

Part 2: Medico-legal documentation

Practical completion of pages 1 and 4 of the J88 form

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Abstract

This is Part 2 of a three-part series on medico-legal documentation. Part 1 addressed the knowledge and skills necessary to complete a legal J88 document. The aim of Part 2 is to give practical guidance on completion of the J88 form in the case of assault. Part 3 will address the sexual assault section of the J88 form. As a legal document, the J88 form must be completed accurately with regard to demographic information, including the time and date of examination, to assist with interpretation of the findings. The full names of the person examined appear on the SAPS 308 form, and must be confirmed by the patient and an identification document, if available. The name of the healthcare provider must be identifiable and contact details must be stated to assist with tracing, if necessary. A complete history is important because a differential diagnosis needs to be considered, and the clinical findings must be consistent with the description of the incident in terms of time, mechanism of the injury and the place at which the incident took place, as these all add to the probability that the incident occurred as disclosed. The health worker has a dual responsibility with regard to both the health and medico-legal aspects pertaining to the patient and must record these in the clinical notes. Only medico-legal aspects are recorded on the J88 form. A top-to-toe, back-to-front examination must be performed methodically, since the person may be unaware of certain injuries. The healthcare worker must write a conclusion in the space provided. Support of the history with the clinical picture is the basis for the conclusion.

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This is Part 2 of a three-part series on medico-legal documentation. The aim of Part 2 is to provide guidance on the completion of the J88 in cases of assault.

Introduction

The J88 form must be legibly completed by a medical practitioner and signed on every page¹ (see Part 1: medico-legal documentation for more information). The J88 form was designed prior to the formal training of forensic nurses, and the term "medical practitioner" practically includes registered nurses, since forensic nurses are not yet registerable despite the fact that Forensic Nursing has recently been recognised as a speciality field.

Demographic information

The demographic information [police station, Criminal Administration System (CAS) number, the information about the investigating officer and the name of the patient, as supplied on the South African Police Service (SAPS) 308 form], must be completed by the same person who completes

the medical information. The J88 form is supplied by the investigating officer and is included in certain evidence collection kits.

The number of a case consists of the police station at which the case was registered and the CAS number which indicates a numeric reference to the specific case registered at a specific police station in the current month and year.

The time and date are the time and the date of the examination. The time must be completed in a 24-hour notation. The date must be entered as two digits for the day and the month, and four digits for the year, e.g. 06 02 2013 for 6 February 2013.

The examiner's information and contact details

The particulars of the examiner may be handwritten. A stamp is acceptable.¹

Registered qualifications are the qualifications and registration number at the relevant professional council. The registration number is important information for

the professional expert witness. It not only confirms the qualification, but also affirms expertise.

It is advised that all relevant contact information is supplied, including a cellular telephone number, landline number and facsimile number.

The place of examination refers to where the examination is performed, e.g. Thuthuzela Care Centre, Bloemfontein, or the street name and number, in the case of a private practitioner.

The physical address is the address at which a subpoena could be served, e.g. the clinic, facility or street address.^{1,2} An e-mail address must be documented, in addition to the physical address, since e-mail addresses are more likely to remain current than physical addresses. The registration number at the relevant professional council is an additional resource with regard to the whereabouts of the person who completes the J88 form since the information must remain current.

The full names of the person examined appear on the SAPS 308 form, and must be confirmed by the patient and an identification document, if available. Other names by which the person being examined is known can be added in brackets.

It is particularly important in cases in which a suspect is being examined to ensure that there can be no argument as to the identity of the person. The name of the suspect must be confirmed with a police official. Request the signature of the suspect on evidence collection forms, and ask the police to take a thumbprint. This may seem excessive, but experience has shown that suspects can manipulate crucial biological results and examinations to ensure that they are inadmissible.

Providing the age of adults may be sufficient, but it is suggested that the date of birth is indicated for children.¹

The sex of the patient is indicated as male or female by means of a tick in the appropriate block. If applicable, a sex modification, intersex and/or the sex that the person prefers to be should be indicated.

General history

Document the source of the history, the language used and the name and capacity of the interpreter, if applicable.

