health
Department:
Health
PROVINCE OF KWAZULU-NATAL

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

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CLINICAL FORENSIC MEDICAL SERVICES

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.

G.P.-S. 002-0350

SAPD SAPS 308

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

DEEL/PART I
MOET **ALTYD** VOLTOOI WORD/MUST BE COMPLETED IN **EVERY** CASE

VERSOEK AAN MEDIESE BEAMPTE/PRAKTISYN * REQUEST TO MEDICAL OFFICER/PRACTITIONER

Ek, No. ..... Rang ..... Naam ..... Stasie .....
I, No. ..... Rank ..... Name ..... Station .....
'n lid van die Suid-Afrikaanse Polisiediens versoek hiermee die mediese beampte van die distrik
a member of the South African Police Service, hereby request the medical officer of the district
.....
om die klaer/klaagster (volle naam) te ondersoek in 'n saak van
to examine the complainant (full name) to examine ....., in a case of
.....

Plek
Place .....
Datum
Date .....

.....
HANDTEKENING VAN POLISIEBEAMPTE
SIGNATURE OF POLICE OFFICIAL

Besonderhede van saak/Particulars of case:

Datum ..... Tyd ..... Plek ..... MR/MAS No. .....
Date ..... Time ..... Place ..... CR/CAS No. .....
Stasie ..... Kort beskrywing .....
Station ..... Short description .....
.....
.....
.....
.....
.....
.....

DEEL II/PART II
TOESTEMMING/CONSENT

Ek, (volle name) .....
I, (full names) .....
Ouer/Voog van (in geval van minderjarige) ..... Ouderdom .....
Parent/Guardian of (in case of minor) ..... Age .....

verleen hiermee toestemming dat hy/sy/ek volledig deur die mediese beampte van
hereby consent to his/my/her being subjected to examination by the medical officer of .....

ondersoek word en dat die bevindinge vir strafregtelike verrigtinge genotuleer mag word.
and to the recording of findings for criminal proceedings.

Ek verleen ook toestemming vir die neem van alle monsters, soos benodig, vir laboratoriumtoetse asook vir die neem van die nodige foto's van beserings
I also consent to the collection of all necessary specimens for laboratory tests and for the taking of necessary specimens for laboratory tests and for the

wat verband hou met die rede vir hierdie ondersoek.
taking of necessary photographs of injuries related to the reason for this examination.

.....
HANDTEKENING VAN KLAER
SIGNATURE OF COMPLAINANT

Plek
Place .....
Datum
Date .....

.....
HANDTEKENING/SIGNATURE
GETUIE I/WITNESS I

.....
HANDTEKENING/SIGNATURE
GETUIE II/WITNESS II

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

DEEL III/PART III

MOET SLEGS VOLTOOI WORD I.G.V. AANSOEK INGEVOLGE ART 335B VAN DIE STRAFPROSESWET, NO. 51 VAN 1977
MUST ONLY BE COMPLETED I.T.O. APPLICATION IN TERMS OF SECTION 335B OF THE CRIMINAL PROCEDURE ACT, NO. 51 OF 1977

Ek, No. ..... Rang ..... Naam .....
I, No. ..... Rank ..... Name ..... versoek die landdros te
(distrik) ..... request the magistrate at
(district) ..... om toestemming te verleen tot die mediese ondersoek van
..... to grant consent for the medical examination of
..... die minderjarige slagoffer om die volgende redes:
..... a victim; who is a minor, for the following reasons:

Merk toepaslike blokkie met X
Mark applicable block with X

Die ouer/voog van sodanige minderjarige—
The parent/guardian of such minor—

- kan nie binne 'n redelike tyd opgespoor word nie; of
  cannot be traced within a reasonable time; or _____
- kan nie betyds toestemming verleen nie;
  cannot grant consent in time; _____
- is 'n verdagte ten opsigte van die misdryf waarvan die mediese ondersoek uitgevoer moet word;
  is a suspect in respect of the offence for which the medical examination must be conducted; _____
- weier onredelik om toe te stem dat die ondersoek uitgevoer word;
  unreasonably refuses to consent that the examination be conducted; _____
- weens geestesongesteldheid onbevoeg is om toe te stem dat die ondersoek uitgevoer word; of
  is incompetent on account of mental disorder to consent that the examination be conducted; or _____
- oorlede is.
  is deceased. _____

Motivering vir noodsaaklikheid van ondersoek (moet in alle gevalle voltooi word)
Reason for necessity of examination (must be completed in all cases) .....

.....

.....

Plek
Place .....
Datum
Date .....
Tyd
Time .....

