ONE STOP CRISIS CENTER

Policy and Guidelines For Hospitals, Ministry Of Health Malaysia

KEMENTERIAN KESIHATAN MALAYSIA

First published in Malaysia in July 2015
One Stop Crisis Center: Policy and Guidelines for Hospitals,
Ministry of Health, Malaysia

Procedures were coordinated by:
Surgical and Emergency Services Unit,
Medical Services Development Section,
Medical Development Division,
Ministry of Health Malaysia.

Institute for Medical Research Cataloging in Publication Data
A Cataloque Record for this book is available from the
Institute for Medical Research, Ministry of Health Malaysia

National Library of Malaysia Cataloging in Publication Data
A catalogue record for this book is available from the
National Library of Malaysia

MOH/P/PAK/290.15(G4)

ISBN 978-967-0769-09-7

CONTENT

FOREWORD	
The Director General of Health Malaysia	v
Director, Medical Development Division	vi
Head of National Emergency Medicine and Trauma Services	vii

LIST OF ABBREVIATIONS	vii

THE POLICY	
1.0 Introduction	2
2.0 Policy Document Statement	2
3.0 Objectives of OSCC Service	2
4.0 Components of OSCC Services	2
5.0 Organization	3
6.0 General Statement	3
7.0 Training and Education	5
8.0 Quality Improvement	5
9.0 Job Description: Roles of Specific Personnel	5
10.0 Infrastructure	6

GUIDELINES FOR THE MANAGEMENT OF ALLEGED RAPE AND SEXUAL ASSAULT	
1.0 Definitions	8
2.0 Objectives	9
3.0 Level of Hospitals Based On Availability of Services	9
4.0 Work Procedure for Handling Rape and Sexual Assault Cases	10
5.0 Flowchart for Handling Alleged Rape	12
6.0 Job Description	12
7.0 Survivor Presents Within 72 Hours of the Incident	16
8.0 Survivor Presents More Than 72 Hours After the Incident	19
9.0 Management of Sexual Abuse in Adolescents	20

10.0 Genital Examination in Suspected Child Abuse	20
11.0 Non-Urgent Examination	21
12.0 Examination under Anesthesia	21
13.0 Chain of Evidence	22
14.0 Forensic Issues in Rape	22
15.0 Special Issues in Rape	22
16.0 Writing of Medical Report	23
17.0 Follow Up Care for Survivors	23
GUIDELINES FOR THE MANAGEMENT OF CHILD ABUSE AND NEGLECT	
GUIDELINES FOR THE MANAGEMENT OF SODOMY	
1.0 Introduction	26
2.0 Definition	26
3.0 Acute Case	26
4.0 Triaging System at the Emergency And Trauma Department	26
5.0 Consent	26
6.0 Maintaining the Chain of Custody of Evidence	27
7.0 The Adult Sexual Assault Survivor	27
GUIDELINES FOR MANAGEMENT OF DOMESTIC VIOLENCE	
1.0 Introduction	32
2.0 Definitions	32
3.0 Work Process	33
4.0 Others	36
APPENDIX 1-14	38-103
REFERENCES	105
TECHNICAL COMMITTEE ON OSCC POLICY AND GUIDELINES	107

FOREWORD

Datuk Dr. Noor Hisham Bin Abdullah

Director General
Ministry of Health Malaysia

"The survivors or victims are seen in a holistic approach at the same time preserving its confidentiality. Care and treatments are given from the acute phase until rehabilitation phase involving follow up by the respective disciplines and also rehabilitation and psychological treatment and support."

One Stop Crisis Center is one of the services provided by the Emergency and Trauma Department in all Ministry of Health hospitals in Malaysia established since 1996. It is meant to assist the survivors or victims of crisis with the involvement of multiple agencies under one roof to fight against any forms of violence such as rape, child abuse, sodomy and domestic violence.

The survivors or victims are seen in a holistic approach at the same time preserving its confidentiality. Care and treatments are given from the acute phase until rehabilitation phase involving follow up by the respective disciplines and also rehabilitation and psychological treatment and support.

With all the challenges faced by the Ministry Of Health in managing such cases, it has given opportunities for the service to develop and improve with time. The OSCC policy and guidelines has been developed by the hardworking technical committee involving multiple agencies and shall be used in all hospitals to ensure the standard of care and improves the quality of the OSCC service in Malaysia.

I want to thank the committee for their efforts in producing this policy and guidelines.

FOREWORD

Dato' Dr. Hj. Azman Bin Hj. Abu Bakar

Director
Medical Development Division
Ministry of Health Malaysia

".... objectives in setting up the OSCC service are to provide prompt medical treatment and psychological support and collaborations with other agencies in the management of the victim including medico legal issues."

First and foremost, I would like to take this opportunity to thank and congratulate all individuals involved in the development of this policy and guidelines.

The One Stop Crisis Center services have been established since 1996 within Emergency and Trauma Department, following the increasing number of cases of child abuse, domestic violence, rape & sexual abuse referred to government hospitals throughout the country.

The objectives in setting up the OSCC service are to provide prompt medical treatment and psychological support and collaborations with other agencies in the management of the victim including medico legal issues.

There were many challenges faced by our staffs in managing these caseswhich involve various disciplines such as obstetrics and gynecology, pediatric, forensic, surgical and laboratory. Cooperation with other agencies is deemed important to ensure the process and the continuity of care to the victims is prompt and appropriate.

The development of this policy and guidelines will help to standardize and improve the quality of OSCC services provided by the Emergency and Trauma Department in all government hospitals.

FOREWORD

Dr. Sabariah Faizah Jamaluddin

Head of National Emergency Medicine and Trauma Services
Ministry of Health Malaysia

"The idea for a One Stop Crisis Centre in Emergency Departments was first developed in 1993 following a study that showed that victims of sexual crime were not managed in a survivor focused manner. The aim was to have an integrated & comprehensive multi-agency service centre in managing survivors of sexual crime. "

In Malaysia, news reports of domestic violence, rape & sexual abuse are no longer uncommon at this present time. In the earlier years, management of such cases was disorganized, uncoordinated between agencies and not survivor oriented.

The idea for a One Stop Crisis Centre in Emergency and Trauma Departments was first developed in 1993 following a study that showed that victims of sexual crime were not managed in a survivor focused manner. The aim was to have an integrated & comprehensive multi-agency service centre in managing survivors of sexual crime. Fortunately, in 1996, the Ministry of Health released a directive for a One Stop Crisis Centre to be established in all Emergency and Trauma Departments in Malaysia. Guidelines were developed so that the management would be collaborative between agencies using a standardized protocol.

The service has come a long way since then. Alhamdulillah, I am grateful that the various disciplines, clinical and non-clinical have come together once again to produce these updated guidelines for use in all hospitals and clinics. Our responsibility is mainly towards the clinical and mental well-being of the survivors and meticulous management of medico legal evidence to ultimately ensure that justice is being served.

I would like to thank and congratulate all those involved in the process of developing this policy and guidelines and hope that we continue to maintain the fostered relationships and over time, keep updating ourselves in this important social matter.

List of Abbreviations

AWAM	All Women's Action Society Malaysia
BP	Blood pressure
DNA	Deoxyribonucleic acid
ETD	Emergency and Trauma Department
EUA	Examination under anaesthesia
HBs Ag	Hepatitis B surface antigen
HIV	Human Immunodeficiency Virus
HVS	High vaginal swab
JKM	*Jabatan Kebajikan Masyarakat*
LVS	Low vaginal swab
MECC	Medical Emergency Coordination Center
NGO's	Non-Government Organizations
O&G	Obstetrics and Gynecology
OSCC	One Stop Crisis Center
SCAN	Suspected Child Abuse And Neglect
STD	Sexually transmitted disease
STI's	Sexually transmitted infections
TPHA	Treponema Pallidum Haemagglutination
VDRL	Venereal Disease Research Laboratory
WAO	Women's Aid Organization


SELAMAT DATANG
KE JABATAN KECEMASAN
HOSPITAL KUALA LUMPUR
O.S.C.C.
BILIK KHIDMAT BERSEPADU
- ONE STOP CRISIS CENTRE -
O.S.C.C. MALAYSIA
PROVIDER
SPECIMEN MANAGEMENT KIT
TCA CARD
BORANG 9
TOXICOLOGY FORM
CONSENT FORM
Sexual assaulted
Scan case
Domestic violence
ALL OSCC
CASES
MUST BE REFFERRED
TO COUNSELOR

THE POLICY

1.0 INTRODUCTION

1.1 The One Stop Crisis Center (OSCC) service is an integrated and comprehensive multiagency service center established in all Emergency and Trauma Departments (ETD) of the Ministry Of Health for the management of survivors of domestic violence, sexual assault, child abuse and neglect. The survivors are seen at the center where all agencies converge to manage them.

1.2 The OSCC shall be suitably located to provide full privacy and confidentiality.

1.3 The OSCC shall be utilized for documentation, examination and management of evidence which includes the collection, labeling and sealing of specimens.

1.4 The management of OSCC survivors shall be a holistic approach to ensure a seamless continuity of care from crisis period to rehabilitative phase.

1.5 The network for the management of OSCC survivors shall be at three levels. The first level involves initial hospital management. The second level involves follow-up. The third level involves rehabilitative programs with various agencies and legal proceedings. ***(Refer to Appendix 1)***

2.0 POLICY DOCUMENT STATEMENT

2.1 This document shall serve as guidance to healthcare providers, hospital managers and policy makers on the requirements, operation and development of OSCC services in Ministry of Health hospitals.

2.2 This document shall assist healthcare providers in managing survivors of domestic violence, sexual assault, child abuse and neglect.

2.3 This policy shall be used in all hospitals and every effort should be made to achieve the goals of this document depending on the infrastructure and human resource available in that hospital. The document shall be reviewed and updated every five years or when the need arises.

3.0 OBJECTIVES OF OSCC SERVICE

3.1 To provide multidisciplinary care of the survivors.

3.2 To identify and manage survivors of domestic violence, sexual assault, child abuse and neglect.

3.3 To provide treatment and multilevel crisis intervention to survivors.

3.4 To ensure the delivery of optimal care and evidence management for the survivors.

3.5 To ensure appropriate management of medico legal evidence. The OSCC shall work with the police to assist in evidence management for medico legal purposes.

4.0 COMPONENTS OF OSCC SERVICES

4.1 Rape and sexual assault

4.2 Child abuse and neglect

4.3 Sodomy

4.4 Domestic violence

5.0 ORGANIZATION

5.1 The Head of National Emergency Medicine and Trauma Services serves as the Advisor to the Ministry of Health on all matters pertaining to this service.

5.2 Dedicated OSCC service units shall be established in every government hospital.

5.3 The OSCC services provided are determined by the category of the hospital, availability of specialist, trained staff and facilities available.

5.4 The OSCC team in each hospital shall be coordinated by the Emergency and Trauma Department.

5.5 The multidisciplinary team shall include:

- 5.5.1 Emergency and Trauma Department
- 5.5.2 Obstetrics and Gynecology Department
- 5.5.3 Pediatric Department
- 5.5.4 Surgical Department
- 5.5.5 Forensic Department
- 5.5.6 Psychiatric Department
- 5.5.7 Medical Social Services
- 5.5.8 Counseling Unit
- 5.5.9 Social Welfare Department
- 5.5.10 Royal Malaysian Police
- 5.5.11 Relevant Non-Governmental Organizations (NGOs)

5.6 Provision to incorporate any other discipline as deemed necessary as co-opt members.

5.7 Inter-agency meetings shall be held periodically to address issues and enhance cooperation at least once per year.

5.8 Close collaboration shall be established with relevant NGOs to improve quality of services.

6.0 GENERAL STATEMENT

6.1 Survivors shall be treated professionally with compassion, empathy and respect with a non-judgmental attitude. Survivors shall be accorded privacy and full confidentiality.

6.2 Stable survivors shall be brought from primary triage counter to the OSCC room immediately for further care. Unstable survivors will be triaged and managed in critical area.

6.3 Consent must be obtained from all survivors prior to examination.

6.4 For children under 18 years of age, consent must be obtained from either the parent or legal guardian or child protector or as ordered by Police Officer under the provisions of the Child Act 2001.

6.5 Survivors shall be managed in the OSCC unless requiring further intervention or admission.

6.6 A police report is not a prerequisite for survivors aged 18 and above to be treated in the OSCC. However, survivors shall be counseled and assisted in making a police report.

6.7 If there is no prior police report, the police shall come to OSCC to assist the survivor or parent/guardian for child survivors to make a police report if required.

6.8 Examination of the OSCC patient shall be the responsibility of the Emergency and Trauma Department for the purpose of obtaining initial history, physical examination and stabilization of the patient.

6.9 For alleged sodomy cases, acute(fresh) cases are defined as those up to 120 hours from the time of incident (Willcort, 1982). All fresh cases shall be seen urgently in OSCC. Cases that present more than 120 hours from the last incident are considered "cold" cases. Alleged rape and child sexual abuse are not included in this definition.

6.10 For alleged rape (WHO 2004) and child sexual abuse, acute (fresh) cases are up to 72 hours from the time of incident. Cases that present more than 72 hours from the last incident are considered "cold" cases.

6.11 Detailed examination shall be the responsibility of the appropriate respective departments. The most experienced and specialized personnel available from the appropriate specialty shall be responsible for examination and specimen collection.

6.11.1 All alleged rape and sexual assault survivors shall be referred, managed and followed up by the attending specialist from the Obstetrics and Gynecology (O&G) Department.

6.11.2 All alleged child abuse and neglect cases shall be referred, managed and followed up by the Pediatric Department, and where available, to a Suspected Child Abuse andNeglect (SCAN) team.

6.11.3 All sodomy survivors shall be referred to the Surgical Department.

6.11.4 Survivors shall be referred to a counselor, psychologist or psychiatrist when necessary.

6.12 The respective specialty managing the survivor shall be responsible for evidence collection, documentation and medical report.

6.13 In some cases, medical reports may be required from more than one specialty for example, report from O&G, Pediatrics and Psychiatric Departments.

6.14 The Police Officer is required to be present during evidence collection to maintain chain of evidence.

6.15 All evidence collected shall be handed over to the Police Officer immediately and shall not be kept in the hospital. Chain of evidence in specimen handling must be maintained and preserved at all times until specimens are handed over to the Police Officer.

6.16 All survivors of rape (or their parents/legal guardians) shall be counseled on the availability of emergency contraception if deemed to be at risk. Post exposure prophylaxis for emergency contraception and prevention of sexually transmitted diseases should be prescribed.

6.17 All survivors should be followed up by the primary managing discipline.

7.0 TRAINING AND EDUCATION

7.1 The Emergency and Trauma Department shall be responsible for conducting training of all staff involved in handling OSCC cases in collaboration with other clinical disciplines and agencies.

7.2 The OSCC Policy and Guidelines shall be made available in all hospitals for reference.

7.3 Appropriate and relevant educational programs shall be made available to all staff involved in OSCC management.

8.0 QUALITY IMPROVEMENT

8.1 A National OSCC Evaluation Team shall be formed to ensure standards for the management of OSCC cases.

8.2 Epidemiological data shall be collected and compiled continuously to monitor trends and improve patient care.

9.0 JOB DESCRIPTION: ROLES OF SPECIFIC PERSONNEL

Managing OSCC cases requires a multidisciplinary approach.

9.1 Emergency and Trauma Department

9.1.1 The Emergency and Trauma Department shall be responsible for the initial management of OSCC cases. These include triage, history taking, general physical examination, clinical stabilization, treatment of injuries, and evidence collection other than that obtained from vaginal examination.