The source of the history is particularly important in the case of children, since in most cases, the history is the major aspect which facilitates arrival at a conclusion in assessment of whether or not sexual abuse of a child has occurred.²⁻⁸ Discrepancies in the history of different caregivers, or inconsistencies in the history in relation to the clinical picture, may point to the physical⁴ or emotional abuse of children.

A complete history in physical assault cases is important because a differential diagnosis needs to be considered, and the clinical findings must be consistent with the description of the incident in terms of time, mechanism of the injury and the place at which the incident took place, as these all add to the probability that the incident occurred as disclosed.

Document the verbatim history, which once again, is most important in the case of children.^{9,10} Cognitive development, language development, recall memory and a host of other developmental aspects have an influence on the way in which children relate information.¹⁰⁻¹⁶ Significant gestures, e.g. pointing to the genital area, must be documented. Although the exact words of the child must be documented in his or her language, if possible, a translation into English and Afrikaans (the two official languages of the court) is essential to ensure understanding by court officials.

To avoid suggestion,¹¹ start with open-ended questions and apply a funnel technique, using the previous response of the child to construct the next question.^{10,16-18} Do not expect too much of the child and document assumptions. "Something funny" or "something bad" is not necessarily sexual abuse. Smaller children may disclose multiple incidents as being one incident. Children are able to provide an indication as to frequency only when they are 8-10 years of age. Prior to the age of four years, the only questions that a child can answer with any amount of reliability are: "Who?" and "What?" questions.¹ A younger child may only be able to provide reliable information on the number of incidents when asked where the incident happened. If the incident is reported as having occurred in more than one place, it is likely that there was more than one incident. The times of the incidents can be approximated by memorable events, e.g. before or after Christmas, a birthday or the birth of a sibling. Children should not be pressurised, since they may try to give answers which they perceive to be the "right" ones.⁹ Children want to please. It is preferable that social workers or other professionals who are trained to conduct interviews with children should be involved.

Relevant medical history

Only aspects of the history that are relevant to the medico-legal examination must be documented on the J88 form.²

All pre-existing conditions that may influence the behaviour, vulnerability of the patient and interpretation of the findings, or which may have an influence on any aspect of the interpretation of the clinical findings, should be recorded.

This includes aspects which may influence the cause and appearance of the injury and related healing, or which may influence the cognitive ability or mental awareness of the patient, as well as his or her disabilities. It also includes aspects which may influence recent surgery (particularly genital surgery in the case of rape) or a history of healed and old injuries (fractures, burns or falls). The recent use of alcohol, medication or recreational drugs must be documented.

Conditions that can aggravate bruising or which could be transmitted sexually, as well as conditions such as diabetes mellitus, asthma, mental and other disability, behavioural disorders, psychoses and human immunodeficiency virus (HIV) infection, should be documented if they have relevance to the medico-legal examination. It is not imperative to document the HIV status of the complainant, although the HIV status of the suspect of rape is important since it may influence the prosecution and decisions about compulsory HIV testing.¹⁸ (The SAPS 308A form must be on record to authorise examination of the suspect in these cases.)

Differential diagnoses must be considered and addressed. Bleeding or coagulation disorders, disorders such as osteogenesis imperfecta, inflammatory bowel disease, corticosteroid medication, anticoagulant medication and constipation, are all elements of the medical history and may be regarded as important in individual cases. It may be important to document diabetes when there is a smell, appearing to be liquor, on the breath of the patient, or if the patient appears to be intoxicated.

History of the incident

The J88 form allows no space for the history of the alleged incident. The history of the incident may be written on a loose page and identified as such, with cross-reference to the J88 form, and identified and signed appropriately, or, if there is available space, written either in the space provided for the medical history, or in that for the clinical findings or the conclusion.

It may be argued that the history of the alleged incident should not appear in the medico-legal report in order for the prosecutor to be able to determine whether or not the physical findings are compatible with certain scenarios.¹⁹ It is reasoned that the information in the J88 form and the formal statement may differ. It is true that in the acute phase after emotional trauma resulting from violence, the person may not be able to recall events correctly, and that any discrepancies may have an influence during the court hearing.²⁰ The history is an integral part of the assessment of a patient from a medical perspective, and the absence of a good history is contrary to good medical practice. The diagnosis or conclusion is ultimately made based on the compatibility of the findings with the history, and in cases of physical abuse, on the incompatibility of the findings with the history.^{2,7,21}

History is essential for a work-up of differential diagnoses and scientific conclusion with respect to the clinical picture.²² The expert witness may not be able to substantiate the conclusion without a properly documented history on the medico-legal report.²³⁻²⁶

The words used by the patient may be used in the history, e.g. "knife", "fist" and "kick", but specific terms must be used where a conclusion is being drawn.