.....
HANDTEKENING VAN POLISIEBEAMPTE
SIGNATURE OF POLICE OFFICIAL

TOESTEMMING VAN LANDDROS/CONSENT OF MAGISTRATE

Ek, ... landdros van die distrik
I, ... magistrate of the district .....
verleen hiermee toestemming tot die mediese ondersoek van
hereby grant consent for the medical examination of .....
Ek verleen ook toestemming vir die neem van alle monsters, soos benodig, vir laboratoriumtoetse, asook vir die neem van die nodige foto's van beserings wat verband hou met die redes vir hierdie ondersoek.
I also consent to the collection of all necessary specimens for laboratory tests and to the taking of the necessary photographs of injuries related to the reasons for this examination.

Plek
Place .....
Datum
Date .....
Tyd
Time .....

.....
HANDTEKENING VAN LANDDROS
SIGNATURE OF MAGISTRATE

TOESTEMMING VAN POLISIE-OFFISIER/STASIEKOMMISSARIS * CONSENT OF POLICE OFFICER/STATION COMMISSIONER

ARTIKEL 335B VAN DIE STRAFPROSESWET, NO. 51 VAN 1977 * SECTION 335B OF THE CRIMINAL PROCEDURE ACT, NO. 51 OF 1977

Ek, No. ..... Rang ..... Naam .....
I, No. ..... Rank ..... Name .....
verleen hiermee, op grond van beëdigde verklarings deur 'n polisiebeampte en 'n geneesheer aan my voorgelê,
hereby, on the grounds of written affidavits by a police official and a medical practitioner given to me,

toestemming tot die mediese ondersoek van
consent to the medical examination of .....

Ek verleen ook toestemming vir die neem van alle monsters, soos benodig, vir laboratoriumtoetse, asook vir die neem van die nodige foto's van beserings wat verband hou met die redes vir hierdie ondersoek.
I also consent to the collection of all necessary specimens for laboratory tests and to the taking of the necessary photographs of injuries related to the reasons for this examination.

Plek
Place .....
Datum
Date .....

.....
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.

G.P.-S. 01/02

J 88 (81/805259)

REPORT BY AUTHORISED MEDICAL PRACTITIONER ON THE COMPLETION OF A MEDICO-LEGAL EXAMINATION

1

To be completed in legible handwriting and signed on every page

A. DEMOGRAPHIC INFORMATION

1. Police station:	2. CAS No.:	3. Investigating officer: Name and number:	4. Time ☐☐:☐☐ Day ☐☐ Month ☐☐ Year ☐☐☐☐

5. Name of medical practitioner:
6. Registered qualifications:
7. Phone number:
8. Fax number:
9. Place of examination:

10. Physical practice address or stamp:

11. Full names of person examined:

12. Sex: M ☐ F ☐

13. Date of birth/apparent age:

B. GENERAL HISTORY

1. Relevant 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 (81/905259)

D. HISTORY IN CASE OF ALLEGED SEXUAL OFFENCE [2]

1. Age of menarche ☐☐ 2. Number of pregnancies ☐☐ 3. Number of deliveries ☐☐ 4. Duration of pregnancy (if applicable) ☐☐ weeks

5. Contraception (indicate with X): Yes ☐ No ☐ 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 intercourse with consent: 11. Number of consensual sexual partners during last 7 days: 12. Condoms: Yes ☐ No ☐

13. Since the alleged offence took place, has the person (indicate with X): bathed ☐ washed ☐ douched ☐ showered ☐ urinated ☐ changed clothing ☐

E. GYNAECOLOGICAL EXAMINATION (State clinical findings)

1. Breast development: Tanner stage 1–5 ☐ 2. Pubic hair: Tanner stage 1–5 ☐ 3. Mons pubis:

4. Clitoris: 5. Frenulum of clitoris:

6. Urethral orifice: 7. Para-urethral folds:

8. Labia majora: 9. Labia minora:

10. Posterior fourchette: scarring: bleeding:
tears: increased friability:

11. Fossa navicularis:

12. Hymen: configuration: 13. Opening diameter (mm): Transverse ☐☐ Vertical ☐☐

14 Swelling: 15. Bumps: 16. Clefts:

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 ☐ Negative ☐ Seal number of Evidence Collection Kit:

2. Specimens handed to: Name: Rank and Force number:

Signature:

3. CONCLUSIONS

Signature of medical practitioner

G. ANAL EXAMINATION (State clinical findings) 3

SKIN SURROUNDING THE ORIFICE

1. Hygiene:
2. Pigmentation:
3. Fissures/cracks:
4. Abrasions:
5. Scars:
6. Swelling/thickening:
7. Redness/erythema:
8. Bruising/haematoma:
9. Tags:

ORIFICE

10. Tears/fissures:
11. Swelling/thickening of rim (tyre sign):
12. Funnelling:
13. Reflex dilatation:
14. Shortening/eversion of anal canal:
15. Cupping:
16. Twitchiness/winking:
17. Discharge:

DIGITAL EXAMINATION

18. Presence of hard faeces in rectum:
19. Laxity (pressure on anal orifice):
20. Thickening of anal verge:
21. Tone (sphincter grip):

