

PITFALLS IN THE MEDICO-LEGAL EXAMINATION AND DOCUMENTATION IN SEXUAL OFFENCE CASES

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FIGHTING DISEASE, FIGHTING POVERTY, GIVING HOPE



Overview of Presentation:

- (1) What is the J88?
- (2) Purpose of the J88 Form
- (3) Inclusions and Exclusions of the Presentation
- (4) Basic of Anatomy of Male and Female Genital Tract
- (5) Dual Roles of the Examiner: Medical vs Forensic Role
- (6) The Neutrality of the Medical Examiner
- (7) How should a History be obtained and documented
- (8) The Importance of Injuries and documentation
- (9) The Timing of the Clinical Examination
- (10)Genital Injuries
- (11)Forensic Exhibits
- (12)Conclusions



What is the J88 Form?

- 1. J88 form is a convenient **format** in which to present the details of a medico-legal examination for judicial purposes
- 2. The report must be legible, complete and in detail.
- 3. The whole report must be completed in the doctor's **own handwriting**. The doctor must sign every page.
- 4. If findings are normal: Write "within normal limits".
- 5. Avoid **abbreviations** like NAD.
- 6. The report must be made in **duplicate** and the original handed to the investigating officer.
- 7. The examining doctor keeps the duplicate.



J88 FORM

- Legal document required by the courts, which is completed at the time of the examination
- Means of communicating the clinical findings as accurately as possible to the court
- The manner of completion of the J88 reflects one's diligence and ability to convey one's findings as accurately as possible to court
- Each of the six pages must be signed by the examiner



DUAL ROLE OF THE HEALTH EXAMINER

The duality of the role of the health care practitioner in the context of Clinical Forensic Medical examinations is of paramount importance and should not be confused

The Therapeutic Role: a holistic, compassionate, caring approach to the patient involving examination, investigations, diagnosis, treatment, prophylaxis, support and counselling, referral and follow-up is very well known.



The Forensic Role:

Has the additional medico-legal role: that of a dispassionate objectivity, neutrality, unemotional and disconnected to the patient's plight, with other responsibilities: forensic techniques, findings, collecting evidence, reaching objective conclusions, completing documentation and giving expert testimony The first involves a caring approach, whilst the second a detachment from personal feelings.



THE NEUTRALITY OF THE EXAMINER

The medical conclusion should reflect the Clinical Forensic Medical Examiner's impartial clinical impression at the time of the examination

An objective opinion is one formed where the history merely guides the examination course and technique, without allowing any influencing of the examiner's opinion



CONSENT

Written consent is required – Form SAPS 308 This includes consent for the following:-

- Clinical examination
- The taking of forensic specimens/photography
- Disclosure of Clinical Examination Findings and laboratory tests to the Court.

Suid-Afrikaanse Polisiediens



South African Police Service

AANSOEK AAN GENEESHEER VIR ONDERSOEK IN GEVAL VAN BEWEERDE AANRANDING OF ANDER MISDAAD REQUEST TO DOCTOR FOR EXAMINATION IN A CASE OF ALLEGED ASSAULT OR OTHER CRIME

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In geval van minderjarige waar voog nie beskirbaar is nie moet Deel III van die vorm ook voltool word. In case of minor where guardian is not available, Part III of form must be completed as well.

DEEL III/PART III

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HANDTEKENING/SIGNATURE



CLINICAL EXAMINATION (CHAPERONE)

- If you are male examining a female patient, a female chaperone should be present.
 Important to record who was present at the examination –ideally a forensically trained nurse.
- The chaperone present reassures/supports the victim and also assists the doctor with the forensic examination and evidence collection.
- Also limits possibility of false allegations against doctor eg: rape, sexual assault etc.
- For very young children may be comforting for the child to have the mother/caregiver present



J88 FORM: Is the report (J88):

- complete –all 4 pages (old J88 form) or 6 pages (new J88 form)
- reflective of all details -history, clinical examination findings, forensic exhibits collected & conclusion
- written legibly -preferably typed reports
- contemporaneously -at the time of the examination, while all the observations are still fresh in the examiner's mind
- with all necessary diagrams –to indicate the location/position of injuries found on the body
- a copy of the J88 must be retained in the patient's file



