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REVIEW (CPD)

Part 3: Medico-legal documentation Practical completion of pages 2 and 3 of the J88 form

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Abstract

This is Part 3 of a three-part series on medico-legal documentation. Part 1 addressed the knowledge and skills necessary to complete a legal J88 document. Part 2 provided practical guidance on completion of the J88 form in the case of assault. This article will focus on pages 2 and 3 of the J88 document, which deals with the alleged sexual offences of both adults and children.

The assumption may exist that the J88 is the only significant document with respect to medical findings in alleged rape and child sexual abuse cases, and that the court needs this information to make a decision on the medical aspects of a case. However, the court needs the information to be interpreted by a medical practitioner, who must indicate the significance of the findings, determine who should supply relevant additional information, and then place the entire picture in context.

This article attempts to highlight the value of the relevant aspects, while raising awareness of an unscientific interpretation of clinical examination.

Keywords: medico-legal documentation, J88 form, sexual offences, pages 2 and 3 of J88 form

Introduction

Accurate medico-legal documentation may prevent the medical practitioner from being summoned as a witness, and makes it easier for testification to occur, since all the relevant facts are available. Documentation which mirrors knowledge and insight provides an opportunity for the court to be efficiently appraised of the events, and provides the necessary support for the justice process. This facilitates a court decision based on the contribution of all role players, of which the medical witness contributes only a part.

The parts of the J88 form that relate to sexual offences needs revision so that the research and advances in knowledge that have taken place over the past two decades can be acknowledged. The information requested in the current form is not relevant in totality, and may raise unreasonable expectations as to the significance of the findings. The prompted information is inadequate in certain aspects, and in others superfluous, or may not encourage good medical practice. The assumption may exist that the J88 is the only significant document with respect to medical findings in alleged rape and child sexual abuse cases, and that the court needs all the information as prompted in the format to make a decision on the medical aspects of a case. However, the court needs the information to be interpreted by a medical practitioner, who must indicate the significance of the findings, determine who should supply relevant additional information, and then place the entire picture in context. The J88 format incorporates the findings of both the adult and the child, without differentiation between the two groups with regard to vast differences in genital anatomy.

This article attempts to highlight the value of the relevant aspects, while raising awareness of an unscientific interpretation of the clinical examination.

Important terminology

The definition of rape according to the Sexual Offences Act[1] needs to be understood during a medico-legal examination. These elements discussed briefly:

- *Rape:* "Rape" is an act of sexual penetration without consent.
- *Sexual assault:* "Sexual assault" is an act of sexual violation without consent. "Sexual assault" is a term that should be used with extreme care, since the definition of sexual violation excludes sexual penetration, thus the term "sexual assault" excludes "rape". To be able to make medical sense of the definitions, the definitions of "sexual penetration" and "consent" need to be known.
- *Sexual penetration:* "Sexual penetration" is defined as penetration to any extent whatsoever by genital organs into or beyond the genital organs, anus, or mouth of another person; anything else into or beyond the genital organs or anus of another person; and the genital organs of an animal, into or beyond the mouth of another person.
- *Consent:* "Consent" is voluntary or uncoerced agreement which excludes submission or fraud; the incapability of appreciating the nature of the sexual act, i.e. being asleep, unconscious,

being in an altered state of consciousness or having impaired judgement due to substances; excludes persons younger than 12 years of age and persons who are mentally disabled.

- *Child sexual abuse:* "Child sexual abuse" is not synonymous with rape, and includes a spectrum of abusive sexual activities. It also includes fondling; sexual grooming; exposure to or the display of (or causing exposure to or the display of) child pornography or pornography to children, using children for or benefiting from child pornography; compelling (or causing) children to witness sexual offences, sexual acts or self-masturbation; and exposure to or the display of (or causing exposure to or the display of) genital organs, the anus or female breasts to children ("flashing").

This explanation does not attempt to explain the official legal definition. For the complete definition, please refer to the Sexual Offences Act. The aim herein is merely to cast light on the medical understanding.

