

STANDARD OPERATING PROCEDURE (SOP)

On

Sexual Assault Forensic Examination (SAFE)

of an Alleged Rape Victim

Department of Forensic Medicine

Faculty of Medicine

UWUSL

Standard Operating Procedure (Sop) For Sexual Assault Forensic Examination (SAFE) Of An Alleged Rape Victim

(1) Title

Standard Operating Procedure (SOP) for Sexual Assault Forensic Examination (SAFE) of Alleged Rape Victims for Medico-Legal Purposes



(2) Purpose

- To provide a standardized, ethical, sensitive, and legally acceptable method for the medico-legal examination, evidence collection, management, documentation, referral, and reporting of alleged rape victims.
- This SOP aims to:
 - Ensure proper medico-legal examination
 - Preserve forensic evidence
 - Provide compassionate victim-centered care
 - Assist administration of justice

- Maintain uniformity of practice

(3) Scope

This SOP applies to,

- Specialists in Forensic Medicine
- Medical Officers performing medico-legal duties
- Demonstrators and trainees in Forensic Medicine
- Nursing officers assisting SAFE examinations
- Government hospitals conducting medico-legal examinations



(5) Responsibilities

The examining doctor shall

- Conduct examination sensitively and professionally
- Request informed consent
- Collect and preserve forensic evidence
- Maintain confidentiality
- Arrange referrals and treatment
- Provide medico-legal opinion
- Maintain chain of custody
- Prepare medico-legal reports

(6) Principles of Examination

The examination shall be,

- Respectful
- Confidential
- Non-judgmental
- Trauma-informed
- Conducted with privacy
- Performed with minimum re-traumatization
- Scientifically accurate
- Legally acceptable
- Human rights of the survivor must be respected throughout the examination.

(7) Requirements

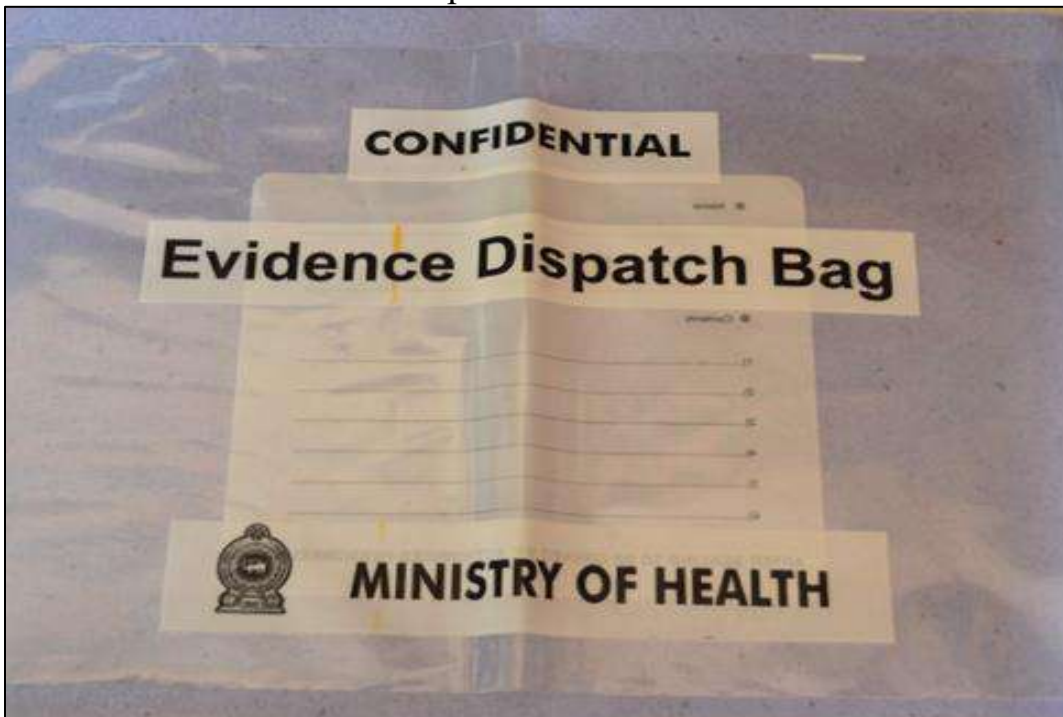
(7.1) Personnel

- Specialists in Forensic Medicine / Grade Medical Officer/Government Medical Officer
- Female chaperon for female victims
- Nursing officer or assistant

- Sterile Swabs



- Evidence Envelopes



- Labels



- Paper bags



- Camera (if available)



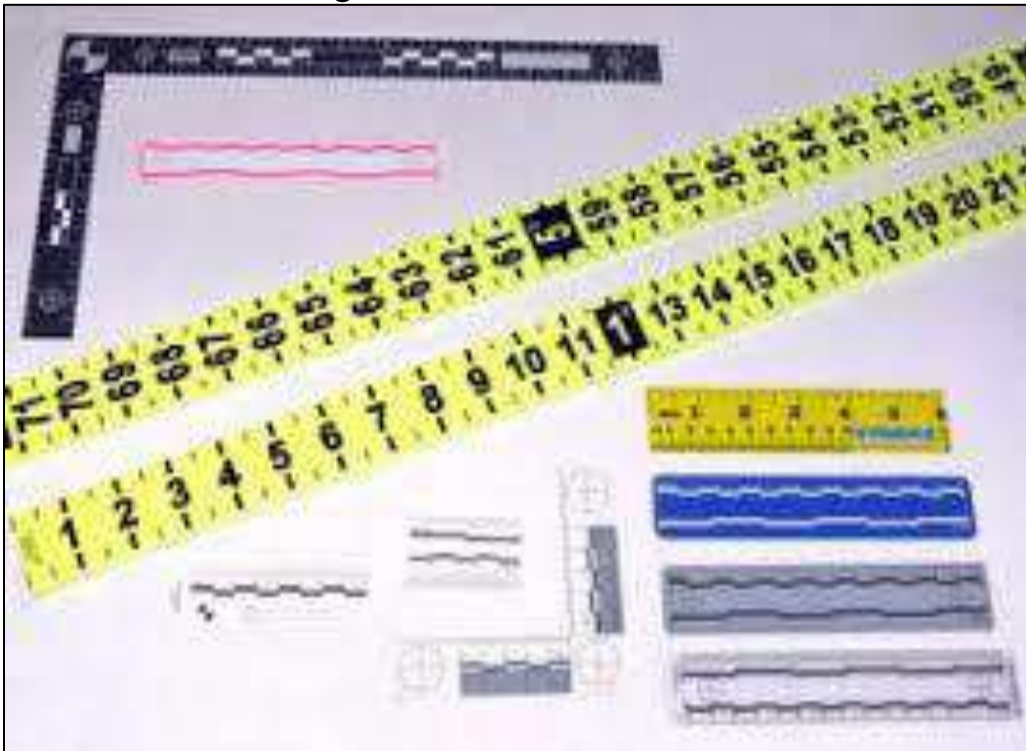
- Speculum (non-lubricated)



- UV light (if available)



- Measuring Scale



- Blood collection tubes



- Documentation forms (MLEF – Medico-Legal Examination Form)

Police Copy 554/10

Form No. 20
Police

අධිකරණ වෛද්‍ය පරීක්ෂණ සටහන Medico - Legal Examination Form

(අ) කොටස : (1-8) පොලීස් ඔෆිසර් විසින් සකස් කළ යුතු වන අතර (ආ) කොටස : (9-22) වෛද්‍ය නිලධාරීන් විසින් සකස් කළ යුතු වේ.
Part A : (1-8) To be filled by Police Officer issuing MLEF
Part B : (9-22) To be filled by Medical Officer

1. පොලීස් ඔෆිසර් : Police Station : 554/10	2. නිකුත් කළ දින : Date of Issue : 20/05/2018	3. අංක : No. : 48/2018
4. වර්ෂය, පවුල, වෛද්‍ය විද්‍යාලය සහ ලිපිනය : Full Name and Address of the examinee		5. උපතේ දිනය : Date of Birth (DOB)
6. වෛද්‍ය පරීක්ෂණයට යොමු කළ හේතු : Reason for referring for examination		7. වයස : Age
8. වෛද්‍ය නිලධාරීන් විසින් පවුලේ නම : Police Officer Issuing		9. වෛද්‍ය නිලධාරීන් විසින් සකස් කළ : Medical Officer

10. පිටුවේ වෙත පත් (Admission) :
11. පරීක්ෂණය (Examination) :
12. වෛද්‍ය නිලධාරීන් විසින් සකස් කළ :
Date and Time :
Date of Discharge :

13. ශරීරයේ වැදගත් තුවාල :
Nature of the bodily harm :

<input type="checkbox"/> අර්බුද	<input type="checkbox"/> පැරදීම	<input type="checkbox"/> අලිංගික කැප	<input type="checkbox"/> අර්බුද
<input type="checkbox"/> අර්බුද	<input type="checkbox"/> අර්බුද	<input type="checkbox"/> අර්බුද	<input type="checkbox"/> අර්බුද
<input type="checkbox"/> අර්බුද	<input type="checkbox"/> අර්බුද	<input type="checkbox"/> අර්බුද	<input type="checkbox"/> අර්බුද

14. වෛද්‍ය නිලධාරීන් විසින් සකස් කළ :
Nature of Offensive Weapon :

15. වෛද්‍ය නිලධාරීන් විසින් සකස් කළ :
Category of Hurt :

16. වෛද්‍ය නිලධාරීන් විසින් සකස් කළ :
Examinations for consumption of alcohol :

17. වෛද්‍ය නිලධාරීන් විසින් සකස් කළ :
Examinations for consumption of drugs :

18. වෛද්‍ය නිලධාරීන් විසින් සකස් කළ :
Examination of alleged sexual assault :

19. වෛද්‍ය නිලධාරීන් විසින් සකස් කළ :
Findings of examination relevant to given history :

20. වෛද්‍ය නිලධාරීන් විසින් සකස් කළ :
Investigations :