J88 - PHYSICAL INJURIES:

- Life threatening injuries take precedence over the collection of forensic evidence eg: stab wound to chest: appropriately referred for emergency treatment.
- There is a window period of 72 hours for collection of physical and biological trace evidence.
- Always enquire about any physical assault
- Genital and bodily (extra-genital) injuries need to be meticulously identified and documented. -(body diagrams/line diagrams, photographs)



J88 TERMINOLOGY:

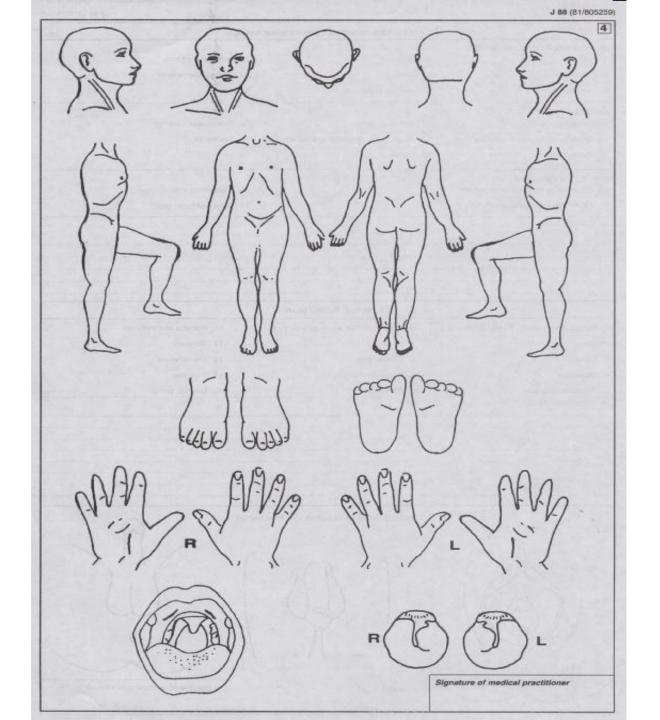
- Use simple English
- Medical terms must be explained by an appropriate lay word/phrase; e.g. Haematoma (swollen bruise)
- Accuracy of terminology is important. e.g. petechiae vs purpura-will depend on size of bruise
- The use of the term "Laceration" for a "cut to the skin" caused by a sharp object is to be avoided. May contribute to a miscarriage of justice because of incorrect description of injuries/wounds
- A Laceration is caused by a blunt force and not a sharp object—hence the mechanism of injury has to account for (corroborate) the clinical characteristics observed in a particular wound.

J 88 (81/805259) G.P.-S. 01/02 1 REPORT BY AUTHORISED MEDICAL PRACTITIONER ON THE COMPLETION OF A MEDICO-LEGAL EXAMINATION To be completed in legible handwriting and signed on every page A. DEMOGRAPHIC INFORMATION Day Month 2. CAS No.: 3. Investigating officer: Name and number: 4. Time Year 1. Police station: 10. Physical practice address or stamp: 5. Name of medical practitioner: 6. Registered qualifications. 7. Phone number: 8. Fax number: 9. Place of examination: 12. Sex: M F 13. Date of birth/apparent age: 11. Full names of person examined: B. GENERAL HISTORY 1. Revelant medical history and medication: C. GENERAL EXAMINATION 1. Condition of clothing: 2. Height (cm): 3. Mass: 4. General body build: 5. Clinical findings. In every case the nature, position and extent of the abrasion, wound or other injury must be described and noted together with its probable date and manner of causation. The position of all injuries and wounds must also be noted on the sketches. 6. Mental health and emotional status: 7. Clinical evidence of drugs or alcohol: 8. CONCLUSIONS Signature of medical practitioner