The history obtained from a medico-legal patient is not a statement. It must be part of the medical assessment and must be stated as being that when questions arise in court.

General examination

Clothing

Clothing worn at the time of the incident, and underwear worn during or after the incident, has relevance.²⁷

It must be indicated if there was a change of clothing since the incident. The information on the J88 form must be limited to the relevant facts.

Ideally, the patient should undress while standing on a clean sheet. On completion, the paper must be folded to protect the substance, and inserted into an evidence collection kit for clothing.²⁸

Include clothes in the documentation that are brought to the examination, indicating that they were not worn at the time of the examination.

The garments should be listed. It may become important in a later court hearing, which garments were present. Independent memory will not assist in answering these types of questions.^{1,19}

The attention of the investigating officer must be alerted to the possibility that garments may have remained at the crime scene. Generally, the colour and style of the clothing are not important.² An assessment of the clothing serves to indicate if any foreign matter was brought in from the crime scene. Locard's exchange principle states that whenever contact takes place, transfer of matter takes place. Transferred matter must be searched for on the clothing.² Matter can be transferred from another body (foreign material and bodily fluids, as well as skin and fibres from clothing) and/or from the crime scene (fibres, dust, mud, gravel and fibres from textiles and other foreign material). In addition, the condition of the clothing may support a history of violence (tears, cuts, broken zippers, missing buttons and missing garments). Apposition of these features to injury may be important in indicating whether or not the garment was worn during the application of force. Imprints from clothing may also be found on the body, in which case the texture of the clothing may be significant for the case.

It may be useful to make a small sketch of features on particular garments on the J88 form or on a loose page, or to take a photograph to refresh the memory later.

Weight, height and body build

Weigh and measure the person, and express the values in kilograms and centimetres. State whether or not the body build is within normal limits in terms of age, sex and height.¹ The World Health Organization percentile charts should be used with respect to children for growth parameters, if of

interest to the particular case. The head circumference of children aged five years old and younger may be indicated in cases of child abuse. Percentiles must be given if the head circumference is relevant to the case (a head circumference above the 90th percentile may be a sign of intracranial bleeding).

Clinical findings

A general examination is indicated. The health worker has a dual responsibility with regard to both health and medico-legal aspects. Health and medico-legal aspects are recorded in the clinical notes. Medico-legal aspects only are recorded on the J88 form. A top-to-toe, back-to-front examination must be performed methodically, since the person may be unaware of certain injuries.^{1,2,6,7} Fingernail state and visible debris should be noted. The dexterity of the patient should be noted as well.^{28,29}

Hidden areas (the soles of the feet, palms of the hands, axillae, inner thighs, behind the ears, tympanums and hairy areas) must not be forgotten.¹ The conscious patient will usually provide an indication of discomfort, which will alert the examiner to assess particular areas. Document any neurological alteration, if present. Document the nature, position (with reference to a fixed surface anatomical point), size (measured accurately, or indicated if approximated),²⁷ shape, depth, surrounds, colour, course, contents, borders, possibility of probable force, age, unusual marks and colouration associated with wounds. Tenderness, pain, stiffness and transientness may also be important. Every injury should be documented, no matter how apparently trivial it seems.

The need for a detailed description of the clinical findings is indicated to prevent confusion. The term "laceration" indicates a blunt injury (synonymous with "tear") and should not be extended to all open wounds, including incised wounds.^{2,27,30} Since the term "laceration" may be differently interpreted by different persons, it must be described particularly well, documenting the appearance of the edges, basis, presence or absence of foreign material and presence or absence of associated signs of blunt injury, in order to differentiate between a blunt and sharp injury. Similarly, understanding of a term such as "superficial" is not interpreted in the same way by all practitioners, and a detailed description will clarify possible inconsistencies in terminology.