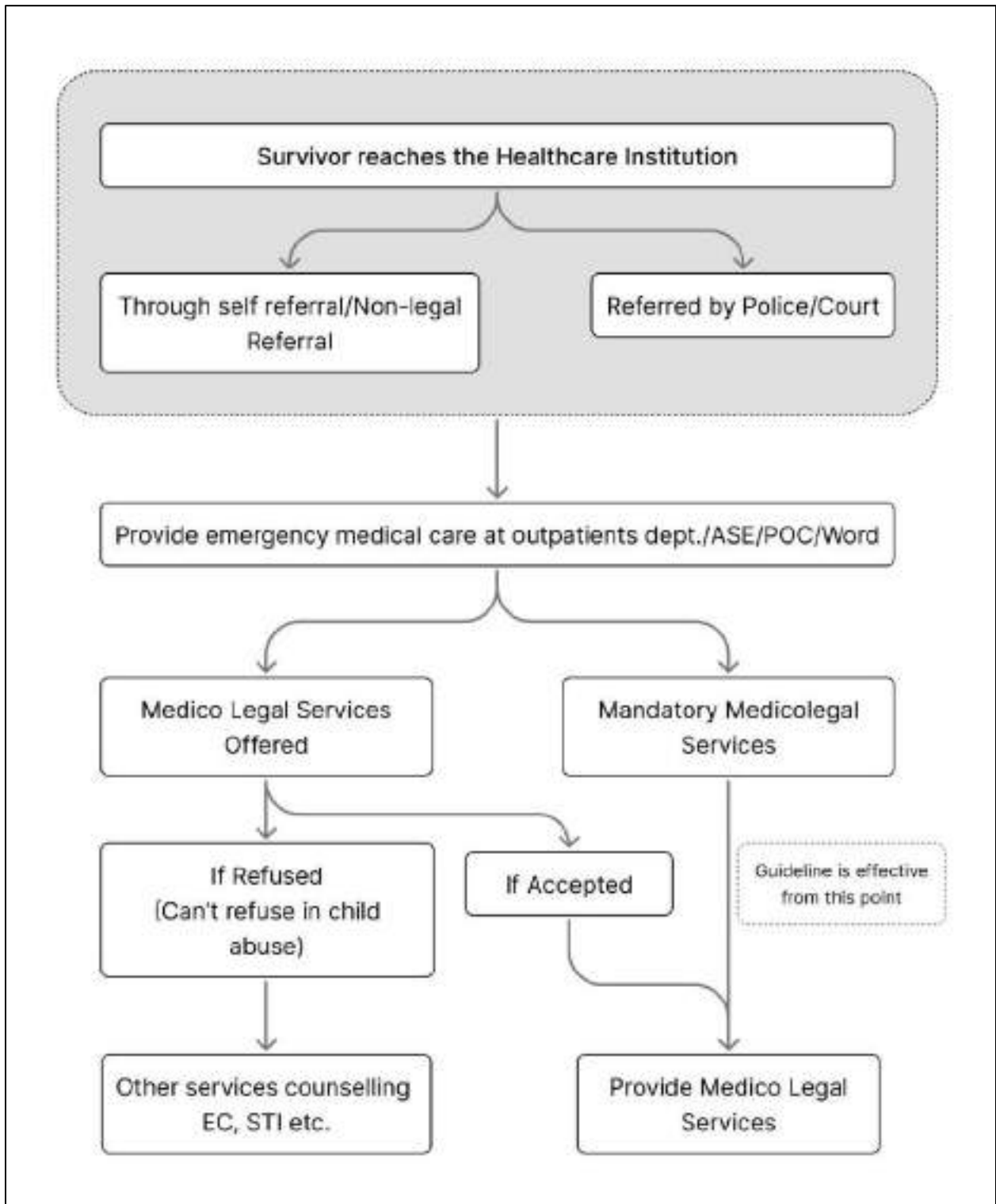
21. වෛද්‍ය නිලධාරීන් විසින් සකස් කළ :
Referrals :

22. වෛද්‍ය නිලධාරීන් විසින් සකස් කළ :
Other opinions/Recommendation :

23. වෛද්‍ය නිලධාරීන් විසින් සකස් කළ :
Remarks :

වෛද්‍ය නිලධාරීන් විසින් සකස් කළ :
Signature, Full Name, SLMC Reg No., Designation of the Medical Officer

(8) Flow Of Medico - Legal Management of Sexual Assault (SAFE Guidelines)



EC-emergency contraception

(9) Medico - Legal Management of Sexual Assault Victim

It is a **Thirteen (13) Stepped Process**

A PC HO PC ELVis R3

1. Authority
2. Preliminaries
3. Consent
4. History
5. Observations
6. Preliminary Investigations
7. Clothing Examinations
8. Examinations
9. Laboratory Tests
10. Visit to scene
11. Referral
12. Review of victim
13. Report Preparation & Giving Opinions

(9.1) Step 1 – AUTHORITY

Ensure examination is requested through,

- MLEF issued by Police or
- Court Order or
- Referred by another consultant

(9.2) Step 2 – PRELIMINARY NOTES

- Record, Examinee's
 - Full name
 - Date of birth
 - Sex
 - Marital status
 - Contact details of the examinee
- Date and time of examination
- Place of examination
- Language used
- Interpreter details if applicable
- Delay in presentation and reasons

අධිකරණ වෛද්‍ය පරීක්ෂණ පොදු පත්‍ර
Medico - Legal Examination Form

අංක 1 : (1-8) පොලීසි නිලධාරීන් විසින් පිරවිය යුතු පොදු පත්‍රයකි.
Part A : (1-8) To be filled by Police Officer issuing MLEP

1. පොලීසි ඔෆිසර් - පාරාමිට් අංකය
Police Station : 554/12

2. නිකුත් කළ දිනය - අදාළ වන දිනය
Date of Issue : 21/05/2018

3. අංකය - අංකය
No. : 42/2018

4. පරීක්ෂකයාගේ සම්පූර්ණ නම සහ ලිපිනය
Full Name and Address of the Examinee
සමස්ත නම : ආර්. ඩබ්ලිව්. ජයවර්ධන
ලිපිනය : 123, පලමු මහල, පලමු පාර, කොළඹ 05

5. පරීක්ෂණයට යොමු කිරීමේ හේතු
Reason for referring for examination
වෛද්‍ය පරීක්ෂණයට යොමු කිරීමේ හේතු : වැරදි මරණයක් සම්බන්ධව

6. නිකුත් කළ පොලීසි නිලධාරීන්ගේ අත්සන සහ අංකය
Police Officer issuing:
අංකය : 123456

7. වෛද්‍ය නිලධාරීන්ගේ අත්සන සහ නම
Signature:
අංකය : 789012

අංක 2 : (9-22) වෛද්‍ය නිලධාරීන් විසින් පිරවිය යුතු පොදු පත්‍රයකි.
Part B : (9-22) To be filled by Medical Officer

9. හානි සිදු කළේ කවුන්ද? (ප්‍රකාශනය) Produced by:

10. ඇතුළත් වෛද්‍යාගාරය
Admission:
වෛද්‍යාගාරය : වෛද්‍ය විද්‍යා මධ්‍යස්ථානය
දිනය : 2018/05/21
විවරණ : B. H. T. No.

11. පරීක්ෂණය
Examination:
දිනය සහ වේලාව : 2018/05/21
ස්ථානය : වෛද්‍ය විද්‍යා මධ්‍යස්ථානය

12. පරිහරණය
Discharge:
දිනය : 2018/05/21

13. ශාරීරික හානිවල ස්වභාවය
Nature of the bodily harm:
අර්ථ දැක්වීම : අර්ථ දැක්වීම : අර්ථ දැක්වීම : අර්ථ දැක්වීම :
අර්ථ දැක්වීම : අර්ථ දැක්වීම : අර්ථ දැක්වීම : අර්ථ දැක්වීම :
අර්ථ දැක්වීම : අර්ථ දැක්වීම : අර්ථ දැක්වීම : අර්ථ දැක්වීම :

14. අත්පිටි හානිවල ස්වභාවය
Nature of Cumulative Weapon:
අර්ථ දැක්වීම : අර්ථ දැක්වීම : අර්ථ දැක්වීම : අර්ථ දැක්වීම :

15. හානිවල ප්‍රභේදය
Category of Hurt
අර්ථ දැක්වීම : අර්ථ දැක්වීම : අර්ථ දැක්වීම :

16. වෛද්‍ය පරීක්ෂණයන් සඳහා
Examinations for consumption of alcohol:
වෛද්‍ය පරීක්ෂණය : වෛද්‍ය පරීක්ෂණය :

17. වෛද්‍ය පරීක්ෂණයන් සඳහා
Examinations for consumption of drugs:
වෛද්‍ය පරීක්ෂණය : වෛද්‍ය පරීක්ෂණය :

18. වෛද්‍ය පරීක්ෂණයන් සඳහා
Examination of alleged sexual assault
වෛද්‍ය පරීක්ෂණය : වෛද්‍ය පරීක්ෂණය :

19. වෛද්‍ය පරීක්ෂණයන් සඳහා
Examination relevant to given history:
වෛද්‍ය පරීක්ෂණය : වෛද්‍ය පරීක්ෂණය :

20. වෛද්‍ය පරීක්ෂණයන් සඳහා
Examination relevant to given history:
වෛද්‍ය පරීක්ෂණය : වෛද්‍ය පරීක්ෂණය :

21. වෛද්‍ය පරීක්ෂණයන් සඳහා
Examination relevant to given history:
වෛද්‍ය පරීක්ෂණය : වෛද්‍ය පරීක්ෂණය :

22. සටහන : Remarks:
වෛද්‍ය පරීක්ෂණයන් සඳහා
වෛද්‍ය පරීක්ෂණයන් සඳහා

වෛද්‍ය නිලධාරීන්ගේ අත්සන සහ අංකය
Signature:
අංකය : 123456

වෛද්‍ය නිලධාරීන්ගේ අත්සන සහ අංකය
Signature:
අංකය : 789012

(9.3) Step 3 – CONSENT

- Request informed written witnessed consent (IWWC) for
 - Examination
 - Sample collection
 - Photography
 - Colposcopy

Consent for Medico-Legal examination, investigation and reporting.		
Name of the Medical Institution:		
I (Name of the examinee) give my consent to Dr.		
to perform the following at the medico-legal examination . (Tick appropriate boxes).		
	Yes	No
1. Obtain information about the incident & Conduct a clinical examination. (including PV, PR examination)	<input type="checkbox"/>	<input type="checkbox"/>
2. Collection of evidence	<input type="checkbox"/>	<input type="checkbox"/>
3. Obtain photographs	<input type="checkbox"/>	<input type="checkbox"/>
4. Special consent for medical referral	<input type="checkbox"/>	<input type="checkbox"/>
5. Provide evidence & medical information to the police and/or courts	<input type="checkbox"/>	<input type="checkbox"/>
Signature/ thumb impression:	Date & time:	
Name & signature of witnesses:		

(9.4) Step 4 – HISTORY

(9.4.1) History Before Incident

Record,

- Previous consensual intercourse
- Menstrual history
 - Menarche/ Age of Menarche:
 - Last Menstrual Period
- Contraceptive use
- Obstetric history
 - Symptoms of pregnancy-Yes/ No
 - Number of children/type of deliveries
- Past medical/ surgical history.
 - Hospitalization(s) with reasons Medications
 - Allergies
 - Disabilities (specify)
- Mental health history
- Drug/ alcohol use

(9.4.2) History of Incident

Record,

- Date, time, and place
- Assailant details
- Type of sexual act
- Threats/intimidation
- Use of force
- Bleeding, pain, ejaculation
- Weapons used
- Drug/alcohol involvement
- Consent-related circumstances

(9.4.3) History After Incident

Record

- Bathing
- Washing genitalia
- Urination
- Defecation
- Brushing teeth
- Changing clothes
- Vomiting
- Use of pads/tampons

(9.5) Step 5 – OBSERVATIONS

- Clothes disturbed or torn
- Alcohol smell
- Fearful behavior
- Emotional state
- Eye contact
- Clothing condition
- Distress
- Crying/depression
- Gait abnormalities
- Physical discomfort

(9.6) Step 6 – PRELIMINARY INVESTIGATIONS

(9.6.1) Photography

- Photographs
 - Injuries
 - Bite marks
 - Clothing damage
 - Stains
- Use
 - Scale/ruler
 - Proper lighting
 - Identification number

(9.6.2) Radiology / Imaging

- Arrange
 - X-rays
 - Ultrasound
 - CT/MRI if indicated

(9.7) Step 7– CLOTHING EXAMINATION

- **Examine clothing before body examination**
 - Document the following
 - Type of clothing
 - Tears
 - Stains
 - Disturbance
 - Missing buttons/hooks
- **Collect trace evidence from clothes**
 - **According to – Locard’s Principle - “Every contact leaves a trace”**
 - Use SAFE KIT whenever possible
 - Take out the catch paper from the catch paper envelope

- Request the victim to stand on the catch paper



- Request to remove her/his clothes one by one
- Dust them on the catch paper
- Fold the catch paper with trace evidences



- Pack in catch paper envelope

STEP 6

PURPOSE - To catch any debris that falls from examinee's clothing while traveling.