J 88 (81/805259) D. HISTORY IN CASE OF ALLEGED SEXUAL OFFENCE 2 2. Number of pregnancies 1. Age of menarche 3. Number of deliveries 4. Duration of pregnancy (if applicable) weeks 5. Contraception (indicate with X): Yes 7. First date of last menstruation: 6. Method and last date of application/ingestion: 8. Duration of period 9. Duration of cycle 10. Date and time of last 11. Number of consensual sexual partners 12. Condoms: Yes No intercourse with consent: during last 7 days: 13. Since the alleged offence took place, bathed washed douched has the person (indicate with X): showered urinated changed clothing E. GYNAECOLOGICAL EXAMINATION (State clinical findings) 1. Breast development: Tanner stage 1-5 2. Public hair: Tanner stage 1-5 3. Mons pubis: 4. Clitoris: 5. Frenulum of clitoris: 6. Urethral orifice: 7. Para-urethral folds: B. Labla majora: 9. Labla minora: 10. Posterior fourchette: scarring: bleeding: tears: increased triability: 11. Fossa navicularis: 12. Hymen: configuration: 13. Opening diameter (mm): Transverse Vertical 14 Swelling: 15. Bumps: 16: Cletts: 17. Fresh tears (position): 18. Synechiae: 19. Bruising: 20. Vagina: Number of fingers admitted: bleeding: tears: discharge: 21. Cervix: erosion: discharge: bleeding: other: 22. Perineum: F. SAMPLES TAKEN FOR INVESTIGATION 1. Forensic specimens taken: Urine sample for pregnancy test: Positive Seal number of Evidence Collection Kit: Negative 2. Specimens handed to: Name: Bank and Force number: Signature: 3. CONCLUSIONS

Signature of medical practitioner

	G. ANAL EXAMINATION (State clinical	findings) 3
SKIN SURROUNDING THE ORIFICE		
1. Hygiene:	4. Abrasions:	7. Redness/erythems:
2. Pigmentation:	5. Scars:	8. Bruising/haematoma:
3. Fissures/cracks:	Swelling/thickening:	9, Tags:
DRIFICE	5.016020000000	
10. Tears/fissures.	13. Reflex dilatation:	16. Twitchiness/winking:
11. Swelling/thickening of rim (tyre sign):	14. Shortening/eversion of anal canal:	17. Discharge:
2. Funneling:	15. Cupping:	
DIGITAL EXAMINATION		
Presence of hard faeces in rectum:		20. Thickening of anal verge:
Laxity (pressure on anal orifice):		21. Tone (sphincter grip):
22. CONCLUSIONS		
	H. MALE GENITALIA	
Genital development: Tanner stage 1–5	6. Pubic hair: Tanner stage 1–5:	11. Prepuce and frenulum:
. Glans:	7. Shaft:	12. Scrotum:
Testes:	8. Epididymus:	13. Vas deferens:
Ulceration:	9. Penile discharge:	14. Smegma:
5. Presence of faeces:		
6. CONCLUSIONS	10. Circumcision:	15. Urethral orifice:
	SCHEMATIC DRAWING OF FIND	ings
	(4)	
		Signature of medical practitioner





	CAS/ No /
	AMINATION BY A HEALTH CARE PRACTITIONER lly or in legible handwriting and signed on every page
	PARTI
CERTIFICATE IN TERMS OF SECTIONS 2	12(4), 212(8) AND 213(3) OF ACT 51 OF 1977 (AS AMENDED)
I,	
(Full na	ames and Surname)
AND AND STORMOOD IN SUND STORMOOD STORMOOD CONTRACTOR OF THE STORMOOD STORM	of or attached to a university in the Republic in my capacity as
	ease specify)
- On the day of	. (month) (year) at H (time of examination)
	Part II, Paragraph B.1 (page 2 of 6) of this J88 form.
The provide principles of the control of the contro	ages 2 to 6 of this J88 form and any additional pages indicated. The form, including any additional pages used where indicated, were ng skill in anatomy and pathology.
- In the performance of my official duties:	
*a) I received and collected from	
	s, specimens and/or tissue specified in this J88 form.
- * I packed and marked the clothing; object/s;	specimens and/or tissue in the manner described in this J88 form.
	of my knowledge and belief and I am making this statement knowing ble to prosecution if I willfully stated in it anything I knew to be false or
DATED AT (plac AT H (time).	ce) ON THE DAY OF (month) (year)
	NAME AND CURNAME
SIGNATURE OF PRINT HEALTH CARE PRACTITIONER	NAME AND SURNAME STAMP OF HEALTH CARE PRACTITIONER
	a certificate issued in terms of either of these sections to ninal proceedings, prima facie proof of the facts alleged.)

