

# The emergency management of a rape case in a nutshell: adolescent and adult cases

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The management of a rape case in the emergency department is shrouded in an unacceptable level of lack of confidence. Since South Africa has a high incidence of rape, the contribution of health practitioners in addressing the crime successfully is essential. The medical management of such cases carries a high level of uncertainty with an accompanying element of not feeling in control. The intimidation associated with the responsibility of being an expert witness complicates the matter further. This article attempts to address the reluctance to get involved in medico-legal cases and emphasises the holistic management of survivors of rape.

**Keywords:** adolescent, adult, medical management, medico-legal, rape, sexual assault

## Introduction

South Africa is known as the rape capital of the world, and has one of the highest prevalence rates of rape globally.<sup>1–3</sup> In 2015, 53 817 sexual crimes were reported.<sup>4</sup> Certain references estimate that a person is raped in South Africa every 35 seconds,<sup>2</sup> but many cases are not reported.<sup>4</sup> The report rate of rape is estimated to vary between one and six cases out of 25.<sup>5,6</sup>

Services for victims of rape are mainly rendered on the primary health care level in the public sector. The medical and medico-legal assessments should be done at the earliest possible time to prevent loss of evidence and enhance the management of the health needs of victims, including post-exposure prophylaxis. Delay in examinations and treatment are unacceptable because of emotional traumatisation as well as possible adverse health consequences.<sup>7</sup> Doctors may feel intimidated by clinical medico-legal practice. Although formal undergraduate training may seem inadequate, management of rape cases falls within the spectrum of general skills of young graduates.

## Legislation and definitions translated for health practitioners

The legal definitions of rape, sexual assault and other sexual offences are complex and phrased comprehensively.<sup>8</sup> In order to support the courts with the necessary information to prosecute and defend the case efficiently, knowledge and understanding from a medical perspective of the elements of the crime is necessary. To reduce the information to that which can be assessed by the health practitioner, only the medically relevant elements are used:

- *Rape* is sexual penetration without consent.
- *Penetration* is penetration, to any extent whatsoever into or beyond the genitals, anus or mouth. (Figure 1)
- *Sexual assault* is sexual violation without consent. Sexual violation excludes rape, since sexual violation according to the definition excludes sexual penetration.

- *Consent* is only valid when it is given voluntarily and uncoerced. To give valid consent, the person should be able to comprehend the nature of the consent, to understand the consequences of the consent, and to act on the reasoning. Submission is not consent. Consent is not valid when force is used, a person is unconscious, or in an altered state of consciousness (intoxicated with drugs or alcohol, hypo- or hyperglycaemia, post-epileptic stupor, etc. to the extent that judgement is impaired), younger than 12 years, or mentally disabled.