History in the case of an alleged sexual offence (Part D of the form)

Consent to the release of any information is imperative.[2] Consent is voluntary, and may be withdrawn or partially withdrawn. The gynaecological history, as it appears in this section, is largely not relevant in cases of pre-pubertal child sexual abuse, and should be indicated as such.

Menarche has no evidentiary value. The sexual maturity and ability to fall pregnant are determined by the Tanner staging of the female breasts, and not the menarche.[3] The information is of medical value in the case of adults and adolescents.

The documentation of recent sexual activity and number of consensual sexual partners during the last seven days may be an infringement on the right to dignity, freedom and security of the person, privacy, freedom of religion, belief and opinion, and bodily and psychological integrity (when making decisions concerning reproduction).[4] It has evidentiary importance in circumstances in which deoxyribonucleic acid (DNA) from more than one person is detected, or if the DNA is from somebody other than the accused, and the significance of this must be discussed with the patient. The information on the possibility that more than one person's DNA may be present is addressed in the evidence collection form in the Evidence Collection Kit, which is seldom read in full in hearings.[5] If the last consensual intercourse took place more than 5-7 days prior to the examination, it is generally regarded as being irrelevant. An arbitrary time limit of 72 hours since the incident is accepted for the collection of specimens.[6]

Elements of medico-legal significance with respect to adults are the number of vaginal deliveries and genital surgeries, current pregnancy, last intercourse with consent, and number of consensual partners (if within 5-7 days prior), condom use and cleansing procedures, with the associated risk of loss of evidence. The question on condom use is confusing.[7] It should be regarded as referring to the alleged rape, and not to the questions on contraception and previous consensual intercourse. The information on the latter must be included in the section on contraception and last consensual intercourse. It may be indicated for the purposes of elaborating on the answer and indicating the interpretation of the question.

Condom use and cleansing are not contraindications to the collection of specimens. Condoms may break or spillage may occur, and DNA may be present, particularly in the cervical os after cleansing. The cleansing procedures should be indicated with a tick in the appropriate block. It is suggested that if none of these is marked, a note should be made that none took place. When testifying, one may feel unsure as to whether or not the question was accidentally overlooked, or if the answers were all negative. Ask about genital wiping as well, and include tissue paper used for wiping in the Evidence Collection Kit, if available. If the person cannot avoid passing urine or defecating prior to evidence collection, it is suggested that he or she wipe before the action and keep the tissue paper in a paper bag or envelope (not plastic) for inclusion in the Evidence Collection Kit.

Contraception, date of last menstruation and menstrual cycle have mere clinical significance. Current menstruation may have a lubricating effect. The positioning of the cleansing procedures is unfortunate since it may be overlooked in males and in cases of anal penetration. The first date of the last menstruation has significance in post-menopausal and lactating females. If the patient was menstruating at the time of the rape, menstrual fluids may provide lubrication.

Only cleansing procedures in acute cases are elements of significance with respect to children. The presence of foreign DNA on a child's body is a rare occurrence after 24 hours of the incident.[8,9] DNA in child sexual abuse cases is more likely be found on clothing and bedding, and on the hands of the children.[8]

Gynaecological examination (Part E of the form)

General information

The aim of documentation of the anogenital tract is to indicate acute injury, structural changes; old injury and the consequences of sexual contact, or contact with infective material, and an assessment of differential diagnoses and conditions that may influence the clinical picture, as well as indications for medical treatment or referral. On the J88 form, information that is significant in adult and adolescent cases only, and information of significance to pre-pubertal children only, are intermingled, and may cause confusion, making the interpretation of the gynaecological examination problematic for the less experienced medical practitioner, as well as the less experienced prosecutor, police official, magistrate or judge and defence lawyer.

