

# FORENSIC MEDICAL EXAMINATION LIVING PERSONS

1. Forensic medical examination of individuals is performed for the following purposes:
  - 1.1 assessment of health damage (injury);
  - 1.2 assessment of health status (e.g. simulation, dissimulation, aggravation, artificial diseases, self-induced injuries);
  - 1.3 verification of sexual assault (rape, violent fulfilment of sexual desire);
  - 1.4 solving other medical questions.

## General requirements for forensic examination of person

1. Forensic medical examination will be performed according to the expert examination order of the processor. The subject of an expert examination can be a victim, suspect or convicted person.
2. Forensic medical examination can be performed either by a **single expert** or by a **commission of experts**. The need for commission expert examination will be defined by the processor. In the event that the forensic medical expert finds based upon the review of preliminary data and his/her professional knowledge that the expert examination should be performed as a commission expert examination, he/she can suggest this to the processor.
3. Forensic medical examination of an individual will be performed in a specially designed room suitable for medical examination and taking analyses, if necessary.
4. When the person is hospitalised, the examination can be performed in the hospital, and, if agreed with the processor, also in a detention institution or at the individual's home.
5. Forensic medical examination of the individual includes review of preliminary data, medical examination of the victim, assessment of medical documentation, performance of additional investigations, if necessary, and finally preparation of an expert opinion.

### 6. Review of preliminary data

The initial task of an expert is the review the preliminary data and questions included in the expert examination order issued by the processor. Preliminary data serve as supportive information for the preparation of an expert opinion. In the event that the circumstances indicated in the preliminary data and anamnesis of the individual do not coincide, then it is the expert's task to find out what really happened to the individual.

### 7. Medical examination of the person

7.1 It is always recommended to perform medical examination during forensic examination of person.

7.2 Medical examination of the person includes taking personal anamnesis and objective description of the injuries and clothes, if applicable.

8. The following will be documented in the expert examination report while taking

**Anamnesis:** individual's explanation of the circumstances (what happened, when it happened and where); health complaints; has the individual turned to the doctor (if yes, then to which healthcare institution, how long was the treatment period, has the individual been on sick leave due to the injury, and are there any recommendations from the doctor); has the individual had injuries before (if yes, then when, and which injuries have required treatment in the hospital); past illnesses and injuries in case they might affect the course of the current injury. When including the complaints in the expert examination report it is recommended to state that such complaints were recorded according to the words of the individual.

## **9. Objective examination**

The aim of an objective examination is to describe the individual's objective findings that differ from the normal findings, and can refer directly to the presence of the injury or consequences of an injury.

Objective examination includes the documentation of general status and description of the injuries.

9.1 General status will include the documentation of the individual's constitution, height and weight (if applicable), behaviour, psychical condition (attitude towards the injury and disease), skin colour (cyanosis, yellowish, pale) and pigmentation, oedema (around the eyes, face, feet), reddening of the eyes, sclera, observation of the spine and extremities (does the person use supportive aids, are the gait and posture normal, are there any differences in the length of the extremities), palpation findings, and the condition of respiratory and cardiovascular system.

Thereafter the expert measures blood pressure, respiration rate, and heart rate and regularity. If necessary, the condition of nervous system and visual and hearing organs will be assessed and described (e.g. assessment of simpler neurological symptoms like standing with closed eyes, tremor in extended hands, muscle rigidity and symmetry of muscle strength in extremities).

## **10. Description of the injuries**

When describing the injuries, it is important to take into account when the individual turned to medical examination, i.e. how much time has passed since the occurrence of the injuries. The shorter this time period is, the better the possibilities are for the expert to define the time and mechanism of the occurrence of the injuries. Frequently the individual is not able to turn to forensic medical examination as he/she needs medical treatment. In such an event it is the task of the doctor to document the presence of injuries in medical documentation, and also describe the injuries. It is important to indicate in the expert examination report the following data:

10.1 Localisation of the injuries (e.g. left or right side of the body, distance from permanent anatomical landmarks, third of an extremity, flexion or extension surface, localisation in relation to anatomical lines and intercostal spaces on chest).

10.2 Type of the injury (excoriation, subcutaneous haematoma, wound, bone fracture, laceration, etc.).

10.3 Shape of injury (e.g. irregular, round, oval, rectangle-like, quadrangle-like, in case the injury resembles some well-known object the name of the object may be used).

