetrator(s) by name or nickname, approximate age, gender, ethnicity, relationship to the patient, and whether the perpetrator(s) are known or unknown to the patient.**
 - Use a numbering system to identify multiple perpetrators by name, if known, or a brief description such as the "big guy." This numbering system can be used to relate the perpetrator to the acts described by the historian and/or patient on pages 3 and 4.

E. MEDICAL HISTORY

1. **Record the name of the person providing the medical history, relationship to the patient, and date and time of examination.**
2. **Any recent (past 60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of physical findings?**
 - This information is requested to avoid confusing pre-existing lesions with injuries or findings related to the alleged abuse.
3. **Any other pertinent medical conditions that may affect the interpretation or physical findings?**
4. **Any pre-existing physical injuries?**
5. **Any previous history of physical abuse and/or neglect?**
6. **Any previous history of sexual abuse?**
7. **For adolescents, ask whether the patient has had other oral, anal, or vaginal intercourse within the past 5 days. If yes, ask when. If yes, ask whether intravaginal ejaculation occurred and whether a condom was used.**

The information is needed by the examiner to interpret the genital findings. The information is also required by the crime laboratory to properly interpret the findings. **Do not record any other information regarding sexual history on this form.**

8. **Record whether menstrual periods have started, the age of menarche, the date of the last menstrual period, and whether the patient is menstruating at the time of the exam.**
9. **Record other symptoms described by the patient and/or historian. Describe onset, duration, and intensity of symptoms.**

F. ACTS DESCRIBED BY HISTORIAN

- Record the name of the historian, his or her relationship to the patient, telephone number, and indicate agency name if law enforcement, Child Protective Services, or a specialized interview center for children served as the historian.
- Record acts described by the historian and any additional pertinent history. Indicate if a question was not asked. For yes answers, ask if there was associated pain or bleeding, and describe in the space provided.

<ul style="list-style-type: none"> Breast/Anal/Genital fondling 	<p>Mark the appropriate box. Mark "attempted" if it is reasonably clear from the interview that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes.</p>
<ul style="list-style-type: none"> Genital: vulva, vestibule, vagina contact/ penetration Anal contact/penetration 	<p>Mark the appropriate box for each method of contact/penetration. Mark "attempted" if it is reasonably clear from the interview that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes. If an object was used, describe it.</p>
<ul style="list-style-type: none"> Oral copulation of genitals Oral copulation of anus 	<p>Mark the appropriate box. Mark "attempted" if it is reasonably clear from the interview that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes.</p>
<ul style="list-style-type: none"> Non-genital acts 	<ul style="list-style-type: none"> Mark the appropriate box. If yes, describe the act and note where it occurred on the adjacent line. Mark "attempted" if it is reasonably clear from the interview that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes. Note: Identify bites and alert law enforcement about their existence. Bites can provide very specific evidence and they fade very quickly. Bites should be swabbed for saliva, measured, and photographed. Contact a forensic odontologist or law enforcement to evaluate the need for impressions. Note: The term suction injury means "hickey."
<ul style="list-style-type: none"> Other act(s) 	<ul style="list-style-type: none"> If yes, describe.
<ul style="list-style-type: none"> Ejaculation 	<p>Mark the appropriate box. For body surfaces, note location(s) on the diagrams. For clothing, bedding, or other surface(s), describe in the space provided. If more than one perpetrator ejaculated, identify each one by number on the lines adjacent to the boxes. If "unsure" is checked, provide a description in the adjacent space.</p>
<ul style="list-style-type: none"> Lubricant products 	<p>Note whether a contraceptive, saliva, or a lubricant product was used. If yes, record the type or brand used, if known.</p>
<ul style="list-style-type: none"> Barriers 	<p>Mark the appropriate box. Indicate whether it was a condom, plastic bag, or other barrier.</p>
<ul style="list-style-type: none"> Force, threats, or weapons 	<p>If yes, describe.</p>
<ul style="list-style-type: none"> Strangulation (choking) 	<p>Mark the appropriate box, including the symptoms. <i>Note:</i> Strangulation occurs more often than previously thought.</p>
<ul style="list-style-type: none"> Pictures, videotapes, or social media 	<p>Mark the appropriate box. Photos, videos, or social media may be taken or shown.</p>
<ul style="list-style-type: none"> Drugs or alcohol 	<p>Ask about the possibility of forced, coerced, or suspected ingestion of alcohol or drugs. Mark the appropriate box. If yes:</p> <ul style="list-style-type: none"> For blood-alcohol analysis, collect 20cc or two 10cc of blood in a gray-stoppered evacuated blood collection vial up to 24 hours post-ingestion. For ingestion of drugs, collect 60cc or two 30cc of urine in a plastic or glass container. It is important to collect the first available sample. Some drugs may be detected in urine up to 96 hours after ingestion.
<ul style="list-style-type: none"> Loss of memory Lapse of consciousness 	<p>If the patient reports ingestion of drugs, describes symptoms, or shows signs of drug ingestion (e.g., lapse of consciousness, memory loss, abnormal vital signs, confusion), collect toxicology samples.</p>
<ul style="list-style-type: none"> Vomited after act(s) 	<p>If yes, describe. Vomiting can also be a possible indicator of drug or alcohol ingestion.</p>
<ul style="list-style-type: none"> Behavioral changes 	<p>If yes, describe.</p>