Internationally, the acronym "TEARS" for acute blunt injury is accepted, where T indicates Tears and Tenderness, E Ecchymoses, A Abrasions, R Redness and S Swelling.[10]

Tanner staging has significance in children and adolescents only, and not in adults. Tanner staging refers to the assessment of sexual maturity, as influenced by endogenous oestrogen. In addition, it serves as objective information on the sexual maturity of the child at the time of examination. The development of secondary sexual characteristics is variable in individuals. Sexual maturity may change significantly between the time of examination and the time of the court appearance. Tanner's work investigated the developmental change in a population of British children,[11] and

cannot be used scientifically for deductions in other populations, including the South African population.[12-15] Tanner staging must not be regarded as an indication of chronological age.[11] The medical significance of Tanner staging lies in the indication of the influence of endogenous oestrogen, adrenal androgens or testosterone, the possibility of pregnancy, a decision on emergency contraception and the vulnerability of tissue to injury.[10,16] When a girl has reached thelarche (breast budding), Tanner stage 3, it must be assumed that she may fall pregnant, and that secondary genital anatomical development is probably present. Menarche is not a reliable indication of the possibility of pregnancy.

Development (oestrogenisation) of the genital tract decreases the vulnerability of the genital tissues to trauma (Table 1). Pubic hair development, an indication of circulating androgens, is of limited value. The position of injuries or details regarding the genitals is described according to the face of an imaginary watch, in the position of the vaginal opening, with the patient in a supine position and the anterior midline indicated as 12h00.[6-7,10,16] Similarly, details of the anus are described with reference to an imaginary watch in the position of the anus, with 12h00 in the front midline and 06h00 the back midline.

Table I: Effects of oestrogen on the hymen and vagina[6,7]

- Elasticity increases.
- The thickness of the hymen increases and the hymen becomes redundant.
- Sensitivity decreases.
- The hymen develops blanched edges.
- The vaginal epithelium changes from single-cell columnar to multilayer squamous epithelium.
- The vaginal pH lowers.

The most vulnerable genital sites are the structures to the back of the 03h00-09h00 line, specifically between 05h00 and 07h00.[16,17] The reason for the increased vulnerability of this area is that this is the area of first contact of the penis with the female genitalia during genital penetration.

Rape is not a clinical diagnosis. Injuries can occur with cooperative intercourse and may be absent in rape in adults and adolescents. The more anatomical genital sites injured and the more severe the injuries, the higher the probability of non-cooperative genital penetration.[17] Extra-genital injuries increase the probability of genital penetration without cooperation. The medical examiner does not have the ability to assess consent in the legal sense, but may be able to give an indication that cooperation is unlikely from a medical perspective, and that consent may not have been valid, because of age, neurological or mental status.

Pre-pubertal girls should be examined in two positions: supine, mostly in the frog-legged position (the dorsal recumbent position is sometimes appropriate) and in the prone knee-chest position.[4,5] The positions of examination must be documented since abnormal findings must be confirmed in the prone knee-chest position.

Infants may be examined on a person's lap. Examination on a lap makes the prone knee-chest position difficult, but not completely impossible. Other positions of examination, such as lateral positions or with the knees against the chest in a supine position (supine knee-chest position), may be helpful in specific circumstances. Experience has shown that, when pacifying a baby by placing him or her over the shoulder of the mother, good visualisation of the anus and the genitals, similar to that gained in the prone knee-chest position, may be achieved.

Extreme care must be taken to not force a child physically or emotionally into an anogenital examination for medico-legal purposes, since the child may perceive it to be as traumatising as the deliberate sexual abuse. Dual responsibility by the clinical forensic practitioner is required in these circumstances. In no circumstances may a child's emotional health be sacrificed for the well-being of a court hearing.

The child must be talked through the examination.[18] A gentle examination which allows the child choice and minimises emotional trauma may be the first step on the journey of healing, by carrying a primary therapeutic message.[19,20] Document the degree of cooperation of the child, since this may have bearing on the technical difficulty of the examination.