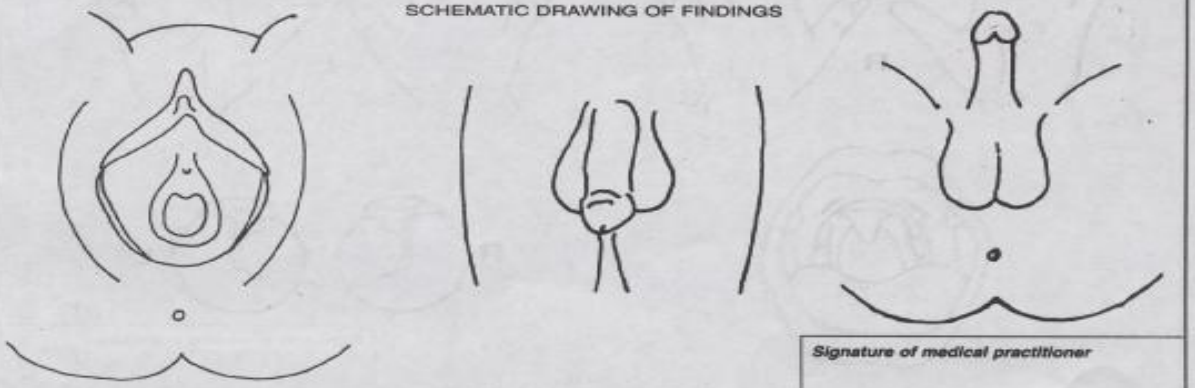
22. CONCLUSIONS

H. MALE GENITALIA

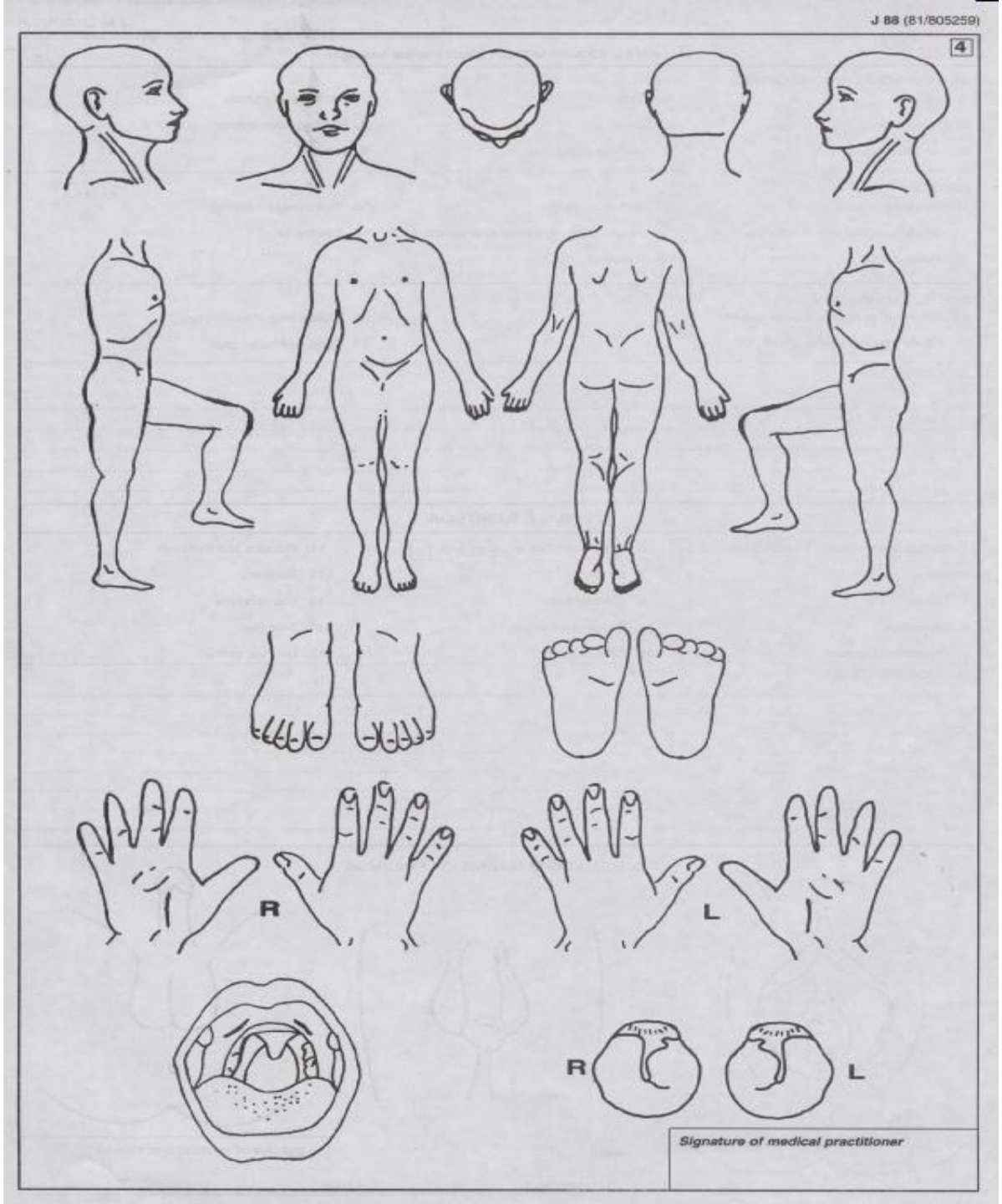
1. Genital development: Tanner stage 1–5 ☐
2. Glans:
3. Testes:
4. Ulceration:
5. Presence of faeces:
6. Pubic hair: Tanner stage 1–5: ☐
7. Shaft:
8. Epididymus:
9. Penile discharge:
10. Circumcision:
11. Prepuce and frenulum:
12. Scrotum:
13. Vas deferens:
14. Smegma:
15. Urethral orifice:

16. CONCLUSIONS

SCHEMATIC DRAWING OF FINDINGS



Signature of medical practitioner


J 88 (81/805259)
4
R
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L
Signature of medical practitioner

REPUBLIC OF SOUTH AFRICA

Police Station: ..... CAS/ No ..... / ..... / .....
Name of Investigating officer: ..... Contact No:.....

REPORT ON A MEDICO-LEGAL EXAMINATION BY A HEALTH CARE PRACTITIONER

To be diligently completed electronically or in legible handwriting and signed on every page

PART I

CERTIFICATE IN TERMS OF SECTIONS 212(4), 212(8) AND 213(3) OF ACT 51 OF 1977 (AS AMENDED)

I, ...
(Full names and Surname)

hereby certify as follows:

- I am in the service of the *State/in the service of or attached to a university in the Republic in my capacity as

*registered medical practitioner/nurse/other *(please specify)* .....

- On the ..... day of ..... (*month*) ..... (*year*) at ..... H..... *(time of examination)*

- and at ..... *(state place where examination took place)*, I examined the person indicated in Part II, Paragraph B.1 (page 2 of 6) of this **J88** form.

- I recorded my findings and observations on pages 2 to 6 of this **J88** form and any additional pages indicated. The facts recorded on pages 2 to 6 of this **J88** form, including any additional pages used where indicated, were established by means of an examination requiring skill in anatomy and pathology.

- In the performance of my official duties:

* a) I received and collected from ..... *(name of person/institute/ State department or body)* clothing; object/s; specimens and/or tissue described in this **J88** form.

* b) I delivered or dispatched to ..... *(name of person/institute/ State department or body)* the clothing, object/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.

The contents of this **J88** form is true to the best of my knowledge and belief and I am making this statement knowing that, if it were tendered in evidence, I would be liable to prosecution if I willfully stated in it anything I knew to be false or which I do not believe to be true.

DATED AT ..... *(place)* ON THE ..... DAY OF ..... *(month)* ..... *(year)*
AT ..... H ..... *(time).*

.....	.....	
SIGNATURE OF HEALTH CARE PRACTITIONER	PRINT NAME AND SURNAME	STAMP OF HEALTH CARE PRACTITIONER

(NB: Section 212(4) and 212(8) provide for a certificate issued in terms of either of these sections to constitute, upon its production at criminal 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

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. Cellular phone number of practitioner:	8. Email of practitioner:
9. Fax number for practitioner:	10. Health care facility/practitioner's patient record no:

B. PATIENT INFORMATION

1. **Full names and surname** (of patient):
.....

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 examination and capacity:

C. MEDICAL HISTORY

1. Intellectual disability noted:

None	Yes	No
Possible impairment	Yes	No
Definite impairment	Yes	No

Specify:
.....
.....
.....

2. Other impairments or disabilities noted:

Hearing impairment	Yes	No
Visual impairment	Yes	No
Mental illness	Yes	No
Other disability	Yes	No

Specify:
.....
.....

3. Relevant medication taken: .....
.....
.....
.....

4. Relevant medical history that can assist with differential diagnosis (State source & method of obtaining information e.g. patient him/herself, third persons: e.g. parent or caregiver, medical records or combination. Indicate if an interpreter was used as well as the language that was interpreted): .....
.....
.....
.....
.....

5. History of the alleged assault and/or rape e.g. date and time (State source & method obtaining information e.g. patient him/herself, third persons: e.g. parent or caregiver, medical records or combination. Indicate if an interpreter was used as well as the language that was interpreted): .....
.....
.....
.....
.....
.....
.....
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.....
.....
.....
.....

