Standard Operating Procedure for Examination of Victim of Sexual Offence

Contents

Registration

All victims of sexual abuse brought for medico-legal examination are registered in a separate register and a unique identification code is given to maintain the privacy of victim. The code at glance should be able to hint on the date and place of examination.

Example 1:

MLSx-001/073

ML-Medico-Legal (optional to department code), **Sx**- Sexual Abuse, **01**-First case, **073**- of year 073 BS

Example 2

WRH-SA-021/072

WRH-Western Regional Hospital, **SA**- Sexual Abuse, **21**- Twenty first case, **072**- of year 072 BS

These codes are then entered in the register along with name/ codename, age, sex of the victim along with investigating police station and officer's name.

In case of referral, the same register is to be used. Hence, secrecy of the register is to be maintained and safety should be ensured to the fullest like any medico-legal document.

An example of format of registration is given below, bound to changes and alterations:

Code	Date of examination	Name	Age/sex	Investigating police station (officer)	Dr. In-charge of MLE	Nature of Incident	Assistants involved	Samples collected

Consent for examination

- Informed and expressed written consent must be taken from victim or victim's family member/guardian, in later case if she is a minor.
- In case, the victim is brought alone for examination and is a minor, consent is taken from accompanying police officer.
- Under no circumstances should a victim be forced to sign the consent or be forced for the examination.
- All the steps of examination should be explained to the victim either in advance or during the procedure. Victim should be informed where and when the examiner shall even touch to examine, heal or retrieve samples from. In case the examiner needs to take photograph of any part of the injury or body parts for documentation or any other purpose e.g. academic, consent needs to be obtained beforehand. Proper labelling with case no, name and date should be visible in the photograph. Identifying marks or points need to be covered. A scale needs to be placed beside the injury without obstructing the injured part.
- Victim should be convinced to answer questions put forward by examiner without any hesitance. She should be explained that every sentence spoken can be of great help to investigating bodies.
- Following consent, it is preferable that the accompanying police officer and examiner of the case are female, but at instances where they are unavailable, victim should be explained how male counterparts can contribute in avoiding obliteration of evidence, if the examination is delayed.

Primary assessment and Conduct towards victim

- Treatment of injury along with prevention of pregnancy and STDs is always given priority before examination of sexually abused victims.
- During primary assessment, life threatening conditions and injuries if present should be provide with appropriate medical and surgical care.
- Compassionate behaviour and selective use of words can help console the victim since they are bound to have mood disorders following the incident. Insensitive language, judgemental and critical comments may contribute to re-victimisation and hence should not be used.
- All victims should be treated with respect and dignity throughout the examination procedure irrespective of their race, religion, cast, lifestyle, gender or occupation.

Some useful techniques while dealing with victim/s:

- Greet the patient by her name and concentrate on what she says as to make her feel comfortable. Introduce yourself and let her know how you are helping her. Give enough time to listen to her and maintain eye contact (appropriate). Empathy and non-judgemental words are to be used when victim recounts her experience.

History Taking

A. History taking in case of sexually abused victims can be challenging as the chances of re-traumatising her can hardly be avoided. It comprises of three parts:

1. General Medical History
2. Gynaecological History
3. History of Assault proper

1. General medical history:

- It is helpful in medical management of patient and equally related to medico-legal investigations. Queries about general health prior to incident, visit to any health personnel before or after incident, any surgical history or history of infectious disease and history of any allergies or hypersensitivity should not be missed.

2. Gynaecological history:

- The first day of last menstrual period is of utmost important to rule out chances of pregnancy. Sexual history should be taken with precaution and gentle words. Prior history of any pregnancy and delivery should never be missed. In case the victim has children, obstetric history should be taken as well. Use of contraceptives in past, their types should be included. Most difficult and important part of history is to ask if the victim had current sexual partner and last sexual intercourse

prior to the incident, which when asked should be ensured that these questions are reinforced with empathy.