If the examinee has changed clothes after the incident, collect only articles of clothing suspected of coming into contact with the perpetrator's weapons as the result of damage (buttonholes, zippers, etc.) inform the investigating officer so that the clothing worn during assault may be collected. If examinee has not changed clothes, collect clothing as described below. Make sure a change of clothing is provided by the examinee.

- Do not cut through any existing rips, tears, or holes in clothing.
- Do not shake out clothing as these materials may be lost. Air dry all clothing. Wet or damp clothing may need additional drying before packaging in a paper bag.
- Photograph the examinee prior to standing to document appearance.

1. Unfold and place a clean hospital bed sheet on the floor.
2. Remove catch paper from the collection envelope, unfold it and place on the hospital sheet.
3. Have examinee step out of shoes on to center of the catch paper. Remove all clothing, placing each item (as it is removed) wrapped in separate plastic and mark. Underwear and ties to be placed in to collecting bag separately in envelope 7 & 8 appropriately. Leave attached sanitary items attached to underwear. Package non - attached items separately.
4. After examinee has disrobed, have examinee step off of catch paper.
5. Refold catch paper to retain contents, and place it in the specimen collection envelope (8), appropriately seal and close.
6. Place the collection envelope along with 7 & 8 in the dispatching bag.

CATCH PAPER

Examinee's Name: Date/Time : Ref. (case/MEF) No :

Collected by :

Content :

To be examined for :

- Now, the removed clothes such as, Brassiere, Underwear, Other stained clothes, etc. should be air dried under shade and pack in separate envelopes as showed below.
- **Packaging of clothes**
 - Use safe kit bags or Use paper bags
 - Avoid plastic bags
 - Label separately
 - Maintain chain of custody

- Pack the brassier separately in the brassiere envelope



STEP 8 **BRASSIERE ENVELOPE**

PURPOSE: To preserve physical or biological evidence on examinee's brassiers.

NOTE : If necessary, air-dry wet or damp items additionally prior to packaging.

1. Wrap the brassiere in a paper provided while disrobing and mark. Then place it in this envelope.
2. Double fold down the top of the envelope, securely close seal and label.
3. Place the Brassiere envelope in the dispatching bag.

Examinee's Name : Date/Time : Ref. (case/MLEF) No. :

Collected by :

Content :

To be examined for :

- Pack the underwear separately in the underwear envelope



STEP 7 **UNDERWEAR ENVELOPE**

PURPOSE: To preserve physical or biological evidence on examinee's underpants.

NOTE : Do not remove attached panty liners or sanitary napkins from underpants. (if necessary, air-dry wet or damp items prior to packaging)

1. Wrap the underpant in a clean paper provided & mark it. Then place it in this envelope.
2. Double-fold down the top of the envelope securely close, seal and label.
3. Place underpant envelope in to the dispatching bag.

Examinee's Name: Date/Time : Ref. (case/MEF) No:

Collected by :

Content :

To be examined for :

(9.8) Step 8 – EXAMINATION

Performed simultaneously with **Trace Evidence Collection**.

- (9.8.1) Extra-Genital (Bodily) Examination
- (9.8.2) Genital Examination
- (9.8.3) Anal Examination

(9.8.1) Extra-Genital (Bodily) Examination

- **General physical Examination**

- Vital signs
- Height
- Weight
- Signs of intoxication
- Nutritional status

- **Injury Examination**

- **4 Types of injuries**

(1) Resistance Injuries (occur due to resistance by the victim when the suspect attempts to remove clothes or apart the legs) Eg.

- **(a) Abrasions over hips** (when attempting to remove underwear)



- (b) **Inner thigh contusions** (when attempting to apart legs)



(2) **Restraining Injuries** (occur due to restraining of the victim in a desired position by the suspect)

- Wrist bruises
- Back injuries
- Forearm grip marks



(3) Threatening Injuries

- Slap marks



- Smothering injuries





- Strangulation marks



(4) Para-sexual Injuries

- **Hostile Bite marks** (with teeth marks)



- **Love bites** (suction petechiae without teeth marks)



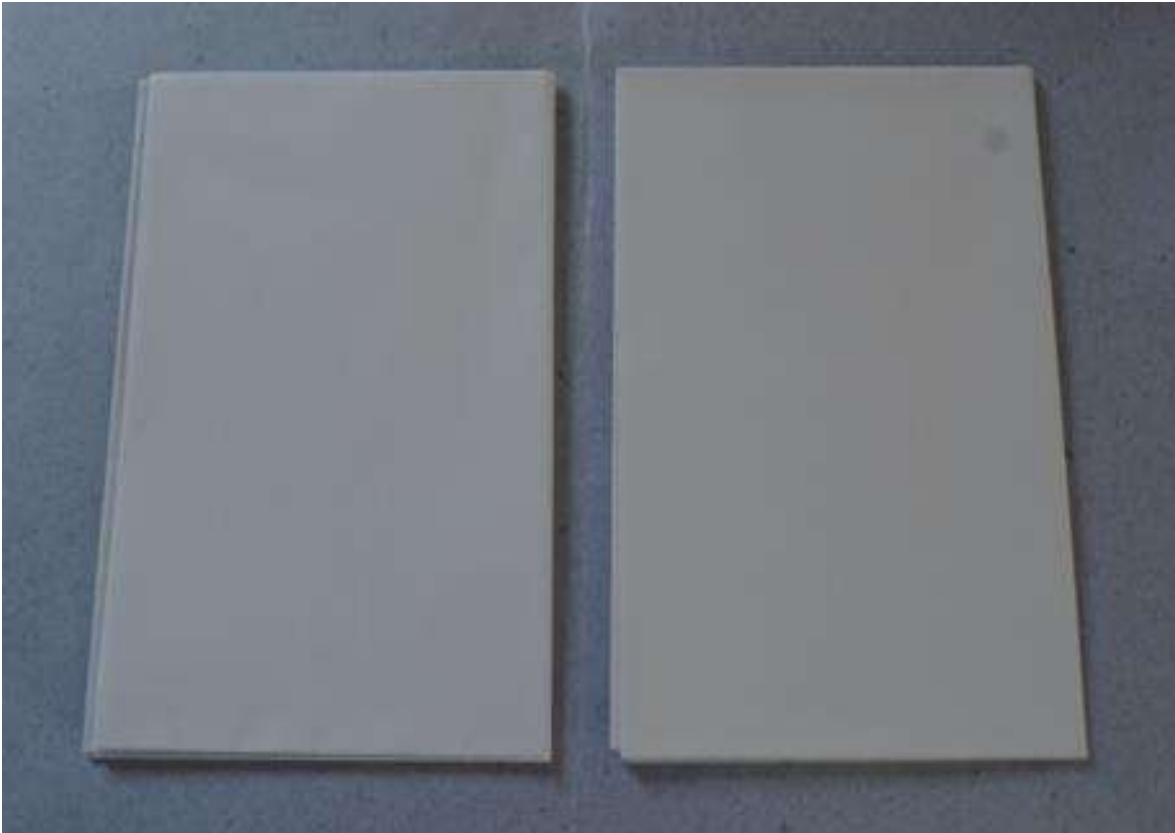
- Suction petechiae



Evidence Collection from Body

Fingernail Swabbing/Scrapings

- **NOTE: Fingernail clippings are preferred. If patient refuses clippings, collect swabbing/scrapings.**
- Remove folded paper from envelope and place, unfolded, on a flat surface
- Hold patient's left hand over the paper and gently clip the entire nail, allowing the clippings to fall on the paper.



- For swabbing, dampen a sterile swab from additional swab and swab under the nails. Place the air-dried swab in the folded paper.



- Then, pack in the fingernail scrapping/swabs envelope

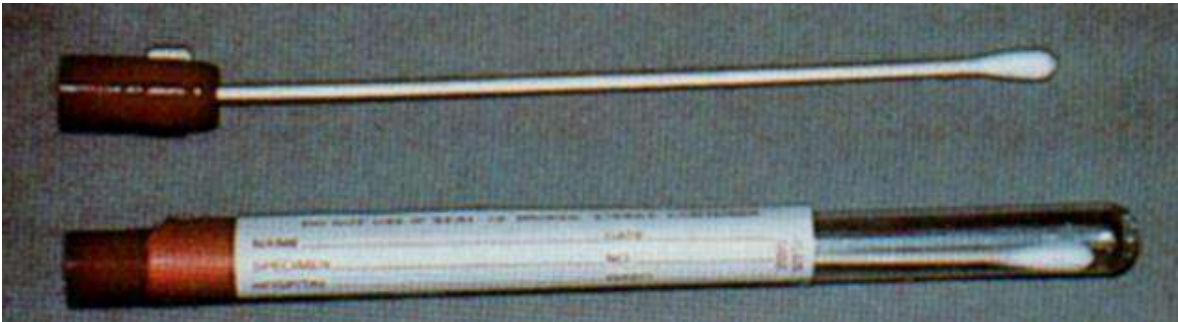


Oral Swabs

- Collect for:
 - Semen detection
 - Saliva evidence
- Carefully swab the buccal area and gum line. Be sure to collect the swabs from the upper and lower buccal areas and gum line, rotating the swabs during collection.



- Place the swabs in the swab box. Mark the swab box “Oral”.



- Now prepare a smear, air dry and
- pack in the SAFE envelope

STEP - 3 **ORAL SWABS/SMEAR**

IF THE EXAMINATION IS MORE THAN 6 HOURS AFTER ASSAULT, OMIT THIS STEP.

PURPOSE: The oral cavity is swabbed to collect semen.

NOTE: Do not wash, brush, rinse, or spit, because of the possibility of enhancing the transmission of HIV/AIDS and other diseases that may be carried in the assailant's semen.