## Consent for medico-legal assessment and release of information

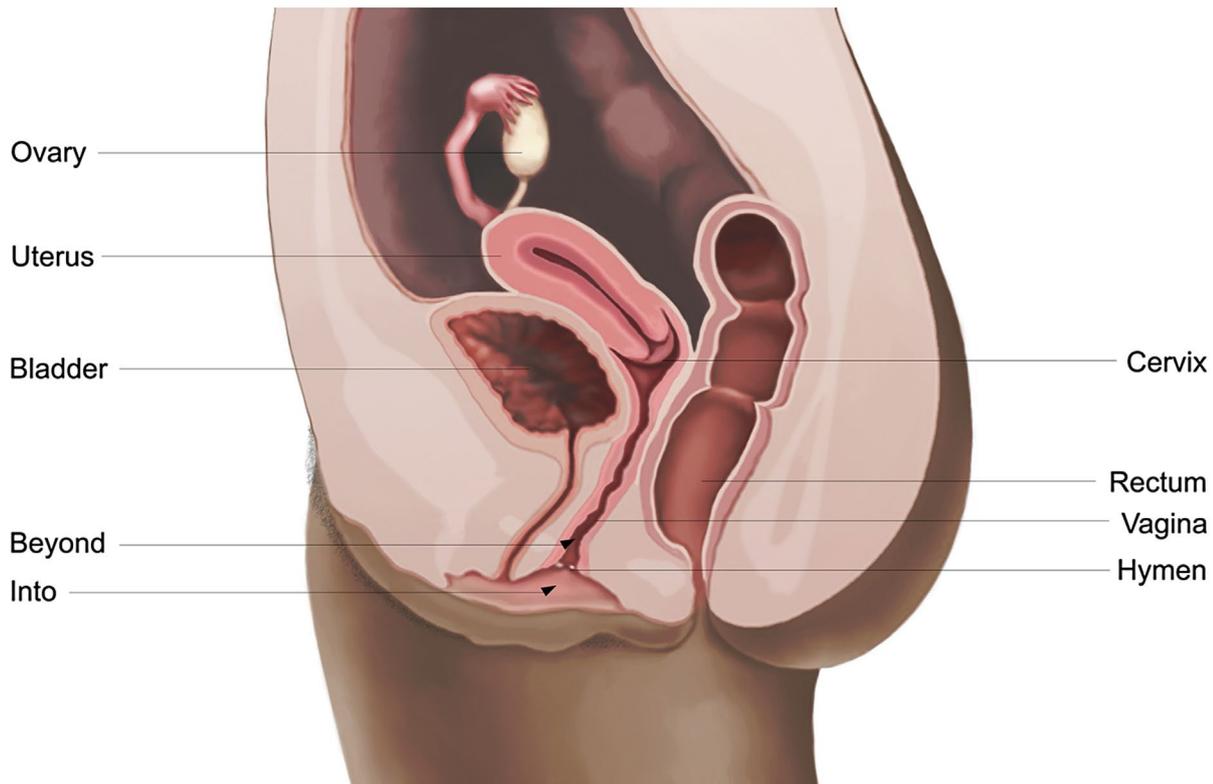
Form SAPS 308 is a pro forma used by the South African Police Services (SAPS), and should be completed for all rape cases when a case or a file is opened. The form consists of three parts:

Part 1: A formal request to the health worker to examine the complainant. Particulars of the case should include information regarding registration of the case, as well as aspects that need particular assessment.

Part 2: Legal, valid and informed consent for the medico-legal examination, collection and investigation of medico-legal specimens, photography, medico-legal documentation, and written consent for release of the information.<sup>9</sup> All persons older than 12 years should give consent for themselves; parents should not give consent for their children older than 12 years. Although the form is completed by the investigating officer, it remains the responsibility of the health practitioner to ensure that the consent is valid.

Part 3: The process to obtain legal and valid consent for children under 12 years of age, or when the child is not of sufficient maturity to give consent.

According to the National Health Act,<sup>9</sup> no patient information may be disclosed without written consent, unless a law or a court order requires disclosure, or if non-disclosure of the information



**Figure 1:** Diagrammatic explanation for penetration to any extent whatsoever into or beyond the female genitalia.

represents a serious threat to public health. Form SAPS 308 gives consent for disclosure of the patient information for criminal proceedings, but only when the form has been properly completed and the complainant, parents or legal guardians are well informed of the implications of the consent rendered. Consent is voluntary and may be withdrawn. Partial withdrawal of consent should be respected, such as discomfort with a speculum examination where the examination should then be completed without using a speculum.

A complainant relating to a sexual offence may not be sent to a police station to open a case. The relevant police department should be informed that a case needs to be opened, if the patient wishes to do so, and the administration should be done at the health facility. The process of taking a formal police statement may not delay an examination or treatment.