^{*} Delete which is/are not applicable

PART II			
DETAILS OF MEDICO-LEGAL EXAMINATION			
A. DETAILS OF PRACTITIONER AND FACILITY			
Name of health facility/practice:	2. Physical address of facility/pra	ictice:	
3. Telephone number of facility/practice:	4. Fax number of facility/practice	=	
5. Qualifications of practitioner:	6. Registration number of practiti	oner:	
7. Cellular phone number of practitioner:	8. Email of practitioner:		
9. Fax number for practitioner:	10. Health care facility/practitions	er's patient record no:	
B. PATIENT INFORMATION			
1. Full names and surname (of patient):	ı	Consent to Examination:	
(o. pasony)		Consent to Examination.	
		Signature of patient	
2. Gender of patient: Male Female	3. Date of birth/age of patient:		
4. Patient accompanied by:	5. People present during examina	ation and capacity:	
C. MEDICAL HISTORY			
Intellectual disability noted:	2. Other impairments or disabilitie	an matadi	
None Yes No	Hearing impairment Hearing impairment	es noted:	
Possible impairment Yes No	Visual impairment	Yes No	
Definite impairment Yes No	Mental illness	Yes No	
Specify:	Other disability	1.02	
opeony.	Specify:	Yes No	
	Specify.		
Relevant medication taken:			
		• • • • • • • • • • • • • • • • • • • •	
4. Relevant medical history that can assist with differential dipatient him/herself, third persons: e.g. parent or caregiver, mused as well as the language that was interpreted):	nedical records or combination. Ind	licate if an interpreter was	
5. History of the alleged assault and/or rape e.g. date and tin him/herself, third persons: e.g. parent or caregiver, medical r well as the language that was interpreted):	ecords or combination. Indicate if	an interpreter was used as	
	• • • • • • • • • • • • • • • • • • • •	***************************************	
	• • • • • • • • • • • • • • • • • • • •	***************************************	
	• • • • • • • • • • • • • • • • • • • •	************	

	Signature of h care practition		

D. HISTORY OF RELEVANCE TO A SEXUAL OFFENCE	
	Menstruating
Wiped Yes No Bathed/washed Yes No	At time of alleged sexual offence: Yes No
Urinated Yes No Defecated Yes No	Since the alleged sexual offence: Yes No
Showered Yes No Swam Yes No L	Currently menstruating: Yes No
Been exposed to rain Yes No	During alleged sexual offence was:
100 100	Condom used:
	Lubricant used: Yes No
4. Currently pregnant: Yes No 5. I	Ever had vaginal delivery: Yes No
If yes, indicate Duration: weeks	f yes, indicate Number:
E. GENERAL EXAMINATION	
Physical Appearance	
a. Height cm	b. Weight kg
c. General body build: *Frail /Normal /Muscular /Obese /Oth	er: Percentiles (children only):
2. Clothing	Terri Sar Constant
a. Left clothes at the scene: Yes No (If yes, move	to section E 3)
b. Changed clothes:	
If clothing is available:	
	2.2.00
1985 1986 1986 1986 1986 1986 1986 1986 1986	of clothing:
Describe:	

d. Stained:	of clathing.
The same and the same are	of clothing:
Possibly blood: Yes No Swabbed:	Yes No
Describe where on clothing:	
Possibly semen Yes No Swabbed:	Yes No
Describe where on clothing:	
Other: Yes No Swabbed:	Yes No
Nature of specimen:	
Describe where on clothing:	
e. Clothing collected for Forensic analysis Yes No Y	Record sample seal number in Section H
If yes, list the items:	
Clinical evidence of drugs / alcohol at time of examination ((e.g. Nystagmus, ataxia, slurred speech, dilated pupils):
Intoxicated / drugged Yes No	
Blood samples taken Yes No	
	Record sample seal number in Section H
Urine samples taken Yes No J	
* Delete which is/are not applicable Mark appropriate block	Signature of health care practitioner