9.1.2 Evidence obtained in the Emergency and Trauma Department shall be managed and handed to the Police Officer with preservation of chain of evidence.

9.1.3 The Emergency and Trauma Department shall coordinate the management of OSCC cases including referrals to relevant team members.

9.2 Obstetrics and Gynecology Department

9.2.1 Obstetrics and Gynecology (O&G) Department shall be the primary team for the management of alleged rape and female child sexual assault survivors which includes history taking, clinical examination, sample evidence collection, treatment and medico legal documentation.

9.2.2 The O&G Department shall also assess if there are female perpetrators implicated.

9.3 Pediatric Department

9.3.1 The Pediatric Department and/or SCAN team shall manage suspected child abuse and neglect. The Pediatric Department in collaboration with the SCAN team shall evaluate the impact of the child abuse and neglect, determine child's safety with other SCAN team members and assist with reports required for the child's protection to prevent further abuse or neglect and coordinate child and family rehabilitation after discharge.

9.4 Surgical Department

9.4.1 The Surgical Department shall be responsible for the management of sodomy survivors and in the assessment of alleged sodomy perpetrators.

9.5 Forensic Department

9.5.1 Forensic department shall be consulted for fresh/acute cases that require evidence management consultation.

9.5.2 The forensic specialist with clinical forensic subspecialty may takeover the medico legal management of appropriate cases.

9.6 Psychiatric Department

9.6.1 The Psychiatric Department shall be involved early for psychological support to OSCC survivors or family members.

9.7 Medical Social Services and Counseling Unit

9.7.1 The Medical Social Services and Counseling Unit shall be involved early for psychological and social support to OSCC survivors or family members.

9.8 Social Welfare Department

9.8.1 The Social Welfare Department shall be responsible for the general social welfare of the survivor and to act as a Child Protector in a suspected child abuse and neglect patient.

9.9 Royal Malaysian Police

9.9.1 All survivors with police report shall be accompanied by a Police Officer to the hospital.

9.9.2 The Police Officer shall be present at the OSCC to receive a new police report or obtain statement from the survivor or parent/guardian.

9.9.3 The Police Officer shall be responsible for the receipt and preservation of chain of evidence.

9.9.4 The Police Officer shall be responsible in protecting the survivor from harassment by the alleged perpetrator, and procure an interim protection order on request from the welfare officer.

9.10 Non-Governmental Organizations (NGOs)

9.10.1 Non-Governmental Organizations shall assist in the management of survivors by providing counseling and shelter placement.

9.10.2 The NGOs shall provide the various hospitals with the relevant information about supportive organizations in their network in managing OSCC cases.

10.0 INFRASTRUCTURE

10.1 MOH shall be responsible for the availability of standard infrastructure at all Emergency and Trauma Departments. ***(Refer to Appendix 2)***

GUIDELINES FOR THE MANAGEMENT OF ALLEGED RAPE & SEXUAL ASSAULT

1.0 DEFINITIONS

1.1 Rape

Rape is dealt under section 375 of the Malaysian Penal Code. According to this section a man is said to commit "rape" when he has sexual intercourse with a woman under the following circumstances:

1.1.1 Against her will. This means that the women is capable of giving her consent but consciously rejects sexual intercourse and is forced into it.

1.1.2 Without her consent. Sexual intercourse may take place without the women's consent because she is incapable of giving her consent.

1.1.3 With her consent when consent has been obtained by putting her in fear of death or hurt to her or any other person, or obtained under misconceptions of the fact, and the man knows or has reason to believe that the consent was given in consequence of such misconceptions.

1.1.4 With her consent when the man knows that he is not her husband, and her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married or to whom she would consent.

1.1.5 With her consent through deception.

1.1.6 With her consent, when at the time of giving such consent, she is unable to understand the nature and consequences of that to which she gives consent.

1.1.7 With or without her consent, when she is under sixteen years of age (statutory rape).

Explanation1
Penetration is sufficient to constitute the sexual intercourse necessary to the offence of rape.

Exception
Sexual intercourse by a man with his own wife by a marriage which is valid under any written law for the being in force, or is recognized in Malaysia as valid, is not rape.

Explanation 2
A woman:

a) living separately from her husband under a decree of judicial separation or a decree nisi not made absolute; or

b) who has obtained an injunction restraining her husband from having sexual intercourse with her, shall be deemed not to be his wife for the purposes of this section.

Explanation 3
A Muslim woman living separately from her husband during the period of *iddah*, which shall be calculated in accordance with *Hukum Syara*, shall be deemed not to be his wife for the purposes of this section.

1.2 Sexual assault

Sexual assault is a criminal offence. Under Section 354 of the Penal Code it is stated as "assault or use of criminal force on a person with intent to outrage modesty".

1.3 Acute case:

Acute (fresh) cases are up to 72 hours from the time of incident (WHO 2004)

1.4 'Cold' case:

Cases that present more than 72 hours from the incident are generally considered "cold" cases however forensic evidence may be available beyond 72hours after the assault. An examination to collect forensic evidence should therefore be based on the facts of the case, the victim's history, the likelihood of recovering evidence that will be needed for a successful prosecution. The 72 hours cut-off should only be used as a guideline and not a rigid policy and some cases between 72 to 120 hours can also be considered as a fresh case for urgent evidence sampling.

1.5 Cases are classified as acute or 'cold' based on the time of the incident. This classification is used as the management differs in terms of evidence sampling.

1.6 All alleged rape and sexual abuse cases should be managed at OSCC in the Emergency and Trauma Department.

2.0 OBJECTIVES

2.1 To provide a guide in the management of alleged rape and sexual assault cases.

2.2 To define the roles of the different departments and agencies involved in the management of survivors.

2.3 To ensure that survivors are treated with respect and all clinical findings and evidence is managed as per guideline.

3.0 LEVEL OF HOSPITALS BASED ON AVAILABILITY OF SERVICES

3.1 Level A hospital (HKL & State hospitals)

All hospitals with O&G Specialists, Pediatricians and Medical Social Worker if available.

3.2 Level B hospital (Other hospitals with O&G specialist)

All cases in Level A & B hospitals must be seen by an O&G Specialist as soon as possible as the experience and credibility of the doctors will be a focus in court. Doctors must be able to describe highly technical matters in simple straight forward language. Handling of all cases requires expertise in interpretation of vaginal injuries and collection of specimens to meet the needs of the judicial system.

3.3 Level C hospital (Hospital without O&G specialist)

All cases in Level C hospitals shall be seen by Medical Officer with months training post housemanship in O&G or to discuss the case with the covering O&G Specialist. The Medical Officer during their training in O&G Department must be credentialed and privileged to see such cases. A total of 5 cases and 2 reports under supervision of the specialist are necessary before they are privileged to see cases on their own.

4.0 WORK PROCEDURE FOR HANDLING RAPE AND SEXUAL ASSAULT CASES

4.1 Survivors may present to the hospital in various ways:

4.1.1 Walk in through triage.

4.1.1.1 With a police report.

4.1.1.1.1 The survivor should be escorted by Police Officer.

4.1.1.1.2 An unmarked police car should be used for transport to the hospital.

4.1.1.2 Without a police report.

4.1.1.2.1 A police report must be made at the OSCC.

4.1.1.2.2 Survivors are not to be sent to police station to make a report.

4.1.1.2.3 A survivor may be identified by triage staff with probing, investigative & inquisitive history taking

4.1.2 Brought by parents / guardian / teacher / child protector.

4.1.3 Pregnant.

4.1.4 Brought in semi-critical or critical condition.

4.1.5 Referred from Level C Hospitals or Health clinics.

4.1.6 Emergency and Trauma Department Call Centre.

4.2 Online triaging of patient should be done.

4.2.1 In handling all cases presenting to the Emergency and Trauma Department.

4.2.1.1 The survivor should be escorted by well-trained staff whereby pre-counseling can be given while awaiting further management.

4.2.1.2 The registration process should be done by the health personnel.

4.2.1.3 If the patient is clinically stable, secondary triaging (taking of vital signs) can be done in the vicinity of the OSCC room.

4.3 Police report.

4.3.1 A police report must be made, whereby the police will release an order in the form of *Borang Pol59* to request the doctor to examine and collect evidence with consent, to aid in the investigation. ***(Refer to Appendix 3).***

4.3.2 If the police report is not readily available, examination of the patient can be done with only the *Borang Pol59.*

4.3.3 If the survivor presents to the Emergency and Trauma Department without a police report then it shall be done in the OSCC room. The survivor should not be made to go to the police station. Privacy and confidentiality of survivors must be respected at all times.

4.3.4 Survivors who are 18 years old and above who do not wish to make a police report should be adequately counseled by the attending specialists and advised to make a report. If the survivors choose not to do so, the doctor shall do a physical examination to determine and treat injuries, obtain necessary blood samples for detection of infectious diseases and only with survivors consent, arrange for counseling and follow up. The survivors shall be referred to other disciplines when necessary.

4.3.5 For all cases of alleged statutory rape, for the survivors of 16 years old and below, police report must be made urgently. At the hospitals, police report to be made by Medical Officer or specialist whereas at the health clinics, where nurses are the first contact, medical report to be made by nurses.

4.3.6 If the Child Protector who is a gazette officer from the Social Welfare Department requests for the child to be examined, examination without a police report can be done and a written request from the Child Protector must be obtained ***(Refer to Appendix 4)***. However if DNA samples are to be taken, police report by the Child protector or Medical Officer who brought in the child must be done to facilitate the presence of the Police Officer to receive the forensic evidence.

4.3.7 In cases of child sexual abuse where the child complains of vaginal pain or dysuria, but there is no history of sexual abuse or the child is too young, medical examination as per clinical condition can be done and if findings suggestive of sexual abuse are found, police reports can be lodged within 24 – 48 hours after examination based on facts of the case, the child's history and the likelihood of recovering evidence. A police report should be lodged either before the examination or immediately after the examination depending on when sexual abuse is suspected and the acuteness of the last incident.

4.3.8 If the survivor is critically ill or mentally unstable and the police report has not been made, it is to be made by the attending Medical Officer. Police report is to be made by Medical Officer or specialist.

4.4 Consent

Consent must be obtained prior to the clinical examination and evidence collection. The legal age for providing consent is 18 years and above.

4.4.1 For survivors aged 18 years and above:

4.4.1.1 Survivors consent for physical examination, genital examination and evidence collection is taken using the consent form in the rape form. ***(Refer to Appendix 5).***

4.4.1.2 In a critical/semi critical case where patient has been brought in for examination, consent can be given by police or attending specialist.

4.4.2 For survivors below the age of 18 years.

Consent for examination and evidence collection is taken from the parents, legal guardians, Police Officer or Child Protector.

4.4.3 Special circumstances.

There have been instances where the child's parents request for an examination.

4.4.3.1 For pain in the genitalia or on passing urine.

4.4.3.1.1 Parental consent is implied as in part of a full physical examination for medical illness.

4.4.3.1.2 Police report is not required in this instance.

4.4.3.1.3 Parents should be present at the time of examination.

After the examination if there is a strong suspicion of sexual abuse the attending doctor must:

- **Inform the Child Protector by sending the *Borang 9* to the Social Welfare Department**
- **They will have to lodge a police report if the parent/guardian is reluctant to lodge a police report.**

4.4.3.2 Parents fear that the child has been raped.

4.4.3.2.1 Police report is required in this instance

4.4.3.2.2 Parental consent is required.

5.0 FLOWCHART FOR HANDLING ALLEGED RAPE (Refer to Appendix 1)

6.0 JOB DESCRIPTION

6.1 Role of the O&G specialist and O&G Medical Officer

The doctors' function is **not to determine** if rape has occurred. Rape is a legal term, not a medical term; whether a crime has been committed is to be determined by the courts. Responsibilities of O&G Specialist and O&G Medical Officer in the management of alleged rape cases seen at the OSCC involve the following:

6.1.1 Documentation of pertinent history.

6.1.2 Careful physical examination.

6.1.3 Prompt treatment of physical injuries.

6.1.4 Psychological support, arrangements for follow-up counseling.

6.1.5 Collection of forensic evidence.

6.1.6 Evaluation for sexually transmitted infections (STI's) and preventive care.

6.1.7 Evaluation for risk of pregnancy and prevention.

6.1.8 Follow up care of the victim.

6.2 Important points to note

6.2.1 History and physical injuries are to be documented using standard terminology as in Table 1 (Refer to Appendix 6). Examination of the genital area should be done by O&G Specialist. Examination of the anal region in sodomy should be done by the surgeons.

6.2.2 Optimal management of the victim involves a multidisciplinary effort which comprises of O&G specialist, O&G Medical Officer, Medical Officers and nurses in the Emergency and Trauma Department, support personnel which comprises of Medical Social Worker, Child Protector, public prosecutor and Police Officer.

6.2.3 History, general physical examination, and pelvic examination are performed methodically, keeping in mind that the primary goal is to attend to the patient's medical needs first.

6.2.4 The gathering of evidence proceeds simultaneously with the physical examination.

6.2.5 Treatment entails attention to physical injuries, potential venereal disease and pregnancy, and psychiatric intervention.

6.2.6 Police Officers have difficulty to synchronize time for examination of fresh cases of alleged rape or sexual abuse. If the O&G Specialist is held up for any reason, the specialist should liaise with the Police Officer for the time of examination. O&G Medical Officer can start with history taking and general examination while waiting for the O&G Specialist to do the examination of the genitalia. For fresh cases, examination has to be done as soon as possible to facilitate collection of forensic evidence. OSCC should inform the O&G Head of Department if the specialist is delayed.

6.3 Cases that will require admission

6.3.1 Survivors requiring medical management for acute physical and emotional trauma.

6.3.2 Concern for personal safety of survivor. Admit if case is seen after office hours to be referred to the Medical Social Worker/Social Welfare Department/NGOs for shelter and protection.

6.3.3 All suspected child sexual abuse after discussion with the SCAN team/Pediatrician/Adolescent Pediatrician. All suspected intra-familial child sexual abuse or those involving young children below 12 years of age must be admitted for protection and more detailed history taking.

6.3.4 Survivors who are pregnant and present with complications due to pregnancy.

6.3.5 Survivors requiring acute management of vaginal trauma requiring examination under anesthesia (EUA).

6.4 To prepare the survivor for the examination

6.4.1 Introduce yourself.

6.4.2 Date and time of the examination and the name of staff present during the interview and examination to be noted.

6.4.3 Ensure that the trained support person of the same sex accompanies the survivor throughout the examination.

6.4.4 Explain what is going to happen during each step of the examination, why it is important, what it will tell you, and how it will influence the care you are going to give.

6.4.5 Reassure the survivor that she is in control of the pace, timing and components of the examination.

6.4.6 Limit the number of people allowed in the room during the examination to the minimum necessary.

6.4.7 Preferably O&G, Surgical and Forensic Specialist not to be called to examine the survivor at the same time. Try to minimize overcrowding but to examine consecutively as far as possible so the survivor does not have to dress and undress many times.

6.5 Documentation of pertinent history

6.5.1 Let the survivor tell her story and write every detail as soon as possible.

6.5.2 Do not write down after the survivor has narrated her story **FULLY** by memory but write down as the history is being taken.

6.5.3 Record precisely, in the survivor's own words, important statements made by her, such as reports of threats made by the assailant.

6.5.4 Include the name of the assailant, and use statements, such as "survivor states" or "survivor reports".

Because the determination of rape is made in a court of law, the wording of the history should reflect only the survivor's report of the incident. The wording should not be expressed as statements of fact about the event.