1. Use the swab provided in the kit in the container, gently, without touching teeth.
2. Hold a swab and carefully insert between the upper and lower teeth between the lip and gums and stroke the gumline.
3. Repeat one dry mouth swab from the inside collected on the slide provided. Careful smear is prepared 7 x 100 in the corner of the slide. Air dry the smear and package in slide holder.
4. Place air-dried swab in the holder provided.
5. Place swab container and the slide in the holder in the collection envelope. Seal and label.
6. Place the envelope in the identifying bag.

Examiner's Name: _____ Date/Time: _____ Ref. Case No./EP/No. _____

Collected by: _____

Comment: _____

To be returned to: _____

Indicate if the swab was visualized Yes No

If yes, with: _____

Buccal Swab for victim DNA sample

- Collect victim DNA reference sample.
- Have the patient rinse his /her mouth with water prior to this evidence collection step. Remove components from kit envelope.
- Open the swab protector and slide the protector back to expose the swab head.
- Using the swab, vigorously swab the inside of both sides of the patient's cheek for 5 to 10 seconds.
- The swabs should be air dried for 03 hours before packaging. During drying make sure that the swab is not contacting with any surface (bench top or wall of the tube etc.)
- Pull the swab head back into the protector and re-close the protector around the swab head.

- Buccal Swab Brush



- Cotton Buccal Swab



Head Hair Samples

- **NOTE: Collect a minimum of 10 Cut hair from various scalp locations.**
- Remove folded paper from envelope and place, unfolded, on a flat surface.
- Place the hairs in the center of the paper and refold paper so as to retain the hairs

STEP 4 KNOWN HEAD HAIR STANDARDS.

PURPOSE: To collect known head hair for comparison purposes.

NOTE: Do not cut hair. Do not use forceps to pull hair.

1. Use a single zip-lock provided in the kit.
2. Pull out 20 full length hairs from different regions of the scalp, i.e., front, top, back, left side, and right side, ensuring a representative sampling of all lengths and colors of hairs. (examines may do this under supervision)
3. If head is injured, also collect a few hairs as close to the wound as possible.
4. Place collected head hairs in zip-lock bag.
5. Return specimen envelope (use zip-lock bag to the seal and label).
6. Place the envelope in the dispatching bag.

Examinee's Name: _____ Date/Time: _____ Ref. (case/MLF) file: _____

Collected by: _____

District: _____

To be submitted for: _____

Samples from body surface

- Collect dried secretions by lightly moistening two of the provided swabs with distilled water, and then thoroughly swabbing the area with both swabs.
- Re-swab the area with two additional dry swabs at the same time.
- Mark on each swab box whether the swabs are the first or second swabs. Also identify on
- each box whether or not the swabs are suspected semen, saliva, blood, or other. If other, please describe.
- Place each set of swabs in the appropriate box.
- Identify the location from which the samples were removed on the anatomical drawings on the envelope.

(9.8.2) GENITAL EXAMINATION

Observe

- Pubic hair
- Labia majora/minora
- Fourchette
- Hymen
- Vaginal wall
- Cervix
- Bleeding/discharge
- Foreign materials

Sample Collection

Pubic Hair Combing

- Remove the folded paper and comb provided in the “Pubic Hair Combing” envelope.
- Unfold the paper and place under the patient’s buttocks
- using the comb provided, comb the pubic hair in downward strokes to allow any debris or loose hairs to fall onto the paper.



- Remove the paper from under the patient.
- Place the comb in the center of the paper and refold so as to retain the comb and any evidence collected.
- **Note: hair for DNA testing is packed in folded paper and stored in 4⁰ C**

Pubic Hair Cut Samples



- Remove folded paper from envelope and place, unfolded, on a flat surface. Place hairs in the center of the paper and refold so as to retain the hairs.
- **Collect minimum of 3-cut pubic hairs from various regions of the pubic area.**
- **Pack in the pubic hair envelope**

STEP 13

PUBIC HAIR STANDARDS

WHICH EVER IS COLLECTED AT A LATER DATE, HOWEVER NO MICROSCOPICAL PUBIC HAIR COMPARISONS WILL BE PERFORMED WITHOUT KNOWN PUBIC HAIR STANDARDS.)

PURPOSE: To obtain known pubic hair standards for comparison purposes. (i.e. will questioned hair have cutting, coloring, perm, wax, and/or hair straightening)

NOTE: Do not cut hair. Do not use forceps.

1. Use the zip lock plastic bag provided.
2. Pull up to 15 hairs from four different regions of the body area (examiner may collect under supervision).
3. Place pulled hairs into zip lock bag and seal well when.
4. Return the zip lock bag to the collection envelope. Seal and label.
5. Place collection envelope in the shipping bag.

Examiner's Name _____ Date/Time _____ Ref. Case No./EF No. _____

Collected by _____

Control _____

To be analyzed by _____

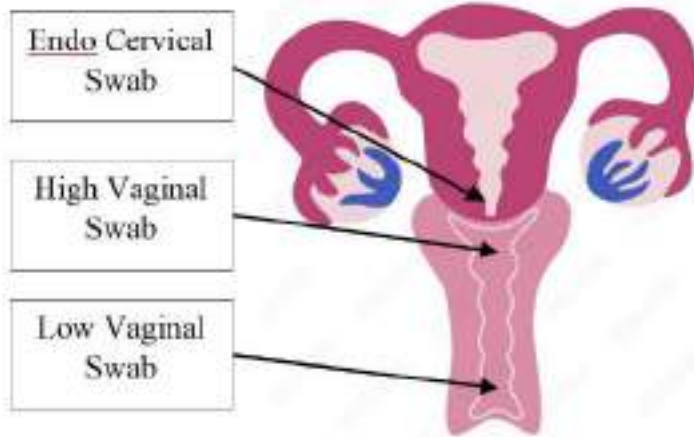
External Vaginal/ Swabs

- Moisten swabs provided with a minimal amount of distilled water.
- Holding the swab briskly swab the external genitalia, including along the folds.
- In a female patient, swab between the labia majora and the labia minora. Be sure to rotate the swabs during the collection procedure.



- In a male patient swab the coronal sulcus, entire penis and scrotum.
- The swabs should be air dried for at least 04 hours prior to packaging. Place the swabs in the box and mark “Genital / Penile”.

Internal Vaginal Swabs



1. Low Vaginal Swab

- Carefully swab the vaginal vault using swabs.
- Get swabs from low vaginal, high vaginal/posterior fornix.



Low Vaginal Swab

2. High Vaginal Swab

- Prevent contamination with low vaginal sperms.
- If hymen is torn - use non-lubricated speculum
- if hymen is intact- use glass-sheathed swab



High Vaginal Swab

3. Endo Cervical Swab

- Prepare the smear using the swab.

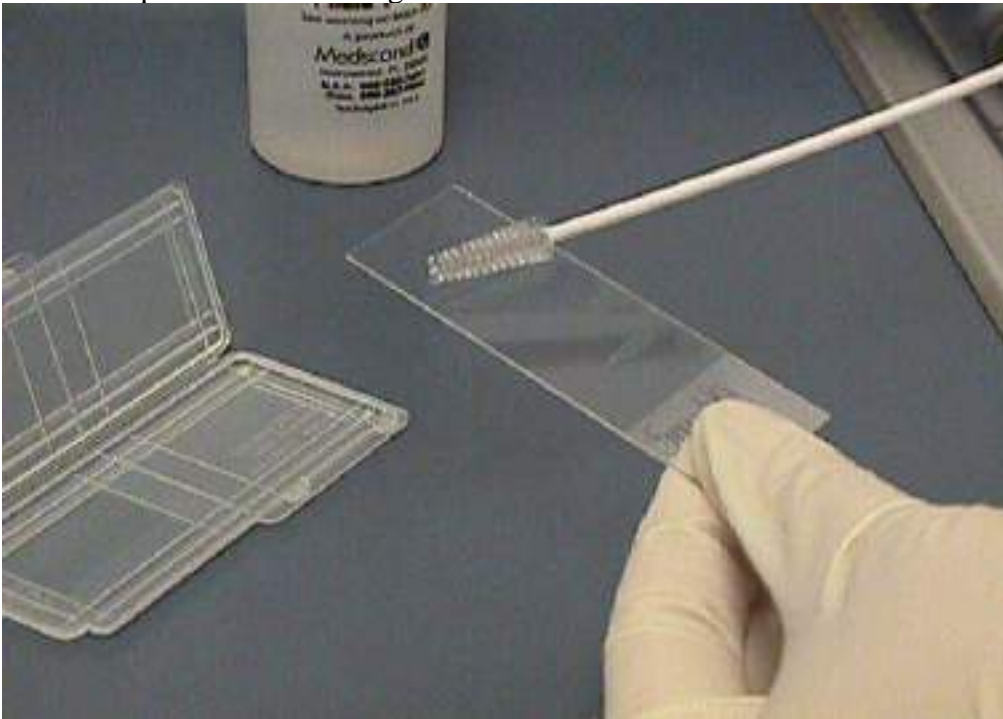
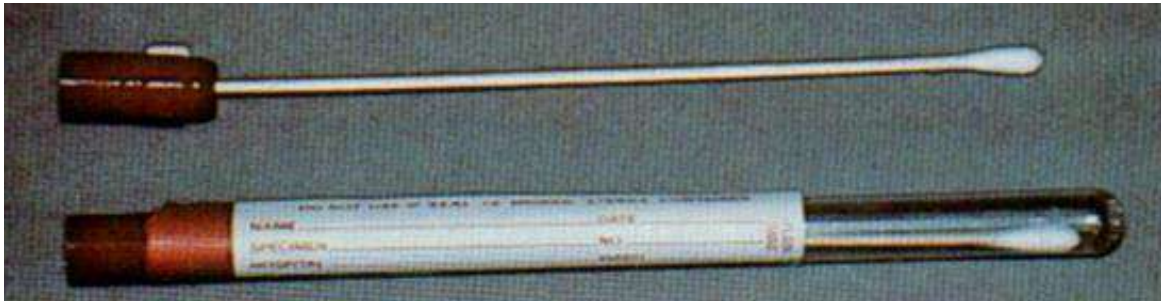


Photo-micrograph of the smear showing sperms



- The swabs should be air dried for at least 04 hours prior to packaging. Place the swabs in the swab box and label “Vaginal.”



Finally, pack in the vaginal swabs/smears envelope.

STEP 14 **VAGINAL SWABS/SMEAR**

PURPOSE: To recover the biological fluids.

NOTE: 1-48 hours or more after the patient also collect two cervical smears (not provided) after genital swabs have been collected.

