FORENSIC MEDICAL REPORT (FMR): SEXUAL ASSAULT EXAMINATION

INSTRUCTION MANUAL

REQUIRED USE OF STANDARD FORENSIC MEDICAL FORM:

This format is intended to document forensic medical findings and, as such, is not a complete medical treatment record.

These instructions contain the recommended methods for meeting the minimum standards requirements for performing forensic medical examination.

NOTE:

- This information is confidential. Every effort must be made to protect the privacy and safety of the patient.
- The victim must be given appropriate treatment and counseling as per the need. Victim must not be refused treatment and examination for want of police papers.
- Exposure to sexual violence is associated with a range of health consequences for the victim. Comprehensive care must address the following issues: physical injuries; pregnancy; STIs, HIV and hepatitis B; counseling and social support, follow-up consultations and appropriate referral.
- The examination should be conducted in private but the patient should be allowed to request a support person (e.g. family member or rape councilor) to be present. If the patient does not request the presence of a support person, a female nurse or other suitable chaperone should be present during the examination.

Registration of sexually assaulted victims & Preliminary information:-

- Whenever such cases reports to the hospital, it shall be registered as MLC whether patient comes on her own or is brought by the police.
- If patient comes on her own then decision to inform the case to police shall be taken after obtaining due consent from the patient and or guardian.

Instructions for filling the Forensic Medical Form:

Complete this report in its entirety. Use N/A (not applicable) when appropriate to show that the examiner attended to the question.

Use of this form:

- Each hospital can use already printed version of this form or can generate the same form through software.
- Write or type the name of the Department/ hospital/ Unit including place where the examination was conducted.

I: GENERAL INFORMATION AND CONSENT:

1. Enter the OPD number/ IPD Number.
2. Enter the MLC number.
3. Enter the full name of the patient/ victim or survivor.
4. Enter the age/ sex of the patient. Also enter the marital status of the patient i.e., whether single, married, divorced etc.
5. Enter the patients address with contact number if any.
6. Enter the date and time of arrival of the patient or victim at the hospital.
7. Brought by:
    a. If the patient is accompanied by a police or law enforcement officer, enter the officer's name, buckle/ identification number and police station of accompanying police with letter no/date etc.
    b. If the patient comes on her own then enter the name of the person (if any) with relation who accompanied the patient.

NOTE:

a. In the past rape survivor examination was only done after receiving police requisition. Now the police requisition is not mandatory for a rape survivor to seek medical examination and care. The doctor should examine such cases if the survivor reports to the hospital first without FIR. He then informed the police accordingly as per the request of the patient.

b. A survivor may come to the hospital only for treatment for effects of assault. Under section 39 CrPC the doctor is not bound to inform such cases to the police. **Informed refusal for not informing the police should be documented.** Neither court nor police can force the survivor to undergo medical examination. It has to be with his/her/ parental/ guardian's informed consent (depending on age)

8. Consent:

- Ask the patient (or the patients parents or guardian, if appropriate) to read the items and initial.
- The consent form will be signed by the person him/herself if s/he is above 12 yrs. of age.
- Consent must be taken from the guardian/parent if the survivor is under the age of 12 years or if the survivor is unable to give his/ her consent by reason of mental disability.
- The provision of the parents consent is not applicable when the health professional reasonably believes the parent(s) or guardian committed the sexual assault on the minor.
- In case an invasive procedure needs to be performed, age of consent is 18 years. Invasive procedures include per-vaginal, per speculum, per-rectal examinations. Non-invasive procedures include physical examination & evidence collection from exposed parts of the body.
- Consent of the patient to be taken for the following purposes:
  - Medical Examination & treatment
  - Forensic medical examination & Collection of the evidence
  - Informing police for purposes of investigation
  - Treatment
- Please note that the patient or guardian may refuse to give consent for any part of the examination. In this case the doctor should explain the importance of examination and evidence collection. It should also be explained that refusal for such examination will not affect/compromise treatment. Such informed refusal for examination and evidence collection must be documented.
- Patient and her relative/ guardian should be explained that at any stage during examination and evidence collection she may ask the doctor to stop and that it will not have any effect on the quality of her treatment.
- In the event the victim does not consent to give the information to police, then the patient must be reassured that the examination findings will be kept confidential and

will not be divulged to the police by the doctor himself/herself without his/her consent.

9. Doctor should take all reasonable efforts to note down at least two marks of identification.
    a. Right thumb impression in case of females and left thumb impression in case of male may be obtained.
    b. Identification marks must be in the form of moles, scars, tattoos, preferably from the exposed parts of the body. While describing identification mark emphasis should be on size, site, surface, shape, colour, fixity to underlying structures.
10. If female patient is to be examined by a male doctor then such examination shall be made in presence of a female person i.e., nurse/ attendant/etc. In such circumstances the name and signature of the female person in whose presence the examination is conducted shall be obtained against this column. If female patient is being examined by female doctor then "not applicable' must be written against this column.
11. Enter the date and time of arrival of the victim/ patient at hospital.

(II) History/Details of alleged sexual assault:

a) As far as possible history shall be obtained from the victim in his/ her own words. If it is not possible to collect the history from the victim because of medical reasons then the name of the person with relation who provided the history must be documented. If patient himself/ herself provides the history then 'not applicable' must be written as appropriate. While recording the history of assault, keep following points in mind:

- Doctors should keep in mind that sexual assault is a social stigma and is a traumatizing experience. Hence one must be very sensitive and compassionate while eliciting the history. Talk with the patient in a non threatening environment and do not be judgmental, and do not interrupt the patient while eliciting the history.
- Physical and mental comfort to the victim helps to elicit proper history. This can be achieved by providing privacy and empathetic approach by the team. History should be in her own language.
- While taking history, no third person/ police is allowed. Relative could be allowed to be present if the patient/ victim is comfortable and gives consent for the same. If she

refused to answer, unnecessary pursuance should not be done. Importance of history for treatment purposes as well as its legal implications can be explained.

- When intervening the patient about the assault, ask her to tell you in her own words what happened to her. Document her account without unnecessary interruption; if you need to clarify any details, ask questions after your patient has completed her account.

Some of the important points to be elicited in the history of sexual assault are as follows.