6.5.5 Questioning should be done gently and at the survivor's own pace.

6.5.6 Avoid questions that suggest blame, such as "what were you doing there alone?" Take sufficient time to collect all needed information, without rushing.

6.5.7 Take a detailed history. The questions asked while the history is being taken should not be judgmental, moralistic or opinionated.

6.5.7.1 Events preceding the assault

6.5.7.2 Place of assault

6.5.7.3 Drugs or alcohol consumed by victim

6.5.7.4 Details of the assault

6.5.7.5 Damage or disruption to clothing

6.5.7.6 Site and mechanism of injuries - to include details of any weapons used

6.5.7.7 Defense used by victim

6.5.7.8 Any loss of consciousness

6.5.7.9 Exact nature of assault

6.5.7.10 Digital/vaginal

6.5.7.11 Oral/vaginal

6.5.7.12 Oral/penile

6.5.7.13 Penile/Vaginal If yes were there any ejaculation?

6.5.7.14 Penile/Anal If yes were there any ejaculation?

6.5.7.15 Digital/anal

6.5.7.16 Lubricant or condom used?

6.5.7.17 Foreign body

6.6 Gynecological history

6.6.1 Age of menarche

6.6.2 LMP

6.6.3 Menstrual cycles

6.6.4 Any gynecological problems -Current or past

6.7 Obstetric history

6.7.1 History of previous termination of pregnancy

6.7.2 Outcome of any previous pregnancy.

6.8 Sexual history

6.8.1 Sexually active –Yes/No

6.8.2 Last coitus date, time use of any lubricant

6.8.3 Genital problems past/present

6.8.4 Sexually transmitted disease

6.9 Medical history

6.9.1 History of serious illness

6.9.2 Psychiatric illness

6.10 Surgical history

6.10.1 Previous surgical procedures

6.11 Other relevant history

6.11.1 Bruising tendency

6.11.2 Skin problems

6.12 Social history

6.12.1 Current occupation

6.12.2 Student – studying /drop out

6.12.3 Married/Single/Divorcee/Widow

6.12.4 Living with family or apart

7.0 SURVIVOR PRESENTS WITHIN 72 HOURS OF THE INCIDENT

Documenting injuries and collecting samples, such as blood, hair, saliva and swab for DNA, within 72 hours of the incident may help to corroborate the survivor's story. **The earlier you see the patients the more findings will be obtained.**

All information to be recorded in the survivor's medical record and in the rape evaluation flow sheet (enclosed in the rape kit).

The Police Officer should be present at the time of examination to collect the forensic specimens.

7.1 Physical Examination

7.1.1 A meticulous physical examination should be performed.

7.1.2 The purpose of the examination is to assess and treat physical injuries, as well as collect evidence submersible in court proceedings.

7.1.3 Never ask the survivor to undress or uncover completely. Examine the upper half of her body first, then the lower half. Give her a gown to cover herself.

7.1.4 The survivor should disrobe while standing on a brown paper to catch any falling debris, hair or fiber.

7.1.5 Record the anatomical position of the wound (laceration, bite marks, abrasion bruises, contusions, incised wound, gunshot etc.) and use accepted terminology.

7.1.6 Measure the dimensions of the wound and shape of the wound.

7.1.7 Most common sites of extra genital trauma are the mouth, throat, wrists, arms, breasts and thighs are to be examined.

7.1.8 Record findings on pictograms for easy review later.

7.1.9 If the person presents more than 72 hours after the rape, the amount and type of evidence that can be collected will depend on the situation.

7.2 The genital examination

7.2.1 Objectives of the genital examination are to:

7.2.1.1 Identify and retrieve any stains, secretions, fibers, hairs or particles that could be relevant to the police investigation.

7.2.1.2 Precise documentation of all injuries (fresh and healed) that might relate to the alleged incident.

7.2.1.3 Detection of sexually transmitted infection.

7.2.2 Collect evidence as you go along. Note the location of any tears, abrasions and bruises on the pictogram in the examination form.

7.2.3 Systematically inspect, in the following order, the mons pubis, inside of the thighs, perineum, anus, labia majora and minora, clitoris, urethra, introitus and hymen.

7.2.4 If there is history of sodomy, patient is to be examined by the surgical team.

7.2.5 Look for any signs of infection such as ulcers, vaginal discharge or warts.

7.2.6 Check for injuries to the introitus and hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards.

7.2.7 If there has been vaginal penetration, gently insert a speculum, lubricated with water or normal saline.

7.2.8 Under good lighting inspect the cervix, then the posterior fornix and the vaginal mucosa for trauma, bleeding and signs of infection. Look for presence of foreign body in the vagina.

7.2.9 If tears are present specify whether fresh or old tears and specify the position.

7.2.10 Fresh tears appear as bleeding raw edges and do not unite but round off in 3 days.

7.2.11 Use a pictogram to illustrate your findings for easy review later.

7.2.12 Normal variants of hymen : ***(Refer to Appendix 7)***

7.3 Management

7.3.1 Medical treatment is initiated if indicated for abrasion and laceration wound. Dressing or pain relief may be required.

7.3.2 Treat, or refer all unhealed wounds, fractures, abscesses, and other injuries and complications.

7.3.3 Injuries requiring immediate medical attention take priority over forensic sampling.

7.3.4 If survivor requires EUA for laceration wounds or tears that require suturing, consent to be taken from the victim as in any other case before undergoing a procedure. In a life-saving situation when patient is unconscious, consent to be given by the O&G Specialist / Consultant on call or in charge.

7.3.5 The following swabs are to be taken :

7.3.5.1 To be sent to the Chemistry Laboratory by the Police Officer:

7.3.5.1.1 Swabs from the cervical introitus for semen (DNA)*

7.3.5.1.2 Swabs from posterior fornix, high vaginal swab (HVS) for semen (DNA)*

7.3.5.1.3 Low vaginal swab (LVS) for semen (DNA)*

***All swabs are taken in pairs and all specimens should be air-dried before packaging.**

7.3.5.1.4 Blood for DNA

7.3.5.1.5 Blood for Alcohol

7.3.5.1.6 Blood for Drugs

7.3.5.1.7 Finger nails clippings to be sent if the survivor reports that she scratched the assailant.

7.3.5.1.8 If presence of fresh bite marks swab moistened in distilled water or saline to loosen the cells followed by a dry swab to collect the loosened cell to be taken from the groove of the bite mark for DNA.

(Note: To label from which area/part of the body the swab was taken)

7.3.5.1.9 There is no need to send scalp hair of survivor for DNA.

7.3.5.1.10 Any foreign material, hair that has been recovered during examination to be sent for DNA.

7.3.5.1.11 Collection of clothing items for DNA to be dried and packed individually to prevent cross transfer.

Important to note: Survivors name on the label to be printed instead of hand written to avoid ambiguity and it must be the same as in the survivor's identification document

7.3.5.2 To be sent to the hospital Virology Laboratory by Police Officer:

7.3.5.2.1 Swabs from post fornix for microbiological examination.

7.3.5.2.2 Swabs from cervical introitus microbiological examination.

***All swabs are taken in pairs and all specimens should be air-dried before packaging.**

7.3.5.2.3 Blood for infective screening. (HIV, HBsAg, VDRL/TPHA)

Note: All swabs and specimens to be clearly labeled, sealed by the attending nurse. Witnessed and counter signed by the attending O&G Specialist before handing over to the Police Officer.

DNA evidence is part of the investigation. Prosecution requires other corroborative evidence to prove the case.

7.3.6 Emergency contraception is medically warranted. Nausea, vomiting, breast tenderness are side effects that you should inform to the survivors.

Levonorgestrel 1.5 mg orally as a single-dose regimen to be served before survivor leaves OSCC.

OR

Copper Intrauterine Device- insertion within 5 days from incident in women who are parous and as a form of long term contraception.

7.3.7 Tetanus vaccination should be administered if there are laceration and abrasion wounds that may be soiled with dirt and mud.

7.3.8 Antibiotics for survivors of rape due to multiple assailants are:

7.3.8.1 Tablet Doxycycline 100 mg twice daily x 2 weeks

7.3.8.2 Tablet Metronidazole 200 mg three times daily x 2 weeks

7.3.9 HIV prophylaxis is indicated if assailant is known to be:

7.3.9.1 Intravenous drug user.

7.3.9.2 Involved in bisexual/homosexual activities.

7.3.9.3 Practices unsafe sex.

To discuss case with Infectious Disease Specialist before any HIV prophylaxis is commenced.

7.3.9.4 Social support and psychological counseling are essential components of medical care for the rape survivor. All survivors should be referred to the Medical Social Worker with their consent.

8.0 SURVIVOR PRESENTS MORE THAN 72 HOURS AFTER THE INCIDENT

The 72 hours cut-off is considered a window of opportunity to successfully treat survivors for sexually transmitted infection and any pregnancy that might have resulted from sexual assault however that has nothing to do with the likelihood of recovering forensic evidence as stated in **1.4.**

It is not common to find any physical evidence more than one week after an assault. If the survivor presents within a week of the rape, or presents with complaints, do a full physical examination as above.

The amount and type of evidence that can be collected will depend on the situation.

All information is carefully recorded in the survivor's medical record and/or in a rape evaluation flow sheet (enclosed in rape kits).

8.1 Physical Examination

8.1.1 Note the size and color of any bruises and scars. ***(Refer to Appendix 6).***

8.1.2 Note any evidence of possible complications of the rape like deafness, fractures, abscesses, etc.

8.1.3 Check for signs of pregnancy.

8.1.4 Note the survivor's mental state whether withdrawn, depressed, or suicidal.

8.2 Examination of the genital area

8.2.1 Note any healing injuries to genitalia and/or recent scars.

8.2.2 If the assault occurred more than a week ago and there are no bruises or lacerations and no complaints (e.g. of vaginal or anal discharge or ulcers) there is little indication to do a pelvic examination.

8.2.3 Even when one might not expect to find injuries, the survivor might feel that she has been injured. A careful inspection with subsequent reassurance that no physical harm has been done may be of great relief and benefit to the patient and might be the main reason she is seeking care.

8.2.4 Check for injuries to the hymen and introitus by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards.

8.3 Management

8.3.1 If a survivor comes after 72 hours, DNA specimens are required only on case to case basis based on the facts of the case, the victims history Evidence has shown that spermatozoa has

been found to be present in the vagina for up to 7 days after the incident. If swabs for DNA have been taken, blood sample for DNA should also be sent to the Chemistry Laboratory. Blood for infective screening to be sent to the hospital Virology Laboratory.

8.3.2 If survivor comes more than 72 hours, do a urine pregnancy test or ultrasound examination to confirm pregnancy and refer for antenatal booking at the O&G clinic or to discuss on role of termination on pregnancy depending on the period of gestation. Vaginal examination is not required if patient is confirmed to be pregnant.

(Refer to Appendix 8 for Guidelines For The Management Of Unwed Pregnant Women Below 18 Years and Appendix 9for Guidelines For The Management Of Pregnant Survivors Above 18 Years)

8.3.3 For the above group, blood grouping, blood counts and urine for albumin and proteins as well as screening for sexually transmitted disease are to be done as in any antenatal case.

8.3.4 STI screening includes HIV, HBsAg and VDRL/TPHA.

8.3.5 Treat, or refer for treatment, all unhealed wounds, fractures, abscesses, and other injuries and complications.

8.3.6 Tetanus usually has an incubation period of 3 to 21 days. Vaccination to be administered if there is laceration and abrasion wound that may be being soiled with dirt and mud.

8.3.7 All survivors should be referred to the Medical Social Worker with their consent. Most survivors of rape will regain their psychological health through the emotional support and understanding of people they trust, community counselors, and support groups.

8.3.8 Antibiotics for high risk group –multiple assailants:

8.3.8.1 Tab Doxycycline 100 mg twice daily x 2 weeks

8.3.8.2 Tab Metronidazole 200 mg three times daily x 2 weeks

8.3.9 HIV prophylaxis is indicated if assailant is:

8.3.9.1 Intravenous drug user.

8.3.9.2 Involved in bisexual/homosexual activities.

8.3.9.3 Practices unsafe sex.

To discuss case with Infectious Disease Specialist before any HIV prophylaxis is commenced.

8.3.10 If survivor is suicidal or depressed admit and refer to the Psychiatrist.

9.0 MANAGEMENT OF SEXUAL ABUSE IN ADOLESCENTS

(Refer to the Guidelines For The Hospital Management Of Child Abuse And Neglect, MOH/P/PAK/130.07 (GU)).

10.0 GENITAL EXAMINATION IN SUSPECTED CHILD ABUSE

10.1 Doctor should inform the child the reason an examination is required and what it entails according to the child's developmental level.

10.2 Urgent treatment needed for the child when:

10.2.1 There is obvious physical trauma or suspected internal trauma.

10.2.2 There are signs or symptoms of systemic illness or local signs and symptoms especially significant genital discharge or bleeding or ano-rectal pain.

10.2.3 Acute sexual abuse (incident within 72 hours before presentation) as forensic evidence may be present for only a matter of hours.

10.2.4 Extreme distress either of child or parent may influence timing of examination even though technically a cold case.

10.3 **Do not use a speculum** when examining a prepubertal child. **No digital assessment to be done.** Only exception will be if the child presents with trauma/foreign body requiring EUA. Calm the parents by keeping them informed.

10.4 Examine child in the knee chest position in cooperative child.

10.5 Use a moistened cotton swab with water and gently stretch the hymen all around to look for any partial or complete fresh hymenal tears and presence of hymenal tissue.

10.6 Spread apart any areas that appear to be notches or clefts with the swab to see the depth of the notch or cleft.

10.6.1 Deep notches and complete cleft are commonly found at 3 and 6 o'clock position as well as posterior part of the hymen.

10.6.2 Abrasions and mild submucosal hemorrhages disappear within 3 to 4days.

10.6.3 Marked hemorrhages persist for 11-15 days.

10.6.4 Petechiae resolve within 48hours in the prepubertal girls and 72 hours in the adolescents.

REMEMBER that the absence of abnormal physical findings

NEVER excludes the possibility of child sexual abuse.

11.0 NON-URGENT EXAMINATION

11.1 When the incident occurred more than 72 hours prior to arrival. Involving long term abuse.

11.1.1 Examination should be planned with family's needs in mind.

11.1.2 There is general concern about the possibility of sexual abuse but no specific indication, e.g. dysuria or pain in genitalia.

11.1.3 Pediatrics assessment finds physical suspicion, e.g. purulent vaginal discharge.

11.1.4 Psychological assessment shows behavioral problems.

12.0 EXAMINATION UNDER ANESTHESIA

12.1 All children below the age of 5 years should have EUA to confirm findings. If the child is cooperative and is not distraught, examination can be carried out in OSCC.

12.2 If the older child is distraught and refuses to be examined the child needs to be admitted for EUA.

12.3 In the presence of painful injuries e.g. vaginal wall tear.

12.4 Risk of sexually transmitted disease and child does to allow adequate swab.

12.5 If there is suspicion of a foreign body.

13.0 CHAIN OF EVIDENCE

13.1 All specimens collected during the examination should be properly labeled, sealed and packaged.

13.2 Collection of these specimens is to be documented, signed, witnessed and dated.

13.3 Each step of evidence collection should be documented by the attending nurse, O&G Specialist/Medical Officer, Police Officer and laboratory staff who collects and handles the specimens.

13.4 Transport and delivery of DNA specimen as well as blood for DNA, drugs and alcohol to the Chemistry Laboratory is the responsibility of the Police Officer.

13.5 Blood for infective screening VDRL/TPHA, HbsAg, HIV to be sent to the hospital Virology Laboratory by the Police Officer. Swabs from post fornix and endocervix for microbiological examination are to be sent to the hospital Virology Laboratory.