Page 3 of 6

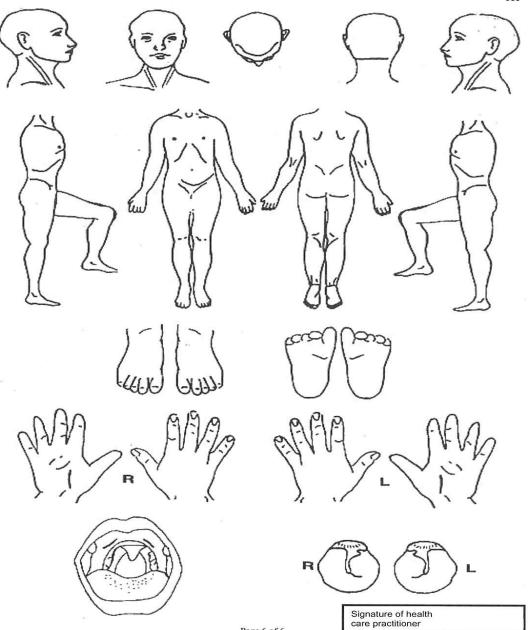
F. CLINICAL FINDINGS			
Clinical findings: Describe the nature, position, extent and estimated age of the abrasion, bruise, cuts, laceration, scars or other injury together with its possible causation (add pages if required). Indicate whether any of the injuries are life threatening. The general position of all injuries must be noted on the sketches			
***************************************		•••••••••••••••••••••••••••••••••••••••	
		••••••	

	• • • • • • • • • • • • • • • • • • • •		
G. SPECIFIC EXAMINATIONS			
G.1 ORAL EXAMINATION (delete if not applicable)			
1. Gums	2. Frenulum of to	ongue	
3. Frenulum of upper and lower lips	4. Tongue		
5. Palate	6. Teeth		
7. Inside of cheeks	8. Other		
G.2 ANAL EXAMINATION (delete if not applicable)			
1. Perineum			
2. Acute injuries:			
3. Mucocutaneous changes:			
Skin surrounding orifice:	Orifice:		
4. Venous engorgement			
5. Dilatation			
G.3 MALE GENITALIA EXAMINATION (delete if no	t applicable)		
Genital development (children) Tanner stage 1-5:		ldren) Tanner Stage 1-5:	
		idien) ranner Stage 1-5.	
3. Prepuce & frenulum	4. Glans		
5. Shaft	6. Scrotum		
		Signature of health care practitioner	

G.4 GYNAECOLOGICAL EXAMINATION (delete if not applicable) 1. Breast development (children) Tanner stage 1-5:				
3. Mons Pubis 4. Clitoris 5. Frenulum of clitoris 6. Urethral orifice 7. Labia Majora 8. Labia Minora 9. Posterior fourchette/Commissure 10. Vestibule Fossa navicularis				
5. Frenulum of clitoris 6. Urethral orifice 7. Labia Majora 8. Labia Minora 9. Posterior fourchette/Commissure 10. Vestibule Fossa navicularis				
7. Labia Majora 8. Labia Minora 9. Posterior fourchette/Commissure 10. Vestibule Fossa navicularis				
Posterior fourchette/Commissure 10. Vestibule Fossa navicularis				
Fossa navicularis				
Paraurethral area				
11. Hymen Configuration: Posterior rim: Margin or edge of hymen:				
12. Vagina 13. Discharge (describe)				
14. Cervix 15. Other injuries noted:				
H. SPECIMENS COLLECTED FOR INVESTIGATION (delete if not applicable)				
1. Sexual assault evidence collection 2. Alcohol collection kit				
kit seal no./ sticker seal no./ sticker				
3. Clothing kit seal no./ sticker 4. Urine and/or other samples (specify & provide seal no.)				
I. TECHNOLOGY USED (delete if not applicable)				
Photographs taken Yes No Colposcope used Yes No	\neg			
Name of photographer: Toluidine Blue used Yes No				
Other (specify): J. ADDITIONAL PAGES USED AND ATTACHED				
Number of pages added:	_			
K. CONCLUSIONS (take account of history and all findings, both positive and negative)				
Motivate reasons for conclusions made:				
L. TRANSFER DETAILS				
J88 form handed to: Name: Rank:				
Signature: Contact No.:				
Signature of health	\dashv			