Signature of health care practitioner

D. HISTORY OF RELEVANCE TO A SEXUAL OFFENCE (delete if not applicable)

1. Since the alleged offence took place has the patient:

Wiped	Yes / No	Bathed/washed	Yes / No		
Urinated	Yes / No	Defecated	Yes / No		
Showered	Yes / No	Swam	Yes / No		
Been exposed to rain	Yes / No				

2. Menstruating

At time of alleged sexual offence:	Yes / No
Since the alleged sexual offence:	Yes / No
Currently menstruating:	Yes / No

3. During alleged sexual offence was:

Condom used:	Yes / No
Lubricant used:	Yes / No

4. Currently pregnant: Yes / No

If yes, indicate Duration: _ _ weeks

5. Ever had vaginal delivery: Yes / No

If yes, indicate Number: _ _

E. GENERAL EXAMINATION

1. Physical Appearance

a. Height _____ cm b. Weight _____ kg

c. General body build: *Frail /Normal /Muscular /Obese /Other: _____ Percentiles (children only): _____

2. Clothing

a. Left clothes at the scene: Yes / No (If yes, move to section E 3)

b. Changed clothes: Yes / No

If clothing is available:

c. Torn/ripped/damaged: Yes / No Specify item of clothing: _____

Describe: .....

d. Stained: Yes / No Specify item 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 } **Record sample seal number in Section H**

If yes, list the items: .....

3. 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**
Alcohol evidence collection kit completed	Yes / No	
Urine samples taken	Yes / No	

* ***Delete which is/are not applicable***
Mark appropriate block

Signature of health care practitioner

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 tongue
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 not applicable)

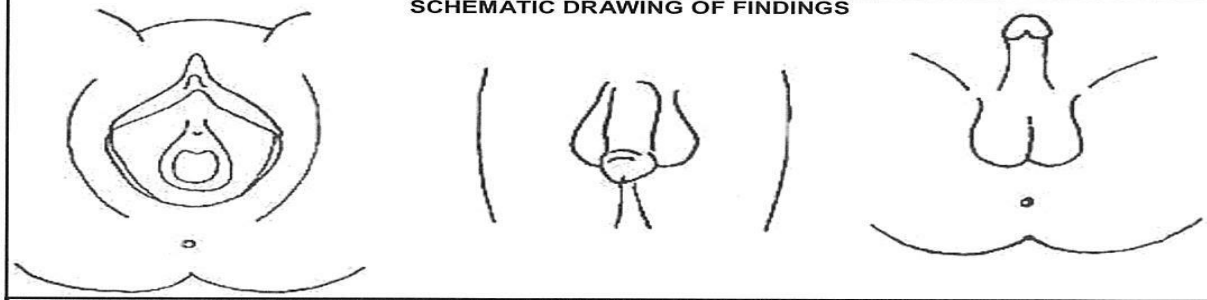
1. Genital development (children) Tanner stage 1-5: ☐	2. Pubic hair (children) Tanner Stage 1-5: ☐
3. Prepuce & frenulum	4. Glans
5. Shaft	6. Scrotum

Signature of health care practitioner

G.4 GYNAECOLOGICAL EXAMINATION (delete if not applicable)

1. Breast development (children) Tanner stage 1-5: ☐	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	10. Vestibule 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:

SCHEMATIC DRAWING OF FINDINGS



H. SPECIMENS COLLECTED FOR INVESTIGATION (delete if not applicable)

1. Sexual assault evidence collection kit seal no./ sticker	2. Alcohol collection kit 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
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: .....
.....
.....
.....
.....