3. History of assault proper:

- It should be kept in mind that the objective of obtaining this part of the history is to detect/treat all acute injuries, assess risk of ill consequences (pregnancy, STD), as a guide to collect specimen for forensic examination.
- The best way to extract history is to allow victim to tell each and every details in her own words, only after it is ensured that the victim is comfortable.
- Do not interrupt her. In case of any query it is advisable to note it down to enquire later.
- Never use word "Why?" as it may imply to have her blamed.
- Victims usually do not feel comfortable in disclosing embarrassing details of assault where examiner should use calm tone of voice and maintain eye contact without expressing shock/disbelief and extract the detail as much as possible.
- Major objective of history of assault is to help us gather information regarding and not limited to: date, time and location of incident, identity and number of abusers, description of contacts (physical), use of instruments/weapons for restraining purposes and use of any stupefying drugs or medications.

Physical Examination:

General principle of examination mentioned below is advisable to be considered before any examination of victim of sexual abuse:

- ✓ Examination of general and mental status, which if altered or impaired needs to undergo assessment as to whether it is due to chronic illness or effect of any stupefying drugs/medication given.
- ✓ Vitals should be recorded.
- ✓ General physical examination and examination of anal and genital region must be done carefully.
- ✓ Any physical injuries if present, description with body maps is advisable. Type, size, location and colour of the injury must be clearly explained.
- ✓ Photography needs a separate consent; in case photographic evidence of any positive findings is considered helpful evidence.
- ✓ Diagnostic imaging techniques like CT scan, X rays and Ultra sonogram can detect fractures and injuries to internal organs, which is to be done wherever feasible.
- ✓ Informed consent must be obtained to draw blood samples for testing with STDs (Sexually Transmitted Diseases) as well as for evidence collection eg DNA.
- ✓ Examination of the victim is best done in warm and clean private setting with proper lighting.

- ✓ If the victim is brought for examination in the clothes worn at the time of incident, patient is asked to undress over a clean white/bright coloured sheet of paper. Privacy should be provided while the patient undresses her clothes. Partial undressing is suggested. A gown is to be kept ready for use later, as the clothes will need to be subjected to analysis.

I. General examination:

- General and stepwise examination of the victim is necessary. Vitals are recorded initially including height and weight of the patient. Initiate with examination of general body starting from head and going downward to the toe.
- Any injuries if traced should be photographed and documented stating its type, size, site, location and colour. Any marks of treatments if present should be noted as well.
- Scalp should be palpated to look for boggy swellings and any injuries to head should accompany with examination of retina and eardrums with ophthalmoscope and otoscope respectively.
- Suction type bruises (bite marks) or any other injuries like ligature mark, patterned abrasions, etc predominantly found around the neck should be dealt meticulously.
- Both breasts should be examined turn wise to look for any scratch abrasions or bite marks.
- Abdominal and pelvis examination should not be confined to physical examination. Imaging techniques (where feasible)

must be used to rule out any internal injuries or rarely to detect prior pregnancy.

- Examination of bilateral upper and lower extremities can reveal contusions (circular or oval) caused while trying to restrain the victim.
- In case any biological evidence is traced, careful retrieval with cotton stick swabs or tweezers is recommended.

II. Local Examination:

Examination of genitalia, perineum and anal region together is understood as local examination in relation to victim of sexual abuse.

A. Procedure of examination:

- For best of ease, patient is kept in supine position with knees help up and legs separated, in other words known as lithotomy position.
- In case the victim is child. Left lateral decubitus position with right leg slightly spread apart or knee chest position is advisable.
- The upper portion of the body is to be covered with hospital sheet till the examination is being performed. Light should be focused on vulva region of the victim.
- Tenderness over any region can be elicited by mere touching. Local anaesthesia might be used in case the pain is hindering the examination, esp. in case of victim is a child.

