GUIDELINES FOR THE COMPLETION OF THE J88 FORM

GENERAL:

- The Report may be written on the patients file, but the information as set out in the J88 must be in the report.
- The more legible completed and detailed the report, the less the chance that the doctor will have to appear in court to testify.
- The **whole** report has to be completed in the doctor's own handwriting as the Police are not allowed to write on the J88 form. Alternately the report may be typewritten.
  The health care practitioner must sign every page.
- If findings are normal, write within normal limits.
- Do not use unfamiliar abbreviations like NAD or draw a line through the relevant part as you may be expected to explain the meaning of such entries in court.
- The original copy of the J88 must be given only to the investigating SAPS officer; retain a duplicate copy in the patient record.
- The health care practitioner / institution must manage all cases from the various Magisterial Districts falling within a particular Health District in KwaZulu-Natal. It is the duty of the health care practitioner to familiarise him- or herself with the demarcation of the District and the magisterial areas that fall within that district.

DETAILED PROTOCOL FOR COMPLETION OF J88 FORM

(Numbers As On Form)

A. DEMOGRAPHIC INFORMATION:

1. Police Station: (see SAP 308).
2. CAS no: (see SAP 308). Write the full number including that of the year, as the case may have been in progress for longer than one year.
3. Investigating officer: name and number: (see SAP 308).
4. Time: Use 24 hour notation: e.g. 06:10.
   Date: Always use six blocks: e.g. 06 (day) 12 (month) 2002 (year).
5. Medical Practitioner: use stamp if available.
6. Registered qualifications: use stamp if available.

7. Phone number: provide work, home and cell phone numbers, Include area code.

8. Fax number.

9. Physical Practice address: use stamp if available. Provide street name and number for delivery of subpoena.

10. Place of examination – state name of clinic, hospital or private rooms.

11. Full name of person examined: write full name as it appears on identity document or birth certificate. Add name by which person is called in brackets (e.g. “Suzie”)

12. Sex: write male or female.

13. Age: add date of birth, if available, especially in children.

B. GENERAL HISTORY:

NB: State clearly whether source of information was the complainant himself/herself or a third party (who must be identified).

1. Relevant medical history and medication:

- Enquire about previous injuries such as fractures, falls or burns. If necessary find old patient records or request social worker to access National Child Protection Register from the Department of Welfare and Population Development.

- Emphasize conditions that could lead to non-accidental injuries, that cause or aggravate bruising or that can be transmitted sexually. These include diabetes, asthma, epilepsy, mental retardation, behavioral disorders, psychoses and HIV infection .

- In children, ask about bedwetting, encopresis, vaginal burning, vaginal discharge, nappy rashes and etopic eczema.

- Document any medical condition diagnosed during examination such as common cold or heart murmur.

Medication:

Include any medication that could cause or aggravate bruising or bleeding, influence mental awareness or cause acute episodes of hypertension. These include steroids, immunosuppressive medication, anti-convulsives, anti-depressants, anti-histamines, anti-hypertensives and hypnotics.

C. GENERAL EXAMINATION:

1. Condition of clothing

- The colour, styling and general cut of the article of clothing are generally not important.
- Describe tears, missing buttons, torn or absent pockets and stains (blood dirt, grass, mud, semen, urine or vomitus).

2. Height: In centimeters

3. Mass: in kilograms

4. General body building:

- State whether body build is within normal limits in terms of age, sex and height.
- State whether there is exceptional muscular development such as in athletes and bodybuilders.
- State whether there is emaciation or obesity. Use the body mass index for adults and the WHO weight for age centiles for children under five.
- In case of sexual offences involving children and young women, relate age to Tanner scales as recorded in section E and H.
- In order to assess physical powers and development, use of percentile charts for height, weight and head circumference should be made.