Document the use of special techniques or technology, such as Foley's catheter technique, a colposcopy or toluidine blue, to assess the hymen of an adolescent.[21,22] Toluidine blue is a tissue stain used to identify and confirm injuries.[6,8,13,20-22] The nuclei of cells in the deeper layers of the epidermis have affinity for toluidine blue, which is removed from intact skin during destaining.[23,24] A 1% solution of toluidine blue in sterile water is applied to the area where injuries are expected, and/or confirmation of injury needed.[16,23-25] The stain is removed with a cotton wool swab and a water-based gel after approximately one minute. The visibility of injuries increased from 4% by gross observation to 54% when toluidine was applied to adult victims of rape.[24] Posterior *fourchette* lacerations were visible in 4% of adolescents with gross visualisation, and in 28% in adolescents when the stain was used.[24] Negative effects on the DNA or the patient have not been found.[26]

Foley's catheter technique, or any other procedure which carries a risk of contact with a pre-pubertal hymen, is absolutely contraindicated in the relevant group. The pre-pubertal hymen is extremely sensitive and girls do not tolerate even the slightest touch. The vestibule is also sensitive, but can generally tolerate gentle touch.

If a child is examined under anaesthesia or sedation, it must be documented as such. Examination for child sexual abuse under anaesthesia should only be carried out for medical (not medico-legal) indications when the benefits for the health of the child clearly outweigh the risks.[16,27] The quality of the medico-legal assessment is negatively affected by anaesthesia and sedation. General muscle relaxation may influence the tone of the pelvic floor and allow anal dilatation.[28] Positive findings are unlikely to be confirmed in the prone knee-chest position owing to technical challenges. Sedation and anaesthesia are unlikely to aid the medico-legal process since the probability of collecting foreign DNA from the genitals of a pre-pubertal child is extremely low,[7] and a normal examination is expected in 70-90% of cases. DNA evidence in cases of child sexual abuse is more likely to

be obtained from clothes, bed linen and from the hands, since children tend to touch where it is uncomfortable.[8]

Indications for children to be examined under anaesthesia are medical, i.e. in the event of multiple injuries, abdominal pain, active anogenital bleeding, and when there is a history or indication of foreign objects being used.

The needs of the prosecutor are not an indication for anaesthesia of a child as it is not in the child's best interests.

Anatomy

The *labia majora,* the lateral borders of the genitalia, is the first position of entry or penetration into the female genitals.[1]

The *labia minora;* the boundaries of the adult and adolescent vestibule, which includes the vaginal orifice; the urethral orifice and the orifices of the Bartholin ducts, are small in the pre-pubertal child, and do not extend to the position of the posterior fourchette, a ridge formed by the posterior parts of the *labia minora.* The vestibule is not mentioned in the J88 form, but the paraurethral area (folds) anteriorly and the *fossa navicularis* posteriorly are both parts of the vestibule. The vestibule of a pre-pubertal girl is bordered by the *labia minora* anteriorly and the *labia majora,* forming the *posterior commissure*, posteriorly. Together with the *fossa navicularis,* the posterior *fourchette* in adolescent and adult females during labial separation are the most vulnerable structures during penile-genital penetration.[17,29-30]

The hymen is a double membrane which partially (or rarely completely) covers the external vaginal orifice and is located at the junction of the vestibular floor and the vaginal canal.[31] The external surface is lined with highly differentiated squamous epithelium with loose cornification. The internal surface is lined with vaginal epithelium.

The examination of the hymen is not significant in sexually active females. Fresh tears indicate recent vaginal penetration, but the absence of trauma does not exclude penetration. A less important finding regarding the hymen is the configuration (ring-like or annular, half-moon-like or crescentic, two openings or septate, remnants, *carunculae myrtiformes* and rolled edges). It is more important whether or not the hymen is oestrogenised in the case of children and adolescents.[3,7,10] Oestrogenisation is expected in the infant up to the age of three years, and in pubertal and adolescent females, as from Tanner stage 3.[32] Atrophy of the genital tissues due to low oestrogen effects is expected in pre-pubertal and post-menopausal females. Oestrogenisation of the hymen should be clinically assessed and documented, since oestrogenisation lessens the probability of injury to the hymen and other genital tissue. The effects of oestrogen on the hymen and vagina are listed in Table I.