- Examination and management of tears can be done simultaneously, with assistant documenting the findings.
- Start the external examination of genital region, Mons pubis and anal region. Proceed to examination of vaginal vestibule (labia majora, labia minora, clitoris, hymen/remanants, posterior fourchette and perineum. Cotton swabs should be used to trace minor and small injuries.
- A swab from external genitalia should be taken before any digital or speculum intervention. Inspection of vaginal wall and endo-cervical canal can be done with aid of speculum (if required) inserted gently with prior counselling, as this intrusion might be distressing to victim and the action might remind her of the assault.
- It is advisable to immerse speculum in warm water before inserting it. It is inserted along the longitudinal plane of vulva tissue then rotated into final position.
- Swabs can be collected from mid and deep vaginal canal following the insertion of speculum.
- In case patient refuses speculum to be used, swabs can be blindly collected from mid and deep vaginal canal.
- Anal injuries are traced by applying gentle pressure over the anal opening. Digital rectal examination or proctoscopy is suggestive only if instrumentation of foreign body insertion is given in history or there is profuse anal bleeding.

- Recording of any injuries should be documented with all its aspects like type, size, site, location and colour. In case of lacerations depth should also be included. In case of incised would tailing of the wound and in case of chop wounds bevelling surfaces can provide hint on direction of force applied.

Example:

A contusion, measuring 2.5X1cm, bluish in colour, is present on the outer aspect of mid 1/3rd of right arm, 12cm above the elbow joint.

Here,

- Type: Contusion,
- Size: 2.5X1cm,
- Site: Outer aspect of mid 1/3rd of right arm,
- Location: 12cm above the elbow joint colour:
- Bluish can provide us an idea of where actually was the injury caused, causative agent (blunt, probably pressure by finger tips), age of the wound (app. 1-2 days) and grievousity.

Sample collection and Medico-legal issues:

- Depending on the need, tests like simple routine blood test, routine urine test, urine pregnancy test, tests specific for sexually transmitted infections, X-rays, CT scans and/or ultrasound etc should be done in all cases although results are bound to come negative.
- It is always better to collect evidence during medical examination, but treatment should be given priority. MBBS graduate with training in this field can collect forensic evidence.
- The collection of the specimen for evidence should be decided on case by case basis and examiners discretion should be used. Not all body material need to be collected as part of the forensic specimen collection.
- All evidence collected should be air dried in room temperature and packed in a paper envelope before dispatching.
- Blood samples need to be refrigerated.
- Proper sealing and labelling of the evidence must be best done in front of the examiner himself/herself. Proper chain of custody must be maintained.

A forensic examination is formally defined as a “medical examination conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion”.

Documentation

All findings should be documented meticulously and systematically. Confidentiality should be maintained. The documents should be stored in a secure place.

ANNEX 1

अनुसूची-१० क

(नियम ८क को खण्ड (क) संग सम्बन्धित)

यौनजन्य अपराध सम्बन्धि शारिरीक परिक्षण प्रतिवेदनको ढाँचा

(महिलाको हकमा)

REPORT OF MEDICAL EXAMINATION IN SEXUAL OFFENCE

(FEMALE SUBJECT)

1. Case Registration No.:

2. Name of the Office referred for examination (with letter reference No. and Date)

3. Name of the accompanying Police Personnel:

DETAIL ABOUT THE EXAMINEE

1. Name/ Code Name (To maintain confidentiality):

2. Age and Sex:

3. Address:

4. Marital status:

5. Guardian's Name and relation:

6. Date and time of examination:

7. Attendants Name/address:

8. Identification marks:

9. Consent for examination: I am fully aware about the process and possible consequences of the examination; I hereby give my full consent for medical examination without any compulsion. (Consent should be

taken in the form of signature / thumb print.) For minors Consent should be taken from guardians.