- Date, time and place of assault.
- Details of assailant/s like their number and features if known.
- Details of the act or acts alleged.
- Did she experience any pain at the time of incident or subsequently?
- Description of the type of surface on which the assault occurred.
- The nature of the physical contacts
- Threat (describe type of threat) / use of force, blows, grasping, grabbing, holding etc, weapons used and injuries caused. This is to identify pattern of injury and patterns of injury which may correlate with the alleged weapon and with the part of the body used and to identify the parts of the body which may show injuries consistent with method used. Threats of harm if present may explain the lack of physical injury.
- Use of physical restraints (describe types used). This is to identify pattern of injury which may correlate with the type of restraint used and to alert the police to search the crime scene for the type of physical restraint described.
- Penetration attempted/ complete (oral, vaginal, anal) by penis /fingers /objects. To identify need for swabbing of respective orifices for semen or to look for evidence of injury by penis, a finger or a specified foreign object.
- Ejaculation; in vagina, anus, mouth, on breast or on other body parts or on clothing, bedding or other places. This is to note the presence or absence of semen in stated site and to identify need for swabbing victim's clothing, other object and relevant body parts for semen of assailant.
- Oral contact of offender's mouth with victim's face, body or genito-anal area, biting (describe where). This is to identify the sites on the body where swabs should be taken for the detection of saliva from the assailant.

- Was there attempted or complete sucking, licking, kissing, and fondling? This is to identify need for swabbing of victim's concerned body parts for saliva of assailant.
- Was there use of condom and / or foam or jelly or lubricant? This is to explain the condition of the semen (e.g. foams or jelly may have spermicidal activity) and to explain the paucity of injuries where a lubricant is used.
- Injuries inflicted on assailant.
- Whether she resisted – in which manner.
- Loss of consciousness if any. This is to investigate the possibility of drug-facilitated rape, to clinically explain any loss of memory or any incomplete recall concerning the event and to investigate the patient to exclude an underlying head injury.
- Any subsequent activities by the patient that may alter evidences, for example, vomiting, defecation, bathing or showering, genital wiping or washing douching, urination, removing or inserting tampons/ the use of tampons/ sponges or diaphragms, eating or drinking; brushing teeth; oral gargling; and changing of clothing etc, should also be documented. These post-assault activities, hygiene and delay in examination will have an impact on the presence of physical injuries and the value of special investigations. For example, many of the minor injuries would heal and the swab for semen/saliva may be negative if the evidence is lost because of these activities or person is examined more than 72 hours after the assault.
- Is there history of last consensual sexual intercourse, if yes when. (This information should be recorded only if there has been any consensual intercourse within past week, because detection of sperm or semen of the consensual relationship, if any has to be ruled out as against the detection of sperm or semen of the accused. Also, this needs to be done on a case-to-case basis, when such information would contribute to identifying the assailant.)
- Any form of contraception used.
- Any history of sexually transmitted diseases/ infections prior to assault.

b) History of drug / alcohol being given to the victim before or during the assault. This is to be entered if relevant.

c) Enter the details whether the patient menstruating at the time of assault?

(III) Medical, Obstetrical and Surgical History:

a) Enter the relevant details regarding menarche / menopause. Enter the date of LMP (Last Menstrual Period).

b) Enter the patient's menstrual status at the time of examination i.e. menstruating or not if relevant. Otherwise note- 'not applicable'.

c) Enter the obstetric details of the patient if relevant from forensic point of view. Note about pregnancies, deliveries, live births, abortions and deaths (G/P/L/A/D). Otherwise note- 'not applicable'.

d) Enter the details of contraception used if relevant from forensic point of view. i.e., Yes/No. If yes, method used.

e) If patient/ victim is pregnant at the time of assault, then details like length of gestation must be included. Otherwise note- 'not applicable'.

f) Enter past medical/surgical history if relevant from forensic point of view. Otherwise note- 'not applicable'.

(IV) General physical examination: This examination is aimed at knowing the important parameters pertaining to overall health status of the person so that prioritization of medical and forensic examination can be done.

a) General Mental condition: In order to comment on the general mental condition the examining doctors is advised to refer 'the rape trauma syndrome' detailed in annexure. It should be also kept in mind that doctor is not able to appreciate the signs of mental condition after the sexual assault in each and every case. The observations to be done in relation to this must include whether she was agitated, restless, numb, anxious, able to respond to questions asked by the doctor. It is advised that the doctor record her feelings in her own words for ensuring accuracy. Cases of sexual assault are underreported due to the attached social stigma. Hence it is pertinent that such reporting be interpreted as an act of courage. The survivors may respond in different ways in such traumatic events. To comment on emotional / mental status use terms like distressed, agitated, shocked, hopelessness, despair, powerlessness and loss of control, flashbacks, disturbed sleep, denial, guilt and self blame, shame, fear, numbness, mood swings, anger, anxiety, helplessness, fear of another assault etc. If the physician does not find a specific term to describe the emotional status, a statement to this effect may be made here.

b) BP (Blood Pressure), Pulse, Respirations (RR), Height, Weight: Take the vital signs, i.e., blood pressure, pulse, respiration. Also note height and weight as a part of routine general examination.

c) Signs of intoxication by drugs and / or alcohol: If the patient reports ingestion of drugs, describe symptoms, or shows signs of drug ingestion, collection of toxicology samples is recommended. *Various symptoms &/ signs suggestive of drug and/or alcohol ingestion:* e.g., lapses of consciousness, memory loss, impaired memory, abnormal vital signs, poor coordination and balance, confusion, vomiting, nystagmus, specific smell, talkativeness, drowsiness, mood changes, dizziness, changes in visual capacity, slurred speech, apathy, inability to stand or walk etc.

d) Examination of clothes (if same as those worn at the time of assault). Examine for evidence of tears, loss of parts, stains, turned inside out, condition/loss of buttons, and other damage sustained as a result of the assault, foreign materials including fibres, twigs, hair, grass, soil or debris from the suspect or the crime scene, blood or seminal stains, etc. If not wearing the same clothing, then it should be documented. This information should then be given to the investigating officer so that arrangements can be made to retrieve the clothing before any potential evidence is destroyed.

e) Stains / foreign materials on body: Document any stain or foreign material on body. Collect the stain material by a cotton swab moistened with distilled water. Also collect the foreign material and preserve it after air drying. Skin soiling must be noted with special reference to the hands, the back of the legs and the buttocks, the abdomen and the top of the thighs, etc. Any soiled area must be swabbed with plain cotton swabs, moistened with sterile water. Skin may be examined by an ultraviolet light for areas of fluorescence. Document positive areas & collect swabs from skin.

f) Finger nails examination: Examined for length and the presence of ragged or broken nails and of chipping of nail varnish, any foreign material under nails etc.

g) Gait of victim: The gait of the victim should be carefully observed, with emphasis for pain in any specific posture.

h) Abdominal Examination with Special Reference to pregnancy: If applicable this may be done.