14.0 FORENSIC ISSUES IN RAPE

14.1 Forensic evidence is best obtained from physical examination as soon as possible after the incident, and should not be delayed if it is still within 72 hours post incident.

14.2 Each item of clothing worn during the incident to be packed in bags provided in OSCC. It has to be labeled correctly by the attending OSCC nurse, with survivor's name in the presence of the investigating Police Officer and the attending doctor.

14.3 Forensic swabs for DNA are to be taken before swabs for bacteriological examination.

14.4 Forensic swabs should be thoroughly air dried before sealing in the kit.

14.5 Police Officer should be available before examination of alleged rape cases and for transporting specimens to the Chemistry Laboratory.

Note: Specimens for confirmation of sexually transmitted disease, HIV or Hepatitis will be sentto the Virology Laboratory. If chain of evidenceis needed to be maintained, then the Police Officer shall be responsible to send the specimens.

14.6 Forensic timescales (persistence of DNA)

14.6.1 Vaginal penetration up to 7 days.

14.6.2 Anal penetration up to 72 hours.

14.6.3 Oral penetration up to 48 hours.

14.6.4 Bite marks 48hours or longer.

15.0 SPECIAL ISSUES IN RAPE

For cases of pregnant survivors please refer to the guidelines.

(Refer to Appendix 8 &9)

16.0 WRITING OF MEDICAL REPORT

16.1 O&G Specialist who examined the survivor to write medical report. The attending specialist can be called to court to testify.

16.2 Details have to be carefully and accurately documented in chronological order. Complete relevant medical examination. Avoid medical jargon. Include relevant negative findings as well as positive physical examination findings.

16.3 Record time and date patient was examined.

16.4 Diagrams are useful.

16.5 Doctor's responsibility is to document injuries, the state of the hymen, vagina etc. and to determine whether there was any evidence of sexual intercourse.

Evidence of sexual intercourse does not mean rape had taken place and a negative finding does not rule out rape. The final decision is a matter for the court to decide.

17.0 FOLLOW UP CARE FOR SURVIVORS

17.1 It is possible that the survivor will not or cannot return for follow-up. Provide maximum input during the first visit, as this may be the only visit.

17.2 Attending O&G specialist should review blood sent for infective screening and results of swabs from post fornix and endocervix for microscopy and bacteriology and to call back survivors for treatment if indicated. Survivors are to be referred appropriately to the respective discipline.

17.3 Follow-up visit to the attending O&G specialist should be arranged for reasons stated below. OSCC nurses are to call and make appointment at the O&G clinic and patient to be given a short memo of her history and examination finding.

17.3.1 Survivor was not given Emergency contraception when patient came beyond 72 hours of the incident and there is a possibility she may get pregnant and requires further follow up.

17.3.2 If survivors mental and emotional status need to be assessed again.

17.3.3 If confirmed to be pregnant, for antenatal booking and follow up.

17.3.4 If sexually active for pap smear examination and contraceptive advice.

17.4 Cold cases are not to be sent to the clinic but to be seen at OSCC itself.

GUIDELINES FOR THE MANAGEMENT OF CHILD ABUSE AND NEGLECT

Refer Guidelines For The Hospital Management Of Child Abuse And Neglect
MOH / P / PAK / 130.07 (GU)

GUIDELINES FOR THE MANAGEMENT OF SODOMY

1.0 INTRODUCTION

Specialist who performs evidential examinations on sexual assault survivors must be familiar with the related medico legal aspects.

2.0 DEFINITION

Sodomy is defined as sexual intercourse between 2 persons by introduction of penis into the anus of another person.

The Malaysian Penal Code (*Kanun Keseksaan*) section 377(a) defined sodomy as "any person who has sexual connection with another person by introduction of penis into the anus or mouth of another person is said to commit carnal intercourse against the order of nature".

In section 377 (c) when the above act committed without the consent or against the will of another person, or by putting the other person in fear of death or hurt to the person or any other person.

In section 377 (CA) the above offences is committed by introduction any objects into the vagina / anus of the other person without the other person's consent.

3.0 ACUTE CASE

By Malaysian definition, acute (fresh) cases are up to 120 hours from the time of incident (Willcort, 1982).

4.0 TRIAGING SYSTEM AT THE EMERGENCY AND TRAUMA DEPARTMENT

Critically or semi-critically ill victims should be attended in the acute area of Emergency and Trauma Department and subsequently transferred to the respective department concerned.

Stable victims who presented within the specified time frame should be assigned priority in triage and will be directed to the OSCC. Acute cases should be seen within 90 minutes upon arrival at the OSCC.

If more than 120 hours have passed since the assault, a complete physical examination should still be conducted to examine for injuries to the body and the genitalia, to offer treatment and to provide information for support resources.

5.0 CONSENT

5.1 An appropriate signed written consent must be obtained by the attending doctor before beginning the examination, treatment, and evidence collection.

5.2 For those under 18 years old, the consent shall be obtained from the parents/guardian/Police Officer/ protector which have been stated in Child Act 2001.

5.3 A signed written consent for the sexual assault examination does not replace the general consent for routine diagnostic and medical procedures that are standard with emergency treatment and done in accordance withhospital policy.

5.4 When obtaining signed written consent for a sexual assault examination and evidence collection:

5.4.1 The doctor must inform the survivor of his or her rights. The survivor or the person who gives the consent on behalf of a child has the right to decline any or all parts of the examination that entails evidence collection.

5.4.2 The survivor needs to be made aware that evidence deteriorates over time and may be unobtainable if it is not collected and preserved promptly.

5.4.3 The doctor must explain that the collected evidence may lead to the identification of the offender.

5.4.4 The survivor must be informed that consent for the evidence-collection examination, once given, can be withdrawn at any time for all or part of the procedure.

5.4.5 The survivor must be informed that specimen and evidence collected can be used as evidence in court.

6.0 MAINTAINING THE CHAIN OF CUSTODY OF EVIDENCE

6.1 To maintain the chain of custody, all documentations of evidence transfer must include the following information:

6.1.1 Name of the attending doctor collecting the evidence.

6.1.2 Name of the person handling the evidence.

6.1.3 Name of the person receiving the evidence.

6.1.4 Date and time of transfer of the evidence must be clear.

6.1.5 All evidences and specimens collected must be sealed and labeled.

6.1.6 There should be a proper documentation of the transfer of the evidence or specimen.

7.0 THE ADULT SEXUAL ASSAULT SURVIVOR

7.1 Triage at the Emergency and Trauma Department

7.1.1 When a survivor comes to Emergency and Trauma Department an within 120 hours after the assault, she or he should be triaged, assessed for stability, and escorted promptly to a private area for the initial assessment.

7.1.2 All suspected cases should be directed and managed in the OSCC.

7.1.3 The examination should be conducted without delay to minimize the loss or deterioration of evidence.

7.1.4 A trained paramedic should be assigned to each victim.

7.1.5 A survivor should wear his/her own clothing until it has been collected properly.

7.1.6 The examiner should carefully explain the process of the examination to the survivor. After the survivor has been informed of her/his rights and agrees to the examination, a written consent for the examination is obtained before proceeding.

7.1.7 For the detail of consent refer to paragraph 5.

7.1.8 If the survivor wants to report the assault, the Police Officer should be notified.

7.1.9 If the survivor consented for forensic examination and evidence collection, then the protocols designated for forensic examination and evidence should be implemented.

7.1.10 There are cases where Police Officer may bring a survivor with a specific instruction on the Borang Pol 59, the attending doctor should be aware that decision to examine, conduct evidence collection and management on survivor should be a professional discretion of the doctor.

7.1.11 The Police Officer shall be present in the OSCC during the entire examination and evidence collection.

7.2 Survivors Interview

7.2.1 Follow the usual clerking format.

7.2.2 Begin the history taking with less invasive, general questions, such as medical and surgical history, use of medications, and drug allergies. This is to prevent confusion with injuries related to the sexual assault.

7.2.3 The attending doctor should document the following information:

7.2.3.1 The name, age, sex, and race of the victim.

7.2.3.2 The survivor's vital signs.

7.2.3.3 The date, time, location, and/or physical surroundings of the assault, including odors; any witnesses.

7.2.3.4 The survivor's personal hygiene (e.g., showered, bathed, brushed) since the alleged assault incident.

7.2.3.5 The name(s), number, race(s), and any other identifier(s) of the perpetrator(s), if known.

7.2.3.6 The use of weapons, physical force, restraints, injuries, forced drug or alcohol use, and verbal and/or nonverbal threats.

7.2.3.7 The threats, types of force, or other methods used by the perpetrators(s) (including drug-facilitated assault) and the area(s) of the body affected.

7.2.3.8 The sexual acts committed by the perpetrator(s); the sexual acts the survivor was forced to perform on the perpetrator(s).

7.2.3.9 Whether the survivor recently inserted tampons or any other foreign objects into his/her own orifices.

7.2.3.10 The frequency and sequence of the sexual acts

7.2.3.11 Detail of sexual act (e.g.: position, ejaculation, condom used, biting, kissing etc.).

7.3 Physical Examination

The patterns of injury associated with sexual assault result from restraining methods used by the perpetrator, the violent acts of the perpetrator, as well as the survivor's attempt to defend her/himself.

7.4 Evidentiary Examination

7.4.1 A full evidentiary examination includes:

7.4.1.1 Collecting clothing; trace evidence;.

7.4.1.2 Samples from under the survivor's nails; pubic and scalp hair samples. Scalp hair of at least 10 samples shall be collected for morphological comparison. Scalp hair and pubic hair combing should be collected if history available showing that the survivor has not changed bathed or washed from the incident.

7.4.1.3 Reference blood (e.g.: for DNA, alcohol, toxicology, etc.).

7.4.1.4 Reference blood for STI (e.g.: VDRL, gonorrhea, HIV etc.)

7.4.1.5 Cotton swabs taken from the skin, sites of injury (bite marks), and bodily orifices.

7.4.2 For collecting dried stain swab from the survivor body the swab should be moistened with sterile water.

7.5 Collection of Clothing

7.5.1 The survivor's clothing worn during the incident should be collected in paper bag or envelope.

7.5.2 Each items of clothing should be packed in individual paper bag or envelope with label, sealed and documented before handed over to the police.

7.5.3 The proper method of collecting the clothing:

7.5.3.1 The survivor is to stand on two sheets of clean paper on the floor, one sheet on top of the other. The purpose of the bottom sheet of paper is to protect evidence on the clothing from being contaminated by debris or dirt on the floor. Any trace evidence that found should be collected as trace evidence specimen.

7.5.3.2 The survivor should remove her/his shoes prior to stepping on the paper for disrobing to avoid contamination of loose trace evidence with non-evidential debris from the shoe soles. The shoes should be collected and packaged separately.

7.5.3.3 The survivor's clothing should not be shaken to avoid loss of microscopic evidence. Holes, rips, or stains in the survivor's clothing must not be disturbed by cutting.

7.6 Collection of Foreign Material

7.6.1 If the survivor gives a history of scratching the assailant or if foreign material is observed under the nails, fingernail scrapings/clipping should be collected.

7.6.1.1 The right- and left-hand collections are performed as separate procedures.

7.6.1.1.1 Each of the victim's hands should be held over an unfolded, flat collection paper.

7.6.1.1.2 Then scrapings/clippings are taken from under all five fingernails.

7.6.1.1.3 The used scraper is placed in the center of the paper, which is then refolded to retain the debris and the scraper and placed in a labeled container.

7.6.1.1.4 The clipper should be used once, label and submitted.

7.6.1.1.5 The two envelopes are identified as containing "right-hand fingernail scrapings/clippings" or "left-hand fingernail scrapings/clippings."

7.6.2 When a stain is present it should be photographed by Police Officer before collection. The area is swabbed, and injuries that might be associated with the blood should be noted.

7.7 Anorectal Examination

7.7.1 Examined for signs of injury and foreign materials if the survivor's history indicates that anal penetration occurred.

7.7.2 The physical examination proceeds beyond the standard inspection of the anus and the perianal area to include a careful examination of the distal anus using an anoscope / proctoscope or flexible endoscope.

7.7.3 The anorectal findings are documented in the text and on the body diagram.

7.7.4 Toluidine blue dye may be used when necessary around the perianal after external anal sampling but before the anoscopic examination aids in the visualization of injuries. Injuries should be photographed by Police Officer at the time of their detection (e.g., before the use of swabs in the anorectal area).

7.7.5 For all acute cases external anal swab should be collected.

7.7.5.1 First, swab the area around the anus for DNA. Then another swab on the perianal region. Third swab from any area of the perianal region is for microbiological examination.

7.7.5.2 The sphincter is dilated using an appropriate size, preferably lubricated proctoscope. While examining, 3 internal swabs shall be taken (2 swabs for DNA and 1 swab for microbiology test).

7.8 Laboratory Examination

7.8.1 Before the completion of the evidence examination, a sample of venous blood is obtained as a reference specimen for the survivor's DNA.

7.8.2 Blood for DNA is collected using FTA® Card.

7.8.3 Blood sample should be taken for :

7.8.3.1 STD profile (Syphilis, Hepatitis B, Herpes Simplex).

7.8.3.2 Toxicology and drug abuse.

7.8.4 Urine sample should be taken for:

7.8.4.1 Pregnancy test for female.

7.8.4.2 Toxicology and drug abuse.

7.8.5 All trace evidences, clothings, swabs, blood FTA® Card for DNA and blood and urine for toxicology and drug abuse to be sent to Department of Chemistry, Malaysia *(Jabatan Kimia Malaysia)*.

7.8.6 STD profile and swabs for culture to be sent to the hospital pathology laboratories.

GUIDELINES FOR THE HOSPITAL MANAGEMENT OF DOMESTIC VIOLENCE

1.0 INTRODUCTION

The One Stop Crisis Center management of domestic violence survivors in Malaysia incorporates the treatment of physical, psychological and financial abuse or neglect by a spouse or family member as stated in the Domestic Violence Act of 1994. The One Stop Crisis Center assists survivors of domestic violence to come forward for protection and treatment while maintaining privacy and confidentiality.

Doctors must understand that medical treatment of the physical sequelae of domestic violence alone is inadequate to stop the cycle of violence. As well as providing medical treatment, the doctor must assist the survivor to access police protection, shelter, legal advice and counseling via the Medical Social Worker or Social Welfare Officer.

2.0 DEFINITIONS

In this document, the following terms shall be defined as:

2.1 **Domestic violence** (Domestic Violence (amendment) Act 2012) is the commission of one or more of the following acts:

2.1.1 Willfully or knowingly placing or attempting to place the victim in fear of physical injury;

2.1.2 Causing physical injury to the victim by such act which is known or ought to have been known would result in physical injury;

2.1.3 Compelling the victim by force or threat to engage in any conduct or act, sexual or otherwise from which the victim has right to abstain;

2.1.4 Confining or detaining the victim against the victim's will;

2.1.5 Causing mischief or destruction or damage to property with intent to cause or knowing that it is likely to cause distress or annoyance to the victim;

2.1.6 Causing psychological abuse which includes emotional injury to the victim;

2.1.7 Causing the victims to suffer delusions by using any intoxicating substance or any other substance without the victim's consent or if the consent is given, the consent was unlawfully obtained; or

2.1.8 In the case where the victim is a child, causing the victim to suffer delusions by using any intoxicating substance or any other substance; and

2.1.9 By a person whether by himself or a third party, against:

2.1.9.1 his or her spouse

2.1.9.2 his or her former spouse

2.1.9.3 a child

2.1.9.4 an incapacitated adult

2.1.9.5 any other member of the family

2.2 **Spouse:**

Husband, wife, ex-husband or ex-wife, including a "de facto spouse" a person who has gone through a form of ceremony which is recognized as a marriage ceremony. According to the religion or custom of the parties concerned, not-withstanding that such ceremony is not registered or not capable of being registered under any written law relating to the solemnization and registration of marriages.(Domestic Violence Act of 1994) Or, Heterosexual cohabitant partners where unmarried heterosexual couples live together in a relationship that resembles a marriage.