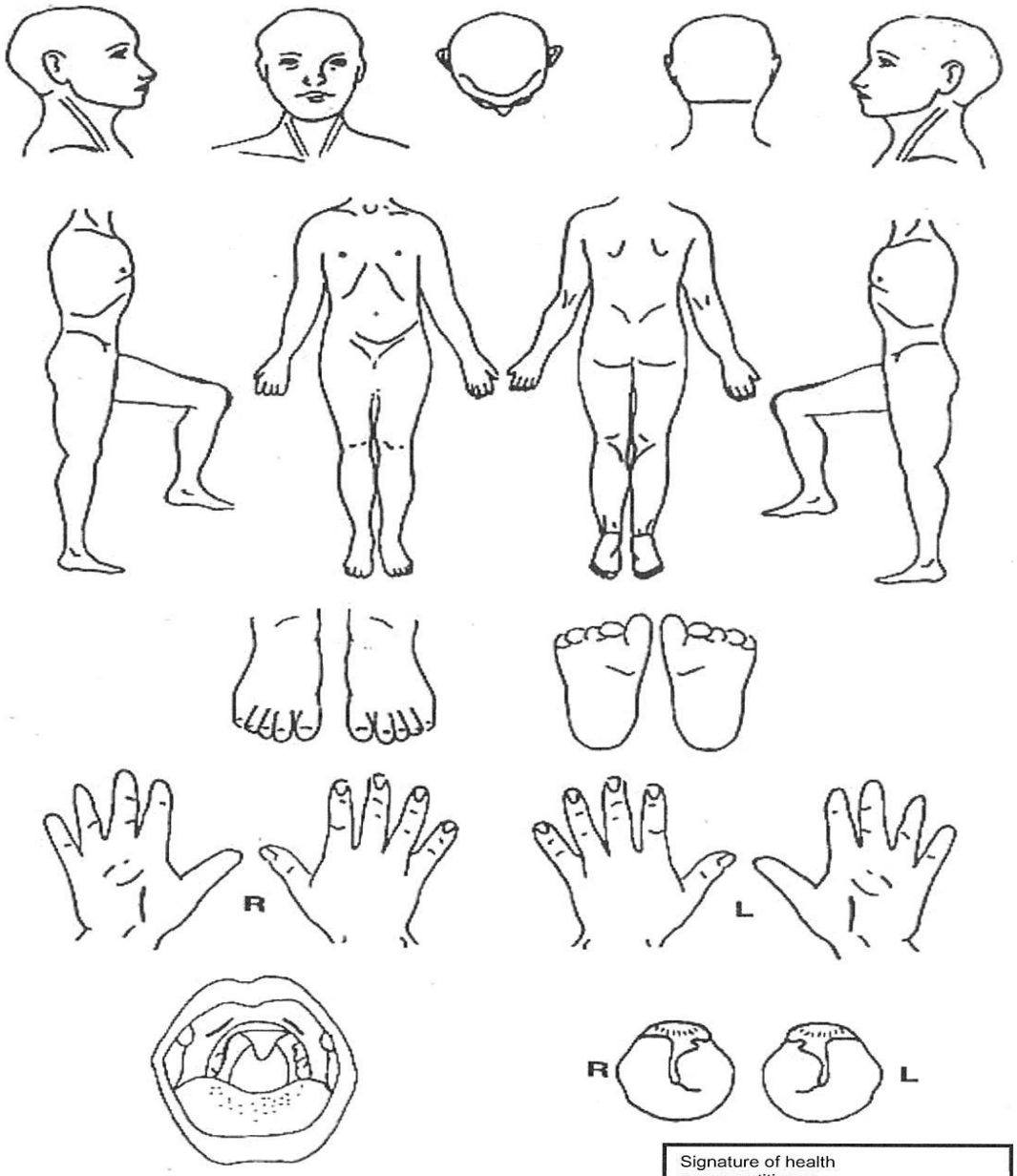
L. TRANSFER DETAILS

J88 form handed to:

Name: Rank:

Signature: Contact No.:

Signature of health care practitioner



Signature of health care practitioner

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

- Police Station: refer SAP 308
- CAS (Crime Administration System) 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

1. Intellectual Disability noted
2. Other impairments or disabilities noted
3. 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 life-threatening