(V) Injuries on body (if any):-

- Without accurate documentation and proper interpretation of injuries, any conclusions drawn about how injuries occurred might be seriously flawed. This will have profound consequences for both the victim and accused. Injury interpretation is entirely dependent on the accuracy and completeness of the recorded observations of wounds.
- Body charts may be used for recording the injuries. If there is history of buccal / anal penetration & bite marks, appropriate swabs should be taken as indicated. If necessary use separate sheet.
- Always use standard, universally accepted descriptive terms for classifying injuries. Use of a standard terminology not only assists in identifying the mechanism by which the injury was sustained but also contributes to a better understanding of the circumstances in which the injuries may have been sustained. When used correctly, a standardized system of wound classification and description may allow deductions about the weapon or object that caused the injury.
- Wounds are generally classified as abrasions, bruises/ contusion, lacerations, incised wound, stab wounds etc. Do not use short forms while describing the injury like CLW as its create confusion.
- While describing the injury always note the name of injury, its site, dimensions, margins, color, evidence of any foreign body etc.
- It is important to keep in mind that injuries might not always be seen. There may be circumstances in which the survivor may have been threatened with bodily harm, physically restrained, or afraid to resist for other reasons, thus explaining absence of injuries. In fact, only one-third of cases of sexual assault have visible injuries. In absence of injuries also cases have been proved.
- In dark skinned people bruising can be difficult to see, and thus tenderness and swelling if present is of great significance.
- Follow-up examination for injuries: If there is deep bruise or contusions, signs of injury will usually show after 48 hours. Therefore it is mandatory to repeat the examination of the survivor for recording the appearance of bruise. Bite marks may not be obvious immediately following an assault, but may become more apparent with time. A

recommendation should be made to the law enforcement agency to arrange for follow-up inspection within one to two days.

- Examine all the parts of the body for injury/s. Special attentions may be given to following areas. Head, neck, face, breasts, upper limbs, buttocks, inner aspect of thighs, other areas if any.
- Examine and note the areas where the patient complains of ***tenderness or discomfort*** and further confirm the appearance of bruising at this site at a later ***follow-up*** up examination.

I: THE GENITO-ANAL EXAMINATION:

General instructions:

- Before embarking on a detailed examination of the genitor-anal area, it is important to try and make the patient feel as comfortable and as relaxed as possible. Ask the patient to tell if anything feels tender. A careful observation of the perineum is made for evidence of injury, seminal stains and stray pubic hairs etc.
- **Note:** A swab of the external genitalia should be taken before any digital exploration or speculum examination is attempted (See section Forensic Specimen Collection)
- Per vaginal and per speculum examination is not a must in case of a child, when there is no history of penetration and no visible injuries.

Type of positions for ano-genital examination in an adult	
Position	**Purpose**
Lithotomy • supine with legs in stirrups • supine with feet on footrests with elevated back • buttocks should extend to just beyond the edge of the table	• Visualisation of vagina and anus • Table does not interfere with insertion of the speculum
Lateral recumbent (lying on side with knees slightly bent)	Visualisation of vagina and anus when patient is uncomfortable or unable to assume other positions

Following examination shall be carried out as per the need:

a) Pubic hairs: Examined for matting, any loose hairs, and foreign material. If the hairs are matted together, a portion must be cut off and preserved (see forensic specimen collection).

Combing the pubic hair for specimens of free foreign hair and clippings of a few of the patient's pubic hairs for comparison may be done at this point of examination.

b) Labia Majora: Examine for swelling/edema, bleeding, injuries.

c) Labia Minora: Examine for swelling/edema, bleeding, injuries.

d) Clitoris: Examine for abrasions, contusions, lacerations etc.

e) Fourchette & Introitus / Vagina: Look for bruises, redness, bleeding and tears, which may even extend into the perineum, especially in the case of girl children. A gentle stretch at the posterior fourchette area may reveal abrasions that are otherwise difficult to see, particularly if they are hidden within slight selling or within the folds of the mucosal tissue. Asking the patient to bear down may assist the visualizing of the introitus. In case injuries are not visible but suspected; 1% Toluidine blue dye test may be done (See section J- Specific Examination). If there is vaginal discharge, comment on the type i.e., texture, colour, odour etc.

Note: ***The two-finger test of admissibility*** *should not be performed in cases of sexual assault as information about past sexual conduct has been considered irrelevant to the case in several judgments (Section 146 of the Indian Evidence Act & deletion of Sub-section (4) of Section 155.) Even the test has no scientific validity and is subjective. On the basis of test results doctors should not identity that victim is habituated to sexual intercourse or not.*

f) Hymen (if relevant) : Evidence of recent disruption of the hymenal ring, such as reddening, laceration or tear, or bleeding should be sought. Gentle pulling the labia (towards the examiner) will improve visualization of the hymen. Presence of intact hymen at this site should be documented but does not rule out vaginal penetration.

g) E/o Perineal Tear if any: Examine for swelling, bleeding and degree of trear.

h) Urethra: Look for swelling/edema, discharge, injuries. Comment on the type i.e., texture, colour, odour etc of the discharge.

i) Physical Signs of S.T.D: Look for various signs suggestive of STIs (Sexually transmitted infections) & document as whether appreciated or not. If patients tested negative at the time of the medical forensic exam and chose not to receive prophylaxis, follow-up testing should be conducted. Infectious agents acquired through the assault may not have produced sufficient concentrations of organisms to result in positive test results at the medical forensic exam. For nonsexually active patients, a baseline negative test followed by an STI could be

used as evidence; if the suspect also had STI. The CDC recommends that in this case the follow up exam be done within a week.

If signs appreciated then note down the sings and collect samples for medical/hospital laboratory (not for forensic lab). If possible give provisional diagnosis or differential diagnosis at the time of examination and give final opinion after receipt of lab result.

- Various STDs and the list of samples that has to be collected is as follows[1]:

Disease	Sample
Neisseria Gonorrhea	Swab and smear from urethra and cervix infected part
Trichomonas Vaginalis	Swab and slide from the vagina
Candida Albicans	Swab and slide from the vagina
Herpes Simplex	Slide from ulcer
Treponoma pallidum	Slide from genital ulcer
Human Pipiloma virus HPV	Smear from growth Blood
Hepatitis	Blood for serological test
Herpes Simplex Virus	Slide and blood
HIV	Blood, vaginal discharge

- **Sexually Transmitted Diseases:** Incubation period of common infection[2]:

Infection	**Incubation period**	**Infection**	**Incubation period**
Gonorrhea	3-4 days	Warts	several months
Trichomonas	1-4 weeks	Herpes	2-14 days
Chlamydia	7-14 days	Herpes Vaginosis	2-14 days
Syphilis	3 months	---------	------

j) Anus & anal folds/rectum: Bleeding/ swelling/ injuries/ discharge/ stains/ warts around the anus and anal orifice must be documented. Examine the anal sphincter and document findings. Per-rectal examination to detect injuries/ stains/ fissures/ hemorrhoids/ in the anal canal must be carried out and relevant swabs from these sites should be collected. Respectful covering of the thighs and vulva with a gown or sheet during this procedure can help prevent a feeling of exposure. The uppermost buttock needs to be lifted to view the anus. This should be explained. The patient can hold the buttock up herself, if she is comfortable and able to do so. Gentle pressure at the anal verge may reveal bruises, lacerations and abrasions. Digital rectal examinations are recommended if there is a reason to suspect that a foreign object has been inserted in the anal canal, and should be performed prior to a proctoscopy or anoscopy.

k) PS (persepculum)/ PV (pervaginum) examination: Relevant findings should be clearly noted.

l) Any other findings: Any other important and relevant finding which not covered above must be entered.