1. Perform any appropriate digital a cervical, non-colposcopic smear or other test field in the vagina, if it is not during the above exam in 22 hour 4 days prior. Place the swabs in a large zip lock bag, seal, label and place inside the envelope, if possible. If the swabs are not fully dried, wrap it in clean paper, include sterile container for transport, to be sealed in a paper bag, and label. Do not place in the envelope. High level of investigation effort necessary.
2. Use swabs provided in the kit, working by without touching the necks.
3. While holding the swab about 2 cm into the vaginal canal, rotate the swab around the region while sweeping to ensure adequate coating of swab. Allow adequate time for saturation - at least 30 seconds.
4. Prepare one dry swab from the necks. (Do not allow an area of 1 x 1 cm in the center of the slide.) Air dry the swab and package in inside zip lock bag, seal and label.
5. Repeat the same for low & high vaginal and hibrida and insert them separately.
6. Place the zip lock bag with swabs in the collection envelope, seal and label.
7. Place the collection envelope in the shipping bag.

Examinee's Name: _____ Date/Time: _____ Ref. No./VLET/No: _____

Collected by: _____

Consent and file location: _____

To be examined for: _____

Indicate if the swab was recollected Yes No

If yes, with: _____

Hymenal Examination

- Type of hymen
 - If <1-year girls -
 - 50% Fimbriated,
 - 50% Annular,
 - If >1-year girls –
 - (a) 10% Fimbriated Hymen (folded hymen)



(b) 10% Annular Hymen (found right round)



(c) 50% Crescentic Hymen (only in the lower half)



(d) Few- Fenestrated, Septate, Imperforate Hymen.

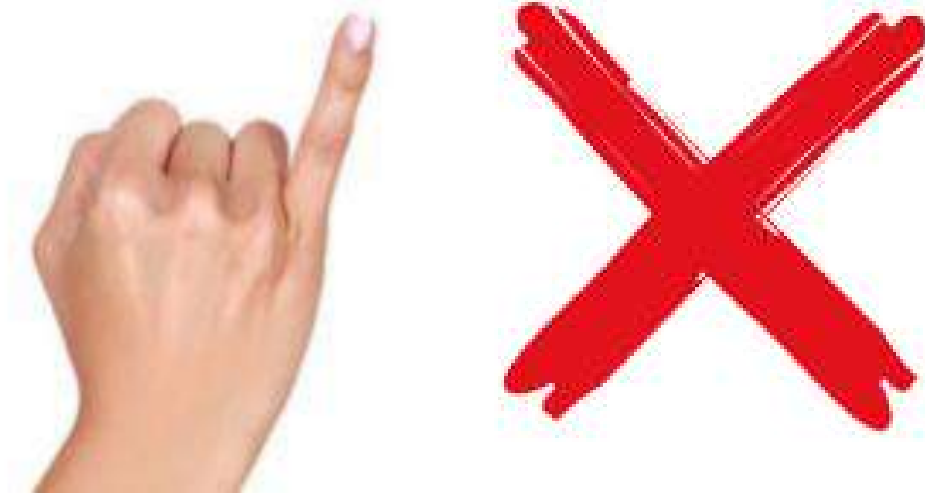
Transverse diameter of the hymen should be assessed -

- it is assessed by the insertion of Fingers

(1) <1 year- almost 100% closed

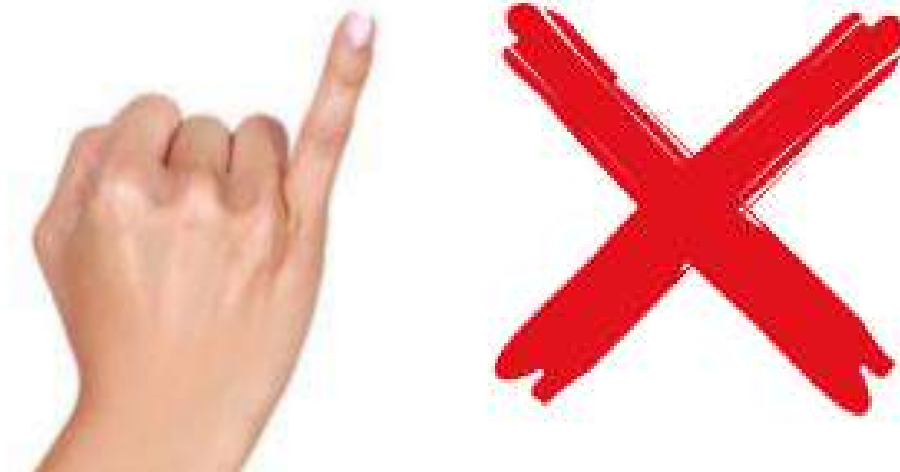
(2) Pre- pubertal- < 1 cm

- a. cannot insert even 5th finger



3. If Pubertal- about 1 cm

- a. still cannot insert even 5th finger

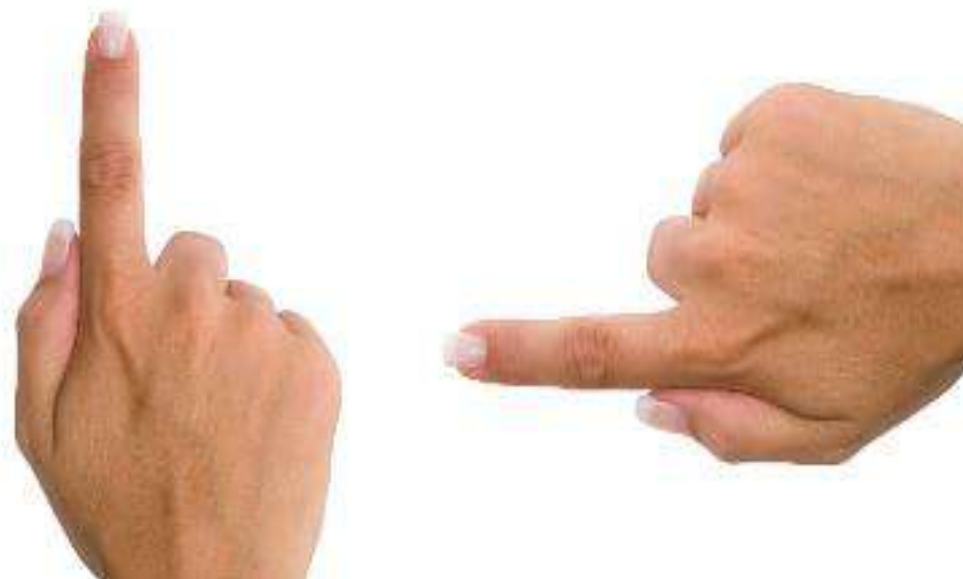


4. Post pubertal- <1.5 cm

a. Now can insert only the **5th finger**



5. If index finger can be inserted, suggestive of finger penetration,



6. If 2 fingers can be inserted, suggestive of penile penetration



Also assess the following also

- Fresh/healed tears
- Tenderness
- Redness
- Swelling

Important Interpretations

- **Partial Hymenal Tears interpretation**
 - Tears do not extend to wall of the vagina
 - Partial tears can Heal in 3 different shapes

- **1. Bumps or tags of the Hymen**



2. Attenuation of the Hymen



3. Cleft or notch of the Hymen



- **Complete Hymenal Tears- interpretation**

Tear extends to vaginal wall

1. Anterior half tears - congenital folds > traumatic tear

2. Posterior half tears - traumatic > congenital

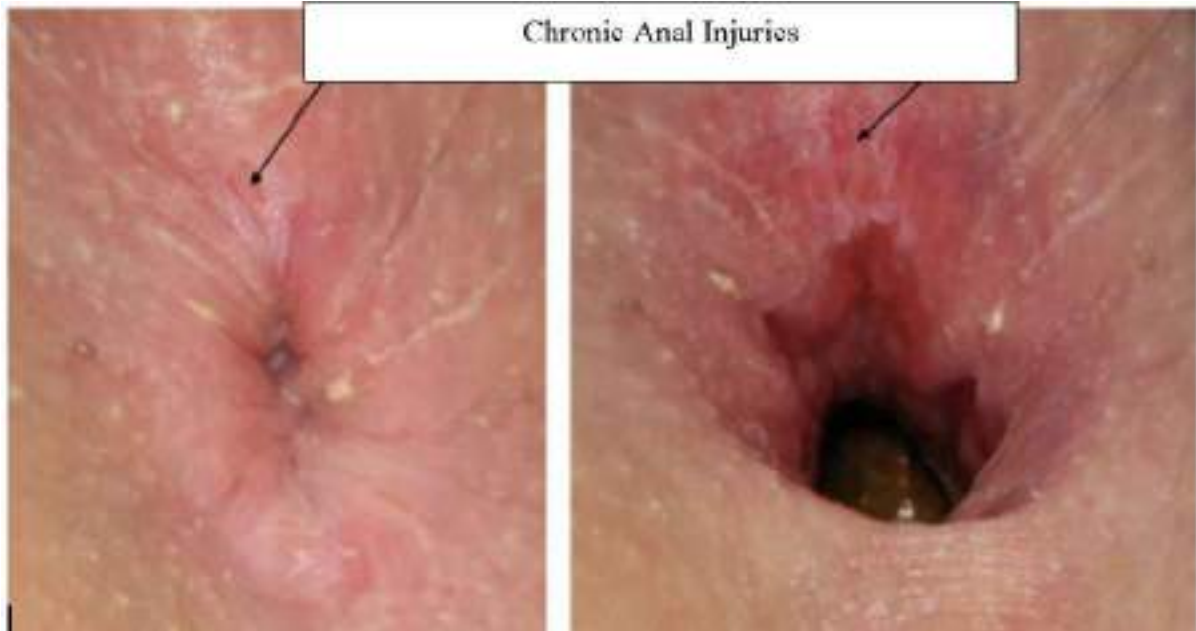


- Fresh Tears
- Old Tears

(9.8.3) ANAL EXAMINATION

Observe

- Perianal area
- Anal opening
- Anal canal
- Lubricants
- Blood
- Semen
- Reflex anal dilatation
- Injuries/scars



Collect - **Anal swabs**

- 1) External Anal Swab
- 2) Internal Anal Swab – to prevent contamination with external samples use non-lubricated proctoscope.



- **NOTE: Swabs may be moistened with a minimal amount of distilled water for the comfort of the patient.**
- Carefully swab the anus. Swab perianal, anal, and deep anal areas.
- The swabs should be air dried for at least 04 hours prior to packaging. Place the swabs in the swab box and check mark “Anal”.

- Then, pack in the rectal swabs/smear envelope

STEP 15

RECTAL SWABS/SMEAR

PURPOSE: To recover biological fluids of alleged suspect:

1. After collecting through anal canal, inserting external swab/smeatal, add collection bag(s) swabs, if available, from the perianal area.
2. Use index finger to depress rectal wall, swab area, to reach for the apex. Observe the insertion of the direct visualization from above the tip of the anoscope using good light.
3. Use the swabs provided. Preferably without occluding the swabs.
4. HOLD THE ANOSCOPE IN TO THE VIEW. Hold the swabs to insure air-dry coating. Allow adequate time for saturation - at least 30 seconds.
5. Place in dried swabs in a sealed leak container.
6. May Note the name of a different location/submit the area if required. Label accordingly if available.
7. Place the envelope in the shipping bag.