10. Brief History of the incident, as stated by examinee or guardian (How, When, Where and what had happened?):

11. Medical history (Emotional, Medical and Psychological history including past medical history):

12. Clothes changed or not after incident:

13. Whether clothes and body parts washed or not after the incident:

14. Description of the examination of clothes (Any tear, scratches, stain and foreign materials :

EXAMINATION

1. General physique and vitals:-

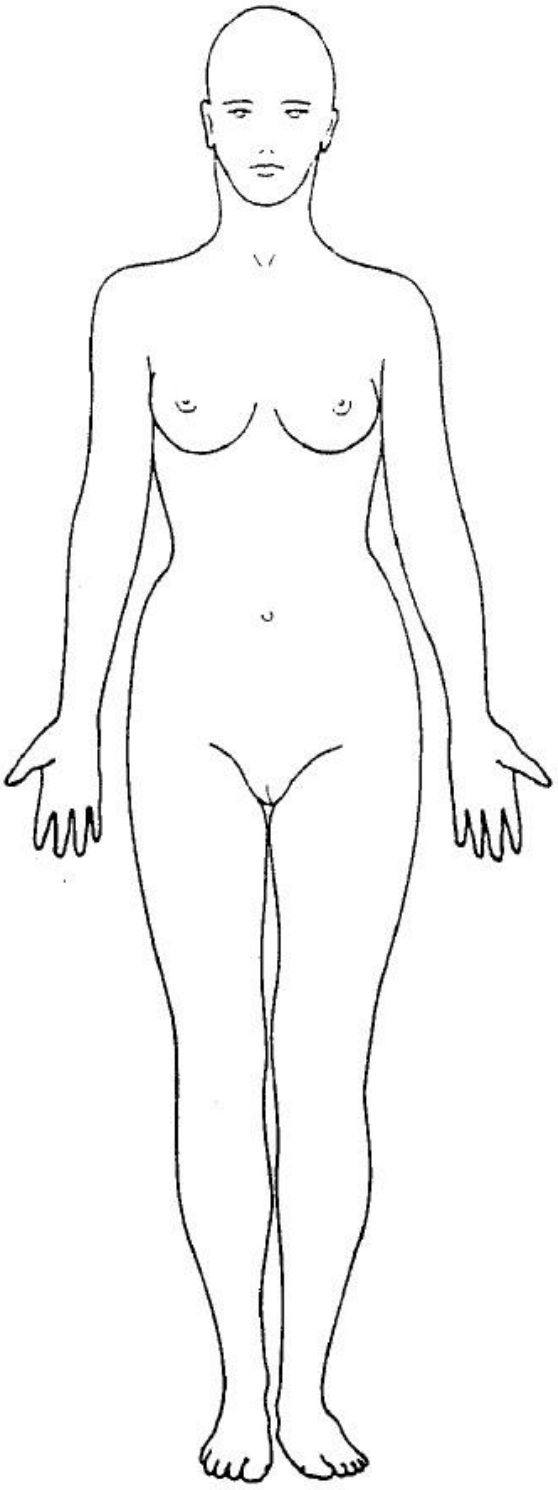
   Height: Weight: Pulse: B.P:

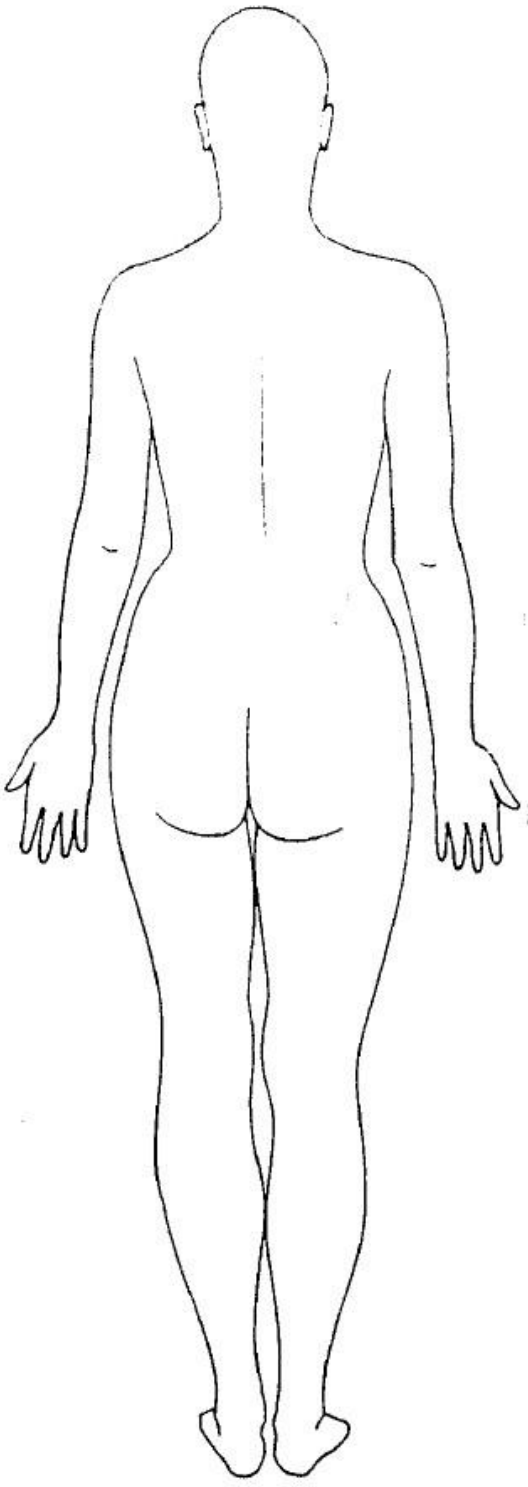
   Temperature: Respiratory rate: Degree of consciousness:

   Any disability:

2. Injuries on the bodies (Name, Size, Site, Color, Surrounding area, Sign of treatment, Bleeding Marks, Sign of Healings, any Imprints etc.) Please use the figure provided to depict the injuries as best as possible:

FULL BODY, FEMALE—ANTERIOR AND POSTERIOR VIEWS

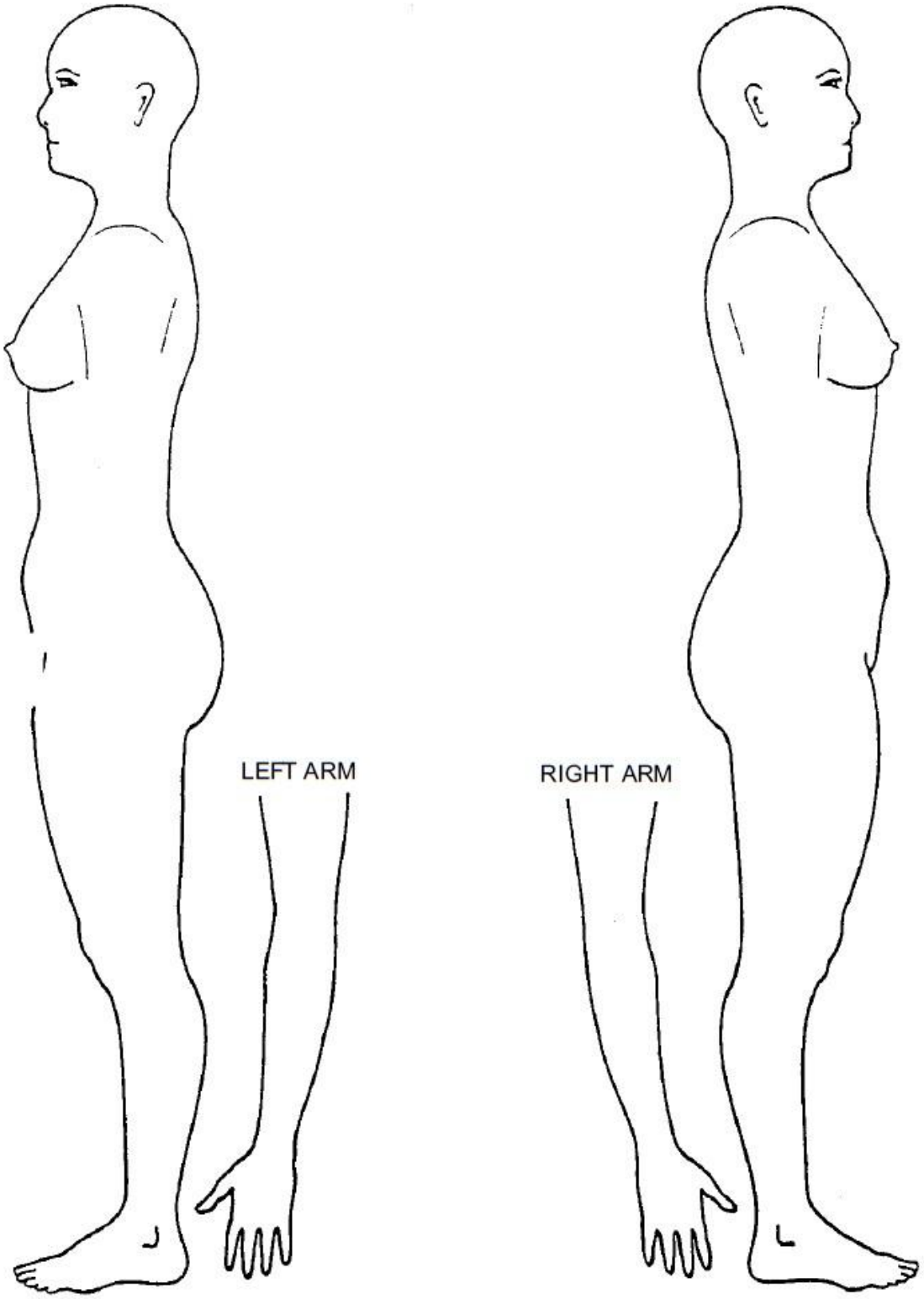




Name _____ Case No. _____

Date _____

FULL BODY, FEMALE—LATERAL VIEW



Name _____ Case No. _____

Date _____

3. Genital injuries (Name, Size, Site, Color, Surrounding area, Sign of treatment, Bleeding Marks, Sign of Healings, Imprints, any content, stain and discharge etc.) Please use the figure provided to depict the injuries as best as possible:-

(a) Perineum :

(b) Vulva:

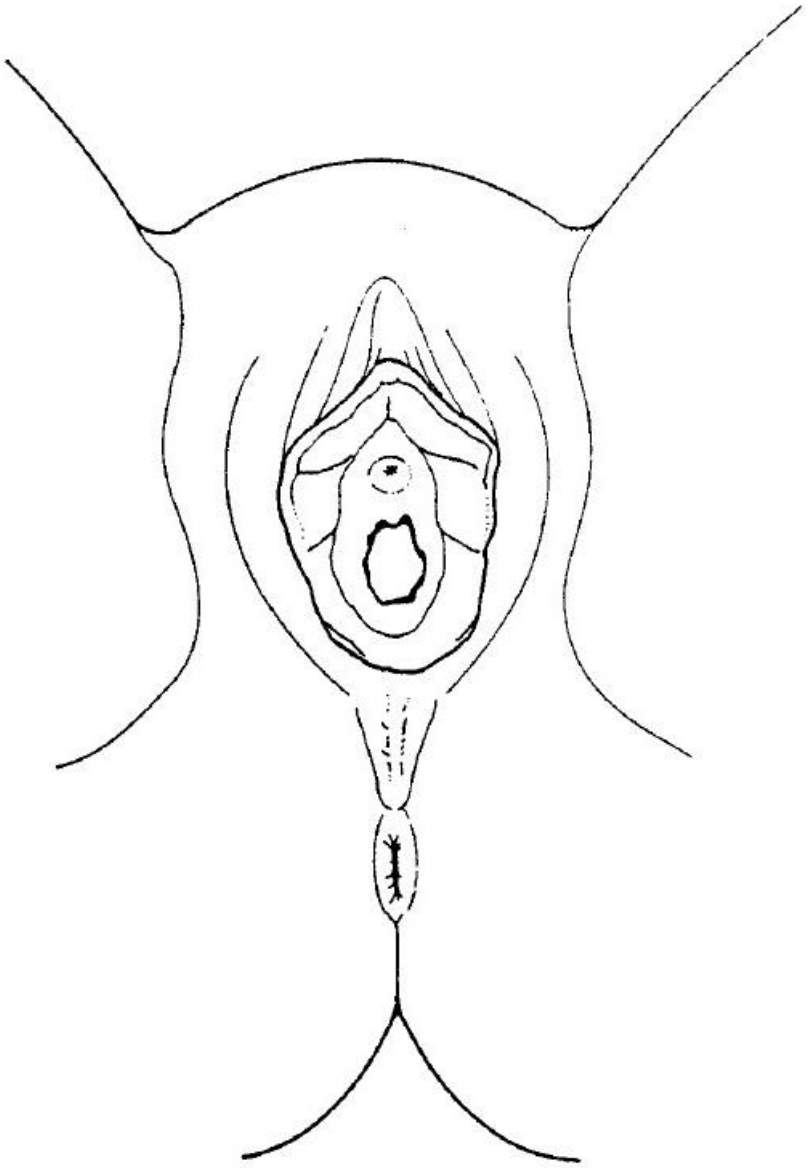
(c) Vagina:

(d) Hymen:

(e) Perianal area and anal orifice:

(f) Oral cavity:

PERINEUM—FEMALE



Name _____ Case No. _____

Date _____

4. Conditions of pubic hair (Matted, stained, any foreign hairs) :-

5. Bite marks: - (enclose photos if possible)

6. Specimen preserved for further analysis:-

(a) Blood (Alcohol, Drug, Grouping, DNA, HIV AIDS, VDRL, HBS-Ag, TPHA)

(b) Urine (Intoxication/pregnancy) (c) swab from stains

(d)Vaginal swab (e) Foreign hairs/debris

(f) Hair from the examinee (g) Nail scrapings

(h) Others:

7. Investigation and reports:-

8. Treatment (including prevention of pregnancy, vaccination and sexually transmitted diseases):-

9. Referral (Where and Why?):-

10. Follow up visits suggested on :-

11. Psychiatric evaluation and psychosocial counseling:-

12. Condition of teeth (Type of dentition and Number of teeth) :-

$$\frac{8\,7\,6\,5\,4\,3\,2\,1 / 1\,2\,3\,4\,5\,6\,7\,8}{8\,7\,6\,5\,4\,3\,2\,1 / 1\,2\,3\,4\,5\,6\,7\,8} = \text{(Total teeth)}$$

Opinion of the expert:(while framing opinion the examiner should analyze her mental status, possible causation of injuries and their time of infliction, age estimation in case of minors or teenagers and general condition of the examinee. If there are signs of alleged sexual activities mentioned in history also should be considered while framing opinion. In case of complete negative findings in examinee the examiner cannot declare that the alleged incident did not take place).

(a) Opinion about mental status of the examinee:-

(b) Opinion about the injuries on body:-

(c) Opinion about the condition of genital organs:-

(d) Opinion about age of the Examinee:-

(e) Other opinion, if any :-

Name of the Examiner:-

Signature:- Qualification:-

NMC／ NHPC Reg. No. :- Office/Hospital/Health Centre:-

Date:- Seal of the Hospital/Health Centre:-

Note

- परिक्षण कार्य संभव भएसम्म Forensic विषयको विशेषज्ञता, सो नभएमा तालिम प्राप्त चिकित्साकर्मीले गर्नुपर्दछ ।
- परिक्षण 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 सक्कल प्रति नै संलग्न गर्नुपर्नेछ ।*
- निर्धारित स्थानमा विवरण उल्लेख गर्न नपुग भएमा छुट्टै Paper sheet प्रयोग गर्नु पर्नेछ ।