J: SPECIFIC EXAMINATIONS: (These examination shall only be done wherever facilities exists and if indicated).

a. **Toluidine blue dye test**: Toluidine blue dye is used to assist in the identification of recent genital and perianal injuries. After the initial examination of the posterior fourchette and fossa navicularis and the collection of swabs, apply 1% aqueous solution of Toluidine blue dye to the posterior fourchette and fossa navicularis. After allowing a minute for the dye uptake, remove the excess with lubricant, such as K-Y jelly or 10% acetic acid. Dye uptake is considered positive and affirms injury when there is residual blue coloring of the laceration or its border after the excess dye has been removed. Abrasions from forced cunnilingus have resulted in a diffuse pattern of dye uptake.

   Indication: To visualize subtle injuries (hen injuries are not appreciated by naked eye examination).

   Advisory: Record observations, take colposcopic photographs (if possible). It should be done before Per Speculum examination, but after collection of vaginal samples, as spraying of the dye and washing away the excess can cause loss of evidence.

b. **Inspection of the Wet mount slide of the vaginal swab under the light-staining microscope** (for sperms):
   - Wet mount slides are used by the medical examiner to determine the presence or absence of motile or nonmotile human spermatozoa in the vagina of the patient
   - The presence of motile sperm in the vaginal pool is the best indication of recent ejaculation. The absence of motile sperm, however, does not negate the possibility of recent ejaculation as sperm may become non-motile within hours of entering the vaginal environment.
   - Because sperm motility decreases quickly with time; wet-mount evaluation during the exam can provide the only opportunity to see sperm motility. In most cases, sperm becomes nonmotile in the vagina within 10 to 12 hours after ejaculation. Both motile and nonmotile sperm may be found in the cervix for longer periods of time after the assault than in the vagina. Sperm may not be found after an assault for many reasons.

- Since sperm motility can only be observed on an unstained wet mount slide, the motility examination must be performed under a microscope as a part of the forensic medical examination of the patient.
- The chance of observing motile sperm can be improved by using a phase contrast or other "optically staining" microscope, and by prompt examination.
- The wet mount slide has evidentiary value and must be retained and submitted along with other evidence collected from the patient. Even when sperm are not observed initially in the motility examination, they may be detected during subsequent examination of the dried and stained smear by the crime laboratory.

Prepare and observe a Wet mount slide as described below:

- Label a slide as "wet mount" and include the patient's name.
- Place a drop of normal saline or buffered nutrient medium on the slide to preserve the motility of the sperm. A glucose fortified solution of balanced salts, such as Ringer's, Tyrode's, or Dulbecco's at normal osmolality, pH 7.2-7.4 is recommended. Prepared solutions of media designed to enhance sperm survival during microscopic examinations are commercially available.
- Select one of the swabs collected from the vaginal pool (see sample collection section K/17) and roll the swab back and forth in the drop to transfer cellular debris to the medium. Place a cover slip on the slide.
- Examine the wet mount slide within 5 to 10 minutes using a biological microscope at 400 power, or by using a phase contrast or other "optically staining" microscope to determine whether or not motile or non-motile sperm are present. Examiners rather than hospital lab personnel should view these slides. Otherwise, delays between preparation of slides in the exam room and analysis in the hospital lab could cause a negative result (e.g., sperm present, but not motile).
- Label and air dry the swabs and slide; do not remove the cover slip. Label the swab used to make the wet mount slide so that the crime laboratory knows it was used for this purpose.

Result of Examination: Comment on whether motile or non-motile sperm are present or not. Sometimes examiner may not be able to properly interpret the results or identify the sperms. In such instances doctor should document the same. After examining the slide for

motile spermatozoa the same slide must be air dried and sent to Forensic science laboratory in addition to other slides. It must be noted that absence of spermatozoa does not rule out sexual intercourse.

Reasons for negative wet smear in alleged victims of sexual assault:

- This could be because, there was use of condom or the assailant may have a vasectomy or disease of the vas.
- Delay in the analysis
- Washing of the genitals
- Sexual intercourse without ejaculation or
- Sexual intercourse with ejaculation outside the genitalia etc.

c. **Anoscopic/ Colposcopic examination**: Anoscopic examination need only be used in cases of anal bleeding or severe anal pain or injury suspected or if the presence of a foreign body in the rectum is suspected. **Colposcopic examination** (Only when facility available) is required to be done when injuries are not appreciated by naked eye examination & when collection of photographic evidence required. Minor skin and/or mucosal surface trauma such as abrasions, lacerations, petechiae, focal edema, hymenal tears, and anal fissures are more easily seen with magnification, and photographs can be taken for documentation. Video cameras can be attached to colposcopes to record images.

Note: If any examination not done then give reasons:- Reasons should be documented for not performing any examination.

d. **Alternate light Source:** Use of the wood's lamp or other alternate light sources for collection of secretions and/or foreign materials.

A visual examination of the patient's body and hair can be aided with the use of a long wave ultraviolet light, commonly known as a Wood's lamp. Other light sources which provide alternate wavelengths of light can also be used. These lights are used to scan the body for evidence such as:

- dried or moist secretions;
- fluorescent fibers not readily visible in room light; and
- subtle injury.

Areas to examine: Use these lights in a darkened room to examine the patient's entire body. Take care to protect the patient's eyes when using ultraviolet light. Specifically examine these areas of the body:

- head, face, hair, lips, perioral region, and nares;
- chest and breasts;
- external genitalia, perineal area, inner thighs, and pubic hair;
- buttocks, skin, and anal folds; and,
- any area indicated by the patient's history.

Detecting semen:

- Dried semen stains have a characteristic shiny appearance and tend to flake off the skin.
- Semen may exhibit an off-white fluorescence under ultraviolet light.
- Fluorescent areas may appear as smears, streaks, or splash marks.
- Moist or freshly dried semen may not fluoresce.