2.3 Interim Protection Order, IPO (Domestic Violence Act of 1994):

An Interim Protection Order is issued by the court pending investigations of an offence prohibiting the person against whom the order is made from using domestic violence against the victim. A police report must be lodged to obtain an Interim Protection Order.

2.4 Protection Order, PO (Domestic Violence Act of 1994):

The court may issue a Protection Order restraining the person against whom the order is made from inflicting domestic violence.

2.5 Incapacitated adult (Domestic Violence (Amendment) Act 2012):

Means a person who is wholly or partially incapacitated or infirm, by reason of permanent or temporarily physical or mental disability or ill health or old age, who is living as a member of the family of the person alleged to have committed the domestic violence, and includes any person who was confined or detained by the person alleged to have committed the domestic violence.

2.6 Gender sensitivity:

The way service providers treat male or female clients in service delivery facilities and thus affect client willingness to seek services, continue to use services and carry out the health behavior advocated by the services. For example, if the survivor is of female gender, female staff shall be prioritized to manage the survivor.

2.7 Para Counseling:

The act of listening, application of soft skills, communicating and advising with verbal and non-verbal cues with empathy to establish rapport with survivors throughout the hospital management of domestic violence survivors.

Note: As there is a separate guideline on child abuse management, violence involving children will not be discussed in the context of domestic violence.

3.0 WORK PROCESS

3.1 Triage:

3.1.1 The triage staff shall be proactive to detect survivors of domestic violence to immediately ensure confidentiality and privacy of domestic violence survivors.

3.1.2 The triage staff shall be trained to detect atypical presentations of domestic violence survivors such as trauma signs which do not correlate with their injury complaint.

3.1.3 Survivors shall be triaged according to the severity of the injuries sustained. Critical or semi critical survivors shall be triaged to the red or yellow zones respectively. Non critical survivors shall be immediately ushered to a designated OSCC facility. ***(Refer to Appendix 10)***

3.1.4 For non-critical survivors, secondary triaging of vital signs shall be performed in the designated OSCC facility.

3.1.5 Survivors from the green zone who are not detected earlier on by the triage staff shall be ushered to the designated OSCC facility immediately.

3.1.6 Further assistance in providing protection, counseling, medico legal services and social support shall be arranged by the respective clinical department in charge of survivor.

3.1.7 Gender sensitivity and competency in para-counseling shall be implemented in managing the survivor.

3.2 History taking

3.2.1 A complete relevant history shall be taken which include chief complaint, mechanism of injury, past medical and surgical history and relevant social history. ***(Refer to Appendix 11)***

3.2.2 It is important to recognize abuse especially in survivors who are not forthcoming of the incident. The following indicators suggest the presence of domestic violence:

3.2.2.1 Injuries inconsistent with the stated history.

3.2.2.2 Diminished self-image, depression, or suicide attempts.

3.2.2.3 Self-abuse.

3.2.2.4 Frequent Emergency and Trauma Department or doctor's office visits.

3.2.2.5 Symptoms suggestive of substance abuse.

3.2.2.6 Self-blame for injuries.

3.2.2.7 Partner insists on being present for interview and examination and monopolizes discussion.

3.2.3 Avoid confronting the abusing spouse or family member.

3.2.4 Additional questions to be asked in a non-judgmental manner not in the presence of the survivor's spouse to help detect survivors of domestic violence:

3.2.4.1 Have you been kicked, hit, punched, or otherwise hurt by someone within the past year? If so, by whom?

3.2.4.2 Do you feel safe in your current relationship?

3.2.4.3 Is there a partner from a previous relationship who is making you feel unsafe now?

3.3 Physical Examination

3.3.1 Thorough examination of the survivor starting with a primary survey and followed by a secondary survey shall be conducted.

3.3.2 All injuries shall be documented in detail.

3.3.3 If sexual abuse is suspected, survivor shall be examined as outlined in the alleged rape, sexual assault and sodomy protocol.

3.4 Investigations

3.4.1 Blood and urine investigations shall be ordered as necessary.

3.4.2 Radio imaging shall be ordered as necessary.

3.4.3 If a toxicology specimen is needed to be sent to Department of Chemistry, Malaysia, a police report shall be lodged and the designated Police Officer shall bring the specimens to Department of Chemistry, Malaysia.

3.5 Referral

3.5.1 Survivors who require referral to other clinical specialties or who require admission shall be managed accordingly.

3.5.2 All survivors shall be referred by the attending doctor to the Medical Social Worker Department or Social Welfare Department.

3.5.3 The attending doctor shall arrange a referral to Psychiatry or Clinical Psychologists if necessary especially if there are signs of acute psychosis or suicidal ideation.

3.5.4 The attending doctor may consider advising the survivor to seek additional assistance from relevant NGO's. e.g., distribution of leaflets about All Women's Action Society Malaysia (AWAM), Women's Aid Organization (WAO).

3.6 Further Care & Protection:

3.6.1 If the survivor is still at risk of further injury by the spouse, unsafe to be discharged home and has no social support, temporary lodging or safe shelter home shall be arranged for the survivor.

3.6.2 The Medical Social Worker Department or Social Welfare Department shall be contacted to arrange temporary safe shelter home and social support for the survivor.

3.6.3 The Medical Social Worker or the Social Welfare Officer shall arrange for an Interim Protection Order and Protection Order for the survivor if required.

3.6.4 Networking with local NGOs shall be established to help identify shelter homes for survivors in addition to shelter homes which are provided by the government.

3.6.5 Confidentiality of the shelter home location shall be maintained.

3.6.6 While waiting for a shelter home, the survivor shall be lodged in a safe area in the hospital as decided by the hospital administrators.

3.6.7 The transportation of the survivor to the shelter home or designated safe accommodation shall be arranged by the hospital if required.

3.6.8 If the safety of the survivor during transportation to the shelter home is at risk, the police shall be contacted to provide escort.

3.7 Lodging a police report

3.7.1 Do not force the domestic violence survivor to make a police report; the survivor has the right to refuse police intervention.

3.7.2 The survivor shall be assisted to lodge a police report where appropriate.

3.7.3 The OSCC staff shall assist the guardian/relative/person in charge of the survivors who are mentally or physically incapacitated to lodge a police report.

3.7.4 A police report can be made at any time and should not delay the initial treatment and examination of the survivor.

4.0 OTHERS

4.1 Support & Informing Family

4.1.1 Survivors of a legal consenting age may choose not to inform family members of their situation.

4.1.2 For survivors with life threatening injuries, family members shall be informed regardless of the survivor's refusal to inform the family.

4.2 Follow up by health staff after discharge

4.2.1 All high risk domestic violence cases referred to the medical social workeror social welfare officer shall be followed up either by conducting a home visit or contacted by phone.

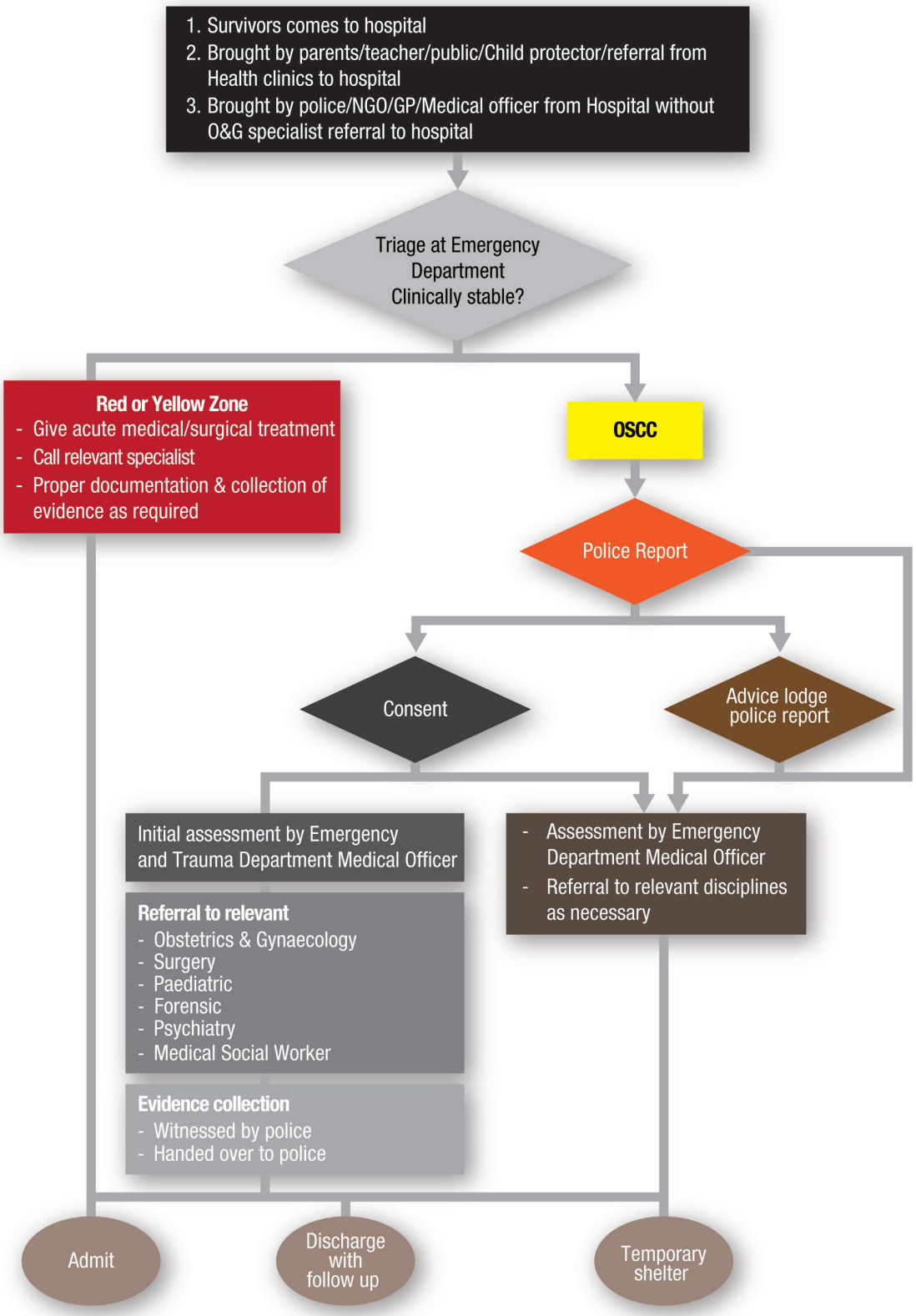
4.2.2 For non-high risk domestic violence cases, further follow up by phone or home visit shall be done if necessary.


SELAMAT DATANG KE JABATAN KECEMASAN HOSPITAL KUALA LUMPUR
O.S.C.C.
BILIK KHIDMAT BERSEPADU
- ONE STOP CRISIS CENTRE -
O.S.C.C. MALAYSIA
PROVIDER
SPECIMEN MANAGEMENT KIT
TCA CARD
BORANG 9
TOXICOLOGY FORM
CONSENT FORM
Sexual assaulted
Scan case
Domestic violence
ALL OSCC
CASES
MUST BE REFFERRED
TO COUNSELOR