The hymen is vulnerable, particularly during childhood. Assessment of the hymen cannot be used to establish whether or not previous penetration has occurred.[33-39] Congenital absence of a hymen in girls with a normal Müllerian system has not been described.[40-42] The use of the term "hymen intact" is not recommended because of the lack of specificity. The size of the opening of the hymen cannot be measured accurately and shows wide variation, and an overlap between the normal and abnormal measurement is not recommended.[28,43]

Hymenal injury can only be caused by a penetrating force, and not by straddle injury, like bicycle riding, horse riding, gymnastics or falls, which may cause injury to the external genitals only.[10,37,44]

Synechiae refers to the fusing of the *labia minora* and is a non-specific finding.[28] (The treatment is short-term oestrogen cream application.) Abnormal findings of the pre-pubertal hymen must be confirmed in the prone knee-chest position and documented as such. Likewise, the positions used in the examination must be documented.[10, 37,44]

Fibrosis *(scarring),* during the healing of anogenital injuries, occurs infrequently, and may be difficult to prove on clinical grounds.[45]

"Increased friability" is a term applied when the *posterior fourchette* or the *posterior commissure* forms small tears when a labial separation technique is used.[44,45] It may be caused by infection, trauma, and even suboptimal hygiene, and must be regarded as a non-specific sign.

Bleeding and tears of the *posterior fourchette* refer to fresh injury or to non-abusive pathology.

The vagina of a pre-pubertal child may only be examined by carrying out an inspection. The vagina opens in the knee-chest position, and the walls of the vagina can be assessed. Assessing how many fingers are admitted into the vagina is medically and medico-legally insignificant, unethical and constitutes an assault on the patient. It is extremely traumatic in children, and should not be attempted in any circumstances. It may be necessary to look for foreign objects in the vagina of an adult. An examination under anaesthesia should be performed on pre-pubertal children if a foreign body is suspected, or when resistant genital discharge is present. A bimanual examination can be carried out for medical indications and to detect foreign objects in adults and adolescents, but never in pre-pubertal children and sexually inactive adolescents.

Discharge and bleeding can be observed in children without having to conduct an internal vaginal examination. It is with reason that no information on the presence or absence of semen is requested. Semen liquefies and the presence or absence of semen is not reliably visible. If the presence of semen is suspected, the substance should be described. The presence and source of any bleeding must be documented. An interpretation of the relevance of sexually transmitted diseases to child sexual abuse is complex, and must be performed using scientific principles.[10,16,28,34,35,44,46] If discharge is present in a case of alleged child sexual abuse, a culture must be performed according to scientific principles.[37,47,48] The dispatch of such a specimen must be documented. The chain of evidence may be a problem since the specimen cannot be managed by a forensic laboratory, but the decision about the admissibility of the evidence lies with the court, and the result is essential in order for a conclusion to be drawn.

The cervix of pre-pubertal girls can commonly be seen in the prone knee-chest position with good lightning. An otoscope

may be used as a light source, but contact with the hymen is contraindicated. It must be documented that an internal examination was not indicated in the case of a child. The cervix is the most likely site in an adult for a positive DNA finding when the patient has washed, or if the examination was delayed. Erosion is not a sign of genital penetration, but is a medical condition.

The perineum is the area between the genitals and the anus. Since the perineum is an anatomical structure of both the male and the female, care must be taken to address this in male and anal examinations as well.

Samples taken for investigation (Part F of the form)

Use one of the numbered stickers in the Evidence Collection Kit, if available, to stick here.[7] The J88 form has the same serial number. If a sticker is not available, document the number of the kit accurately. If forensic evidence has not been collected, indicate this.

The part on "specimens handed to" on the form should be completed in all cases, including physical assault.