Note: The appearance of fluorescent areas does not confirm the presence of semen, as other substances such as urine or body lotions may also fluoresce. Independent confirmation of these findings by the crime laboratory is required. Shall only be used to visualize the stain and for collection of swab from that area.

K: FORENSIC EVIDENCE:-

- The samples must be collected as per history & physical findings; which are mentioned in the manual. The list of samples to be preserved is annexed herewith which is the part of requisition to FSL for relevant examination. Here it must be remembered that specific mention in words as to which samples are collected & which are not collected is very necessary. If no samples collected then it should be specifically documented under note column of the report along with the reason for non collection. If any advice is given to the police official regarding sample collection then it should also be documented in note column.
- It is advised that samples must be collected as per important points noted during history taking and examination findings of the victim. This screening will also help in avoiding unnecessary sample collection.

<u>General information for collection of forensic evidence:</u>

Collection of Evidence-Time Frame Guidelines[3]:

- Please make an assessment of the case and determine what evidence needs to be collected before you begin. This procedure cannot be done mechanically and will require some analysis. The nature of forensic evidence collected will be determined by two main factors - history of assault and time lapsed between assault and examination.
- ***If a woman reports within 96 hours of the assault, all evidence including swabs must be collected without fail, in keeping with the history of assault.***
- ***Please keep in mind that spermatozoa can be identified only for 72 hours after assault. So if a survivor has suffered the assault more than three days ago, please refrain from taking swabs for spermatozoa. In such cases swabs should only be sent to FSL for tests for identifying semen.***
- ***Evidence on the outside of the body and on materials such as clothing can be collected even after 96 hours.***
- An exception must be made in peculiar cases. If the survivor has not washed or bathed at all, between the assault and examination, no matter how much time has lapsed, it is still advantageous to take all swabs.
- The nature of swabs taken is determined to a large extent by the nature of assault and the history that the survivor provides. The kinds of swabs taken should be consistent with the history. For example, if the survivor is certain that there is no anal intercourse; there is no use of taking an anal swab.

Key components of proper evidence collection & handling are:

- Collect carefully, avoiding contamination;
- Collect specimens as early as possible; 72 hours after the assault the value of evidentiary material decreases dramatically;
- label all specimens accurately;
- All appropriate evidences including swabs and slides ***must be air dried*** prior to packaging
- Placing items in appropriate evidence containers;
- Labeling & sealing the evidence containers.
- Storing evidence in a secure area; and
- Maintaining the chain of custody.

Labeling Evidence Containers:

- All items of evidence must be clearly labeled to enable the person who collected the evidence to later identify it in court and to ensure that the chain of custody is maintained.

Label envelopes or boxes with the following information:

- Sample no, Full name of patient, date of collection, MLC No, Name of the sample, signature of the doctor.

Sealing evidence containers:

- Proper sealing of containers ensures that contents cannot escape and that nothing can be added or altered.

  Proper sealing of evidence containers can be accomplished by:

  - Securely taping the container (do not lick the adhesive seal); and Signing and dating the seal by writing over the tape onto the evidence container.
  - **Note:** Stapling is not considered a secure seal.

The following general procedures apply to the use of swabs for the collection of various materials for forensic analysis:

- Use only sterile, cotton swabs.
- Place swabs collected from a site in glass test tube. Use different test tubes for the swabs collected from different sites. Then put glass test tubes in paper envelope or boxes.
- Do not place the swabs in medium as this will result in bacterial overgrowth and destruction of the material collected by the swab. Swabs placed in medium can only be used for the collection of bacteriological specimens.
- Moisten swabs with sterile water/distilled water when collecting material from dry surfaces (e.g. skin, anus). Distilled water is prefereed to saline for moistening the swabs, because saline can crystallize and confound the findings[4].
- If microscopy is going to be performed (e.g. to check for the presence of spermatozoa), a microscope slide should be prepared. Label slide and after collecting the swab, rotate the tip of the swab on the slide. Both swab and slide should be sent to the laboratory for analysis.
- All swabs and slides should be dried before sealing.

Following types of evidence is generally collected as per the need.

GENERAL EVIDENCE:

1. **Debris from collection paper** (on which survivor is undressed)**:** *This is collected for evidence of* any foreign material, its nature, source etc.

   Ask the victim to stand on the major brown/white paper to collect loose foreign bodies from cloth and body surface, which is folded and kept in a paper envelope. This procedure only done if victim has not changed her clothes, and or taken bath.
2. **Clothing** (each garment should be properly labeled and placed separately in paper bag **after drying**): Cloths are tested for evidence biological stains such as blood, semen, and saliva from the suspect hairs from the assailant, (if present) its nature, blood group and DNA profiling and for evidence of any foreign materials such as grass, soil fibres or debris from the suspect or the crime scene, its nature, source etc. Purpose is for Identification of assailant using semen, blood or saliva stains or hair on clothing, to show corroborative evidence of force having being used e.g. torn clothing and to identify place where the crime was committed.
   - Request the victim to undress herself behind the curtain stand and provide her with necessary hospital linen (dress).
   - Note the presence of stains – semen, blood, foreign body etc.
   - Note if there are any tears or marks on clothes.
   - Allow clothes to air dry and ensure that they are folded in such a manner that the stained parts are not in contact with unstained part of the clothing.
   - Preserve clothes in paper bags, seal and label them. **Do not use plastic bags.** Plastic retains moisture which can result in mold and deterioration of biological evidence.
   - In case if the victim has changed the cloth, then there is no need to collect the present cloths unless there is specific indication for it. This fact shall be documented in report. However police should be instructed to collect the clothes worn at the time of offence.
3. **Any sanitary napkins, panty liners, diapers or tampons** (worn by the patient for the period of up to 24 hours after the assault): Collected for evidence of stains/semen, its nature, group and DNA profiling. Other specimens may be encountered during an examination, for example, tissues, diaphragms, and condoms. These should be collected, dried and sealed in paper envelope separately.

TOXICOLGY SAMPLES:

Note: In addition to clinical implications, the presence of alcohol and/or drugs in the patient's blood or urine or vomited matter may have legal significance. The assailant may have used drugs to subdue the victim (**drug-facilitated sexual assault**). The victim may have lost the ability to make rational decisions, or may have affected ability to offer resistance, lost consciousness, or may have no recollection of events. There may not be any physical or genital injuries in a given case. Drugs and/or metabolites of drugs such as marijuana, cocaine, methamphetamine, benzodiazepines [including diazepam (Valium) and flunitrazepam (Rohypnol)], and gammahydroxybutyrate (GHB) can be detected through testing blood and urine samples.

Collect toxicology samples if the patient (indications):[5]

- is unconscious;
- exhibits abnormal vital signs;
- reports ingestion of drugs or alcohol;
- exhibits signs of memory loss, dizziness, confusion, drowsiness, impaired judgment, light-headedness, decrease blood pressure;
- shows signs of impaired motor skills;
- describes loss of consciousness, memory impairment or memory loss; and/or
- reports nausea.