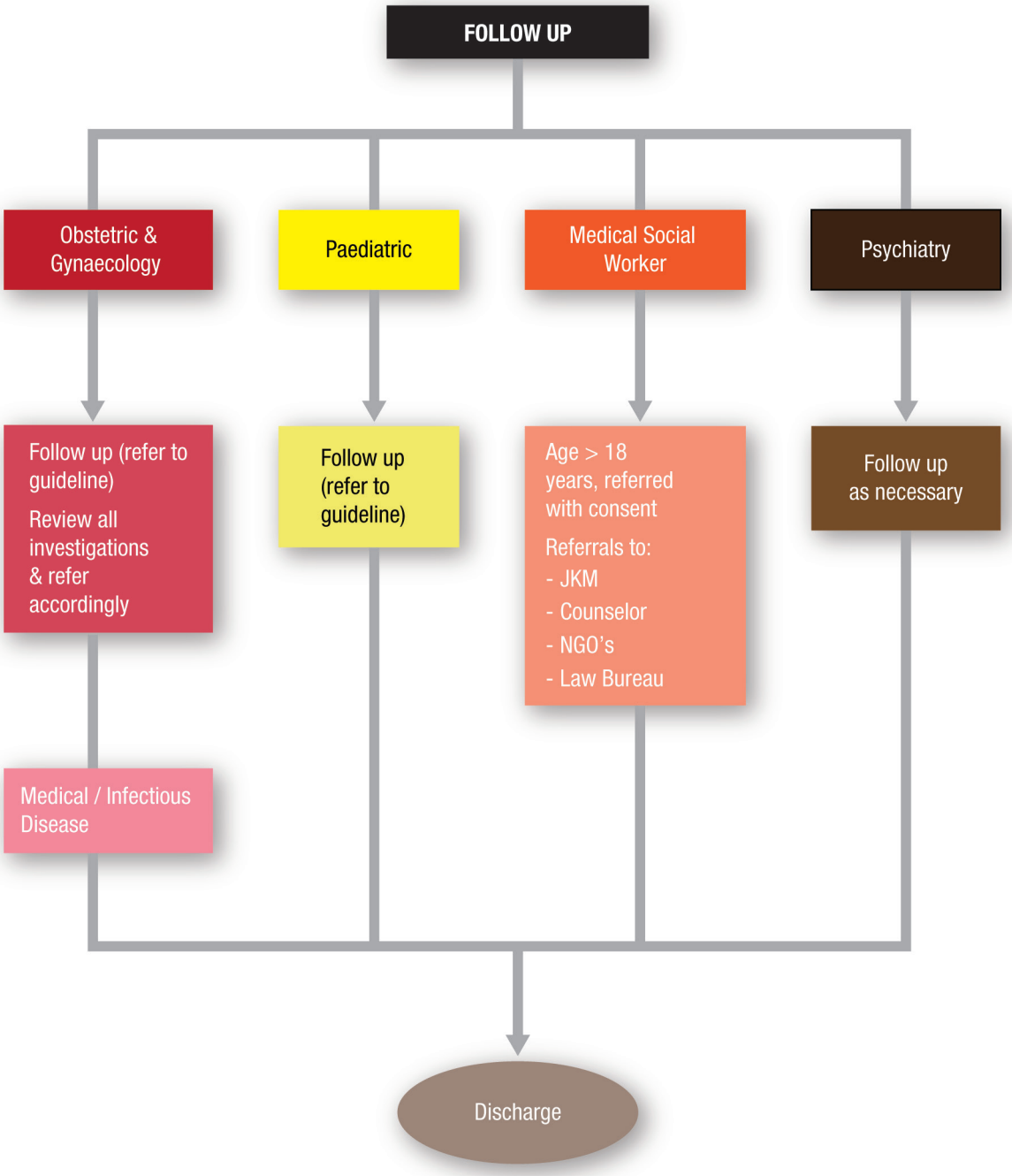
APPENDIX

APPENDIX 1

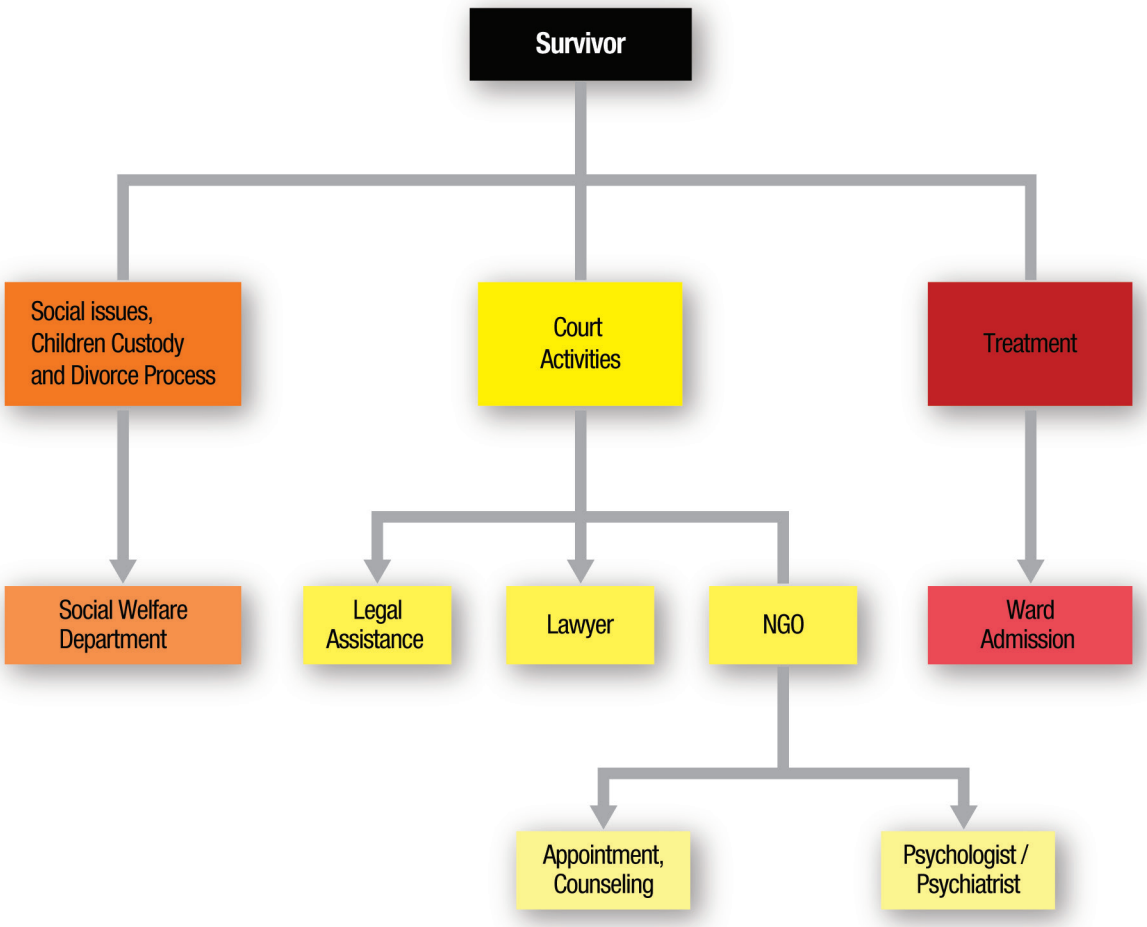
FLOWCHART FOR HANDLING OSCC
Crisis Intervention Level 1: Initial Management



Crisis Intervention Level 2: Follow Up



Crisis Intervention Level 3: Rehabilitation



APPENDIX 2

LAYOUT OF THE INFRASTRUCTURE OF ONE STOP CRISIS CENTRE

1.0 COMPONENTS

Section 1 : CLERKING AND COUNSELING SECTION

- History Taking
- Police Report
- Counseling

Section 2 : EXAMINATION SECTION

- Clinical Examination
- Specimen Collection
- Specimen handling, processing and sealing
- Therapeutic procedures
- Forensic Kit / equipment

Section 3 : LODGING

- Lodging area/Temporary for 24 hours
- Shelter Section

Section 4 : ATTACHED BATHROOM

- Attached toilet with shower
- Locker with a change of clothing

2.0 CHARACTERISTIC

2.1 Within emergency services area
2.2 Conducive and comfortable
2.3 Safe and secure
2.4 Private area

3.0 FUNCTION AND USAGE

3.1 Clerking cases
3.2 Counseling
3.3 Examination with a couch
3.4 Storage for forensic equipment and file
3.5 Basic furniture
3.6 Basic clerking facility-
- 3.6.1 Case sheet
- 3.6.2 Specimen forms
- 3.6.3 Specimens collection equipment

APPENDIX 3

(Pol. 59-Pin. 3/86)

POLIS DIRAJA MALAYSIA

PERMINTAAN UNTUK PEMERIKSAAN DOKTOR BAGI ORANG YANG TERLIBAT DALAM KES POLIS

Kepada PEGAWAI PERUBATAN YANG MENJAGA RUMAH SAKIT…….....

Diminta tuan memeriksa……..……..

No. K.P.P.N…… Umur…… Jenis……..

Keturunan……..... Sebab peperiksaan dikehendaki:
(Potong mana-mana yang tiada dipakai)

(a) Orang salah *(b)* Orang cedera *(c)* Orang lain yang terlibat dalam suatu kes Polis

(d) Orang bangsat atau tidak berdaya upaya (di bawah seksyen 6, Bab 191)

(*Lihat* **Borang Surat Akuan di bawah**)

Tarikh dan jam dihantar ……..……..

Diiringkan oleh ……

No. Aduan/Balai ……....

Keadaan dan butiran ringkas kes yang berkenaan……

.Sama ada surat akuan dikehendaki atau tidak…..

Sama ada yang berkenaan itu hendak dikawal atau tidak……..

Tarikh …… *Tandatangan*... ……

K.P.D……

Ulasan Pegawai Perubatan jika surat akuan tidak dikehendaki…….. …….

……

Tarikh…….

Pegawai Perubatan ……

SURAT AKUAN DI BAWAH SEKSYEN 9 UNDANG-UNDANG ORANG BANGSAT
DAN TIDAK BERDAYA UPAYA (BAB 191)

Saya……

mengakui bahawa …….

telah dibawa ke hadapan saya dalam kawalan Mata-Mata……..

didapati berdaya/tidak berdaya mencari sara hidup.

……..

.

Tarikh……. *Pegawai Perubatan*……

Pegawai Perubatan dikehendaki melaporkan kepada Polis atau Majistret dengan segeranya dalam hal keadaan merbahaya yang membawa maut.

Apabila surat akuan dihendaki maka Mata-Mata yang mengiring hendaklah diarahkan supaya menunggu surat itu dikeluarkan dan kemudian menyampaikannya terus kepada Ketua Polis Balai.

……...
PNMB , K

BORANG 4

AKTA KANAK-KANAK 2001
[Subseksyen 20(1) dan (4)]

PENGEMUKAAN KANAK-KANAK KE HADAPAN PEGAWAI PERUBATAN

Kepada,

.....

.....

.....

.....
(Alamat hospital atau klinik kerajaan)

Seorang kanak-kanakyang dikenali sebagai ……lelaki / perempuan. Umur : ……* Sijil Kelahiran No. / Kad Pengenalan No.: ……..….. telah diambil ke dalam jagaan sementara di bawah *seksyen 18 / subseksyen 20(4) Akta.
(Nama pegawai perubatan)

Saya berpendapat bahawa kanak-kanak itu memerlukan pemeriksaan atau rawatan perubatan dan dengan ini mengemukakan kanak-kanak itu ke hadapan anda.

Menurut seksyen 21 Akta, anda:–

(a) hendaklah menjalankan atau menyebakan dijalankan pemeriksaan terhadap kanak-kanak itu;

(b) boleh, pada memeriksa kanak-kanak itu dan jika dibenarkan sedemikian oleh *Pelindung / pegawai polis, melakukan atau menyebabkan dilakukan apa-apa tatacara dan ujian yang perlu untuk mendiagnosis keadaan kanak-kanak itu; dan

(c) boleh memberikan atau menyebabkan diberikan apa-apa rawatan yang anda fikirkan berikutan keputusan diagnosis itu.

DIBERIKAN di bawah tandatangan saya dan cop rasmi *Pelindung / pegawai polis pada……. hari bulan ……. tahun ……..

……
*(Tandatangan *Pelindung / pegawai polis)*

Nama : ……
Alamat pejabat : ……

Catatan * Potong mana-mana yang tidak berkenaan

BORANG 8

AKTA KANAK-KANAK 2001
[Seksyen 24(2)]

PEMBERITAHUAN UNTUK MEMPEROLEH KEIZINAN BAGI RAWATAN PERUBATAN KANAK-KANAK

Kepada,

……

……

……

……

*(Nama dan alamat *ibu / bapa / penjaga kanak-Kanak / orang yang mempunyai kuasa untuk mengizinkan rawatan perubatan kanak-kanak)*

DENGAN INI DIBERITAHU bahawa ……
(Nama pegawai perubatan)
pegawai perubatan di…… yang telah memeriksa
(Nama hospital atau klinik kerajaan)
Seorang kanak-kanak yang dikenali sebagai…… *lelaki / perempuan. Umur : …… * Sijil Kelahiran No. / Kad Pengenalan No.: …….. berpendapat bahawa kanak-kanak itu –

(Catatan: Tandakan (/) pada kotak yang berkenaan)

☐ mengalami penyakit, kecederaan atau keadaan serius

☐ memerlukan pembedahan.

☐ memerlukan rawatan psikiatri.

Menjadi kewajipan saya di bawah perenggan 24(2)(a) Akta untuk memperoleh keizinan bertulis anda bagi rawatan perubatan atau pembedahan atau psikiatri dilaksanakan terhadap kanak-kanak itu.

DIBERIKAN di bawah tandatangan saya dan cap rasmi *Pelindung / pegawai polis pada…….… hari bulan ……tahun…… .

……

*(Tandatangan *Pelindung / pegawai polis)*

Nama : ……

Alamat pejabat : ……

BORANG 9

AKTA KANAK-KANAK 2001
[Seksyen 27]

PEMBERITAHUAN OLEH PEGAWAI PERUBATAN ATAU PENGAMAL PERUBATAN BERDAFTAR

Kepada,

.....

.....

.....

.....
(Pelindung dan alamat pejabat)

Saya ..... Kad Pengenalan No.: ..... seorang * pegawai perubatan / pengamal perubatan berdaftar di.....

.....
(Nama dan alamat hospital atau klinik)

2. Saya telah memeriksa atau merawat seorang kanak-kanak yang dikenali sebagai ..... *lelaki / perempuan Umur:.....Alamat:.....

..... Saya mempercayai atas alasan-alasan yang munasabah bahawa kanak-kanak itu dicederakan dari segi fizikal atau emosi akibat teraniya, terabai, terbuang atau didedahkan, atau teraniaya dari segi seks.

3. Oleh yang demikian, saya merujuk hal ini kepada Pelindung untuk tindakan lanjut.

**4. Untuk makluman tuan, saya telah mengambil kanak-kanak itu ke dalam jagaan sementara.

Bertarikh…….hari bulan……tahun…….. .

……

(Tandatangan

**pegawai perubatan / pengamal perubatan berdaftar)*

Nama : ……..

Alamat pejabat : ……

……

……

Catatan **Potong mana-mana yang tidak berkenaan*
***Potong jika tidak berkaitan*

APPENDIX 5

KEIZINAN BAGI RAWATAN PERUBATAN ATAU PEMBEDAHAN ATAU PSIKIATRI DILAKSANAKAN TERHADAP KANAK-KANAK

Saya ……

*(Nama *Ibu / bapa / penjaga kanak-kanak / orang yang mempunyai kuasa untuk memberi keizinan)*

Kad Pengenalan No.:…… ……

telah menerima suatu salinan Pemberitahuan di bawah Subseksyen 24(2) Akta daripada ……

*(Nama dan alamat *Pelindung / pegawai polis)*

Saya telah dirundingi dengan sewajarnya tentang kehendak rawatan perubatan atau pembedahan atau psikiatri yang akan dilaksanakan terhadap kanak-kanak yang dikenali sebagai……

(Nama kanak-kanak)

dan saya meberikan keizinan bagi rawatan sedemikian dilaksanakan terhadap kanak-kanak itu.

……

*(Nama *Ibu / bapa / penjaga kanak-kanak / orang yang mempunyai kuasa untuk memberi keizinan)*

Nama: ……

Alamat: ……...

……..……

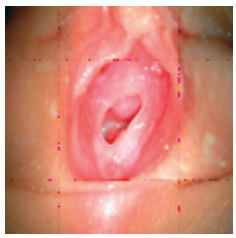
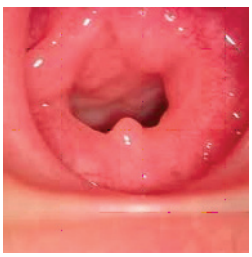
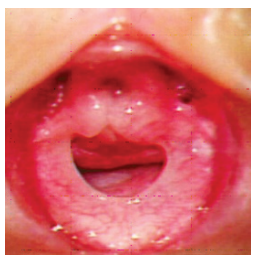
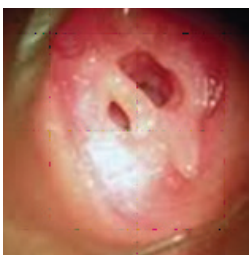
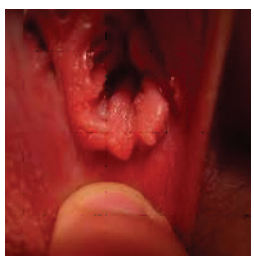
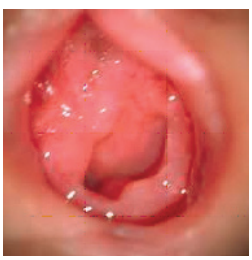
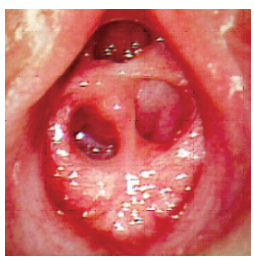
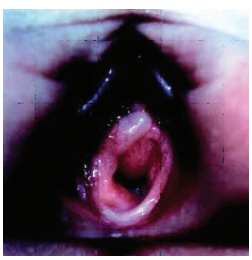
Catatan: * *Potong mana-mana yang tidak berkenaan*

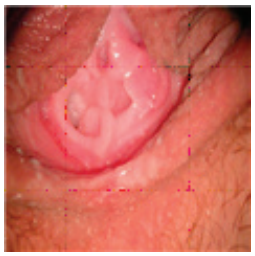
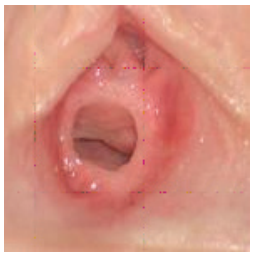
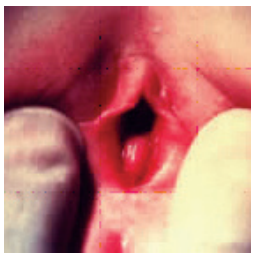
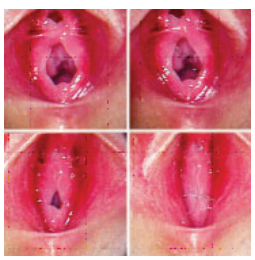
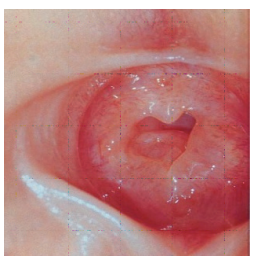
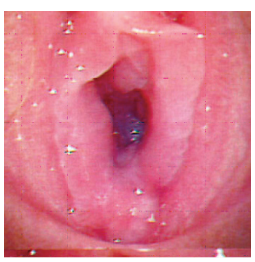
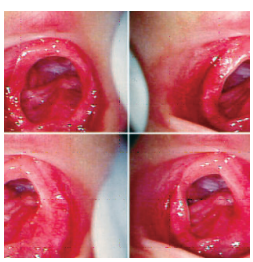
APPENDIX 6

Table 1 : Describing features of general physical injury

FEATURE	NOTES
Accepted terminology	Abrasion, contusion, laceration, incised wound, gunshot
Site	Anatomical site of wound
Size and depth	Measure dimensions and estimate depth of wound
Shape	Describe shape(linear, curved, irregular)
Surrounds	Any bruising, swelling
Color	Observation of color
Contents	Any presence of foreign body
Age	Comment on evidence of healing

Table 2 : Normal Variants of hymen

HYMENAL CONFIGURATION		NORMAL HYMENAL VARIATIONS	
Annular		Hymenal bumps or moulds	
Crescentric		Hymenal tags	
Fimbriated		Shallow/superficial notch or cleft in the inferior rim of hymen below 3 o'clock- 9 o'clock line	
Septated		Longitudinal intravaginal ridges	

Estrogenized adolescent hymen		Vestibular bands extending from 2' oclock position	
Imperforate hymen in a prepubertal girl		External ridges	(picture not available)
Appearance of the introitus changes using different examination techniques in a pepubertal girl. Introitus of the same child as different types of labial traction are used.		Septal remnant	
Normal estrogenized hymen		Redundant hymenal tissue	

APPENDIX 8

GUIDELINES FOR THE MANAGEMENT OF UNWED PREGNANT WOMEN BELOW 18 YEARS

1.0 INTRODUCTION

A teenage girl may become pregnant as a result of varying situations. Some during a long-term dating relationship, while other's become pregnant as a result of rape.