Examiner's Name: Date/Time: Ref. Case/ILEF) No.

Collected by:

Content and location:

To be submitted for:

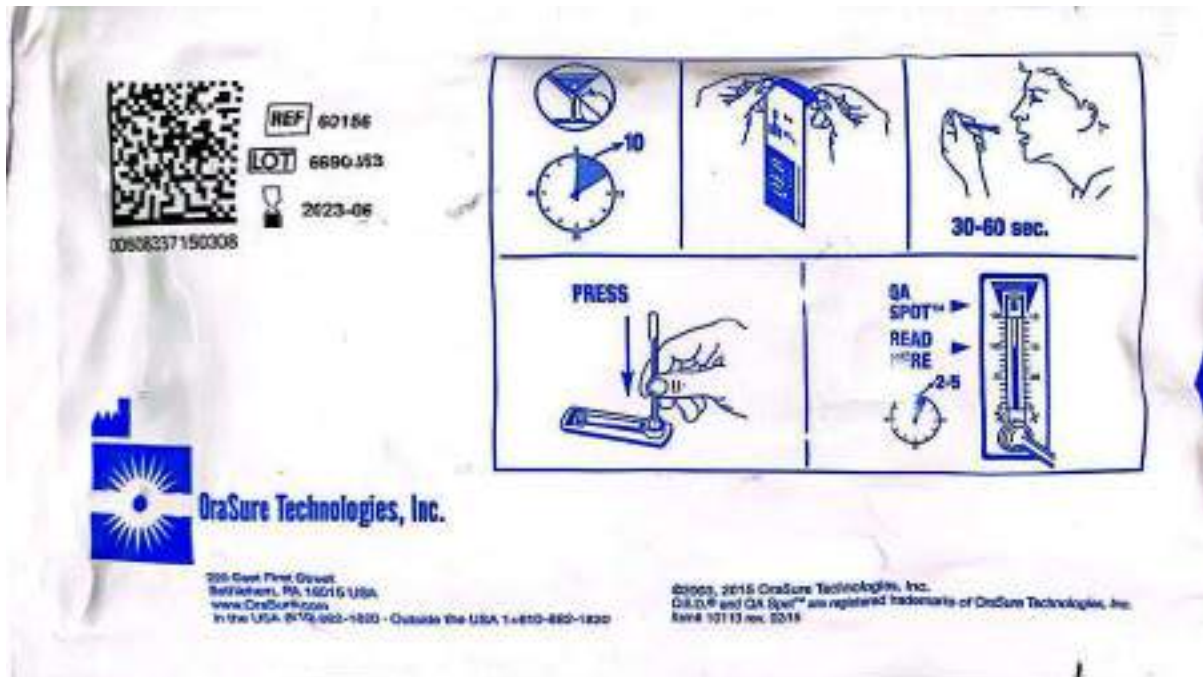
Indicate if the swab was moistened Yes No

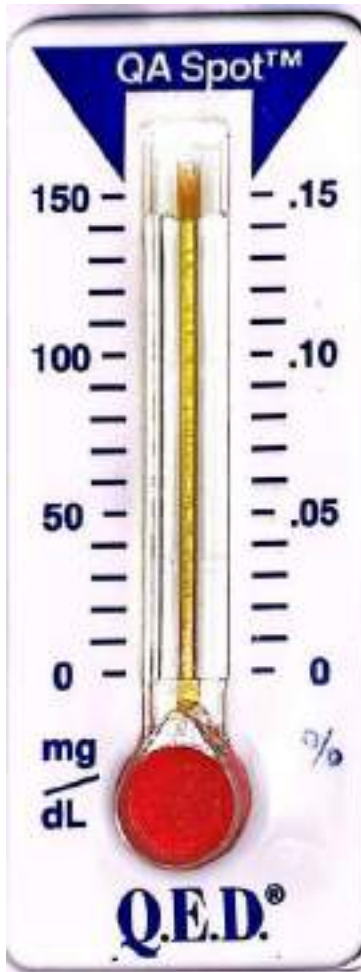
If yes, with:

(9.9) Step 9 – LABORATORY TESTS

1. Saliva- screening for alcohol

Saliva Alcohol Test (QED) - Quantitative evaluation of alcohol





1. Blood For Quantitative Analysis

(a) Alcohol & Toxicology- **GREY** tube with (K oxalate and Na fluoride)

Blood (10 ml)
in the last 4 days.



Grey Tube

(b) Forensic samples - Victim's DNA - PURPLE tube with EDTA
Blood- 10 ml



Purple Tube

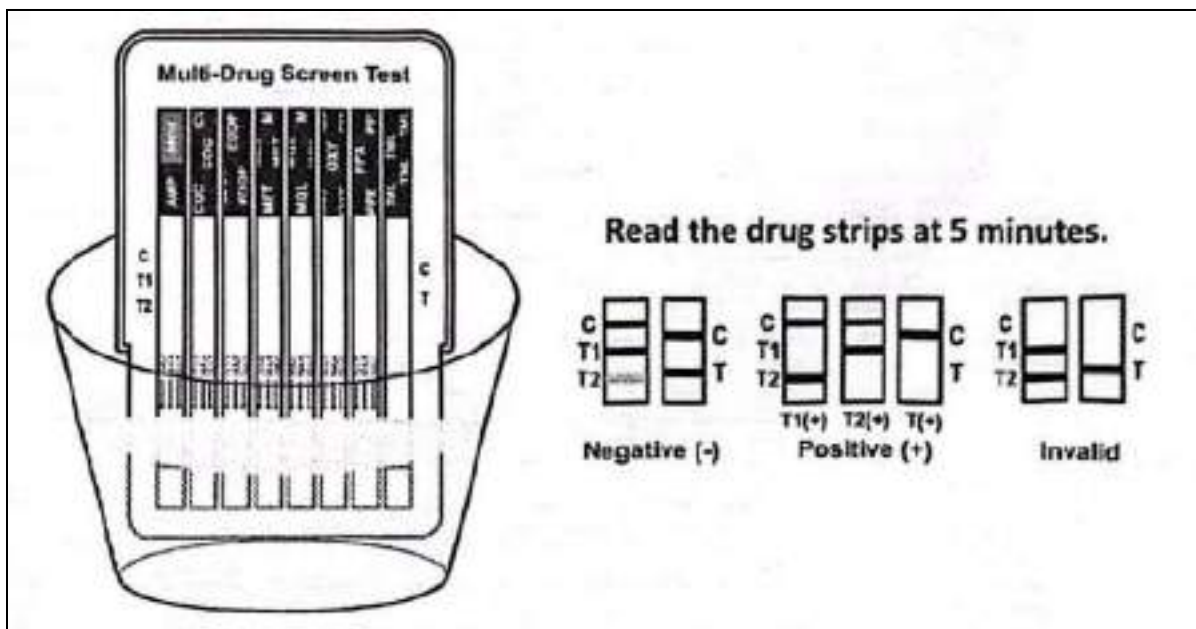
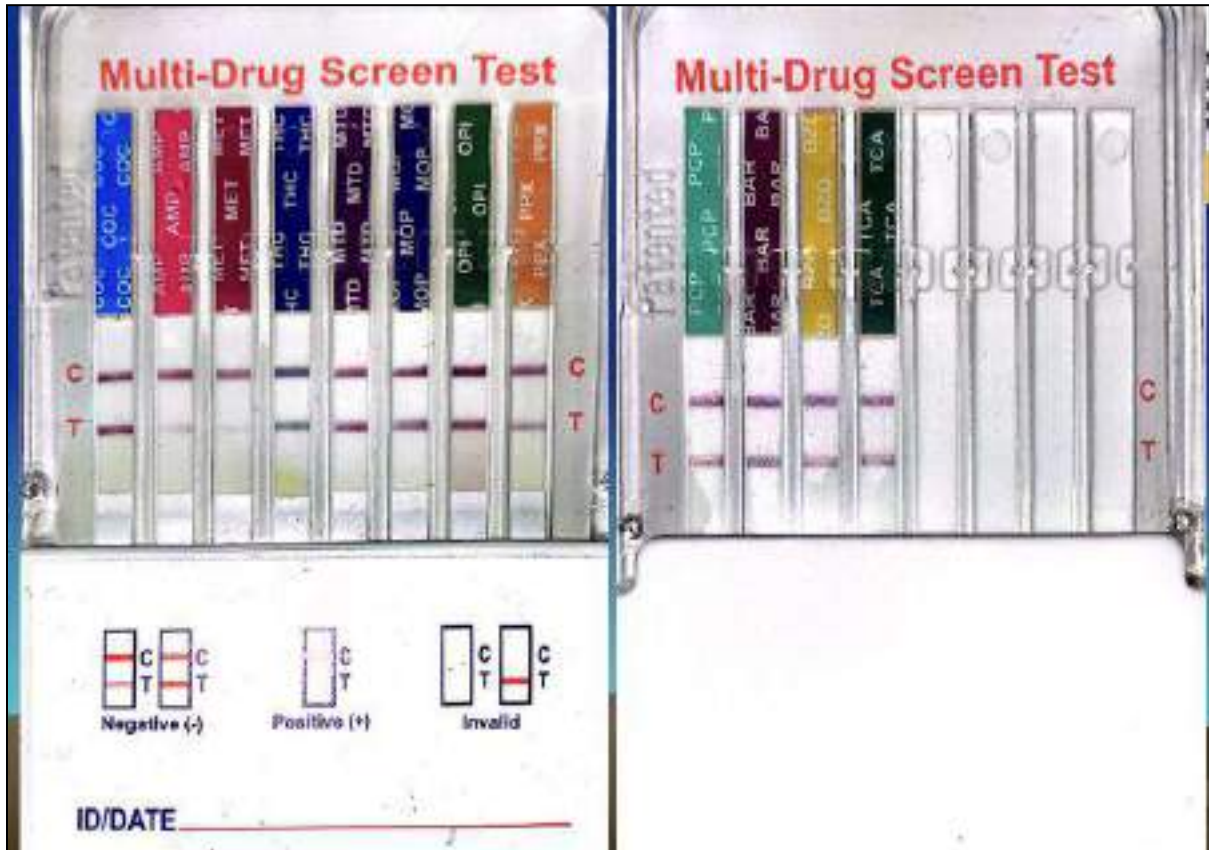
(3) For serum studies - RED topped tube – plain bottles -
blood 10ml



