Standard Operating Procedure

on

Injury Examination

Contents

Registration

Every case brought for medicolegal examination of injury should be provided with unique identification number. Unique identification number can be as below:

MEI – 074 – 0001

MEI = Medicolegal Examination of Injury

074 = Year of examination

0001= Entry number of the case for the year 2074 (e.g. 1,2,3 so no)

This identification code is used while taking photograph of the injury.

Also note down the date and reference number of the requisition letter. Keep one copy of the letter with you for your record.

Return other copy to the police after signing at the back. While signing at the back write your full name, date and contact number. Put your stamp of organization's stamp if available.

Unrestraining

Ask the police to unrestraint the examinee.

If the examinee is handcuffed, ask the police to remove it. Examination of the examinee with restrain is unethical and is against the medical ethics as well.

Police might try to scare you that the examinee might harm you and run away. But there is no point of harming you because you are examining the examinee to document injuries which might have been inflicted as a result of torture in the custody. So in that sense you are actually doing work in the examinee's favor.

Rapport building

Build rapport by being friendly and empathetic.

Ask the accompanying police to stay out of the room or at least to a distance where your conversation with the examinee is inaudible to him. Maintain privacy at every level of examination.

Introduce yourself and inform that you will be carrying out the examination procedures.

Ask the examinee Name, Age, Sex, Occupation and proceed for taking history of the case.

History taking

History of the case should be recorded in patient's own language.

Focus on how the injury was inflicted and when and by what weapon it was inflicted. Also note down who inflicted the injury.

What was done after the infliction of the injury? Acquire documents of treatment if any.

Record every events chronologically because you have to correlate the age of injury while preparing report.

Consent

Explain what you are going to do and take consent for examination. Also, disclose that the matter will be divulged to the court of law.

Take consent for examination in written form in your note.

In case of minor (<16 years) take consent from the available guardian. If no guardian is available take consent form the police. Representative from welfare organization can also give consent for examination.

In some cases the examinee might deny for examination. He or she might even deny for giving history. In such case forceful examination is not recommended. Explain to the examinee that it will go against him, and stop further proceedings. Take signature of any two available persons as a witness mentioning that the examinee denied medical examination.

Examination

- Proceed for examination.
- Look for identification marks e.g. scars or moles over the visible parts of the body.
- Measure the size (with the help of measuring scale), shape and color of the scar or mole. Then measure its site and location. Site and location can be measure in the same way as you measure site and location for the injury. For example A black, circular mole of 0.3 cm x 0.3 cm is present at left cheek 10 cm from top of head and 5 cm from mid anterior line. Take two such identification marks.
- Record the dental findings by opening the mouth and use torch light to visualize oral cavity properly if necessary. Note down total number of teeth (temporary/mixed/temporary) any fillings, dentures and any abnormalities present.

Perform general examination

- Take Vitals i.e. Pulse, Blood pressure, Respiratory rate and Temperature (axillary temperature). If patient is unstable treat first / refer to ER.
- Examine pallor, Icterus, lymphadenopathy, cyanosis, clubbing, edema and signs of dehydration.
- Do systemic examination if required. E.g. Auscultation of the chest in case of blunt trauma to the chest.
- Measure height and weight of the examinee.

Examine the injury

Note:

1. Type of injury
2. Color
3. Size
4. Site
5. Location
6. Degree of healing (fresh, healing, healed)
7. Presence of scab
8. Range of motion of affected joint if present.

Example:

Bluish contusion of 3 cm x 3cm is present at later aspect of mid third of left arm 7 cm above the left elbow joint.

Refer the case to the emergency department if immediate treatment is needed.

Photography

Take photographs of the injury.

You can use any descent digital camera for this purpose.

If you don’t have a digital camera use your smart phone. But make sure that your smart phone’s picture gallery is not sync to social medias. Auto sync to social medias can void privacy of the patient.

Make a tag of 2 cm x 1 cm of the unique code that you allotted initially while registering the case.

Put a scale and a tag at one side of the injury, preferably at the bottom and take few photographs. Take some photographs with wide angle view so that the injury and the injured area is visible in on shot and take some photographs with close up views of the injury only. Make sure that the images are clear. Now select altogether two best photographs of each injury save in your computer by making a separate folder.

Documentation

Documents the findings in your note paper (any A4 paper or any decent size of paper) that you have examined.

Write clearly in your note because this will be your vital information upon which your final report will be based upon.

The consent that you have obtained from the examinee is also documented in this note paper.

The denial for examination by the examinee and the names and signatures of any two available witnesses are also recorded here.

This piece of paper, though is a rough of your final report, is sometime asked by the court to verify your final report. So save it properly.

Sample collection

Sometime police might ask to collect swab from suspicious stain or bite marks for DNA analysis.

For swabbing the suspicious stains or bite mark use double swab technique.

First, swab the suspicious area with a cotton swab moistened with normal saline and then again swab the same area with dry cotton swab. Preserve this dry cotton swab for DNA analysis and discard the first wet swab. Dry the second swab in room temperature and pack it in paper envelope.

Dot not pack while the swab is still wet. It may destroy the sample due to rapid degradation as a result of mold formation.

Also do not pack sample in plastic sheet or plastic container. These cause moisture built up which facilitates mold infestation and samples get destroyed. However, this is not the case when paper envelop is used. Paper is porous and hence prevents moisture build up.