5. Clinical findings:

- Document systemically as set out in J88.
- Avoid using technical, medical terminology.
- Indicate extent and position of injuries on sketches provided in contrasting colour pen.
- Number each lesion (1)…….(2)…..etc. on sketch and describe on form as follows:

- ❑ 2cm laceration sutured with 4 stitches on left forearm.
- ❑ Circumorbital swelling and bruising left eye, with subconjunctival bleeding.

6. Mental health and emotional status:

- Document whether person is abnormally calm, distraught, weeping, hysterical or stuporous.

- If any suspicion of mental retardation exists, relate mental age to chronological age in adults and milestones for age in children.

- Note any discrepancy in gender identification, such as cross-dressing and relate any deviation in sexual orientation such paedophilia or bisexuality.

- Note any abnormal knowledge of sex related language in young children.

- Note any symptoms and signs of psychotic or psychoneurotic behavior including mood disorders where the mood does not conform to the existing circumstances of the person involved.

7. Clinical evidence of drugs or alcohol:

- Document any obvious smell of liquor or dagga.

- Obvious clinical signs include abnormal size of pupils, congested conjunctivae, nystagmus, dry mouth and slurred speech.

- If necessary take blood and urine samples.

- Inspection injection sites for needlestick marks.

8. Conclusion:

In order to be able to come to a conclusion as to whether the clinical findings are compatible with the time and circumstances of the alleged incident, a short history is necessary. The history should not be documented on J88 but on the SAP 308 or a separate page. The history should be very brief and give only the essential facts necessary for a medical conclusion e.g.

- It is alleged by the complainant that on the 18th December 2001 at 20h00 she was assaulted with a belt (or "belt like object") on her back by an adult male.

- The mother (Mrs X) alleges that child Y was sexually assaulted by an adult male sometime during the first 3 months of this year.

- Child Y alleges that before Christmas during the holidays when visiting family an adult male known to Y, sexually assaulted her.

NB: Never give the name of the accused or alleged perpetrator. Do not give any more detailed information, as it might not be exactly the same as in the statement given to the Police by the complainant. Discrepancies in the statements given could be used by the defense counsel to dispute the evidence in court.

The final conclusion should be short and clear:

- Injuries compatible with/not compatible with time and circumstances of alleged incident.
- Injuries compatible with injuries caused by a sharp object / compatible with injuries caused by a blunt object. Do not name the object, as the knife mentioned by the patient, might actually have been a sharpened screwdriver. In court counsel for the defense will again attempt to use such discrepancies to the advantage of the accused.

D. HISTORY IN CASE OF ALLEGED SEXUAL OFFENCE:

It is important to explain to the complainant /parents/ guardians that the testimony by the doctor will be given in a closed court and that not even the mother will be admitted without the consent of the doctor and the complainant.

1. Age of menarche:

   In child sexual assault cases involving children or cases where the assault is reported years after the initial incident, the effect of oestrogenisation on the hymen must be considered when examining the patient.

2. Number of pregnancies.
3. Number of deliveries.
4. Duration of pregnancy.
5. Contraception.
6. Method and date.
7. First day of last menstruation.
8. Duration of period.
9. Duration of cycle.

   Some of the above factors have an effect on vaginal lubrication. If the victim was menstruating during the alleged sexual assault, blood might be found on the suspect, and a blood sample for DNA typing is necessary. Menstruation also increases the risk of contracting a STD, including HIV infection.

10. Date of last intercourse with consent:

    In a teenage girl alleged to be a virgin do not complete this question until after the examination. Many girls will not immediately admit to having had intercourse with a boyfriend until confronted with the medical evidence. If consensual intercourse was on same date as incident, note exact time as well.

11. Number of consensual sexual partners during last 7 days:

    Blood samples will be obtained (on request by the police) from all the partners for DNA typing in order to distinguish their semen from that of the accused.

12. Condoms:

    Important to alert the police about the use of a condom as they must endeavor to find it. Vaginal cells from the complainant can sometimes be found on the condom. A vaginal swab must always be taken, as leakage from a condom remains a possibility.