G. ACTS DESCRIBED BY PATIENT

Interview approach:

- Determine and use terms familiar to the patient.
- Allow the patient to describe the incident(s) to the extent possible.
- Follow-up questions may be necessary to ensure that all items are covered.
- Avoid asking questions that may be leading or suggestive.
- Gather as much information as possible from law enforcement officers and social workers to avoid redundant interviewing.

1. Record the acts disclosed by the patient and to whom.

Each act may lead to evidence of a chargeable crime. Any penetration, however slight, of a genital or anal opening by an object or body part constitutes an act. Oral copulation only requires contact.

- For yes answers, ask if there was associated pain or bleeding. Sometimes patients report no pain but say “tickled.”
 - Use quotation marks to quote relevant statements. Example: “He puts his private in my pee pee.”
 - Document if statement(s) made by the patient were spontaneous (i.e., not in response to a question or comment).
 - Patient statements not heard directly by the recorder may be included (e.g., the child told the teacher that “he put his private in my pee pee”).
 - Under non-genital acts, the term suction injury means “hickey.”
 - Saliva or lubricant. If lubricant used, describe by name, color, odor, flavor, and container description (if known or disclosed).
 - Condom or other forms of covering: Describe type or brand used (if known)
 - If the patient experienced a lapse of consciousness, collection of toxicology samples as specified by local policy may be indicated.
2. Describe pain and/or bleeding (using patient’s exact words) and any additional pertinent history.

H. GENERAL PHYSICAL EXAMINATION: Record findings on diagrams and legend.

1. Record vital signs, height, weight, percentiles, and BMI.
2. Record who is with child during the examination or indicate N/A
3. For females, record Sexual Maturity Rating/Female Tanner Stage – Breast

Sexual Maturity Rating/Female Tanner Stages – Breast	Genital Tanner Stages
1. Preadolescent 2. Breast and papilla elevated as small mound; areola diameter increased 3. Breast and areola enlarged; no contour separation 4. Areola and papilla form secondary mound 5. Mature; nipple projections, areola part of general breast contour	1. No or fine vellus (peach fuzz) hair 2. Sparse; long, straight, pigmented hair 3. Increased density; dark coarse curly hair 4. Abundant hair; sparing medial thighs 5. Abundant hair; spreading to medial thigh

4. Describe the patient's general physical appearance.
5. Describe the patient's general demeanor.
 - Describe behaviors such as crying, fearfulness, willingness or ability to cooperate, responsiveness, ability to give history, etc. Avoid the use of vague, subjective, or judgmental descriptors. Documenting helps the examiner recall the patient's behavior and response during the examination for future reference. The issue of non-cooperativeness is relevant because it can cause exam delays and impair the examiner's ability to collect evidence.
6. Record any relevant statements made during the exam and use quotation marks for direct quotes.
7. Conduct a general physical examination. Record all findings and whether the general exam was within normal limits.

Physical Findings: A physical finding includes observable or palpable tissue injuries, physiologic changes, or foreign materials (e.g., grass, sand, stains, dried or moist secretions, or positive fluorescence). If none of the above are present, mark "No Findings."