Label the envelope properly and seal it with wax seal.

For the label, include the following parameters on the envelop or the pack

1) unique identification number that you have allotted in the beginning during registration
2) name of the examinee or code name if any
3) date and time of collection
4) name of the sample collected
5) investigation required
6) your name and signature.

Hand over sample to the police along with the final report. Chain of custody should be maintained. Record the date, name, position, signature and contact no of the police personnel receiving the sample and the report.

Report Writing

This is the final step in preparation of medicolegal report of injury.

The format of the report is provided in Rajpatra 2073 and a sample is also included in the

Annex i.

Prepare report in computer using Microsoft word. Hand written report is discouraged.

Make two copies of the report. One copy is to be given to the police and the other copy is to be kept as record in the department. The final report and the rough documentation note of examination and police requisition letter should be stapled together and filed.

Also save the soft copy of the report and the digital photographs in the computer making separate folder.

The digital photographs of the injury can also be printed and attached with the final report.

While giving opinion regarding severity, ask yourself whether the injury can cause death in normal course of time and without being intervened by any complication or not. If your answer is yes then the injury is fatal otherwise it is not fatal. Likewise, whether the injury is grievous (अंगभंग) or not you can consult muluki ain 2020 B.S under section "कुटपिट को महल". For the purpose of convenience they are innumerated as below:

If any of the following conditions result from assault that amounts to grievous hurt (अंगभंग)

a. Permanent privation of vision
b. Permanent privation of smelling power of nose
c. Permanent privation of hearing capacity of ears
d. Permanent privation of talking power of tongue
e. Cutting breasts of female to loss of function
f. Emasculation in male and infertility in female due to injuries
g. Fracture and dislocation of joints of spine, hands and legs leading to disability

Sometime you might have to give opinion regarding disability resulting from the injury. If it is the case then call the examinee at later date to reassess the examinee and give opinion regarding

disability. Normally, Disability documentation and reporting is a domain of concerned specialty. Hence it is preferable to seek help of expertise in that very field. For example neurological disability after severe head or spinal trauma is to be given by the neurologist, impairment of vison in case of eye injury is to be given by ophthalmologist and so on. You can give opinion regarding the disability only after having consulted with the concerned specialist.

Annex A – Injury Examination Report

अनुसूची-१०
(नियम ७ को उपनियम (२) संग सम्बन्धित)
घाउ जाँच केश फारामको ढाँचा

INJURY EXAMINATION REPORT
(IT IS USED IN CASE OF EXAMINATION OF DETAINEE ALSO)

1. Case Registration No.:
2. Name of the Office referred for injury examination (with letter ref. No. and Date) :
3. Name, Age/ Date of birth and Sex of the injured person:
4. Address:
5. Name of the accompanying Police Personnel:
6. Name of the Hospital/Health centre:-
7. Date, time and place of examination:-
8. Identification mark of the examinee :-
9. Consent for examination taken from :-

   Injured person Family member or others

10. Brief history about the incident (how and when the injuries were produced?):-

11. Medical history of the examinee :-

12. General Physique and vitals :-

Height: Weight: Pulse: B.P:

Temperature: Respiratory Rate:

Degree of Consciousness:

13.Injuries (Name, Size, Site, Color , Surrounding area, Signs of treatment, Bleeding Marks, Sign of Healings, any Imprints and content etc.) :-

A. Type of injury

a. Simple:-

b. Angabhanga (Grievous) :-

c. Severe:-

d. Other remarks:-

B. Type of weapon/object used:-

i) Blunt force ii) Sharpe force iii) Pointed objects

iv) Projectile v) Heat vi) Chemical

vii) Others (Specify)

C. Condition of the patient at the time of examination :-

D. Severity (Explain the severity in terms of existing condition and possible complication) :-

E. Investigation and reports (for example X-ray, USG, Blood, Urine etc) :-

F. Treatment provided (briefly) :-

G. Referral (Where and Why?):-

H. Follow up (if necessary) :-

I. Re- Examination (Whether case needs information about grade of disability) :-

Opinion: (Condition of examinee, severity of the injury, age of the injury and possible causative objects should be considered to frame opinion)

Name of the Examiner:-
Qualification:-
Office/Hospital/Health Centre:-
Date:-
Seal of the Hospital/Health Centre:-

Signature:-
NMC／ NHPC Reg. No. :-

Note

- घा जांच कार्य संभव भएसम्म Forensic विषयको विशेषज्ञता, सो नभएमा तालिम प्राप्त चिकित्साकर्मीले गर्नुपर्दछ ।
- घा जांच गर्ने चिकित्साकर्मीलेनै प्रतिवेदन तयार गर्नु पर्दछ ।
- संभवभएसम्म Computer Type गरी प्रतिवेदन तयार गर्नु पर्नेछ, सो नभएमा स्पष्ट वुझिने गरी उल्लेख गर्नु पर्नेछ । साथै परिक्षण प्रतिवेदनको सक्कलै प्रति संलग्न गर्नुपर्नेछ ।
- निर्धारित स्थानमा विवरण उल्लेख गर्न नपुग भएमा छुट्टै Paper sheet प्रयोग गर्नु पर्नेछ।