Page 5 of 6

Signature of health care practitioner



Page 6 of 6



Detailed Protocol for Completion of J88 Form (Numbers as on the Form): PART I

- Police Station: refer SAP 308
- CAS (<u>Crime Administration System</u>) No: refer SAP 308. Write the full number
- Investigating officer: Name and Number: see SAP308
- Contact Number: Obtain from the SAP 308
- Part I: Certificate ito 212(4) of the CPAct 51 of 1977 must be completed fully
- Purpose of s212(4) Certificate



Detailed Protocol for Completion of J88 Form (Numbers as on the Form): PART II

A. DETAILS OF PRACTITIONER AND FACILITY

- 1. Name of Health Facility/Practice
- 2. Physical Address of Facility/Practice
- 3. Telephone number of Facility/Practice
- 4. Fax Number of Facility/Practice
- 5. Qualifications of Practitioner
- 6. Registration Number of Practitioner
- 7. Cell Phone number of Practitioner
- 8. e-mail address of Practitioner
- 9. Fax Number for Practitioner
- 10. Health Care Facility/Practitioner's Patient Record no.



Detailed Protocol for Completion of J88 Form (Numbers as on the Form)

B. PATIENT INFORMATION

- 1. Full Names and Surname of patient Consent to Examination: Patient's or guardian's signature
- 2. Gender of Patient: Male / Female
- 3. Date of Birth / Age of Patient
- 4. Patient Accompanied by...
- 5. People present during the examination and capacity



C. MEDICAL HISTORY

- Intellectual Disability noted
- 2. Other impairments or disabilities noted
- Relevant Medication taken
- 4. Relevant Medical History that can assist with differential diagnosis: multiple fractures, falls, burns, injuries caused by non-accidental injury or conditions that cause or aggravate bruising: frailty/anti-coagulants
- 5. Include also a brief history of the incident: assault/rape (4**W** and a **H**: **W**hat, **W**hen, **W**ho, **W**here and **H**ow)
- NB: State clearly who provided the information: the *complainant* himself / herself or a third party (who must be identified), and whether an *interpreter* was used and the language used



D. HISTORY OF RELEVANCE TO A SEXUAL OFFENCE

- 1. Since the alleged offence did the patient: wiped, bathed, urinated, passed stools, showered, swam
- 2. Menstruating: at time of offence, after, now
- 3. Was condom or lubricant used
- 4. Currently pregnant: duration in weeks
- 5. Ever had a vaginal delivery: indicate number



E. GENERAL EXAMINATION

- 1. Physical Appearance
- 1.1 Height
- 1.2 Weight
- 1.3 General Body Build
- 2. Clothing: If clothing available describe in detail
- 3. Clinical Evidence of drugs/alcohol at time of examination
- 3.1 Intoxicated
- 3.2 Blood samples taken
- 3.3 Alcohol Evidence Kit completed
- 3.4 Urine Samples taken



F. CLINICAL FINDINGS

- Describe in detail all injuries observed
- Blunt or sharp
- Type/Nature of injury
- Position
- Age of the injury
- Causation of injury
- Number each injury
- Annotate injuries on sketches provided in J88
- Comment on whether the injuries are lifethreatening



G. SPECIFIC EXAMINATIONS

G.1: ORAL EXAMINATION

- 1. Gums
- 2. Frenulum of Tongue
- 3. Frenulum of upper and lower lips
- 4. Tongue
- 5. Palate
- 6. Teeth
- 7. Inside of cheeks
- 8. Other



G.2 ANAL EXAMINATION

- 1. Perineum
- 2. Acute Injuries
- 3. Muco-cutaneous changes
- 3.1 Skin surrounding orifice
- 3.2 Orifice
- 4. Venous Engorgement
- 5. Dilatation



G.3 MALE GENITALIA EXAMINATION

- Genital development (children) Tanner staging
 1-5
- 2. Pubic hair (children) Tanner staging 1-5
- 3. Prepuce and frenulum
- 4. Glans
- 5. Shaft
- 6. Scrotum



G 4. GYNAECOLOGICAL EXAMINATION

- Breast development (children) Tanner Stage 1-
- 2. Pubic hair (children) Tanner stage 1-5
- 3. Mons Pubis
- 4. Clitoris
- 5. Frenulum of Clitoris
- 6. Urethral Orifice
- 7. Labia Majora
- 8. Labia Minora
- 9. Posterior fourchette/commissure



G.4 GYNAECOLOGICAL EXAMINATION cont.