Note:

- Even thought there are no signs suggestive of inebriation by drugs and/ alcohol, but patient gives such history then also doctor should collect the samples for toxicology.
- Collect toxicology samples as soon as possible Alcohol metabolizes rapidly. Many drugs are also quickly eliminated from the body.

4. **Blood in vial:** If ingestion of drugs and or alcohol used to facilitate sexual assault may have occurred within 24 hours prior to the exam, a blood sample of at least 5 milliliters should be collected for alcohol and or drug analysis (toxicology) in gray-top tube (contains preservatives sodium fluoride and potassium oxalate). Be sure to cleanse the arm with a non-alcoholic solution if collection is to be done for alcohol analysis.
5. **Urine in vial:** Collect for alcohol or drug analysis (toxicology) in fluoride glass bulb/ vacutainer. If ingestion of drugs is suspected within 96 hours of the examination, collect the first available urine specimen (approximately 50 ml). This may help to confirm the presence

of certain drugs or their metabolites which may not be detectable in the blood because of short half-life. The number of times that patients urinated prior to collection of the sample should be documented.

6. **Vomited material:** Occasionally, patients of drug-facilitated sexual assault vomit. The analysis of the vomit may also be useful to an investigation. In such cases collect vomited matter in clean sterile container for toxicology analysis.

BODY EVIDENCE (OTHER THAN PERINEAL REGION):

7. **Swabs from cheek & gum area:** Collect for evidence of semen, its nature, blood group and DNA profiling. Semen is rapidly lost from the mouth by dilution with saliva, swallowing, eating, and drinking. If less than 12 hours have passed since the incident, collect ***two swabs*** by swabbing firmly around the gums, frenulums, and in the fold of the cheek. Prepare one dry mount slide from one of the swabs.

   Indication: If there has been any allegation of oro-penile contact within 12 hours prior to examination.

   Preparation of a dry mount slide:

   - Select one of the swabs collected from the vaginal pool. Roll the swab in a rotating motion to make a thin smear on the slide.
   - Label, air dry, package, and seal.
   - Label the swab used to make the dry mount slide so that the crime laboratory knows it was used for this purpose.

8. **Foreign material on body:** Collect to identify it, its nature and source. Types of foreign materials that may be present are fibers, soil, hairs sand, paint glass, grass or other vegetation, other debris. All materials first should be collected in plane white paper and then paper should be folded in such a way that the contents cannot escape. Then this folded paper should be placed in paper envelope.
9. **Semen-like stains on body:** Collect for its nature, grouping & DNA. Also specify site from where the swab collected.
10. **Swabs from suspected or alleged bite marks & from the places that have been licked & kissed along with control sample:** Collect for evidence of saliva, its grouping & DNA. Also specify site from where the swab collected. If the patient history indicates a bite and there are no visible findings, swab the indicated area.

11. **Combing of the patient's head hair:** For collection of loose hairs and to compare with the reference sample of hairs of the victim. Hairs those found to be foreign to the patient can then be compared to reference hairs obtained from potential suspects (if shows comparison then forensic laboratory should be instructed to confirm it with the DNA profiling).
12. **& 13 Fingernail scrapings of both hands separately:** Collect for identification of any foreign trace materials, such as skin, blood, hairs, soil, fibers from the assailant; if human tissue its origin, blood group and DNA. Nail scrapping is done with sterile toothpick. Nail clippings are taken with nail cutter. Both are collected separately for right and left hand. Both these materials so collected are collected in plain paper, folded and then put in paper envelope.

    Indication: If there is a history of the victim scratching the assailant. If patient not able to recollect or not able to tell properly, then collect invariably.

GENITO-ANAL EVIDENCE

14. **Matted pubic hairs:** Collect matted pubic hairs (if present) for identification of human semen, its group and DNA. The dried patch of approximately 10 to 15 hairs to be cut with scissor. Collect in paper, fold and kept in envelope.
15. **Combing of Pubic hair:** For collection of loose hairs and to compare with the reference sample of hairs of the victim. Hairs those found to be foreign to the patient can then be compared to reference hairs obtained from potential suspects (if shows comparison then forensic laboratory should be instructed to confirm it with the DNA profiling). Document if shaved. Approximately 10 to 15 loose combed pubic hairs are to be collected in a clean paper underneath. These collected hairs along with the comb used are kept in same paper, folded and kept in envelope. This is useful for comparison with those of assailant
16. **Vulval (labia majora) Swabs:** Collect at least two vulval swabs for identification of semen/saliva of the assailant, its nature, group and DNA analysis. The genital area must be swabbed to collect possible saliva or semen regardless of Wood's Lamp findings.
17. **Vestibular (labia minora) swabs:** As above.
18. **Vaginal swabs:** One vaginal swab on a sterile swab with air drying to be put in an envelope for identification of semen of the assailant, its nature, group and DNA analysis. Other one should be used for wet mount slide preparation.

19. **Cervical Swab:** One cervical swab on a sterile swab with air drying to be put in an envelope for identification of semen of the assailant, its nature, group and DNA analysis. Other one should be used for wet mount slide preparation if necessary in case if vaginal swab does not yield result.
20. **Vaginal Smear (2)-** One vaginal smear on a glass slide with air drying to be put in an envelope for identification of semen of the assailant, its nature, group and DNA analysis.
21. **Perianal, anal, rectal swabs & smear:** (if applicable). One swab from anal/rectal region each with smear (if applicable) on a sterile swab and a glass slide respectively with air drying to be put in an envelope for identification of semen of the assailant, its nature, group and DNA analysis. **Indication:** Collected when there is history or evidence of anal contact or penetration.

REFERENCE SAMPLE:

Reference samples are used by the crime laboratory to determine whether or not evidence specimens collected are foreign to the patient. Blood, buccal (inner cheek) swabbings, or saliva should be collected from patients for DNA analysis to distinguish their DNA from that of suspects.

Following reference samples may be collected as per the need.

22. **Blood on clean white cotton cloth:** Collected for grouping & DNA analysis. This is more suitable procedure than collection of blood in vial. Air dry before putting into paper envelope.
23. Blood in plain bulb/ vaccutainers for grouping – 2 ml. (if not taken on clean white cotton cloth/filter paper)
24. Blood in EDTA bulb/vaccutainers for DNA analysis – 2 ml. *(*if not taken on clean white cotton cloth/filter paper).
25. Hairs (scalp and pubic) 10-20 strands (cut with scissor) to be collected and packed separately for comparison with the loose hairs found from the body of the victim herself and from the scene.