Characterisation of the surface of excoriation (e.g. covered with crust, lower or higher than the surrounding skin level, or at the same level with the surrounding skin).

10.4 Colour of the excoriation and scratch and subcutaneous haematoma (main colour should be the last one mentioned, e.g. bluish purple and reddish brown).

10.5 Dimensions of the injury (length in case of scratch, length, width or diameter in case of excoriations and subcutaneous haematoma, length in case of a wound).

10.6 Description of wound edges, corners and condition of the surrounding soft tissue in case of wounds.

10.7 Shape, colour and dimensions in case of healed wounds.

10.8 Injuries detected in medical examination will be photographed and numbered, and will be added to the expert examination report as a table of photographs (including also the legend text below each photograph) with the signature and stamp of a forensic medical expert.

Injuries detected in medical examination can be also indicated on a chart.

### **11. Healthcare documentation**

Medical documents are provided to the forensic medical expert by the processor, or will be sent with the individual when he/she comes to forensic medical examination. In the event that medical examination takes place in a hospital, the documents will be provided by the treating doctor.

For the purpose of forensic medical examination it is allowed to use only original documents, or certified copies issued by the healthcare institution and it is not allowed to use only the summaries of healthcare documentation or other abbreviated documents (e.g. statistical forms, blank forms). It is also not allowed to perform forensic medical examination only on the basis of the ICD codes of injuries (diseases) included in the healthcare documentation.

When documenting the contents of these documents in the expert examination report it is not allowed to change their content, but it is allowed to correct typing errors.

The following data from the healthcare documentation will be included in the forensic examination report: date when the documents arrived in the department of forensic medical examination, type of document (original or copy), name of healthcare institution, date and time when the patient turned to healthcare institution, general condition of the patient (consciousness, heart rate, blood pressure, respiration rate and other objective findings characterising the general condition of the patient at the time when he/she turned to the healthcare institution), description of the injuries, initial clinical diagnosis, diagnostic investigations, treatment, final clinical diagnosis, decision at discharge from the hospital (referred to family doctor, medical care institution, medical expert commission, etc.).

In exceptional cases forensic medical examination of an individual can be performed only on the basis of healthcare documentation.

### **12. Expert opinion**

12.1 Expert opinion is based upon the review of preliminary data, findings of forensic medical examination and additional investigations and healthcare documentation submitted for expert examination.

12.2 Expert examination report will be prepared in accordance with the legislative requirements.

12.3 Expert opinion has to be evidence-based, and the expert can answer the questions within the boundaries of his/her competence. Not answering the questions has to be grounded.

### **Expert examination of health condition**

1. Forensic medical examination for the assessment of health condition will be instituted in a situation where it is necessary to make sure whether a person's disease (not a psychological disease) interferes with his/her participation in investigational procedures,

appearance in court, being subjected to punitive measures, or solving any other legal issues.

2. Assessment of health condition will be instituted in the scope of forensic medical examination according to the expert examination order of the **processor**.
3. Health condition will be assessed based upon the medical examination of the individual and available healthcare documentation. In the event that the person cannot come to medical examination for some reason, expert examination can be performed without objective examination.
4. When assessing the health condition, the findings of medical examination (complaints, objective findings), data from healthcare documentation and results of clinical investigations will be taken into account.
5. In order to exclude the possibility of malingering (simulation of health damage or disease) and aggravation (exaggeration of the health damage or disease), subjective complaints have to be proven with objective clinical investigations.
6. In the event that the person refuses medical examination, or if the processor cannot take the individual to the medical examination, the forensic medical expert will include this information in the expert examination report, referring also to the document that proves the refusal for medical examination.

## **7. Individual's medical examination**

The following will be documented in the expert examination report in case of a medical examination of the individual:

7.1 health complaints;

7.2 earlier diseases, has the person turned to the doctor for these diseases (if yes, then to which healthcare institution, how long was the treatment period, has the person been on sick leave due to injuries, what were the recommendations of the treating doctor);

7.3 current diseases, has the person turned to the doctor for these diseases (if yes, then to which healthcare institution, is the person receiving any treatment, and if yes, then which treatment, has the person been treated in the hospital, is the person on sick leave at the time of medical examination);

7.4 earlier injuries (if yes, then when and with which diagnoses, and has the person turned to the doctor due to these injuries);

7.5 general condition (consciousness, blood pressure, heart rate, respiration rate and other indicators);

7.6 description of the damages in the region of joints and bones;

7.7 neurological status (balance in Romberg's position, finger-nose test, assessment of sensory and motor function and reflexes);

7.8 when the person has visual or hearing impairment, it has to be indicated at which distance the person is able to see the fingers or hear the normal talking voice;

7.9 when the person has injuries, these have to be described according to the guideline for establishing health damages in forensic medical examination.