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

1. 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

1. Breast development (children) Tanner Stage 1-5
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

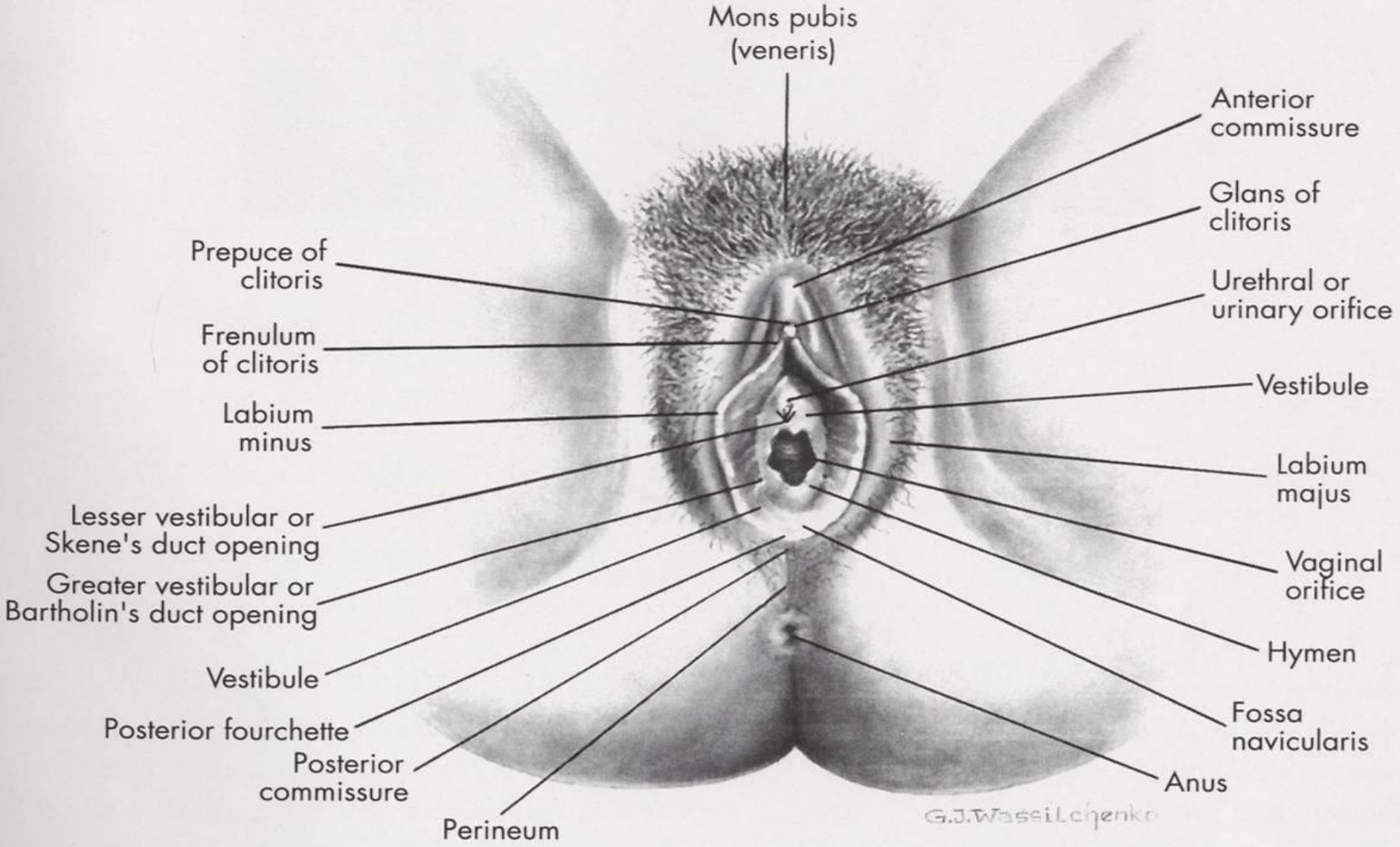
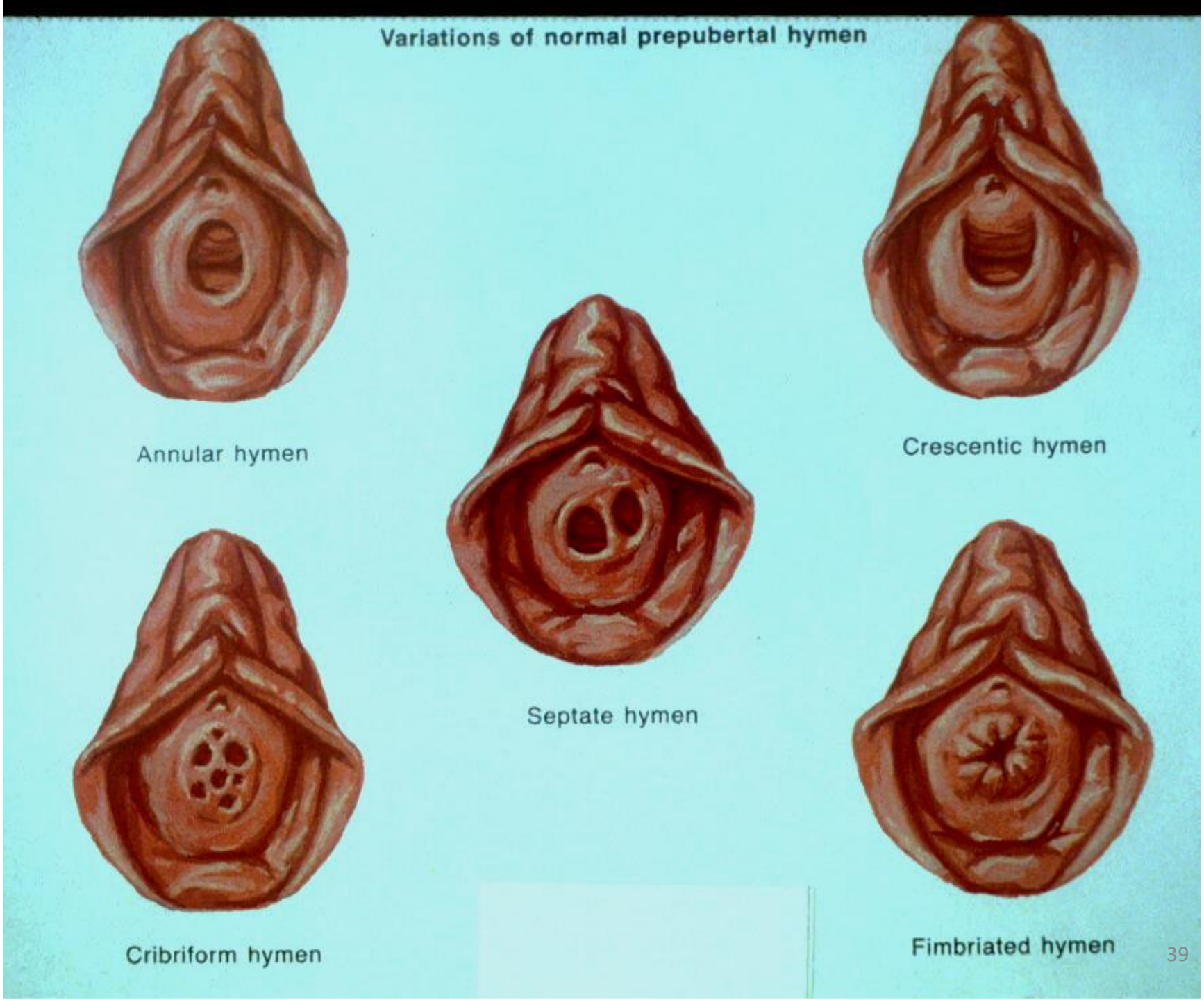