If a completed SAPS 308 form is not submitted, the rights of the rape victim in the emergency setting are not affected in any way, and medical treatment should be provided.<sup>10</sup> Information on the possibility of opening a case, and the implications on loss of evidence if the medico-legal assessment is delayed should be given. With consent of the patient, the medico-legal examination and the collection of evidence should be performed according to protocol. The medico-legal report and collected evidence should be locked away in such a manner that unauthorised access is impossible. After a reasonable time (four to six weeks), during which the patient may consider whether to open a case, the evidence (which includes the medico-legal report) is either released to the investigating officer after submission of the SAPS 308 form, or destroyed.<sup>10,11</sup>

It is recommended that one or two evidence collection kits are kept at the designated health facility with the authorisation of the SAPS, to prevent delay of examinations of walk-in patients and patients who have not made up their minds about opening a case.

#### **Emotional care**

The emotional care of a rape victim in the emergency department includes empathy, a non-judgemental attitude, adequate information, participation in decisions, and allowing for choice. A sense of regaining control is essential. Following these simple guidelines initiates trauma intervention and may serve to prevent post-traumatic stress disorder in the longer run.

#### **Admissions**

Rape cases should be managed as a priority.<sup>11</sup> The rape victim should be assisted in opening a file at the health facility,<sup>9</sup> and kept out of the public eye as much as possible. The evidence collection kit that is brought along to the health facility by the investigating officer should be kept out of view, since it may reveal the reason for the visit.

#### **Intake into the clinical department**

Triage should be done and surgical and medical needs attended to. Prophylaxis against HIV should be initiated as early as possible after exposure.

#### **Timing of the assessment**

The medico-legal assessment, including the physical examination and evidence collection, should not be delayed. Documentation should be done contemporaneously. If delay cannot be avoided, measures should be taken to preserve evidence and minimise emotional trauma.<sup>11</sup>

Emergency medical management takes priority over medico-legal management.<sup>9</sup> It is recommended that specimens are collected from the genitals before catheters are inserted or other cleansing procedures are performed. When cutting of clothing is necessary, care should be taken to refrain from cutting through damage to the clothing, if possible, and ensure that potential body fluid deposits are preserved. Clothing should be folded in such a way that cross-contamination of DNA does not occur. Different body fluid stains should not come into contact with one another.<sup>12</sup>

An arbitrary cut-off point for emergency management of a rape case is set at 72 hours after the incident. If a rape victim presents later than this cut-off point, the relative emergency pregnancy prevention should be administered, but since the probability of recovering foreign DNA diminishes due to loss of foreign body fluid, the examination may be postponed. Scientifically, DNA may, however, be obtained after the 72-hour cut-off time.<sup>13</sup>

## Holistic management of the rape patient

### *The aim of the holistic management of the patient*

Whenever a patient in a medico-legal situation is managed, the health practitioner should realise the dual responsibility involved. The primary responsibility is to the patient, with the secondary aim to serve the ends of justice.

The primary aims of the medico-legal examination are to determine:

- medical and medico-legal history;
- medical and surgical conditions that need attention;
- aspects of the examination that link the patient to the assailant or the scene of the crime;
- injuries: fresh, healing, healed, structural changes;
- consequences of sexual contact in the non-acute scenario (pregnancy and sexually transmitted infections);
- other possible explanations for the clinical picture

### *Triage*

Rape is a violent crime and injuries that need attention should be identified. Medical treatment may be indicated.

### *Waiting time and preservation of evidence*

Time in a waiting area at the health facility may be unavoidable. Waiting areas should be private and comfortable. The patient should be protected from the public, and may not be in contact with the alleged assailant(s). Family and/or friends should be allowed to support the victim. Ideally, a chaperone from the facility should be present during the examination. A support person(s) of the victim's choice may also be present. Police officers are not allowed to attend during the examination.

To minimise loss of evidence, cleaning of clothes, body, hair, etc. should be avoided if possible. If unavoidable, tissue paper should be used to wipe the genitals before micturition and preserved to be included in the evidence collection kit. A sanitary pad may be applied to collect up semen, particularly the older-generation pads without the substances that are in the newer sanitary pads to absorb menstrual flow. During the waiting time, cleansing of the mouth, eating and drinking should only be restricted if there is a possibility of DNA evidence in the mouth.