The information is essential to maintaining the chain of evidence to ensure that the evidence reaches the laboratory or the court in the same condition in which it was in when it left the examiner.[27,49] The J88 form and forensic specimens may only be transferred to the South African Police Service (SAPS), not to a patient. This is the only place that any handwriting, other than that by the medical examiner, may appear.

Anal examination (Part G of the form)

An anal examination must be carried out in all cases, in both adult and child sexual offence cases.[7,16] The anal examination in acute female cases must be performed prior to the genital examination, owing to the possibility of contamination of the anal area or dilution of the evidence by substances like tissue stain and water used for the genital examination. The aim of the anal examination is to detect acute injury (TEARS), structural change, the consequences of sexual contact, or contact with infectious material, and other causes for the clinical picture. The examination includes an assessment of the mucocutaneous condition and the anal orifice.

If an anal abnormality occurs in the midline, it may be non-abusive or non-specific, but if it occurs outside the midline, it is highly suggestive of penetration from the outside.

Hygiene and pigmentation are not significant aspects. Fissures and cracks may be present because of inflammatory disease, penetration from the outside or constipation.[3,37] Differential diagnoses must be considered and addressed.

TEARS are the features of acute blunt trauma.[10,17] Tags, protrusions of anal verge tissue which interrupts the symmetry of the perianal skin folds, are normal or non-specific findings.[28,37] The anal rugae are normally regular and exist due to contraction of the external anal sphincter. The irregularity of the folds supports a history of recent anal penetration, if present, but does not carry particular significance in isolation.[37]

The anal verge is the tissue overlying the subcutaneous external anal sphincter at the most distal portion of the anal canal, and extends posteriorly to the margin of the anal skin. Complete anal dilatation occurs when relaxation of the muscle layers of the anus occurs, so that the examiner can visualise the rectum within 30 seconds of gentle separation of the buttocks to at least 20 mm anteroposteriorly in the absence of stool in the rectum.[7,16] Twitching is successive contraction and dilatation. Anal dilatation cannot be reliably assessed under sedation owing to possible relaxation of the pelvic floor.[28]

Swelling and thickening of the rim, funnelling, shortening of the anal canal and cupping are the result of partial dilatation or relaxation of individual the sphincter muscles, in the absence of relaxation of both anal sphincter muscles.[7,37] The external sphincter muscle may relax, making the pectinate line visible, shortening the anal canal and forming a cup-like or funnel-like appearance of the partially dilated anus. Partial dilatation is a normal feature.[7,37] Tears may result from a variety of causes, including the passage of hard stools and the insertion of objects.

Table II indicates the differences between the various types of fissures.

Table II: Differences between the various types of fissures[32]

	Anal fissure	Crohn's disease	Anal penetration (from outside)
Number	1-2	1-2	Multiple
Site	Midline	Midline and lateral	Midline and lateral
Proximity to anus	Central	Central	Peripheral

Digital examination is not indicated as part of the assessment of anal penetration. The tonus muscle can be assessed by inspection of the perianal skin folds (rugae) and anal dilatation. The presence of stool in the rectum can be visualised when the anus dilates, but does not have medico-legal significance if the anus does not dilate. A digital examination of the anus may cause serious secondary traumatisation, and must only be performed for medial indications.

Male genitalia (Part H of the form)

The features of the glans penis, including the prepuce, meatus and discharge, ulceration of the glans, corona and the frenulum, the latter being the most likely structure to be injured, must be documented. The absence or presence of smegma has not been proven to have medico-legal significance.

The scrotum examination includes a thorough urological assessment, including the testes and the inguinal region. Infections may be present and a vasectomy, orchitis or atrophy may be the cause of the absence of DNA. The examination of male genitalia is complete following an examination of the shaft. An assessment of the perineum must also be included in the male examination.

Conclusion

The decision as to whether or not a crime has taken place is not the responsibility of the health worker. The conclusion merely provides an unbiased opinion on the likelihood of the consistency of the findings with the history.

A normal examination does not exclude genital penetration.

In order to motivate the conclusion, and be able to explain it in court, it is suggested that a short summary is made of elements relevant to the conclusion. This will ensure that the conclusion is holistic, and that elements of the assessment that are significant with regard to the conclusion are at hand in court.