Unwed mothers with an unintended pregnancy have to make a decision whether to keep and raise the baby or to give up the baby for adoption.

Antenatal care is essential for the total wellbeing of the mother and the unborn child.

Unwed mothers should be given the opportunity to carry their pregnancy to full term in a safe and supportive environment.

2.0 OBJECTIVE OF THIS GUIDELINES

2.1 To define the responsibilities of doctors in the management of unwed pregnant mothers.

2.2 The doctor's responsibilities are:

2.3 To manage the above group of patients as any other antenatal mother.

2.4 To provide antenatal care and subsequent follow up.

2.5 To make a decision for medical termination of pregnancy if warranted.

2.6 To refer all patients below 18 years to the Medical social worker /Social Welfare Department.

2.7 For Social Welfare Department notification (*Borang 9-**refer to Appendix 4***) for both babies and mothers.

2.8 To refer to the Child Psychiatrist/Psychiatrist for psychological support.

2.9 To refer all cases to the Paediatric SCAN Team/Paediatrician for subsequent follow up.

2.10 To decide if the mother and baby need to be separated if there is a possibility that the baby may be in danger with the mother.

2.11 To make a police report for all unwed mothers 16 years and below. (Preferably during the antenatal follow up but if missed then during the post partum period).Police report if pregnancy is a result of alleged rape for those victims between 16 years to 18 years.

2.12 To counseling for cervical smears and contraception.

2.13 Maintain confidentiality at all times.

3.0 MANAGEMENT AT ANTENATAL CLINIC

3.1 All unwed mothers to be booked at the antenatal clinic.

They may be:

3.1.1 Victims of rape that were first seen at OSCC.

3.1.2 Referred from the Paediatric wards.

3.1.3 Brought by parents/legal guardian for antenatal follow up.

3.1.4 Discharged from the antenatal ward with no prior antenatal follow up.

3.1.5 Referred from Health clinics, Government hospitals, private clinics or private hospitals.

3.2 Personal details of the patient to be noted in the antenatal records.

3.2.1 Address and phone number.

3.2.2 Next of kin and legal guardian.

3.3 Once patient has been registered, she will be ushered by the clinic staff to be clerked followed by BP and weight monitoring as well as urine dipstick analysis.

3.4 For victims who are pregnant as a result of rape, sexual abuse and incest there is a role for termination of pregnancy if the patient comes in the first trimester and the pregnancy is affecting the victim, mentally and emotionally.

- ***Case to be referred to the Adolescent Paediatrician/ Paediatrician and Child Psychiatrist /Psychiatrist for assessment before any decision is made.***
- ***To discuss case with O&G Head of Department before any decision for Medical termination is made.***

The Guidelines on Termination of Pregnancy form a useful guide in decision making.

3.5 For pregnant unwed mothers due to alleged rape (police case) there is no need to do examination of the genitalia.

3.6 Once the baby is born blood must be taken for DNA analysis in the presence of the Police Officer to be sent to the chemistry lab.

3.7 Patient will be reviewed by the O&G Specialist in the clinic and if this specialist is unavailable patient shall be seen by the Medical Officer.

3.8 Blood for infective screening, ABO grouping and full blood count to be taken if it has not already been done.

3.9 Police report has to be made for all unwed mothers 16 years and below if not already done. However for patients between 17 years to 18 years police report is required in cases of alleged rape and sexual abuse only.

3.10 All patients are to be referred to the Medical Social Worker.

3.11 Some of these patients may already be on the social welfare follow up. Those patients will still require referral to the Medical Social worker at the hospital.

3.12 Patients are to be seen for antenatal follow up as any other antenatal mother.

3.13 Once the infective status is known refer the patient appropriately if required.

3.14 Subsequent follow ups can be done at the nearest Health clinic. However if there are complications, patients will be required to be followed up at the Hospital.

Role of Medical Social Worker

- Contact and inform the patients' family of her condition.
- To help patients solve their problems which directly or indirectly affect their condition.
- To promote continuity of family relationships and prevent family maladjustment.
- Family will be given counseling to deal with the shock and to accept the baby.
- To help patient and their family in their rehabilitation during confinement and after discharge.
- Assist in finding shelter for those whose family has disowned them.
- Assist in adoption for the unwanted babies.
- Home visits –follow up care.
- If the victim has been seen by social worker and need to be discharge over the weekend or Public holiday, you may contact them and discuss the case.

4.0 MANAGEMENT AT THE ANTENATAL WARD

4.1 When patients are admitted to antenatal ward/in labour

4.1.1 Check antenatal records for confirmation of dates /Infective status.

4.1.2 Manage obstetrically as any other antenatal mother.

4.1.3 Check to see if patient on follow up with the Medical Social worker/Social Welfare Department.

4.1.4 Parents will be required to give consent in the event the patient requires an abdominal delivery.

4.1.5 If parents/legal guardians are not available consent to be given by Specialist in charge/ Specialist on call/Child protector.

4.1.6 Refer to the Adolescent Paediatrician/Paediatrician postnatally.

4.1.7 Contraceptive counseling is advocated.

4.1.8 Police report to be made if missed out during the antenatal period for cases stated earlier.

4.1.9 Social Welfare Department notification *(Borang 9 –* ***refer to Appendix 4****)* for both mother and baby.

4.1.10 If the baby died in utero, notification to the Social Welfare Department (*Jabatan Kebajikan Masyarakat*, JKM) is done for the patient only.

4.2 Baby's blood for DNA analysis must be taken in the presence of the Police officer for alleged rape cases, following medical termination of pregnancy in alleged rape cases as well as in cases of fetal demise in alleged rape/ sexual abuse cases.

The Police Officer will maintain "chain of evidence" and send the blood to the chemistry lab for analysis.

4.3 For unbooked cases:

4.3.1 Confirm dates

4.3.2 Infective screening.

4.3.3.3 Police report as in booked cases.

4.3.4.4 Contact next of kin where possible.

4.3.5.5 Refer Medical social worker.

4.3.6.6 Refer to Adolescent Paediatrician/Paediatrician.

4.3.7.7 May require referral to Child Psychiatrist/Psychiatrist.

If no next of kin, in the event patient requires abdominal delivery consent to be given by Specialist in charge/Specialist on call/ Child protector.

Patients are at risk to abscond from the ward. Baby may need to be separated from mother if you feel that the baby may be in danger with the mother.

4.4 Baby can be admitted to the Paediatric ward if safety of baby is a concern. JKM *Borang 9* to be sent for both mother and baby

5.0 MANAGEMENT AT THE GYNAE WARD

5.1 Patient may be admitted to the gynae ward for

5.1.1 Heavy menstrual bleeding (patient may be pregnant).

5.1.2 Miscarriage.

5.1.3 Hyperemesis gravidarum.

5.1.4 Ectopic pregnancy.

5.1.5 Gynaecological problem complicating pregnancy.

5.1.6 Medical disorder in early pregnancy.

5.2 If confirmed to be pregnant manage as any other pregnant patient.

5.2.1 Confirm dates.

5.2.2 Infective screening.

(Patient need not be sent back to OSCC once in the ward)

5.3 Police report to be made for all cases aged16 years and below. For those between 17years to 18 years police report is required in cases of alleged rape and sexual abuse only.

5.4 For patients who are pregnant as a result of rape, sexual abuse and incest there is a role for termination of pregnancy if the patient comes in the first trimester and the pregnancy and is affecting the victim, mentally and emotionally.

5.5 If Medical termination of pregnancy has been decided in the best interest of the victim, consent to be given jointly by the O&G and Paediatric Consultant, and this is to be done after discussion with the Child Psychiatrist/Psychiatrist.

5.6 Products of conception are to be handed over to the Police Officer

5.7 in all cases 16 years and below and in those between 17 years to 18 years is alleged rape cases. In all such cases the Police Officer needs to be present at the time of the procedure.

5.8 Contact next of kin where possible.

5.9 Refer to the Medical Social worker and the Social Welfare Department.

5.10 Refer to Adolescent Paediatrician/Paediatrician.

5.11 Patient may require referral to Child Psychiatrist/ Psychiatrist.

5.12 If there is no next of kin, in the event patient requires laprotomy or evacuation of retained products, consent to be given by Specialist in charge/Specialist on call/Child protector.

5.13 Staffs are to be alert and be on the lookout for attempts to abscond and signs of suicidal.

5.14 To make an appointment at antenatal clinic at the time of discharge.

****IMPORTANT POINT TO NOTE**

1. **NOT FOR DISCHARGE** unless seen by Medical Social Worker/Child protector in the gynae ward or in the obstetric ward after delivery.
2. Even if next of kin/legal guardian wants to take the patient home, it **cannot be allowed** until patient is seen by the Medical Social Worker/Child protector.
3. **Only exception for discharge** is if the patient had been seen antenatally by the Medical Social Worker/ Child protector and the well being of the patient and child has been discussed.

GUIDELINES FOR THE MANAGEMENT OF PREGNANT SURVIVORS ABOVE 18 YEARS

1.0 OBJECTIVE OF THIS GUIDELINES

To define responsibilities of doctors in the management of unwed pregnant mothers.

1.1 The doctor's responsibility is

1.1.1 To manage the above group of patients as any other antenatal mother.

1.1.2 To provide antenatal care and subsequent follow up.

1.1.3 To make a decision for Medical termination of pregnancy if warranted.

1.1.4 To refer patients above 18 years to the Medical Social Worker/*Jabatan Kebajikan Masyarakat* (JKM) only if they want to be referred.

1.1.5 For JKM notification (*Borang 9* – ***refer to Appendix 4***) for only babies born to unwed mothers above 18 years.

1.1.6 To refer to the Psychiatrist for psychological support and in drug users for treatment and rehabilitation.

1.1.7 To refer to the Infectious disease team for treatment when required.

1.1.8 To decide if the mother and baby need to be separated if there is a possibility that the baby may be in danger with the mother.

1.1.9 To counseling for cervical smears and contraception.

1.1.10 Maintain confidentiality at all times.

Role of Medical Social Worker

1. To help patients solve their problems which directly or indirectly affect their condition.
2. To help patient and their family in their rehabilitation during confinement and after discharge.
3. Assist in finding shelter for those whose family has disowned them.
4. Assist in finding shelter for battered women.
5. Assist in financial support.
6. Assist in adoption for the unwanted babies

****IMPORTANT POINT TO NOTE**

1. **Patient can be discharged** without being seen by the Medical Social Worker.

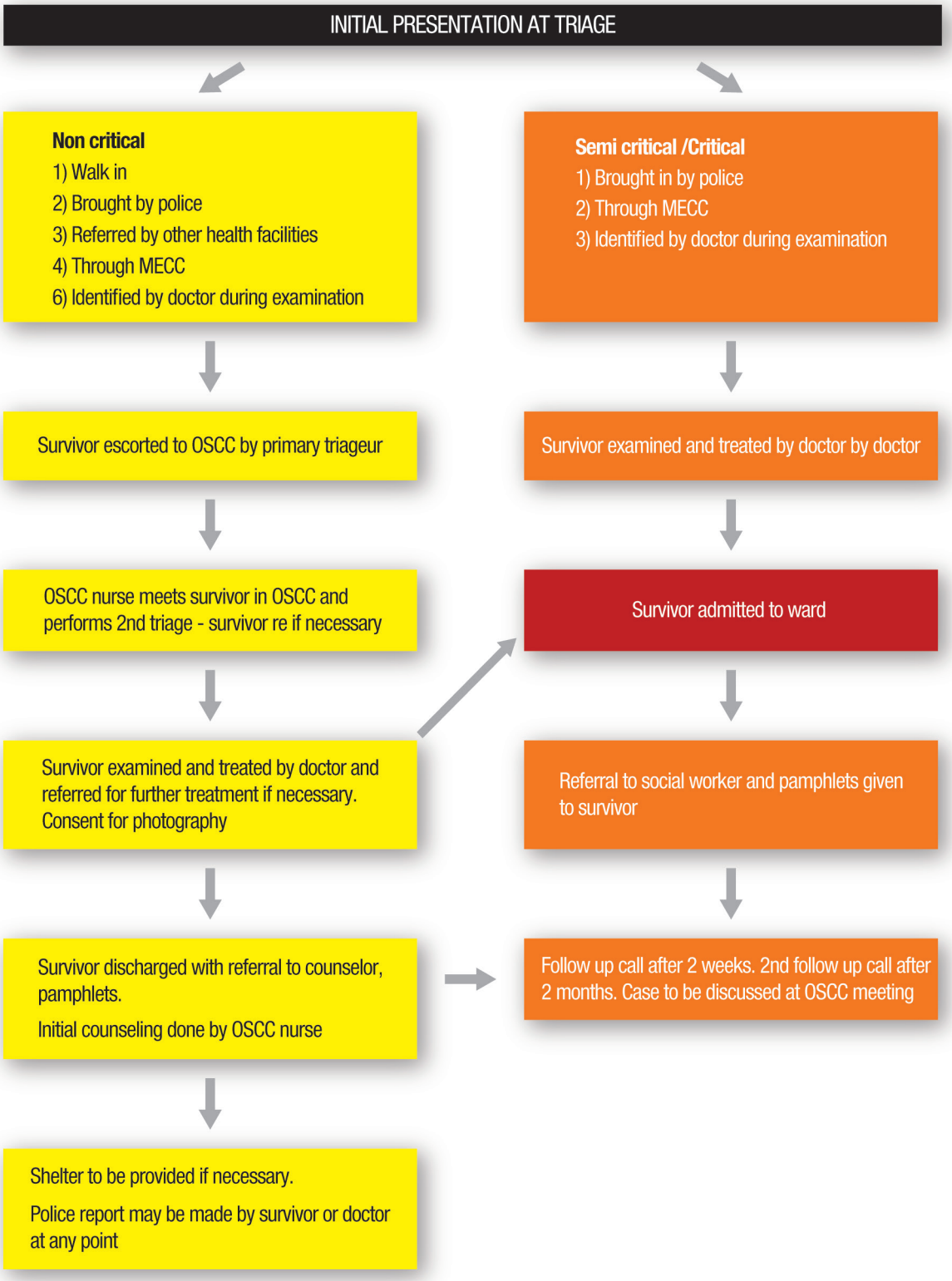
2. **Baby must be seen by the Medical Social Worker/Child protector before discharge.**

3. Problems may arise after office hours and during weekends when Medical Social Workers are not on call. Even if the Specialist on call / Medical Officer has the slightest doubt with regards to the well being of the baby, then the baby shall be admitted to the Paediatric ward after consultation with the Paediatrician on call, but the mother can be allowed to be discharged.