It must be realised that the waiting time is emotionally traumatic to any patient, more so to a patient with foreign body fluids and debris in or on his/her body. It is not in the best interest of the patient and the case to delay the medico-legal examination.

### *History*

Although certain prosecutors discourage the inclusion of the incident history in order to avoid discrepancy between the formal statements and the J88, as the document does not provide space for it, a thorough history forms part of the assessment of all patients and should not be omitted.

Patient information, including medico-legal information, may only be released with written consent or when there is a law or court order that makes it an obligation, or if the public may be at risk if the information is not disclosed. If the patient is not comfortable with the releasing of certain parts of the history, it is not legal to document these in the medico-legal report.<sup>9</sup>

The history of rape victims has two overlapping aspects: history pertaining to the health of the patient, and history pertaining to the medico-legal assessment. The history directs the medico-legal examination and the collection of evidence,<sup>14</sup> and influences the medico-legal conclusions. The medical part of the history includes all aspects of the physical health of the patient. Medical conditions, surgery, medication, disabilities and psychiatric conditions may influence the clinical picture or the ability to give consent. Examples of (medico-legal) relevant information are: current use of topical steroids, anticoagulants, insulin, psychotropic medication, and possible causes for altered states of consciousness, such as diabetes mellitus, alcohol or drug use. The medico-legal report should contain all medical information that is relevant to the crime. The HIV/AIDS status of the victim usually does not have relevance for criminal proceedings, but if the suspect is HIV positive, it may change the nature of the offence if the assailant knew that the victim could possibly be infected.

The source of the history, the language(s) used, and the identity and capacity of an interpreter should be documented. The patient's own words should be used as far as possible, but in addition should be translated into English or Afrikaans for documentation purposes, since the languages of the courts are English and Afrikaans.

Information obtained should include the date and the time of the incident, location, wet or dry weather, surface on which the rape took place, number of assailants, restraints, weapons and forces, injuries sustained by the complainant and assailant, orifices penetrated, relative positions, ejaculation, kissing, sucking, biting, bleeding, menstruation, use of lubricants, use of condoms, consensual intercourse five to seven days prior, cleansing procedures after the incident, use and disposal of sanitary pads, tampons or condoms.<sup>13</sup>

### *Clothing*

The clothing has a bearing on the place, the assailant(s) and the actions relating to the crime. Any change of clothes after the incident should be indicated on the medico-legal report. Garments worn after the incident that may have been in contact with body fluids may be an important source of donor DNA and should be collected as medico-legal evidence. Organic and

inorganic debris from the scene may have been transferred to the clothes and body fluid stains may also be present, either from the assailant or from the victim. If there is a possibility that donor DNA is present, the garment should be collected as evidence, if the patient can be supplied with a replacement garment. If not possible, a specimen may be collected from the garment with a moistened swab. The investigating officer should be informed that the garment may carry valuable evidence to enable him/her to collect this as evidence at a later stage.

Tears in the clothes, broken zippers or missing buttons may support the history of the incident. Apposition of damage to the clothes with injuries sustained may indicate that a certain garment was worn at the time of the incident. The clothes that the victim wore may be important at later court proceedings. Missing garments that may have been left at the crime scene or taken by the assailant should be reported in the medico-legal report. In order to refresh the memory of the health practitioner, it is suggested the individual garments are listed in the medico-legal report.

### **Sobriety**

Sobriety can only be assessed at the time of the examination and expressing conclusions as to the sobriety of the patient at an earlier time is unscientific. Intoxication may be part of the crime and the examination should not be postponed in order for a person to sober up. Symptoms of intoxication, if present, should be evaluated objectively as alcohol is odourless. A smell of liquor, manner of speech, content of speech, level of consciousness, gait, nystagmus, coordination of movement, orientation to place, person and time, etc., are signs that need to be documented. The smell of liquor cannot be used as screening for alcohol consumption, but may support the history of alcohol consumption.