Any indication of imprints or the use of a particular weapon or agent (inflicted injury on children by means of burning or spanking, grasping, shaking, tyre tracks and shoe imprints) must be clearly documented and photographed, if possible.²⁹ The Local Criminal Record Centre may be approached through the investigating officer to take photographs, to maintain a proper chain of custody. If the health worker decides to take photographs as evidence, a clean memory card should be used and all images should be numbered in sequence and submitted accordingly, including faulty and out of focus photographs.

The ageing of injuries is notoriously inaccurate outside the acute phase. Tissue reaction, treatment, suturing, healing and other factors change the appearance of injuries quickly. The age of the injuries can only be indicated as fresh, healing and healed.³¹ The significance lies in the consistency of the appearance of the lesions, together with the obtained history. The ability of the examiner to perceive yellow discolouration in a bruise declines with age.³²

Defence injuries, typically blunt injury to the extensor aspects of the forearms, the lateral aspects of the upper arms and the dorsum of the hand, the thighs (to shield the genitals),³³ and the outer and posterior aspects of the lower limbs and back, may raise suspicion of defensive actions.² When curled up in a foetal position during kicking or punching, defensive bruising is likely to be seen on other surfaces of the trunk and limbs. There could also be cuts to the palms and ulnar aspects of the hands, as well as the web space between the thumb and the forefinger, and bruising on the thighs in an attempt to shield the genitals.³³ Blunt injuries to the abovementioned areas may also indicate defensive action against a sharp injury.⁷

Self-harm is possible to areas on the body that are accessible to the person, who in this way, is able to injure him- or herself. Such injuries tend to be superficial or minor, multiple and regular, with an equal depth at the beginning and at the end (incised wounds), as well as regular and similar in shape (scratches and burns), multiple, parallel or grouped together, and tend to involve non-vital structures (the face and skin, but not the eyes). The injuries are predominantly on the left of the body in right-handed persons, and the converse for left-handed persons. There may be old scars of self-harm or lesser injuries where the initial self-harm was achieved (tentative injury). Self-defence injuries are absent and overlying clothing may be spared.⁷

In cases of gunshot wounds where the police is unaware of the event, your obligation to report it is mandatory, according to the guidelines of Health Professions Council of South Africa's Code of Conduct on issues of confidentiality.³⁴ Fortunately, most cases arrive at the hospital accompanied by the police.

Almost all incidents will be followed by requests and demands for interpretation by various stakeholders, so accurate recording of wound features will help to satisfy these interests. It is by far better to record a description, coupled with a photograph, where possible, than to record a conclusion about a gunshot wound's entry or exit. It is important to record whether or not the site of the injury was under a cover of clothing. If clothes were involved, the damage thereto and presence of any other foreign material noted on the clothes, e.g. soot, powder, dirt and metal, should be recorded. As a general rule, gunshot entry wounds are blunt trauma injuries (have varying combinations of skin loss and defect, abrasions, contusions and foreign material) and resemble the profile of the bullet causing it. Gunshot exit wounds may sometimes resemble entrance wounds for this reason.

Gunshot victims must be X-rayed to show the location of and number of bullets in the body. If it is indicated that the bullets must be removed, damage to the evidence must be avoided, and the bullets handled with gauze, and not with surgical instruments.

Features that may be relevant in the identification of a person, such as tattoos,³⁰ scars or configuration of teeth, must be documented in writing, and preferably photographically. (A forensic odontologist or a dentist must interpret the findings if the dental particulars are relevant.)

When suspects collaborate with the police by confessing or pointing out certain factual information, a J88 form may be required prior to and after the procedure.² It is imperative in these cases to meticulously document all identifiable features and every scar, no matter how small, after the submission of a SAPS 308 form, since the consent must be voluntary. (Suspects are examined on their request in such instances, and a SAPS 308A form will make the information inadmissible in court.) Identification may be contested in court and carries extreme weight.

Avoid the use of technical, medical terminology. Terms such as "anterior", "posterior", "parietal", "occipital" and "conjunctivae" should be phrased using commonly understandable terms. It is acceptable to provide the medical term used in addition to the lay terminology.

The features on the body diagrams should be indicated with cross-references to the clinical notes.