Elements that may be relevant include, but are not limited to:

- The facts supplied by the investigating officer on the SAPS 308.
- The history taken from the patient.
- Collateral history. (This may be inadmissible, being hearsay, but the court must make the ultimate decision on its admissibility, particularly if it is supported by the findings).
- History or observation of behavioural changes, and concerns about behaviour and sexualised behaviour.
- Facts of the medical history that may influence the cognitive ability of the person.
- Medical conditions or medication that may influence the clinical picture.
- Disabilities.
- Clinical features, as described extensively in section 5 under "Clinical findings", as indicated in part 2.
- If the sobriety or the mental state has relevance to the case. (An intoxicated person cannot give valid consent).
- Tanner staging, if sexual maturity is relevant.
- *Pertaining to child sexual abuse:* It needs to be determined whether or not the findings were normal, non-specific, indeterminate, showed clear evidence of genital trauma, or clear evidence of sexual contact. The "absence of a hymen" in pre-pubertal children should not be reported (congenital absence of the hymen has not been found in research). Other elements of child sexual abuse pertain to the clarity and amount of detail regarding the history. (Consistency can seldom be assessed in the medical history because of limited contact time).
- *Pertaining to rape:* Legal terms like "rape", "sexual assault" and "sexual penetration" should not be used since these cannot be assessed clinically. The elements of rape[1] are that it occurred unlawfully and intentionally, and there was an absence of consent and sexual penetration.

The conclusion can address these elements in the following ways.

"Unlawful" must be legally validated, and is not within the skills and knowledge of the health worker. "Consent" is a legal term. The health worker can form an opinion on the probability of the absence of cooperation by assessing the possible influence of extragenital injury, as well as the condition of the clothing, the ability to give consent (age, sobriety, maturity and cognitive ability). "Rape" can occur without any abnormal clinical findings. Consensual intercourse can have injury as a consequence. If more than one genital anatomical site is injured, and if the injuries are more severe than expected, the probability or non-cooperation increases.[17]

"Sexual penetration" is a legal concept. The health worker can provide an opinion on the entity of genital, oral and anal penetration (penetration to any extent whatsoever into or beyond the genital organs, anus or mouth).[1] "Genital penetration" can commonly be diagnosed by the presence of abrasion, bruising and tears to the external genitalia. The presence of "vaginal penetration" can seldom be accurately diagnosed. Accurate documentation must be carried out. The term "sexual assault" excludes the possibility of rape and must in no circumstances be used if the definition (exclusion of penetration) is not understood.

The absence of positive findings most does not exclude the possibility of an offence. It is imperative that this conclusion is made and documented, even in the absence of a specific allegation according to the history. The disclosure of an incident may be a process, not an event, and rigid conclusions may exclude certain possibilities, and may be difficult to explain at a later stage.

When any rigid conclusion that implicates a "definitive", "always", "never" or similar message is documented, the scientific nature of the statement must be well considered, and any possibility that another scenario may be consistent with the facts, however unlikely, must be deliberated. Terms like "likely", "consistent with", "possible", "probable", "often", "seldom" are preferable.

Similarly, any conclusion about a specific weapon, specific dates or times, and names and addresses must be avoided in the conclusion. Weapons may be described as "sharp" or "blunt", times and dates as "consistent with the history obtained", and names avoided.

Scientific classifications must be used in the conclusion. It is suggested that the tool by Adams is used for child sexual abuse.[37] The research of Slaughter indicated that consensual intercourse should not cause injuries worse than a small injury in one anatomical site.[17] Thus, the number of genital sites injured and the severity of the injuries must be considered.

Courts are interested in the amount of force applied that will cause different injuries. Differentiation is unreliable.

The most important concept pertaining to child sexual abuse is that a normal examination is expected, and that child sexual abuse can never be excluded, and seldom confirmed, on clinical grounds.[16,36-38,50-52]

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