### **Mental health and emotional status**

Mental health may be an indication of whether the victim could or could not have given consent, or is mentally incapable or intellectually challenged. All emotions, whether controlled or expressed, after a traumatic episode are normal. Further assessment of mental capacity may be suggested if the examining health practitioner is unsure of the patient's mental capacity.

## **Clinical examination of the patient**

### **Extra genital examination**

A thorough general and systematic clinical examination forms part of the medico-legal examination. Injuries should be described in such detail that the reason for the conclusions are evident. Terminology used should be according to internationally acceptable standards, but also understandable to the layperson. An example is the use of the medically acceptable term 'laceration', which refers to blunt force trauma<sup>15</sup> resulting in

Acute blunt injury of the anogenital area:

<b>T</b>	Tears and tenderness
<b>E</b>	Ecchymosis
<b>A</b>	Abrasions
<b>R</b>	Redness
<b>S</b>	Swelling

**Figure 2:** Acronym used to evaluate blunt acute injury.

compression, crushing and splitting of the skin, unlike sharp force trauma, which causes incised wounds,<sup>14</sup> and may be better understood by a layperson if the term 'tear' is used.

Foreign organic and inorganic debris may be present on the body or in the hair of the patient. The patient may be able to indicate areas on the body where foreign body fluids may have been deposited via licking, kissing, sucking or extragenital ejaculation.

Extragenital injury associated with an alleged rape or in the presence of signs of oral, anal or genital penetration raises the suspicion that the penetration did not take place with the cooperation of both parties. The medico-legal documentation of extragenital findings is made on three levels:

1. A detailed description of the clinical picture to explain the basis of diagnosis and conclusion. This includes the site, size, colour, surface, depth, surrounds and description of the edges, the base, the extent, tenderness, indications of freshness, indications of healing, number and all other significant characteristics of individual features. Features that may lead to identification such as surgical scarring, tattoos and significant patterns of pigmentation should also be described. A request for photography may be made to the investigating officer. This level of the documentation is factual.
2. A comment on the nature and probable cause of the feature/ injury. The nature of the injury as blunt, sharp, caused by a firearm, electrical or thermal is made according to the first-level description. This level of the documentation is medical.
3. An expert opinion on the findings, which is generally a remark on the consistency of the findings compared with the history and an indication that absence of abnormal findings does not exclude the allegation.

### **Oral examination**

The mouth is a sexual organ and penetration by genitals or objects resembling genitalia, into (or beyond) the mouth constitutes rape. All structures in and around the mouth may be injured by penetration or violence. However, injury of the soft palate may be present without symptoms. Areas that need particular attention are the labial frenula. The mouth is also a common area of extragenital blunt force injury, consistent with use of force which may render consent invalid.

### **Anal examination**

An anal examination should be done in all cases. The aim of this assessment is to search for acute injury, signs of healed or structural change, medical conditions that may need treatment and conditions that may mimic anal penetration. The absence of positive findings does not exclude the possibility of anal penetration. Often anal trauma is not disclosed as the initial emotional trauma may complicate memory recall, but this can also be as a result of embarrassment.

Blunt acute injury is evaluated according to the acronym TEARS (Figure 2): T = Tears or Tenderness, E = Ecchymosis (bruising, petechiae or haematoma), A = Abrasion, R = Redness (a non-specific sign), and S = Swelling (a non-specific sign).<sup>16</sup> Signs of penetration include multiple tears of the skin surrounding the anus inside and outside the midline, and extending into the orifice. Inflammatory bowel disease may produce one to two tears inside and/or outside the midline.<sup>17</sup> Tears or fissures in the midline of the orifice may be

caused by the passing of a large hard stool; this should be addressed as differential diagnosis when taking the history.