ANNEX 2

अनुसूची-१० ख

(नियम ८ कको खण्ड (क) संग सम्बन्धित)

यौनजन्य अपराध सम्बन्धी शारीरिक परीक्षण प्रतिवेदनको ढाँचा

(पुरुषको हकमा)

REPORT OF MEDICAL EXAMINATION OF MALE SUBJECT IN SEXUAL OFFENCES

1. Case Registration No.:

2. Name of the Office referred for examination (with letter reference No. and Date)

3. Name of the Accompanying Police Personnel:

DETAIL ABOUT THE EXAMINEE

1. Name/ Code Name (To maintain confidentiality):

2. Age and Sex:

3. Address:

4. Marital Status:

5. Guardian's Name and Relation:

6. Date and Time of Examination:

7. Attendants Name/Address:

8. Identification Marks :

9. Consent for examination: I am fully aware about the process and possible consequences of the examination; I hereby give my full consent for medical examination without any compulsion. (Consent taken in the

form of signature / thumb print.) For minors Consent taken from guardians .

10. Brief History of the incident (How, When, Where and what had happened?):

11. Medical History (Emotional, Medical and Psychological history including past medical history):

12. Clothes changed or not after incident:

13. Whether clothes and body parts washed or not after the incident:

14. Description of the examination of clothes (Any tear, scratches, stain and foreign materials :

EXAMINATION

1. General Physique and vitals:-

Height: Weight: Pulse: B.P:

Temperature: Respiratory Rate: Degree of Consciousness:

Any disability:

2. Injuries on the bodies (Name, Size, Site, color, Surrounding area, Sign of treatment, bleeding Marks, Sign of Healings, any Imprints etc.) :-

3. Genital injuries (Name, Size, Site, color , Surrounding area, Sign of treatment, Bleeding Marks, Sign of Healings, imprints, any stain and discharge etc.) :-

(a) Perineum:

(b) Penis:

(c) Scrotum:

(d) Perianal area and anal orifice:

(e) Oral cavity:

4. Conditions of pubic hair (Matted, Stained, Any foreign hairs) :-

5. Bite Marks:- (Enclose photos if possible)

6. Specimen Preserved for further analysis:-

(a) Blood (Alcohol, Drug, Grouping, DNA, HIV, VDRL, HBS-Ag, TPHA)

(b) Urine. (c) Swab from stains.

(d) Swab from penis (e) Foreign hairs/debris

(f) Hair from the Examinee. (g) Nail scrapings.

(h) Others (including oral sexual activities) :

7. Investigation and reports:-

8. Treatment (including sexually transmitted diseases):-

9. Referral (Where and Why?):-

10. Follow up (if necessary):-

11. Psychiatric evaluation and psychosocial counseling:-

12. Condition of teeth (Type of dentition and Number of teeth to assess age of examinee)

$$\frac{8\,7\,6\,5\,4\,3\,2\,1/1\,2\,3\,4\,5\,6\,7\,8}{8\,7\,6\,5\,4\,3\,2\,1/1\,2\,3\,4\,5\,6\,7\,8} = \text{(Total teeth)}$$

13. Opinion of the expert:

(a) Opinion about injuries on body:-

(b) Opinion about condition of genital organs:-

(c) Opinion about the age of the examinee:-

(d) Other opinion ; if any:-

Name of the Examiner:-

Signature:- Qualification:-

NMC/NHPC Reg. No.:- Office/Hospital/Health Centre:-

Date:- Seal of the Hospital/Health Centre:-

Note

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- निर्धारित स्थानमा स्थान नपुग भएमा छुट्टै Paper sheet प्रयोग गर्नु पर्नेछ ।