14. Since the alleged offence took place, has the person bathed, washed showered, douched, urinated, changed clothing. Much evidence can be destroyed by the listed actions. Traces of evidence may be found in the shower, bath or hand wash-basin. The police may also be able to retrieve toiletpaper containing semen or foreign hair from the toilet bowl.

E. GYNAECOLOGICAL EXAMINATION:

1. Breast development : Tanner stage 1 - 5

2. Pubic hair : Tanner stage 1 – 5

   In peri-pubertal children, Tanner staging is the best way to scientifically describe external sexual maturity, in order to determine any discrepancies between apparent age and chronological age. It also helps the doctor as expert witness to compare apparent age of an abused child at the time of the court case with that at the initial examination.

3. Mons pubis:

   Look for signs of injuries (scratch marks, abrasions, contusions). In case of cesarean section scar, note date of operation.

4. Clitoris: (See E9)

5. Frenulum of clitoris : (See E9)

6. Urethral orifice: (See E9)

7. Para-urethral folds: (See E9)

8. Labia majora : (See E9)

9. Labia minora: In each case, describe all fresh injuries; oedeama, swelling, redness, abrasions, scratches, bruising, petechial bleedings, lacerations or cuts, describe ulcers, rashes, discoloration as well as healed scars, signs of fibrosis or any other abnormalities.

10. Posterior fourchette:

Use clock notation to describe position of injuries. (note the age of lesions).

11. Fossa navicularis:

(See E – 10) note all fresh injuries and scars; use clock notation to describe position .

12-19 Hymen:

Use clock notation to describe position of injuries. Do not perform a digital examination on a virgin.

20. Vagina:

Use clock notation to describe position of injuries. Record any vaginal delivery during past six months and state any possible lesions due to such delivery.

21. Cervix: (See E 20)

22. Perineum (See E 20)

F. SAMPLES TAKEN FOR INVESTIGATION:

1. Forensic specimens taken

NB: It is safer to take an unnecessary specimen rather than to omit collecting a vital one.

- Pregnancy test:

Performing a pregnancy test on all cases of pre-menopausal potentially fertile women not menstruating at the time of the examination. This will serve as a baseline for a possible later decision on therapeutic abortion.

- Seal number of Evidence Collection Kit:

Note both original and re-seal number and add / paste label if available onto J88.

2. Specimens handed to:

It is important to complete this part legibly with the name, rank, number and signature of the receiving officer. The chain of evidence is thus preserved and the health practitioner is no longer responsible for the safeguarding of the evidence collection kit.

3. Conclusions:

This is the most important part of the report. Never use the term rape in a medical report e.g. no sign of rape. A negative medical examination should conclude; absence of injuries does not exclude forcible penetration of vulva/vagina by penis or other object. In case of injuries, state example. Injuries compatible with forcible penetration past labia minora

with bruising of hymen/injuries compatible with forcible penetration into vagina with rupture of hymen…State whether injuries conform to time and date of the alleged incident.

G. ANAL EXAMINATION: 1-22

Use clock notation; state apparent age, degree and severity of lesions.
Measure extent of lesions in millimeters.

Write conclusion as in F3.

H. MALE GENITALIA: 1-15

This part needs to be completed in case of male sexual abuse or when a police suspect must be examined.

- Genital development and pubic hair – Tanner staging:

  This is important to determine sexual maturity.

- Note the nature, extent, anatomical position and apparent age of all injuries.

16. Conclusion:

In young males, compare Tanner staging with chronological age.
State whether your findings are compatible with the history of the alleged incident as provided by the SAPS on the 308 and the person examined.

IMPORTANT:

THE MORE COMPLETE, LEGIBLE AND COMPREHENSIVE THE SUBMITTED FORM IS, THE LESS THE CHANCES ARE OF HAVING TO TESTIFY IN COURT.