Explanation of terms used in the J88 medico-legal report form:

*Anal dilatation* is complete dilatation of both the external and the internal sphincter, allowing visualisation of the rectal cavity within 30 seconds of gentle separation of the buttocks in any position without the presence of stool in the rectum. The prerequisite of an anteroposterior diameter of at least 20 mm has come under scrutiny since the measurement of a structure on a recessed plane is inaccurate. *Twitichiness* refers to the dynamic dilatation of the anus; it opens, closes and opens again.<sup>18</sup> *Cupping* and *funneling* are confusing terms and refer to partial dilatation when the external anal sphincter relaxes and the pectinate line becomes visible as a change in colour between the pink or red of the mucosa and the skin colour. This is normal and should not be misdiagnosed as pathological findings.<sup>19</sup> In the presence of cupping and funneling, the anal canal is everted and shortened, which is also a non-significant finding. The tyre sign, a muscular ring circumferential to the anal orifice, is the result of contraction of the superficial part of the external sphincter in the presence of relaxation of the internal sphincter and is also a form of partial dilatation, and thus not significant.

A rectal (digital) examination should be done only for medical indications. The examination may be similar to the abusive action and traumatic for the patient. Faeces in the rectum are visible when there is complete dilatation, and the tone of the sphincter can be assessed by the structure of the anal folds which is formed during contraction of the external sphincter.

### **Evaluation of sexual maturity**

Breast Tanner staging is an indication of circulating oestrogen levels (sexual maturity) and may not be used as indication of chronological age.<sup>20,21</sup> Breast Tanner stage 3 indicates the possibility to fall pregnant and is an indication for pregnancy prophylaxis.<sup>17</sup> Pubic hair development is a consequence of adrenal androgen production and not an indication of the possibility to fall pregnant. Menarche should not be considered as a prerequisite for pregnancy.

### **Female genital examination**

Genital structures are visualised individually and abnormal features reported by way of a watch-face notation with 12 o'clock being in the anterior midline. The most vulnerable site for injuries during female genital penetration, during both consensual intercourse and rape, is in the area behind the 3 to 9 o'clock line where the first contact with the female genitalia takes place in the area of the posterior fourchette, the fossa navicularis, posterior part of the hymen and labia minora.<sup>16</sup> Injuries of the posterior fourchette, the fossa navicularis, vestibule, labia minora, urethra and other structures within the labia majora are diagnostic of female genital penetration, if accidental causes have been ruled out. Increased friability of the posterior fourchette is diagnosed when small tears appear on the posterior fourchette during labial separation, thus being iatrogenic and not a sign of genital penetration.

The posterior fourchette is mainly injured by the force against the ridge formed during the labial separation of penetration and the fossa navicularis by thrusting. The labia minora and the hymen (particularly in adolescents) also frequently show injury. During adolescence, the hymen changes from a sensitive, inelastic structure to being elastic and redundant, forming a structure that has a high probability not to be torn by penetration.<sup>22–24</sup> Complete

clefts in the 3 o'clock and 9 o'clock positions of the adolescent hymen may be a normal finding, but there is no consensus among the experts due to insufficient research on the feature.<sup>19</sup>

The area behind the 3 to 9 o'clock line should, in addition, preferably be examined with the aid of toluidine blue 1%, a tissue stain with affinity for cell nuclei. Toluidine blue is applied to the area where injury is suspected and, after approximately 60 seconds, removed with a KY gel® swab. Stain is removed from intact epithelium, but remains visible in areas where the epithelium is damaged. False positives include other causes of epithelial damage such as ulcers and vulvitis. False negatives may be caused by oozing of the lesion and other substances such as lubrication that prohibit contact of the stain with cell nuclei. Visibility of genital lacerations of adolescents with the main complaint of rape increases from 4% to 28%.<sup>25</sup>

The entity of TEARS (acute blunt injury) applies.<sup>16</sup> Tears heal to form clefts, but may heal completely,<sup>26</sup> or may not be visible without special techniques such as examination of the adolescent or adult hymen by moving an earbud or similar swab along the hymenal edge on the inside, or by smoothing out the hymenal rim over the balloon of a Foley catheter inserted into the vagina.<sup>27</sup> Clefts may be masked by the redundancy of the adolescent and adult hymen, which form folds that overlap. Bumps and synechiae are not signs applicable to an oestrogenised hymen. A bimanual examination does not yield much forensic evidence and should be done if medical indications exist. The vagina is visualised for TEARS with a speculum in sexually active females, with consent. Foreign objects in the vagina should be searched for. The perineum is commonly injured with tears extending from the posterior fourchette, and abrasions caused by nails may be visible.