CONTROL SWABS:

26. Control swabs from the unstained area adjacent to the skin; collected to interpret the typing results from the evidence swab.

OTHER:

27. Other samples: Collect any other sample which the doctor feels important to be collected or requested by the investigating police officer but not covered in the above listed items.

Note:

- If any sample listed in the above list, not collected then give reasons for the same like not indicated by the history, no evidence of contact etc in the note column.
- The number of samples for forensic science examination should be decided on the basis of history and scientific observations pertaining to the examination of clothing and body. Collection of too many samples can be avoided. As per DNA samples are concerned, routinely, only blood, hair, nail debris, swab from labia minora and swab from vagina must be sent. Other samples must be sent, only if specifically asked by the investigating officer or if found necessary.

Forwarding samples to FSL:

- All samples must be sealed and labeled to avoid tampering. Properly filled requisition form is handed over to concerned police along with samples taking his/her due receipt. Receipt includes signature, name, designation, buckle number of police, name of police station, date and time to maintain chain of custody.
- Samples for microbiological studies which include swabs, smears for STDs and blood for HIV test, VDRL is to be sent to Microbiology department of nearest Government Medical College along with requisition for the same.
- If, it is not possible to immediately handover the samples to the police after examination or if, police is not available to collect the evidence; then such evidence shall be kept in the safe custody of assigned person in the health facility. The details of all handing over from one 'custodian' to the other must be documented and continuity must be maintained.

IX): Provisional/ Final Opinion:

Key Points:

- Opinion must be evidence based. It is mandatory that doctor's forensic medical report shall state precisely the reasons for each conclusion arrived at.
- Rape is not a medical diagnosis, it is a legal definition. Hence word "Rape" should not be used while forwarding opinion and no doctor should opine in medical reports on whether rape occurred or not. Even he should not depose in court on the same issue.

- Do not identify victim as 'habituated to sexual intercourse' on the basis of findings of 'finger test' as identifying the woman as "habituated to sexual intercourse" is unlawful interference with her privacy and unlawful attacks on her honour & reputation and is violation of her human rights. In a prosecution of sexual assault, where the question of consent is in issue, evidence of the character of the victim or of her previous sexual experience with any person is not relevant on the issue of such consent or quality of consent.
- Always keep in mind:

Normal examination findings neither refute nor confirm the forceful sexual intercourse. Hence circumstantial/other evidence may please be taken into consideration.

Reasons for normal examination findings despite history and or positive circumstantial and or other evidence:

Forceful sexual intercourse is possible without leaving any medical evidence. Absence of injury occurs in consensual as well as forced intercourse

- *Apart from this* ***Reasons for absence of general injuries in alleged victims of serious sexual assault include:***
  - *Submission of the victim may be achieved by emotional manipulation, fear of violence or death or by verbal threats.*
  - *The force used, or the resistance offered, is insufficient to produce injury.*
  - *Bruises may not become apparent for 48 hours following assault.*
  - *A delay in reporting the incident will allow minor injuries to fade or heal.*
  - *Survivor being unconscious, under the effect of alcohol/drugs*
- ***Reasons for the absence of ano-genital injuries*** *in alleged victims of serious sexual assault include:*
  - *Less than half of all complainants of sexual assault have injuries to the genital and anal areas.*
  - *The alleged sexual act (such as rubbing, touching) was unlikely to result in injuries.*
  - *Delay in reporting the incidence*
  - *The victim is sexually active.*

- *The natural elasticity of the postpubertal female genitalia, including the hymen.*
- *The natural elasticity of the anus.*
- *The use of lubricants.*
- *Survivor being unconscious, under the effect of alcohol/drugs*

➢ ***Reasons for negative wet smear in alleged victims of sexual assault**:*

- *This could be because, there was use of condom or the assailant may have a vasectomy or disease of the vas.*
- *Delay in the analysis*
- *Washing of the genitals,*
- *if the survivor was menstruating,*
- *Sexual intercourse without ejaculation or*
- *Sexual intercourse with ejaculation outside the genitalia*

Opinion can be divided under following heads:

Provisional/ Final opinion: Enter the approximate time in hours or days after which the examination is performed after the alleged incident. This is important as it may influence the appearance of findings and or/ outcome of chemical analysis reports.

1) *Medico-legal diagnosis and/or Evidence of penetrative or Non-penetrative sexual assault:* Under this head medical examiner has to give opinion regarding evidence of penetrative and non-penetrative sexual assault. Following opinions may be drawn as per the available findings.
   a. If there are recent genital and/or physical injuries (fresh injuries) with wet vaginal/anal smear detecting spermatozoa, the opinion could be stated as *'There is evidence suggestive of recent forceful vaginal/anal intercourse."*
   b. If there are genital/physical injuries but no evidence of spermatozoa in the wet smear, it does not rule out forced penetrative sex. So the opinion should be stated as *"There are signs of use of force/forceful penetration of vagina/anus, however the opinion regarding penetrative intercourse is reserved pending till availability of FSL reports."*
   c. If there are only physical injuries and no genital injuries, and no evidence of spermatozoa in the wet smear, it does not rule out forced penetrative sex. So the opinion should be stated as *"There are signs of use of force, however the opinion regarding penetrative intercourse is reserved pending till availability of FSL reports."*

d. If there are only genital injuries but no physical injuries, and no evidence of spermatozoa in the wet smear, it does not rule out forced penetrative sex. So the opinion should be stated as *"There are signs of use of force/forceful penetration of vagina and/ or anus; however the opinion regarding penetrative intercourse is reserved pending till availability of FSL reports"*.

e. If there is evidence of spermatozoa in the wet smear of vagina, but no physical and genital injuries then the opinion could be stated as, *"There is signs of recent sexual intercourse. However opinion regarding forceful sexual intercourse will be given after the follow –up examination"*.

f. If there are normal exam findings i.e., there are no physical and genital injuries, no evidence of spermatozoa in the wet smear, the opinion could be stated as *"On examination the findings are within normal limit which neither refute nor confirm the forceful sexual intercourse". However, final opinion regarding penetrating intercourse is reserved pending till availability of FSL reports and opinion regarding application of force will be given after follow up examination"*.

***Note**:*

- Opinion on whether the sexual intercourse/ penetration was recent or not shall be given on the basis of age of injuries.

g. **Evidence of non-penetrative assault:** Non penetrative sexual assault may include fondling, sucking, forced masturbation etc. These acts may result into injuries (like bite marks, sucking marks, bruises/contusions, fingernail marks) which must be documented in opinion column as *"there are signs suggestive of bite marks/ sucking marks that are consistent with non-penetrative sexual assault"*. If no signs present then opinion could be stated as "*opinion regarding application of force will be given after follow up examination"*. Forceful kissing/ licking may leave salivary stains that can be detected in swabs taken from such sites by FSL. Hence opinion on this aspect may be framed after the receipt of analysis reports. This evidence may not be available if victim have had a bath or washed herself/ body parts.