Describe lesions in the anatomical position. In particular, the sites of lesions on the arms are distorted if the person is not examined in the anatomical position. Document only own observations. For instance, when a person presents with a cast, it may not be assumed that there is an underlying fracture unless the diagnosis was made and the cast was applied by the same person completing the J88 form. Radiology reports must be attached if a report is available and certified if possible, with reference to the source of the information.

It should be indicated if the mechanism of an injury is unclear. Magnification may clarify the nature of the injury.

Mental health and emotional status

Mental health must be assessed within the experience of the examiner. Intellectual disability may be obvious, but mental age can only be assessed by a practitioner with appropriate experience. If there is uncertainty about intellect, an expert opinion is indicated since this may have an influence on the person's ability to give consent.

All emotions, including the absence of emotional display after a traumatic experience, are valid, and must be indicated.²⁰

Clinical evidence of drugs and alcohol

Document any smells pertaining to liquor, marijuana or other substances. Alcohol (ethanol) is odourless, but the congeners

that are added to the ethanol are responsible for the ketotic smell associated with the consumption of alcohol.

Document objective clinical signs of intoxication or sobriety, including the size of the person's pupils, congested conjunctivae, nystagmus, a dry mouth, behaviour associated with intoxication, an impaired gait, slurred speech, the content of speech, and orientation with regard to the time, place and person.³

When documenting the findings, the differential diagnoses of alcohol or drug intoxication must be excluded, e.g. head injuries, medication, shock, epilepsy, hypoglycaemia, hyperglycaemia and psychosis. Assessment of drug or alcohol intoxication only applies to the time of assessment, and cannot be interpreted retrospectively. Inspect injection sites for needle-stick marks or other signs of injection.

If indicated, collect blood and/or urine, and send the specimens for toxicology screening. Document it on the J88 form and maintain the chain of evidence.³⁵ Preferably, the specimens should be collected in an Alcohol Evidence Collection Kit. The tubes in the Alcohol Evidence Collection Kits contain sodium fluoride, a preservative that inhibits enzymatic action and potassium oxalate, an anticoagulant. If an Alcohol Evidence Collection Kit is not available or has expired, grey stopper glucose tubes may be used instead. The specimens can be placed in an improvised evidence collection kit, like a sealed envelope, and labelled with the name of the person collecting the specimens, as well as the time and place of collection, CAS number and numbers of other evidence collection kits compiled in the same case, i.e. the Sexual Assault Evidence Collection Kit. Document the existence of the specimens in the clinical notes and in the medico-legal report.

The investigating officer is responsible for the transfer of these forensic specimens to a forensic laboratory. Specimens for medical indication must be sent the laboratories used by the facility. Although the chain of evidence may be placed in dispute, the final decision lies with the court.

Diagrams

Completion of diagrams relevant to the extragenital findings on page 4 of the J88 form is imperative as it describes and clarifies the notes on page 1. Preferably, the clinical findings and the diagrams must be cross-referred to enhance the understanding of the lay person and to refresh the memory of the examiner. Features visible on more than one diagrammatic image must be indicated on all of the relevant diagrams.

Conclusion

The conclusion is based on the history and the clinical findings with regard to differential diagnoses, age and body build, clothing, injuries, sobriety and mental and emotional picture.

The conclusion on page 1 of the J88 form pertains to the extragenital assessment, and must not include the conclusion pertaining to the anogenital examination.²⁷

Support of the history with the clinical picture is the basis for the conclusion.

It is suggested that the elements that leads to the conclusion should be briefly summarised for the purposes of refreshing the memory later.

The conclusion may include, but is not limited to the following:

- The history is supported by the clinical findings.
- The clinical findings are consistent with the history.
- Blunt, sharp or thermal injuries support the history as to the mechanism and time of the injuries.
- If there are no positive findings, the conclusion must indicate that the absence of visible abnormalities does not exclude or rule out the allegation. This must be carried out routinely in cases in which no abnormalities are found.

In sexual offence cases, the conclusion must be based on extragenital information, as well as on the information on pages 2 and 3.

Pages 2 and 3 of the J88 form must be cancelled and indicated as having not been completed if doing so is not relevant to the particular case.

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