Foreign organic and inorganic debris and foreign hair may be present on the genitals.<sup>28,29</sup> Sites for evidence collection from the female genitalia includes the vulva, vestibule, high vaginal, fornices and endocervical regions. Evidence should also include the collection of matted hair by cutting it with sterile scissors. The probability of donor DNA is most likely in the cervix and the posterior fornix. The most likely body fluids to yield DNA evidence are blood (most likely), semen and saliva (least likely).

### **Male genital examination**

Similar to female breast Tanner staging, the Tanner staging of males is not an indication of age. Male rape usually happens by oral and anal penetration. The male genital examination does not differ from a urological examination. The aim of the examination is to search for TEARS and consequences of sexual contact. Evidence may be collected from the glans, the meatus and the shaft of the penis as well as from the scrotum. Female cells may be found on the male genitals.<sup>28</sup>

## **Handling of evidence**

### **Collection of evidence kits**

Evidence-collection kits<sup>29</sup> are available from the investigating officer. The contents of evidence-collection kits, such as the number of swabs, change on a regular basis. Each kit contains a user-friendly guide to assist the health worker (see Table 1 for information on the D1 Adult Sexual Assault Evidence Collection Kit). Kits have alphanumeric serial numbers and the contents of a kit share the same serial number. The kits should not be mixed. The specimens are collected in the same way as a pus swab with a similar swab, and are sealed individually in boxes and included in the kit, which is sealed after compilation.

**Table 1:** D1 Adult Sexual Assault Evidence Collection Kit<sup>29</sup>

	Content	Remarks
Peel pouch 1	3 × round-tipped swabs	The water vial is to moisten the round-tipped swabs when collecting evidence from dry areas. Dry swabs are used for moist areas
	1 × water vial	Individual swabs are inserted in EasiSwab Stores
	3 × EasiSwab Stores	Each EasiSwab Store is sealed with three short tamper-evident seals as indicated on the stores
	9 × short tamper-evident seals	*See below on suggestion for sites of evidence collection
Peel pouch 2	1 × evidence collection box	Tampons or condoms may be placed in the evidence collection box and sealed with short tamper-evident seals provided as indicated by the marks on the evidence collection box
	2 × short tamper-evident seals	
Peel pouch 3	1 × large duplex brown paper bag	The large duplex brown paper bag is for the collection of panties or pants with an attached sanitary pad
	2 × long tamper-evident seals	The small bag is for the collection of a pad when separate from the underwear; the wax paper is applied to the sticky part of the sanitary pad
	1 × small duplex brown paper bag	The individual bags are sealed with the included long tamper-evident seals
	1 × piece of waxed paper	
Other	Instruction leaflet	The instruction leaflet supplies information on the process
	J88 form	The J88 form (self-duplicating) is completed. The original is handed over to the investigating official and the copy is kept in the patient record file
	Collection of Forensic Evidence form	The Collection of Forensic Evidence form is completed (self-duplicating triplicate form). The original is included in the evidence collection kit, the first copy is for the patient record file and the second copy is handed to the investigating officer for inclusion in the police docket
	2 × evidence sealing bags (to bag the collection after collection)	The paper bags with the panties and sanitary pad are inserted into the smaller of the two perforated plastic bags supplied
		If a tampon or condom is collected, it is also included in the smaller perforated plastic bag
	1 × zip seal bag with desiccants	Three of the six sachets of desiccant are removed from the zip seal bag and included with the brown paper bag(s) and/or the box in the smaller plastic bag The large perforated plastic bag should contain the original of the evidence collection form, the EasiSwab stores with the specimens and the small plastic bag (sealed) and the remaining three desiccant sachets If the examiner wish to insert other evidence, such as smaller garments, it may be inserted in the bag and the option left open to the laboratory as to whether to process the evidence or not