- Be observant for erythema (redness), abrasions, bruises, swelling, lacerations, fractures, bites, and burns. Note areas of tenderness or induration.

Documentation of Injuries and Findings Using Diagrams and Legend														
<ul style="list-style-type: none">• Record size and appearance of injuries and other findings using the diagrams, the legend, and a consecutive numbering system.• Bruises: Describe shape, size, and color.• Use the legend to list and describe the injury/finding drawn on the diagram. Show the diagram letter followed by the finding number. Use the abbreviations in the legend to describe the type of finding. Example: A-1, EC 2x3cm red/purple indicates that the first finding on Diagram A is an ecchymosis (bruise) that is red/purple in color and 2x3 centimeters in size. See example below.														
<table border="1"><thead><tr><th>Locator #</th><th>Type</th><th>Description</th></tr></thead><tbody><tr><td>A-1</td><td>EC</td><td>2x3cm red/purple</td></tr><tr><td>A-2</td><td>DS</td><td>Dried secretion</td></tr><tr><td>A-3</td><td>CS</td><td>Control Swab</td></tr></tbody></table>	Locator #	Type	Description	A-1	EC	2x3cm red/purple	A-2	DS	Dried secretion	A-3	CS	Control Swab		
Locator #	Type	Description												
A-1	EC	2x3cm red/purple												
A-2	DS	Dried secretion												
A-3	CS	Control Swab												

I. **HEAD, NECK, AND ORAL EXAMINATION.** Examine the face, head, hair, scalp, and neck for injury. Use the diagrams and the legend to record findings.

J. GENITAL EXAMINATION – FEMALES

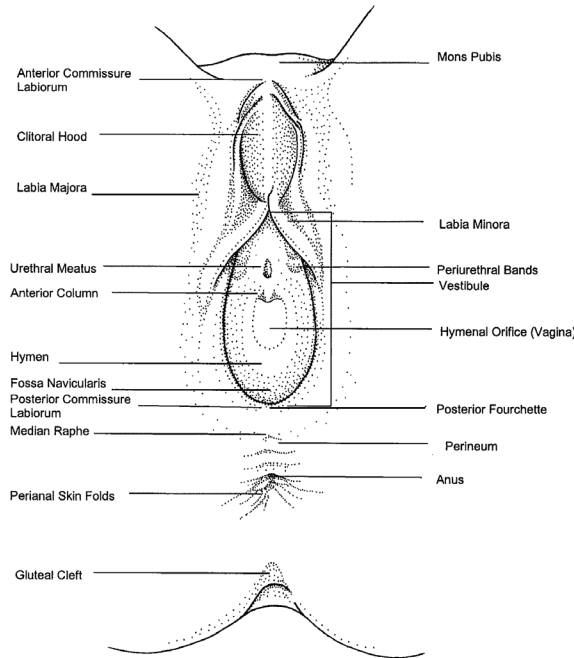
1. **Examine the inner thighs, external genitalia, and perineal area.**
 - Use a colposcope or a digital camera with a macro lens.
2. **Record examination position methods and technique.**
3. **Record Sexual Maturity Rating/Genital Tanner Stage by checking the appropriate box.**
 1. No or fine vellus (peach fuzz) hair
 2. Sparse; long, straight, pigmented hair
 3. Increased density; dark coarse curly hair
 4. Abundant hair; sparing medial thighs
 5. Abundant hair; spreading to medial thigh
4. **Examine the genital structures.** Check the ABN box(es) if there are abuse/assault-related findings.
 - Describe any abnormal or unusual findings.
 - Hymen: Note exam position/orientation in which findings are reported.
 - Pubertal adolescents: If a speculum is used for an adolescent exam, describe the cervix.

<p>Terms relating to the hymen</p> <ul style="list-style-type: none"> • Estrogenized: Influenced by estrogen; hymen takes on a thickened, redundant, pale appearance. • Fimbriate/denticular: Multiple projections and indentations along edge. • Narrow/wide rim: Viewed in the coronal plane-from edge of hymen to muscular portion (attachment) of the vaginal opening. • Membrane thickness: Relative amount of tissue between internal and external surfaces of the hymenal membrane.