10. Vestibule:

- Fossa navicularis and
- Paraurethral area

11. Hymen:

- Configuration
- Posterior rim
- Margin or edge of hymen
- 12. Vagina
- 13. Discharge (describe)
- 14. Cervix
- 15. Other injuries noted

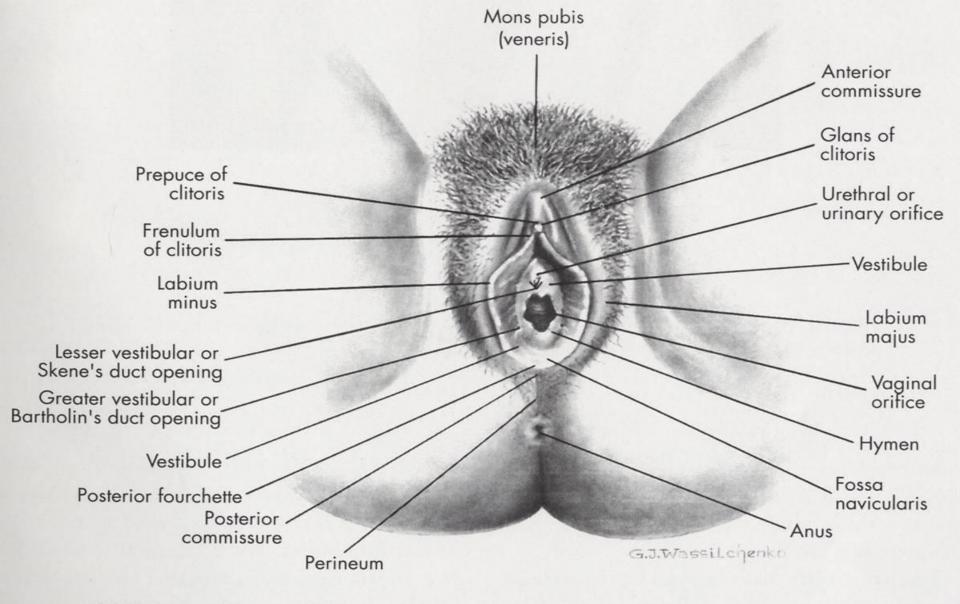
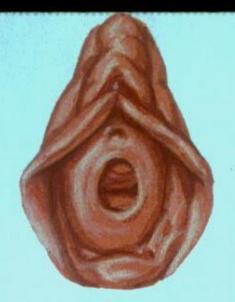


FIGURE 1-1 Anatomical sites on the external female genitalia. (From Lowdermilk DL, Perry SE, Bobak IM: Maternity and women's health care, ed 6, St Louis, 1997, Mosby.)



HYMENAL CONFIGURATIONS:

- Refers to the appearance of the hymenal membrane which partially covers the external vaginal orifice.
- There is wide anatomic variation in anatomic types 6 commonly occurring hymens:
- 1.annular,
- 2.crescentic,
- 3.fimbriated(redundant),
- 4.septate,
- 5.cribiform and
- 6.imperforate hymen (no opening in hymenal tissue)