\*The swabs should be utilised according to the best probability to obtain foreign DNA. Anatomically, after female genital penetration the cervical os and the posterior fornix are the most likely to yield positive results. If anal penetration is reported or suspected, the most important swabs are external anal and rectal swabs. Pertaining to body fluids, blood is the most likely source of DNA, followed by semen and saliva, in that sequence. Condoms may be folded in sterile gauze swabs, and should not be knotted in an effort to retain the semen, since the DNA may degrade if the specimen is not allowed to dry.

Content: three sterilised peel pouches.

The included evidence collection form is completed with specifics of the patient and the person who collected the evidence and particulars of the specimens, which are necessary for the laboratory and/or the court, and consent for the investigation of the specimens by the forensic laboratory.

Other evidence collection kits<sup>29</sup> that may be encountered are:

- D2 Evidence from Body Collection Kit
- D5 Clothing Collection Kit
- D7 Paediatric Sexual Assault Evidence Collection Kit

### Chain of evidence

Evidence-collection kits must be sealed when received, remain in the direct vision of the examining health practitioner after the seal has been broken, must be resealed after the examination, and handed over to a police official immediately, or kept under lock and key, preventing unauthorised access until collection by a police official. Transfer should be documented appropriately. The police official takes over the responsibility for custody of the evidence. This procedure, the chain of evidence/custody/possession, ensures that evidence cannot be tampered with before the kit is handed to the medical examiner, and reaches the laboratory in the same condition it left the custody of the medical examiner.

### Conclusions

Conclusions should take the whole picture into account. The importance of the history is that the clinical picture may support the history by linking the complainant to the assailant or the scene of the crime, as well as support the mechanism of the incident. The condition, presence or absence of clothes, sobriety, mental health and body build of a complainant is as important as the injuries. Extragenital injury may be an indication of force and non-cooperation. Signs of penetration may be obvious, but non-consensual penetration is not distinguishable from consensual intercourse. The more sites injured<sup>16</sup> and the more severe the injuries, the less likely it is that there was cooperation. The absence of abnormalities does not rule out rape, physical assault or most other allegations, and it should be clearly indicated as such. The presence of abnormalities does not confirm rape, but may be consistent with genital, anal or oral penetration.

### Clinical medico-legal report

The J88 medico-legal report is included in the D1 Sexual Assault Evidence Collection kit for adults as well as in the D7 Evidence Collection kit for children younger than 12 years. Although other forms of documentation may be submitted, the J88 format is generally completed. The medico-legal report may only be transferred to a police official with recorded maintenance of the

chain of evidence. The correct completion of the J88 falls outside the scope of this article. Full-text articles are available from the South African Family Practice Journal.<sup>14,30,31</sup>

## Treatment of patient

### Prophylaxis

Prophylaxis against HIV (28 days of full treatment with three drugs), sexually transmitted infection (syndromic treatment for sexually transmitted infections), pregnancy (hormonal emergency contraception) after a negative baseline pregnancy test, hepatitis B and tetanus, as indicated and consented to, should be offered. A starter pack of HIV prophylaxis may be issued before an HIV test has been done. If the HIV result is positive when tested three days later or on the first working day thereafter, the treatment must be discontinued. The absence of a pregnancy test is not an absolute contra-indication for emergency pregnancy prophylaxis. Mechanical methods of emergency contraception (intra-uterine devices) are contra-indicated since the possible trauma during insertion may provide additional possibility of HIV seroconversion.

### The team approach

Information on available services should be given.<sup>7</sup> The rape survivor is referred for medico-legal and emotional purposes to a social worker for counselling, social management and administration of the sex offenders register. Referrals for medical indications are considered. Follow-up for HIV and sexually transmitted infections, consequent pregnancy and continued emotional support is scheduled.

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