EXAMINATION POSITIONS AND TECHNIQUES USES	
<p>Knee-chest</p> <ul style="list-style-type: none"> • Prone: Child rests on knees with upper chest on the examination table in a lordotic (swayback) posture. • Supine: Child rests on back with flexed knees brought to chest. 	<p>Saline/water</p> <p>Used to float/separate the hymenal tissue that may be rolled or overlapping upon itself.</p>
<p>Traction</p> <p>Labia majora are grasped between the thumbs and index fingers and gently pulled toward the examiner.</p>	<p>Moistened swab</p> <p>Used to reposition hymenal tissue. Always use a moistened swab to reduce discomfort.</p>
<p>Separation</p> <p>Labia majora are gently separated in a lateral and downward direction exposing the structures within the vestibule.</p>	<p>Speculum exams: Never used a speculum with prepubertal females.</p>

- Record size and appearance of injuries and other findings using the diagrams, the legend, and a consecutive numbering system.
- Use the legend to help identify and describe the findings drawn on the diagrams. Example: "D-5 LA 1.5 cm" means Diagram D, finding #5 is a laceration, 1.5 centimeters long.
- Describe genital findings as the face of a clock with the top of a genital diagram being 12:00 and the bottom of a genital diagram being 6:00.
- Photograph injuries and other findings using a digital camera with a macro lens or a colposcope with camera attachment.

FEMALE GENITALIA WITH LABELS: SUPINE VIEW
Diagrams of female and male genitalia with definitions are provided in Appendix N of the Protocol



K. GENITAL EXAMINATION – MALES

1. **Examine the inner thighs, external genitalia, and perineal area for injury, foreign materials, and other findings.**
 - Use a colposcope with camera attachment or digital camera with a macro lens.
 - Record size and appearance of injuries, foreign materials, and other findings using the diagrams, the legend, and a consecutive numbering system. Note swelling and areas of tenderness and induration. Describe genital findings as the face of a clock with the top of a genital diagram being 12:00 and the bottom of a genital diagram being 6:00.
 - Photograph injuries and other findings.
 - Record documentation method, examination technique, and position used.
2. **Record Sexual Maturity Rating/Genital Tanner Stage by checking the appropriate box.** See descriptions above.
3. **Record whether circumcised or not.**
4. **Check the ABN box(es) if there are abuse/assault-related findings.**

L. FEMALE/MALE PERIANAL/ANAL EXAMINATION

- 1. Examine the buttocks, perianal skin, and the anal folds for injury, foreign materials, and other findings.**
 - Use a digital camera with a macro lens or colposcope with camera attachment to photograph injuries and other findings.
 - Record examination positions, methods, and observations.
 - Examination position options: supine, prone, or lateral recumbent (lying on side with hips and knees flexed).
 - Use lateral traction on the buttocks or the knee-chest position with lateral traction on the buttocks to conduct the examination.
- 2. Check the ABN box(es) if there are abuse/assault-related findings.**
 - Indicate if anal dilation is immediate or delayed.
 - Indicate if stool is present in the rectal ampulla.
- 3. Record any additional information.**

M. FINDINGS AND INTERPRETATIONS

1. Check the appropriate box to summarize findings.

- Findings and interpretations are based on both the patient history available at the time and the medical examination.
- Check if lab results or photo review are pending.
- Record additional comments regarding findings, interpretations, and recommendations; or, use to describe variations of normal congenital abnormalities.
- *Note:* Examining clinician reserves the right to amend or revise final interpretation pending further consultation

2. Check the box to describe your interpretation of the findings.

3. Local exam team policy may include formal review of the photographic record and this form and/or follow-up exam. Check the box if this is not applicable.

N. LAB TESTS PERFORMED

- Consider abuse history, patient's medical history, and exam findings to determine tests needed.
- Perform lab tests after collection of forensic material.
- Pregnancy testing should be considered for all females Sexual Maturity Rating/Tanner Stage 3 and above, irrespective of menarche.
- Additional tests performed depend upon clinical assessment (e.g., urinalysis, biopsy, cultures, viral titers).

O. PHOTO DOCUMENTATION METHODS

- Document photographic methods used and areas that were photographed. Documentation must clearly link the patient's identity to the specific photographs of injuries and/or findings.

P. PRINT NAMES OF PERSONNEL INVOLVED. OBTAIN SIGNATURE AND LICENSE NUMBER OF EXAMINER.