Red Tube

2. Urine – for Screening - 12 Drugs + Alcohol (Methyl Glucuronide)

Multi-Drug Screen test Kit



3. Urine- screening for alcohol-Qualitative analysis

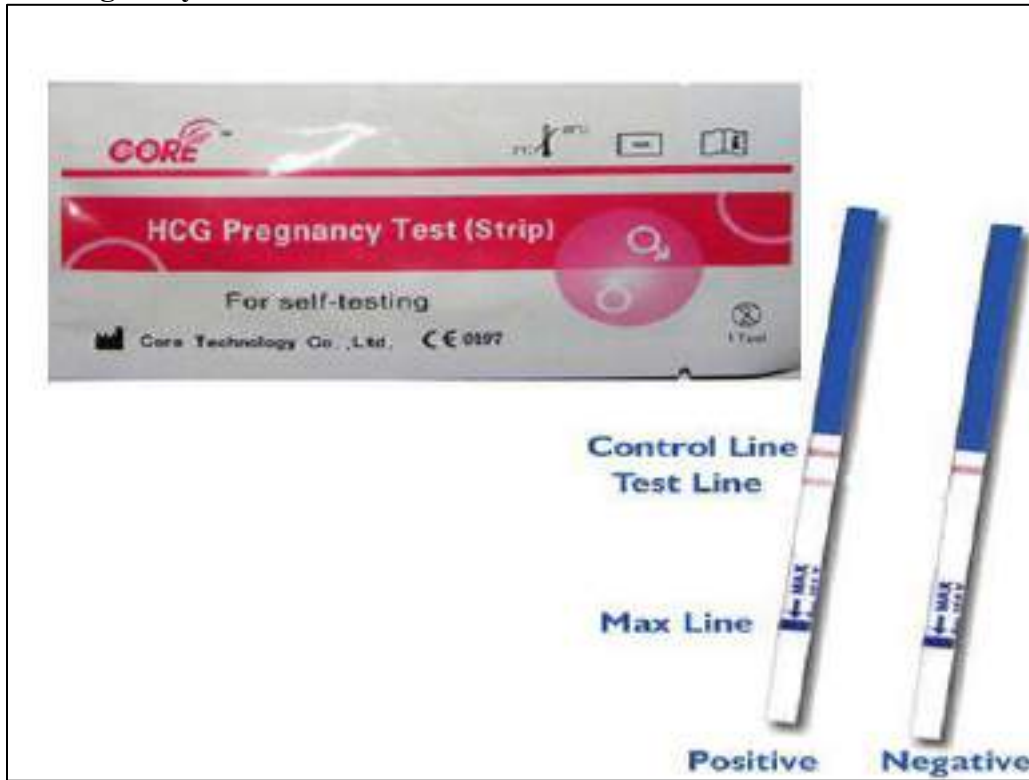
- If taken within 96 hours (4 days)
- 50 ml



Pack in Polythene bags



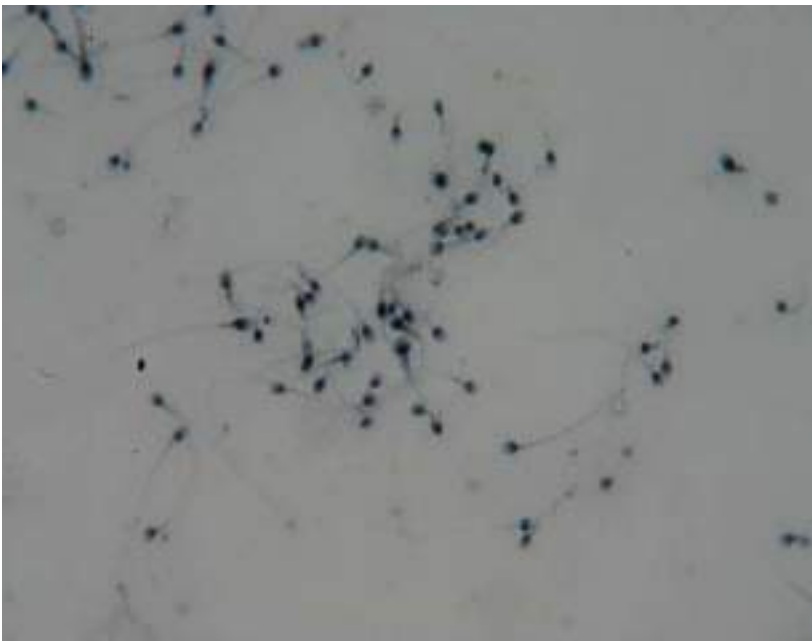
4. Pregnancy test



5. STI screening



- **Microscopy for spermatozoa**



Photomicrograph of sperms in a smear.

(9.10) Step 10 – VISIT TO SCENE

Where necessary

- Visit crime scene
- Correlate forensic findings
- Assist reconstruction
- LOCARDS

Evaluate

- Victim
- Assailant
- Clothing
- Weapons
- Environment





(9.11) Step 11 – REFERRALS

- Gynecology
- Psychiatry
- Clinical psychology
- STD clinic
- Surgery
- ENT
- Dental/maxillofacial units
- MDT for age estimation

(9.12) Step 12 – REVIEW OF VICTIM

Arrange

- Follow-up examination
- Review of injuries
- Psychological support
- STI follow-up
- Pregnancy follow-up

(9.13) Step 13 – REPORT PREPARATION & GIVING OPINIONS

Prepare

- MLEF documentation
- Medico-Legal Report (MLR)

Opinion Should Include

- Nature of injuries
- Mechanism of injuries
- Age of injuries
- Consistency with history
- Evidence of penetration
- Evidence suggestive of intercourse
- Laboratory findings
- Toxicology findings

(10) Format for collecting Medico-Legal information in alleged sexual abuse including diagrams

FORMAT FOR COLLECTING MEDICO-LEGAL INFORMATION IN ALLEGED SEXUAL ABUSE

(Use only for doctor's reference)

Please fill/tick appropriately. Read the entire form and refer the guideline before completion.			
MLEF number:	Police station:	Date of issue:	
Court:	Case number:	Date of order:	Date of trial:
1. IDENTIFICATION			
Full name of examinee:			
Date of birth:	Age:	Years:	Months:
If age is not known, estimated approximate age:			
Sex:			
Marital status: Unmarried/ Married			
Contact details of the examinee: Address:			
Phone number:			
2. PRELIMINARIES			
2.1 PRELIMINARY INFORMATION:			
Place of examination:			
Date & time of the commencement of the examination:			
Examinee produced by (name, rank/number, station etc.): (Police, Prison, NCPA, Probation, Referral from hospital, other)			
Reasons for production:			
Examinee accompanied by if any (if relevant- name and relationship):			
Name of the institution:			
Bed Head Ticket number:			
Date & time of admission:			
Ward number: (Attach photocopy of bed head ticket in relevant cases)			
Interpreter used for history taking:	Yes	No	
Name of interpreter:			
Relationship of the interpreter	Family	Friend	Specify
Language used (please specify in detail):			
2.2 INFORMATION GIVEN BY THE POLICE OFFICER: (where relevant)			
2.3 INFORMATION GIVEN BY THE NEXT OF KIN /ACCOMPANYING PERSON: (where relevant)			

4. HISTORY	
4.1 HISTORY GIVEN BY THE EXAMINEE IN HIS/HER OWN WORDS	
4.1.2 FORCE/INJURIES INFLICTED BY THE VICTIM ON THE PERPETRATOR DURING THE INCIDENT	
4.2 DESCRIBE THE RELEVANT ACTS FOLLOWING THE INCIDENT	
4.3 PREVIOUS SEXUAL ACTIVITY (when & where medico-legally relevant)	
4.4 PAST MEDICAL/SURGICAL HISTORY (where relevant)	
Hospitalization(s) with reasons	
Medications	
Allergies	
Disabilities (specify):	
4.5 MENSTRUAL & OBSTETRIC HISTORY	
Menarche/ Age of Menarche:	
Last Menstrual Period:	Menstruation at the time of incident: Yes/ No
Symptoms of pregnancy: Yes/ No	Period of amenorrhoea:
Number of children/type of deliveries:	Use of contraception:
Past history of abortions:	
4.6 SOCIAL HISTORY	

6. EXAMINATION			
6.1. OBSERVATIONS			
6.2. GENERAL PHYSICAL EXAMINATION			
Pallor:	Pulse:	Height:	Weight:
Disabilities:			
Other:			
Built and nourishment:			
6.3. CLOTHING			
6.4. EXAMINATION OF INJURIES AND SCARS			
(Use diagram form provided (see annexure))			
6.5. REVIEW OF SYSTEMS			
(Negative except as noted below)			
6.6. GENITAL AND PARA GENITAL EXAMINATION			
Breast			
Pubic hair			
Axillary hair			
Evidence of pregnancy/delivery(describe briefly)			

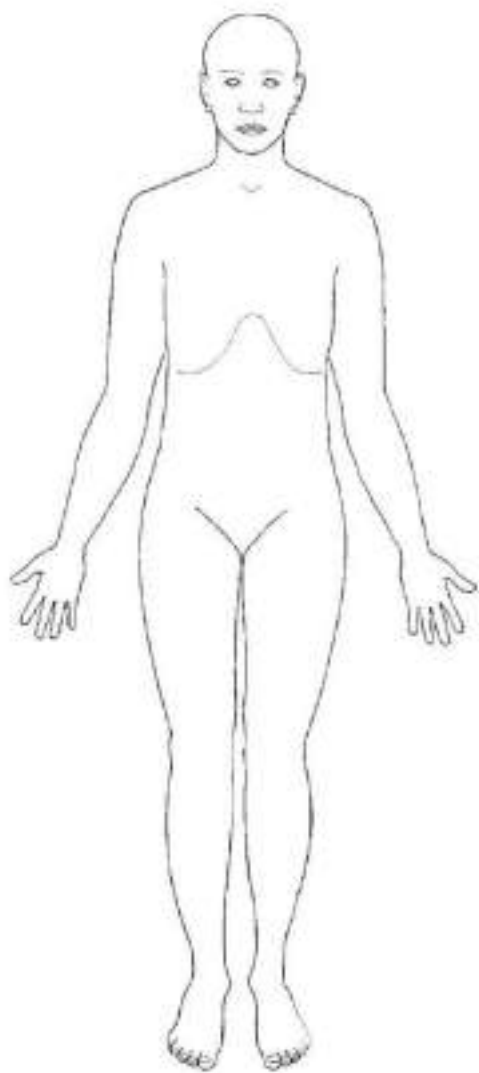
6.7. FEMALE GENITAL EXAMINATION Use diagram form provided (see annexure I)		
6.8. USE OF ANY INSTRUMENT FOR GENITAL EXAMINATION (if relevant)		
6.9. ANAL EXAMINATION Use diagram form provided (see annexure III)		
6.10. MALE GENITAL EXAMINATION Use diagram form provided (See annexure IV)		
7. DIAGNOSTIC STUDIES (where relevant)		
7.1. LABORATORY	Performed or not	Interpretation
Pregnancy test (HCG/ β gravindex)		
UFR		
Stains and swabs for spermatozoa (semen)		
DNA		
Other		
7.2. DIAGNOSTIC IMAGING	Indication	Report
US scan		
X-ray		
CT Scan		
MRI		
Other		
REMARKS		
B. PHOTO DOCUMENTATION(where relevant) Photographs taken by: Recommend follow-up photographs to be taken in 1-2 days (where relevant)		