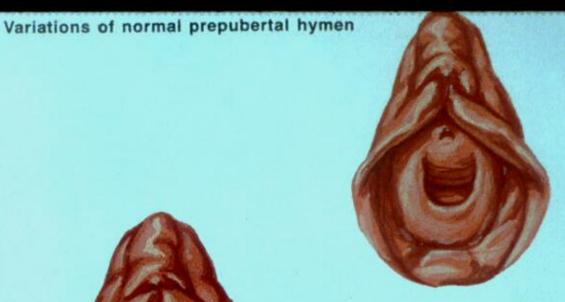
Annular hymen



Cribriform hymen



Septate hymen



Crescentic hymen



Fimbriated hymen

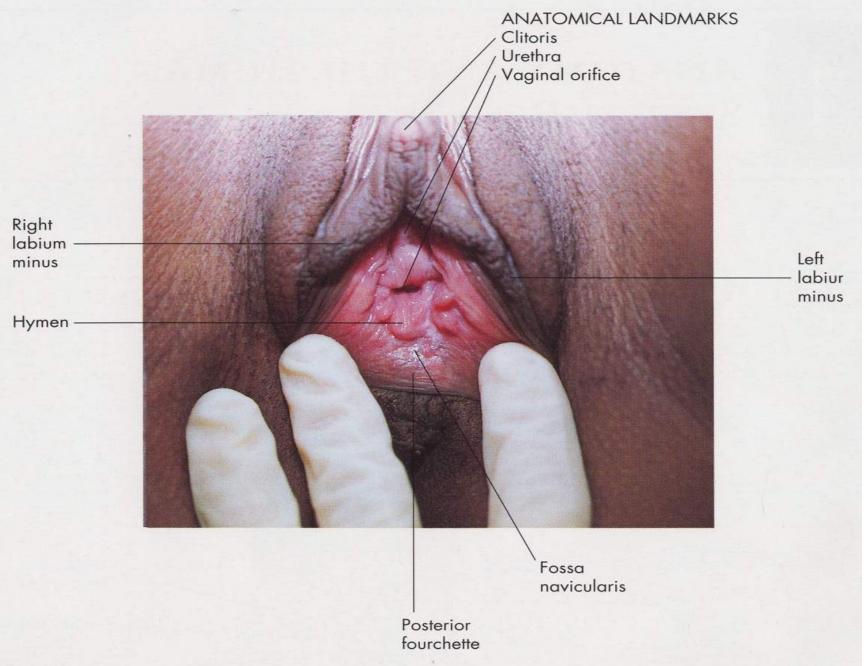


FIGURE 1-2 Common sites of injury to the external female genitalia with penile vaginal penetration when the victim is in a supine position (35mm).



G 4. GYNAECOLOGICAL EXAMINATION continued...

Describe all fresh injuries: (Acronym: TEARS)

T= Tears

E= Erythema/Ecchymosis

A= Abrasions

R= Redness

S= Swelling

- Also describe any ulcers, rashes, healed scars, or any other abnormalities.
- Use clock-face notation to describe position of injuries on genital structures listed above.



H. SPECIMENS COLLECTED FOR INVESTIGATION

- 1. Sexual Assault Evidence Collection Kit No./sticker
- 2. Alcohol Collection Kit No./seal no.
- 3. Clothing Collection Kit No./sticker
- 4. Urine and or other samples: specify and provide seal no.



I. TECHNOLOGY USED

- Photographs taken
 Name of Photographer
- 2. Colposcope used
- 3. Toluidine Blue dye used
- 4. Other (specify)



• J. ADDITIONAL PAGES USED AND ATTACHED

- Number of pages added
- Pages numbered
- Each page to include full names, CAS No.
- Each page to be signed



K. 1. CONCLUSIONS

- Take account of history and all findings, both positive and negative
- Motivate reasons for conclusions made
- Avoid using the term "Rape" in the conclusion
- Rape is a wholly legal definition based on the issue of consent
- This is a finding to be made by the court after hearing all the evidence
- Only the court can decide on the presence or absence of consent on the versions of the complainant and other witnesses



K. 2. CONCLUSIONS continued...

A 2-step approach is recommended for articulating the conclusion:

- The first should be made on clinical/medical grounds alone to determine what the physical finding is; its cause and differentials with no evaluation against the incident history
- The second step is to correlate the diagnosis with the history, indicating the taking of the incident history into consideration



K. 3. CONCLUSIONS continued

1. Assuming the examiner found injuries and is able to indicate a cause, which correlates with the history received the conclusion should boldly be stated as: "Blunt injuries to...which are consistent with the time and circumstances of the alleged incident".

Further elaboration is not needed.

2. Assuming the examination was negative:

"Clinical Examination is non-contributory; and the examination neither confirms nor refutes the allegation".

Again further elaboration is not required.



L. TRANSFER DETAILS

- J88 Form handed to:
- Name:
- Rank:
- Signature:
- Contact Number:

THANK YOU

GROWING KWAZULU-NATAL TOGETHER