FIGURE 1-1 Anatomical sites on the external female genitalia. *(From Lowdermilk DL, Perry SE, Bobak IM:* Maternity and women's health care, *ed 6, St Louis, 1997, Mosby.)*

- **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)


Variations of normal prepubertal hymen
Annular hymen
Crescentic hymen
Septate hymen
Cribriform hymen
Fimbriated hymen

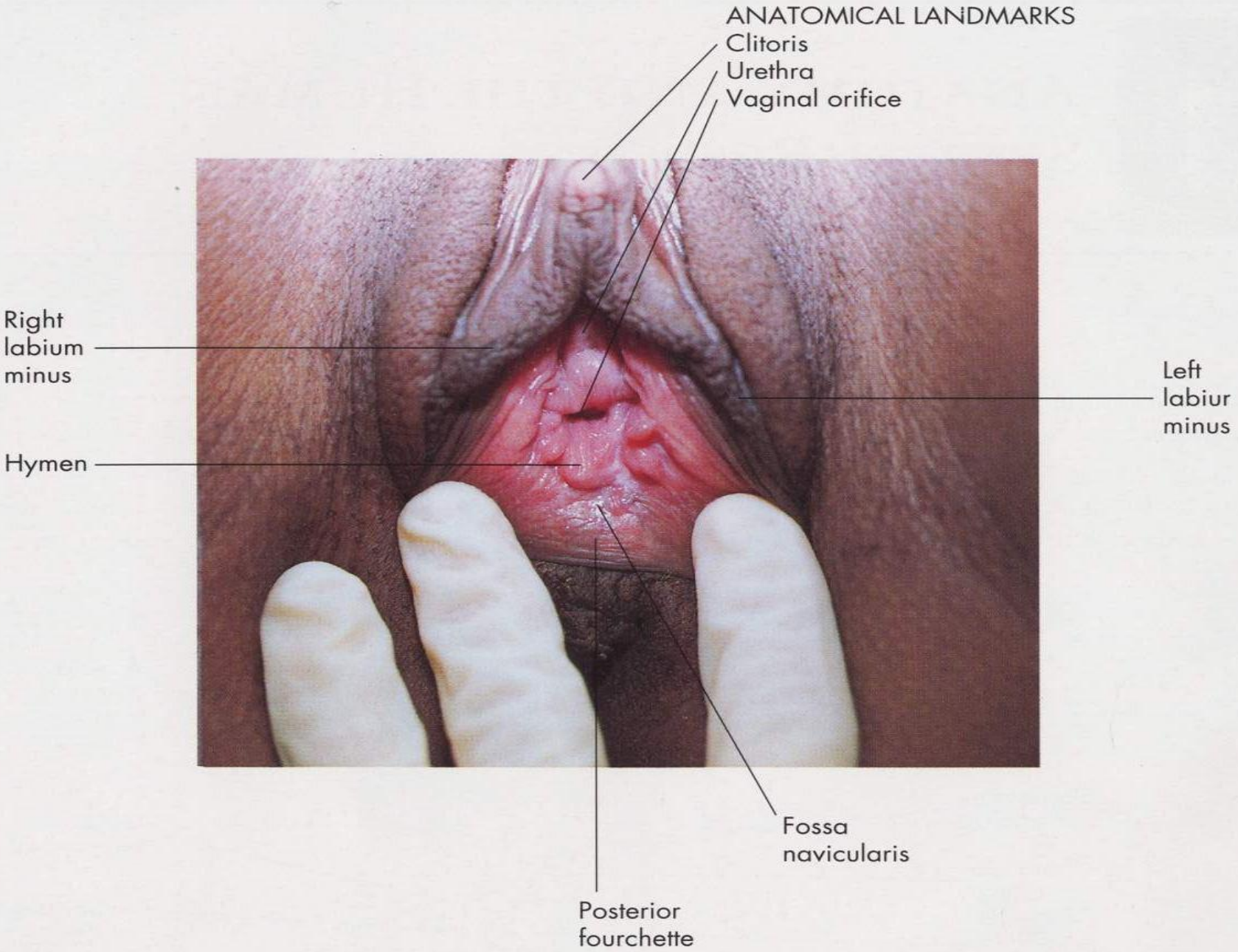


FIGURE 1-2 Common sites of injury to the external female genitalia with penile vaginal penetration when the victim is in a supine position (35mm).

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

1. 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