9. REFERRALS (where relevant)			
Referral	Indication for referral	Date & time of referral	Opinion
STI			
Psychiatry			
Gynaecology & Obstetrics			
Surgery/Urology			
Radiology			
Other			
10. SUMMARY AND OPINION			
Summary of positive findings/important negative findings			
Conclusions and opinions			
11. NAME, SIGNATURE & DESIGNATION OF THE EXAMINER			
11.1. Name/s of others participated/observed the examination:			
12. DATE/S AND TIME/S OF REVIEW:			

Annexure I

Right

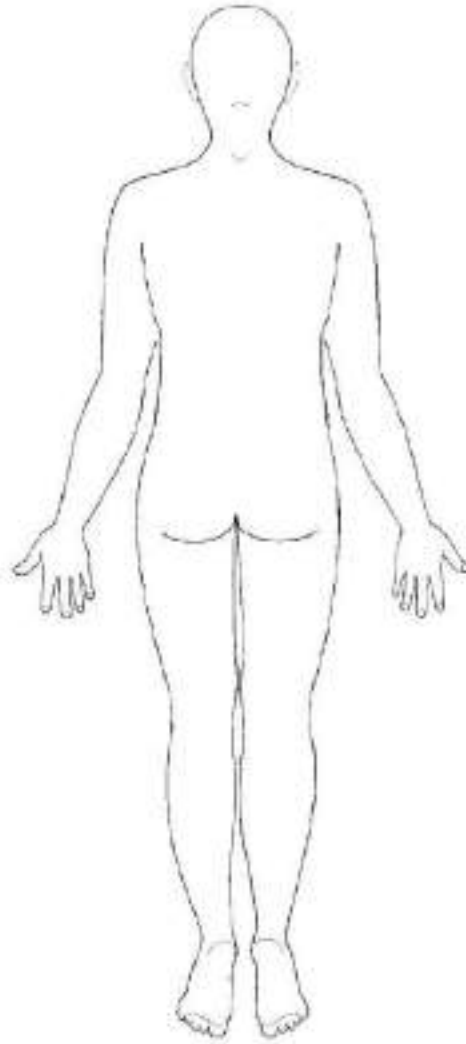
Left



Annexure II

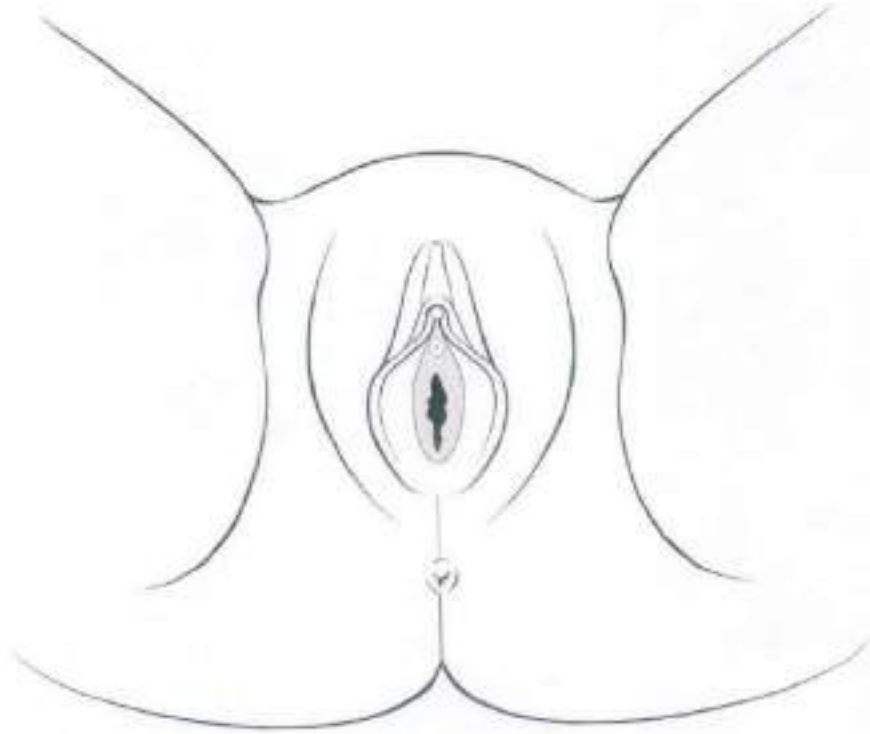
Left

Right

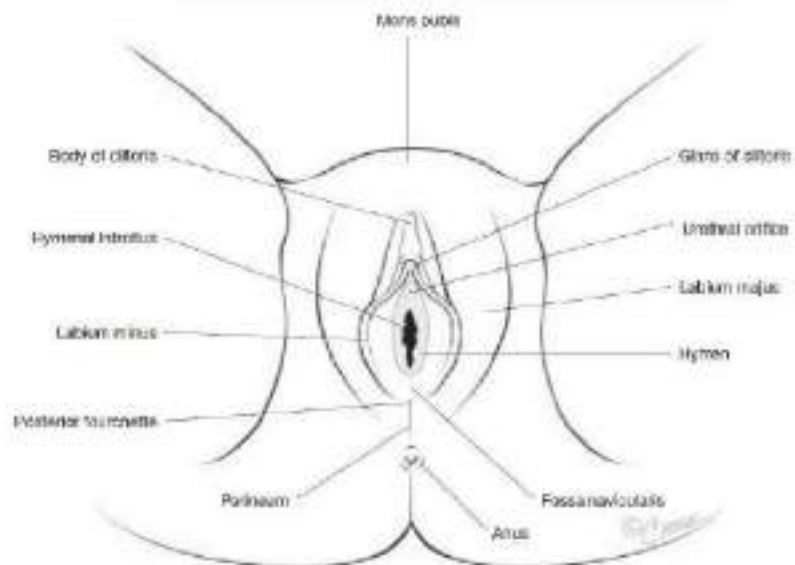


Annexure III

Position	
Technique	



Anatomical sites on the external genitalia of a mature



BOX 1

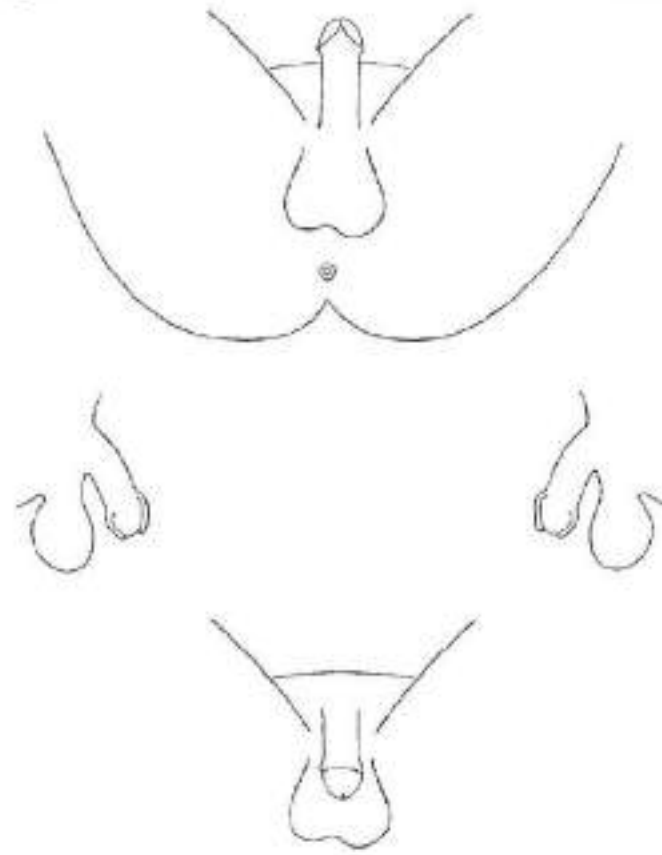
Female genital anatomy and recommended terminology

- The **vaginal vestibule** is the space in front of the hymenal membrane that is enclosed by the labia minora. This is sometimes incorrectly referred to as the introitus.
- Reference to the hymenal opening should be made using the term "**hymenal orifice**" and not "introitus" in order to avoid confusion.
- The **fossa navicularis** is the concave area between the posterior attachment of the hymen to the vaginal wall and the posterior fourchette (or commissure).
- The **posterior fourchette** is the point where the labia minora meet posteriorly and fuse together. It is only present after puberty, though this term is often applied, albeit incorrectly, to pre-pubescent girls.
- The **posterior commissure** is the point where the labia majora meet and fuse together, both before and after puberty.

Adopted from Guidelines for Medico-Legal Care for victims of sexual violence WHO 2003

Right

Left



(11) Medico - Legal Report

Report can be sent in three ways.

1. Medico - Legal report (Health – 1135)
2. SAFE guideline report
3. Free style report

<u>Medico Legal Report</u>	
A. Serial number:	
B. Case No	
C. Court:	
D. Date of Trial	
E. Reference details:	
a. MLEF number:	
b. Date of issue:	
c. Police station/Court:	
F. Identification:	
Full name:	
Date of birth:	
Age:	
If date of birth is not known estimated age:	
Sex:	
Address:	
G. Preliminary details	
Place of examination:	
Date and time of the examination:	
Examination performed by:	
The examinee was produced by:	
Hospital:	
Date and time of admission:	
BHT number:	
Ward:	
Date of review: (if reviewed)	
H. Information about the incident:	
Short relevant history:	

I. Physical examination:

General examination:

Systemic examination: (if indicated)

Wounds and scars:

Mental state:

J. Examination of genitalia: (where relevant)

K. Examination of the anus and perianal area: (where relevant)

L. Medical investigations and results: (where relevant)

M. Referrals and review:

N. Opinion:

O. Recommendations (where relevant)

P. Remarks (where relevant)

Signature of the Medical officer:

Name and qualifications:

Designation and place of work:

SLMC registration No:

Date:

Place:

(12) Important Interpretation Principles

- Absence of Injuries Does NOT Exclude Sexual Intercourse
- Possible due to
 - Delayed presentation
 - Lubrication
 - Stretchable hymen
 - Lack of resistance
 - Intoxication
- Genital Injuries Alone Do NOT Prove Rape
- “Rape” is a legal determination, not a medical diagnosis.
- Confirmatory Evidence of Penile Penetration
 - Spermatozoa in high vaginal swab
 - Pregnancy
 - Certain STIs

(13) Chain Of Custody

All samples must

- Be labelled correctly
- Be sealed
- Be documented
- Include signatures
- Be handed over properly to police/Government Analyst

(14) Confidentiality

All records and findings shall remain confidential and disclosed only to

- Courts
- Police
- Relevant medical professionals

(15) Documentation

Maintain:

- Consent forms
- Examination notes
- Injury diagrams
- Laboratory requests
- Referral letters
- MLR copies

(16) References

1. National Guidelines on Examination, Reporting and Management of Sexually Abused Survivors for Medico-Legal Purposes, College of Forensic Pathologists of Sri Lanka.
2. SAFE – Sexual Assault Forensic Examination of Rape Victims Presentation by Snr. Prof. M Vidanapathirana.

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