2) *Evidence of injuries to the genitals / anus and Evidence of injuries suggesting application of force/ restrained:*

Generally injuries because of application of force or restrain are present on the various body parts like, forearm, inner parts of thighs, legs, neck, facial and intraoral injuries. Injuries will also be present on genitals. Therefore medical examiner should always look for such injuries carefully. If injury/ injuries are present; then opinion could be framed as *"The evidence of injury/ injuries is consistent with application of force or restrain"*. If no injuries appreciated & patient is examined within 24 hours of the assault then opinion could be framed as *"At present there is no medical evidence suggestive of application of force or restrain. However final opinion will be given after follow up examination"*. If no injuries appreciated and no follow up is indicated then opinion may be framed as *"No medical evidence suggestive of application of force or restrain is appreciated"*

3) *Opinion as to age of injuries and causative object:* Opinion as to the age of injuries is given on the basis of color of injury documented in the medical reports. Therefore doctors should mention the color of each injury in injury column while describing the injuries. Following information may be used as a reference for giving opinion on the age of injuries on the basis of color changes.

Age determination of various types of injuries on the basis of color changes:-

ABRASION

Fresh	Bright Red
12 to 24 hours	Reddish scab
2 to 3 days	Reddish brown scab
4 to 7 days	Brownish black scab
After 7 days	Scab dries, shrinks and falls off from periphery

CONTUSION

Fresh	Red
Few hours to 3 days	Blue
4^{th} day	Bluish black to brown (Haemosiderin)
5 to 6 days	Greenish (Haematoidin)
7 to 12 days	Yellow (Bilirubin)
2 weeks	Normal

If there is deep bruise or contusion, signs of injury will usually show after 48 hours. In case you see signs of injury on the follow up, please record them and attached the documentation to MLC papers.

LACERATION

It becomes difficult to estimate exactly the time since injury based on the size and contamination. However a rough estimate can be done based on signs of healing.

INCISED INJURY

Fresh	Hematoma formation
12 hours	Edges- red, swollen
24 hours	Scab of dried clot covering the entire area.
After this rough estimate can be based on signs of healing.	

Note: This is reference information only, as many external and internal factors contribute in the color changes and healing of injuries.

Opinion as to causative object: If injuries are laceration, contusion and or abrasion then opinion may be framed as "Injury no so and so is/ are possible by hard and blunt object". If injury is incised wound then it may be state that "injury no so and so is possible by weapon having sharp edge". If stab injury is present then it may be stated that "injury no so and so is possible by weapon/ object having pointed tip." If imprint contusions are appreciated then opinion may be framed as per the presentation of imprint and may be given in terms of consistency.

4) *Evidence of Sexually Transmitted Infections:* If there are no sings suggestive of sexually transmitted infections, then opinion could be framed as, "At present there are no signs suggestive of sexually transmitted infections, however final opinion regarding its subsequent development will be given after follow up examination". It must be noted that absence of a sexually transmitted infections (STI) in the female does not rule out evidence of sexual connection and the existence of it is not always a positive evidence of sexual connection. If evidence of STI is appreciated in victim then it is absolutely necessary to examine the accused for the presence of for these STIs. Presence of particular STIs (like gonorrhea or syphilis) in both parties is strong corroborative evidence of sexual intercourse.

5) *Evidence as to under the influence of drug/s and/or alcohol:*

- If survivor gives history of drug/alcohol ingestion and shows signs suggestive of inebriation by drugs and/or by alcohol, then opinion could be stated as *"There are signs suggestive of ingestion of drug and/or alcohol and the patient is under the influence or not under the influence of it. However, final opinion is reserved pending till receipt of FSL reports."*
- If there is history of drugs and/ alcohol ingestion but there are no signs suggestive of inebriation by drugs and/or by alcohol, then opinion could be stated as, *"At the time of examination, there is no sign suggestive of ingestion of drug and/or alcohol, however final opinion will be given after the receipt of FSL reports"*.
- If there is no history as well as no signs suggestive of inebriation by drugs and/or by alcohol, then opinion could be stated as *"There is no history and no signs suggestive of ingestion of drug and/or alcohol. Hence, samples for analysis are not preserved"*. In such cases if samples are preserved for analysis at the request of investigation police officer then it should be stated as, *"However, samples are preserved for toxicological analysis as per the request of investigating police officer"*.

6) ***Any other pertinent medical condition (like local infection, dermatitis, or itching due to any reason and related aspect) that may affect the interpretation of current physical findings:*** Sometimes injuries may be confused with such local diseases which can be concluded after meticulous and proper examination of the concerned area. Therefore, the medical examiner should look for such conditions and should differentiate it from injuries. If no such conditions found then opinion could be stated as *"No"*. If such conditions are present then it should be described accordingly.

Note:

- It is mandatory that doctor's forensic medical report shall state precisely the reasons for each conclusion arrived at. The positive and important negative findings on which doctor's opinion is based must find place in forensic medical report because bald opinions not supported by the reasons are not acceptable**.**
- In cases where no sample is collected (if collection not indicated) and no follow up examination is arranged then opinion/s given after first examination shall become the final opinion (and not provisional).

- Date & time: Enter the date & time of the beginning of examination.

- Enter the signature, name, designation and registration number (medical council) of the examining doctor on right side and seal/ stamp of the examining doctor should be given in the box.
- Enter the total number of pages of the report including any extra attached sheet of paper. It is ideal if the doctor puts a signature and date along with MLC number on each page of paper.
- **Handing over of forensic medical reports, forensic evidence etc to police:**
    - Original report should along with forensic evidence (if collected) be handed over to police under due acknowledgement. Enter the name of the police to whom the samples are handed over along with his or her buccal number, police station & district and shall obtain the signature (as a receipt) on second copy of the report or on a handover register specially meant for this purpose.

References:

[1] Manual for medical officers dealing with medico-legal cases of victims of trafficking for commercial sexual exploitation and child sexual abuse. Department of Women and Child Development, Government of India.

[2] See ref 146.

[3] WHO manual:

[4] Girardin B, Faugno D. K, Howitt J. Adult Sexual Assault: Practical management. In: Forensic Medicine: Clinical & Pathological Aspects. Edited by James Payne J, Busuttil A, Smock W. Greenwich Medical Media Ltd- London. 2003. Page 409-451.

[5] Drawn from Connecticut's *Interim Sexual Assault Toxicology Screen Protocol*, 2002 & California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims; Governor's Office of Emergency Services: July 2001)