8. **Expert opinion** is based upon the review of preliminary data, findings of forensic medical examination and additional investigations and healthcare documentation submitted for expert examination.

8.1 Expert opinion has to be evidence-based.

8.2 The expert can answer the questions within the boundaries of his/her competence. Not answering the questions has to be grounded.

8.3 Expert opinion has to include the data about the person's diseases and the diseases have to be proven with objective finding and results of clinical investigations. It has also to be mentioned whether and what treatment (e.g. surgical or medicinal treatment) and special conditions (e.g. diet, help with moving around) the person needs due to his/her health condition.

8.4 Finally the expert should decide whether the person's health condition enables him/her to take part in investigational procedures without jeopardising his/her life and health and answer the questions, in case these do not exceed the boundaries of the expert's competence.

## **Gynaecological and andrological examinations**

1. Forensic gynaecological expert examination will be used when it is necessary to make sure whether the following has taken place:

1.1 vaginal intercourse;

1.2 oral intercourse;

1.2 anal intercourse.

2. Forensic gynaecological expert examination will be performed according to the expert examination order of the processor.

3. Gynaecological examination has to be performed as soon as possible after the intercourse.

4. In the event that gynaecological examination has been performed in a healthcare institution and the results of the examination are properly documented, expert examination can also be performed on the basis of medical documentation in exceptional cases.

5. Consent of a parent or legal guardian is necessary for the gynaecological examination of a person below 16 years of age.

6. When the person refuses gynaecological examination, it has to be so documented in the expert examination order with the person's signature.

7. At least one more person (forensic medical expert, resident or supportive personnel) has to attend the gynaecological examination in addition to the person performing the examination.

8. Performing the gynaecological examination

Gynaecological examination has to be performed in a room that is equipped with necessary furnishing and equipment: healthcare institution where forensic medical expert participates in gynaecological examination with a gynaecologist performing the examination or performs gynaecological examination by himself/herself.

9. Documenting

The following will be documented based upon the words of the victim:

9.1 did vaginal, anal or oral intercourse take place, did the intercourse end with ejaculation (if yes, then where), which preventive measures, if any, were used, was physical violence used (if yes, what kind of physical violence), has the person washed herself before the forensic medical examination, did the person turn to the healthcare institution after the incident;

9.2 complaints about the health;

9.3 gynaecological anamnesis: data concerning menarche, menstrual cycle (including the beginning or last menstruation), the age of starting sexual life, earlier pregnancies, used contraceptive measures, information about the last intercourse before the incident (were preventive measures used), data about earlier gynaecological and venerological diseases (when and in which healthcare institution these were diagnosed, and what treatment was used);

9.4 general anamnesis – information concerning previous health condition, earlier diseases and other data necessary for the expert examination.

9.5 The following will also be documented: general condition, height and weight, chest, waist and hip circumference, status of the skin and visible mucous membranes, description of the hair growth in armpits and status of the breasts (development, shape, pigmentation of the areola, excretion from the nipples).

#### 10. Gynaecological examination

##### 10.1 Inspection of the hymen.

NB! In the event that the intactness of the hymen of the person has not been damaged by sexual intercourse, bimanual examination will be performed via the rectum, if necessary.

##### 10.2 Inspection of the vagina and uterine cervix.

#### 11. Description of the results of gynaecological examination in expert examination report Description of the genital organs:

11.1 hair growth type on vulva (feminine or masculine), development of the external genital organs (abnormalities), characterisation of the clitoris and labia of the vulva, status and colour of the mucosa membranes, status of the external orifice of the urethra;

11.2 status of the hymen: shape (annular, semi-circular, etc.), height, thickness, consistence (beefy, thick), characterisation of the loose edge (thin, thick, dentate, smooth), size (diameter) and shape (round, oval) of the orifice, elasticity of the hymen, presence of natural retractions (characterisation of the edges, localisation, symmetry, opposability), sensation of annular tension to the finger of the expert performing examination;

11.3 in the event that the integrity of the hymen has been broken, the following will be indicated: number and localisation of the ruptures (referring to the position of a clock's hands), characterisation of the edges of the ruptures (bleeding, covered with granulation, scarring, scarred);

11.4 the following table can be used to assess the time elapsed from defloration:

<b>Characterisation of the rupture</b>	<b>Morphological picture</b>	<b>Age of the rupture in days</b>
Fresh bleeding rupture	The edges of the rupture are oedematous, hyperaemic, and bleeding. Blood clots and small haematomas may be present.	2-3 days
Incipient granulation	The edges of the rupture are hyperaemic and oedematous. Incipient granulation covered with serous-purulent or fibrinous coating. Edges of the rupture tend to bleed after touching.	4-5 days
Period of granulation and scarring	The edges of the rupture are slightly erythematous, but do not bleed when touching.	10 days
Old rupture	The edges of the rupture are thickened, divergent, and whitish scar tissue can be sometimes seen in the bottom of the rupture. The mucous membrane covering the edges of the rupture resembles the one on the rest of hymen.	More than 12-14 days Determination of the time of rupture is not

		possible.
--	--	-----------

*Note 1. Healing time of the edges of the hymen depends upon the characterisation of the hymen: it may take approximately 6-9 days in case of low and thin hymen, but up to 10-14 days in case of high and thick hymen.*

*Note 2. Vaginal examination will not be performed in case of recent ruptures of the hymen and it may be performed only after 10-12 days after the injury (refer to point 8 “Taking samples” for information concerning taking sperm samples).*

11.5 characterisation of the vaginal walls, elasticity, colour, amount and characterisation of vaginal discharge (serous, purulent, bloody, foamy), possible anomalies (e.g. vaginal septum), status of the vaginal part of uterine cervix, shape and openness of the external orifice of the uterine cervix;

11.6 status of the perineum: elasticity, colour, venous congestion, presence of injuries.

Description of the status of anal region: pigmentation, shape and openness of the anal orifice, presence of the skin folds around the anal orifice, tone of external anal sphincter, presence of injuries.

## **12. Andrological expert examination**

The aim, terms, general requirements, place of performing and general examination and questioning of the individual about what happened are the same as for gynaecological expert examination.

The following will be documented when examining a male person:

12.1 status of the external genital organs: developmental characteristics, length and circumference of the penis in non-erectile state, presence of any discharge from the orifice of urethra, description of the scrotum (size, pigmentation, localisation of the testicles in the scrotum, their consistence and painfulness), presence of injuries on external genital organs;

12.2 in the event that it is also necessary to examine internal genital organs – prostate and seminal vesicles – this investigation will be performed by the forensic medical expert with a finger via rectum in person’s knee-elbow position. The size, localisation, surface characterisation, consistence, and painfulness at palpation will be defined;

12.3 status of the anal region: shape of the anal orifice (funnel-like anal orifice is characteristic of anal intercourses during a longer period of time), openness of the anal orifice, colour, pigmentation and folds of the surrounding skin, tone of external anal sphincter, status of the visible mucous membranes, presence of injuries in anal region

### 13. Taking samples

#### 13.1 Sperm samples

- In the event that sperm samples have not been taken in the healthcare institution, these will be taken in forensic gynaecological examination.
- Taking sperm samples is rational in case less than 5-7 days has passed from vaginal intercourse, less than 2 days has passed from anal intercourse, and less than 6 hours has passed from oral intercourse.
- Sperm samples will be taken with sterile cotton sticks and will be smeared on a glass plate.

- Sperm samples will be taken from:

- 1) posterior fornix of the vagina, vaginal walls, uterine cervix or uterine canal, in case of fresh rupture of the hymen the sample will be taken without using the colposcope from the vaginal walls within 3-5 cm from the vaginal orifice;
- 2) rectum – within 3-5 from the anal orifice;
- 3) oral cavity – from three different localisations on the oral mucosa and one from the middle behind the front teeth;
- 4) skin – in case there a visible signs of sperm on the skin. Dried sperm is moisturised with a wet cloth and the cloth is then allowed to dry and is thereafter packed in a plastic bag and labelled.

13.2 Scraping under the fingernail – the sample will be taken with a clean instrument or other aid from under the fingernail and is thereafter packed in a plastic bag and labelled separately for both hands.

13.3 Loose foreign materials – hair, fibres of cloth, earth will be dried, packed and labelled.