4. **Only exception for discharge** with the baby is if the patient had been seen by the Medical Social Worker and assessment has been done and the well being of the child has been discussed.

APPENDIX 10

Flow Chart : Survivor flow for Domestic Violence



CLINICAL FORENSIC EXAMINATION FORM FOR ALLEGED SEXUAL ASSAULT

POLICE REPORT NO.:

Police report no:

GENERAL INFORMATION:

Place of Examination : _____

Date of Examination : _____ Time of Examination : _____

Hospital R/N:	OSCC R/N:	Gynae R/N:
Patient's Name (As in I/C / Passport / Birth Cert):		
I/C No. / Passport No. / Birth Cert No. :		
Date of Birth:	Age (base on DOB):	Sex:
Ethnicity:	Religion:	
Occupation:	Marital status: (If yes, state out the number of children)	
Address: Contact no:		
Name of Doctor (General Examination):	Name of Doctor (Specific Examination):	
Designation:	Designation:	
I/C no:	I/C no:	
Name of Assisting Medical Staff:	Name of Assisting Medical Staff:	
I/C no:	I/C no:	

Police Report No.:	Police Station:
Name of Police Officer:	Rank No.:
Name of other person(s) present during consultation (and relationship or designation):	

Delete where applicable

CONFIDENTIAL

Police report no:

CONSENT FORM FOR MEDICAL CONSULTATION

I ……I/C No. …… have been informed and explained by Dr…….. I/C No. …… Designation…… on the details of the forensic medical examination and evidence collection. I understand and agree that the findings and evidence collected will be released to the police and will be used in court.

I hereby consent to the following procedures to be conducted on myself / my son / my daughter / the named person ……(I/C / Passport / Birth cert no:……..)

(Mark each and that applies)

Physical examination of my/his/her body	
Physical examination of the genitalia and/or anus of mine/him/hers	
Collection of specimen from my/his/her body	
Collection of specimen from the genitalia and/or anus of mine/him/hers	
Photography of any findings on my/his/her body	
Photography of any findings on the genitalia and/or anus of mine/him/hers	
Treatment of any identified medical conditions	

Patient's/Parent's/Guardian's/Protector's Signature or fingerprint:

Name:
Date:

Witness's signature:

Name:
Date:

Delete where applicable

CONFIDENTIAL

Police report no:

SURAT KEBENARAN UNTUK MENERIMA KHIDMAT NASIHAT PERUBATAN

Saya ……..

(nombor I/C:……) telah dimaklum dan diterangkan oleh Dr.……yang berjawatan ……. dengan nombor I/C…… berkenaan dengan penjelasan pemeriksaan perubatan forensik dan pengumpulan bahan bukti. Saya faham dan setuju bahawa sebarang hasil pemeriksaan dan bahan bukti yang dikutip akan diberi kepada pihak polis untuk digunakan dalam mahkamah nanti.

Saya di sini memberi kebenaran supaya prosedur-prosedur berikut dijalani ke atas saya sendiri / anak lelaki saya / anak perempuan saya / orang yang bernama ……..(No I/C / Passport / Sijil Kelahiran: ……)

(Tandakan pada yang berkenaan):

Pemeriksaan fizikal pada tubuh badan saya/penama	
Pemeriksaan fizikal pada bahagian genital dan/atau dubur saya/penama	
Pengumpulan spesimen dari badan saya/penama	
Pengumpulan spesimen dari bahagian genital dan/atau dubur saya/penama	
Pengambilan foto pada sebarang hasil pemeriksaan yang dijumpai pada tubuh badan saya/penama	
Pengambilan foto pada sebarang hasil pemeriksaan yang dijumpai pada bahagian genital dan/atau dubur saya/penama	
Penerimaan rawatan jika dirasa perlu dari aspek perubatan	

Tandatangan/cap jari pesakit/ibubapa pesakit/penjaga pesakit/pelindung pesakit:

Nama:
Tarikh:

Tandatangan saksi:

Nama:
Tarikh:

Delete where applicable

CONFIDENTIAL

Police report no:

1. HISTORY OF THE INCIDENT

The following should be noted regarding the alleged assault:

1.1	Time and date of the incident (No need to insist on the accurate time and date):
1.2	Location of the incident: Hotel / House / Car / Outdoor / Others: (The exact address of the incident is not necessary) (specify……)
1.3	Circumstances that led to the incident …… …… …… …… …… ……
1.4	If force/violence used: Yes/No Type of force used: blows / slaps / punch / kicks / strangulation / weapons
	Was any weapon used by the assailant: Yes/No Type of weapon used: gun/sharp/blunt instrument/pointed instrument/ others (specify ……)
	Did the patient put up resistance: Yes/No
	Was the patient restrained Yes/No
1.5	Were any drugs used: Yes/No (specify ……)
1.6	Was any alcohol used: Yes/No (specify ……)

Delete where applicable

CONFIDENTIAL

Police report no:

1.7	Identity of the assailant:	
	How many assailants? ……	
	Is the assailant known to the patient	Yes/No
	Ethnic :Malay / Chinese / Indian / Others (specify: ……)	
	Relation: Father / Step Father / Brother / Cousin / Others (specify: ……)	
	Friend: Boyfriend/Co-worker/Neighbour/Others (specify: ……)	
	Stranger: (specify: ……)	
1.8	Details of the act	
	Type of sexual act:	
	Oral : penetration attempted/completed:	Yes/No/Uncertain
	Vagina : penetration attempted/completed:	Yes/No/Uncertain
	Anal : penetration attempted/completed:	Yes/No/Uncertain
	If no penetration describe what had happened	
	……	
	……	
	What was used:	
	Finger : penetration attempted/completed	Yes/No/Uncertain
	Penis : penetration attempted/completed	Yes/No/Uncertain
	Other objects	Yes/No/Uncertain
	(specify ……)	
	Condoms used	Yes/No/Uncertain
	Lubricants used	Yes/No/Uncertain
	Did the patient experience any pain?	Yes/No
	Was there any bleeding?	Yes/No
	Other symptoms	
	……	

Delete where applicable

CONFIDENTIAL

Police report no:

1.9	History of Events after the incident: **Ask the patient the following questions.** Changed clothes after the incident: Yes/No Washed mouth Yes/No Wiped/washed his/her body Yes/No Had a bath since the incident Yes/No Has the patient defaecated Yes/No Has the patient urinate after the incident Yes/No Has the patient been seen by a doctor Yes/No (specify .....) Did the doctor gave her treatment: Yes/No (specify .....)		
1.10	Menstrual History		
	Menarche:	Cycle: .....regular/irregular	Flow: .....days
	Interval:	LMP:	
1.11	Obstetric History		
	Parity:	Duration of marriage:	
	Abortion:	Date of last child birth:	
1.12	Contraception Yes/No Method: Safe period /Barrier / Pills / IUCD / Sterilization / Other (specify:.....)		
1.13	Sexual History Past experience of sexual intercourse Yes/No Previous masturbation: Yes/No Date of last intercourse:		

Delete where applicable **CONFIDENTIAL**

Police report no:

1.14	Medical History	
	On any medication:	Yes/No
	Specify: …….....	
	Drug Abuse:	Yes/No
	Specify: …….....	
	Alcohol:	Yes/No
	Immunization History (If a child)	Complete/Not complete/Not applicable
	Specify: …….....	
	Last Toxoid /ATT date:	
	Specify: …….....	
1.15	Surgical History	Yes/No
	Specify: …….....	
	Any past surgical procedures of the genitalia?	Yes/No
	Any past surgical procedures of the anus?	Yes/No
1.16	Developmental History (If a child)	

Delete where applicable

CONFIDENTIAL

Police report no:

2. PHYSICAL EXAMINATION

(Record all findings using diagrams and consecutive numbering system)

2.1 Person/s present during the examination
(Only the chaperone or assisting nurse and/or one of the guardian/protector)

Name	I/C no.	Relationship

2.2 General Appearance
(Describe intellect, physique, demeanor, emotional state)

2.3 Vital Signs

Blood Pressure:	Pulse:	Resp:
Temp:	Pupils:	

2.4 Clothing

Wearing the same clothes Yes/No

(Examine and describe, if the same clothing worn during the assault or brought separately. Look for stains, tears, foreign materials etc)

(Ask patient to stand on the paper sheet while undressing)

Collect clothes if indicated Indicated/Not indicated

(Collect outer and undergarments separately in separate bags, labeled separately)

Delete where applicable **CONFIDENTIAL**

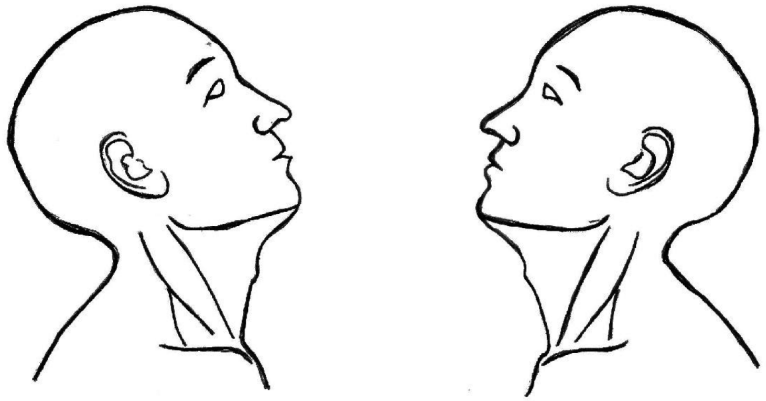
Police report no:

2.5	Body System examination Examine the entire body and collect stains, secretions and foreign materials from the body. (Place notes here and chart the location on body charts)	
	Ear/Nose/Throat	
	Lungs	
	Cardiovascular system	
	Breast (Assess the stage of development)	
	Abdomen	
	Evidence of previous pregnancy (Describe the findings)	Yes/No
	Evidence of present pregnancy (Describe the findings)	Yes/No
	Axillary hair	Present/Absent
	Pubic hair (Assess the stage of development)	Present/Absent
2.6	Secondary sexual characteristics (Tanner Stage Classification) (Describe development and staging here)	
2.7	External injuries Record all findings and injuries (place notes here; all injuries found must be described in detail, location, type, measurements, severity use body charts for diagrams) Injuries	Present/Absent

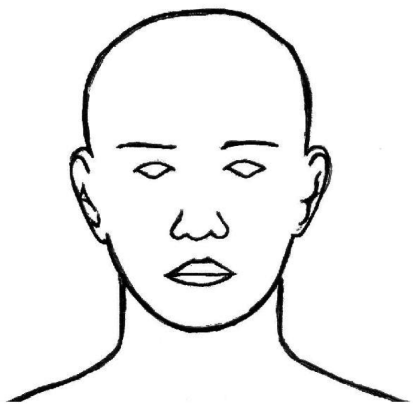
Delete where applicable

CONFIDENTIAL

Police report no:



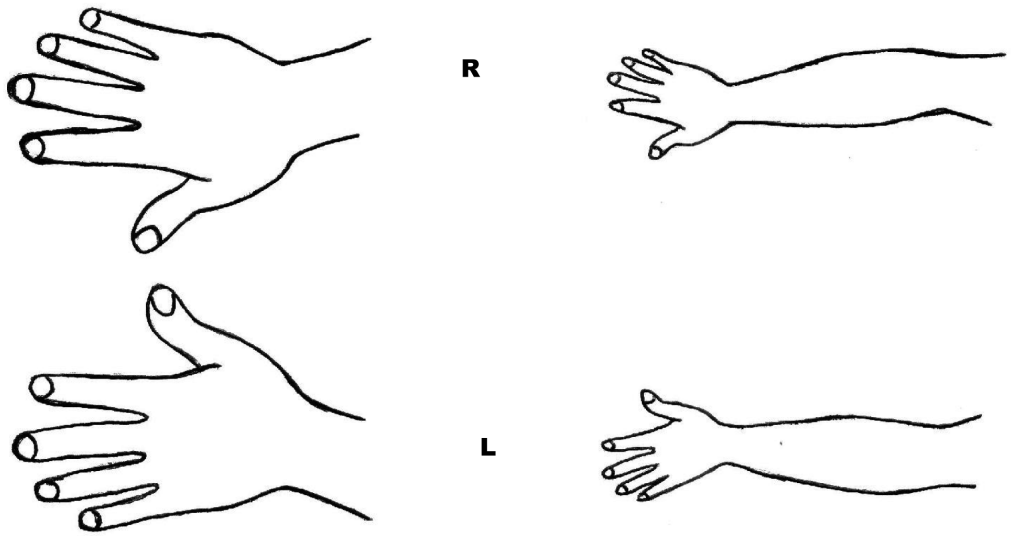
Right **Left**

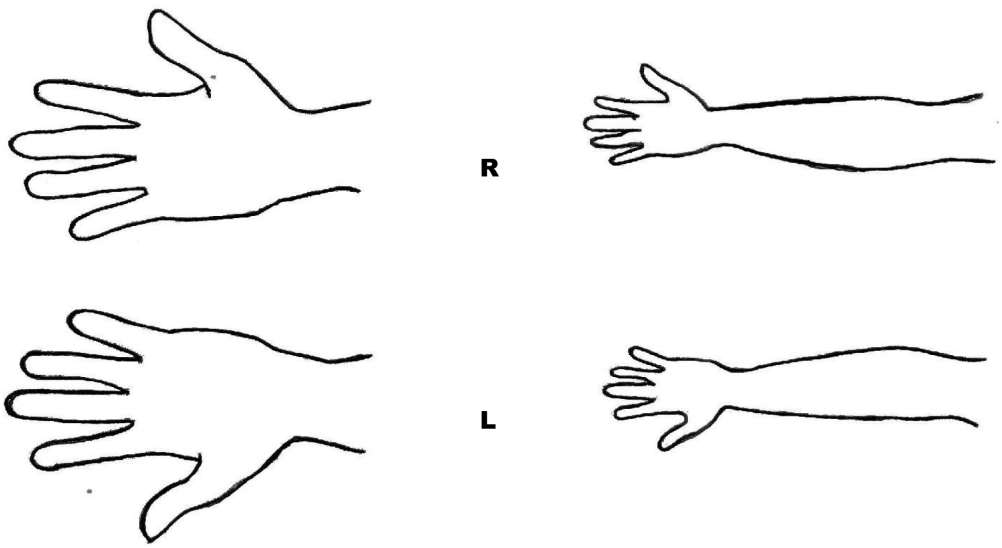


Delete where applicable

CONFIDENTIAL

Police report no:





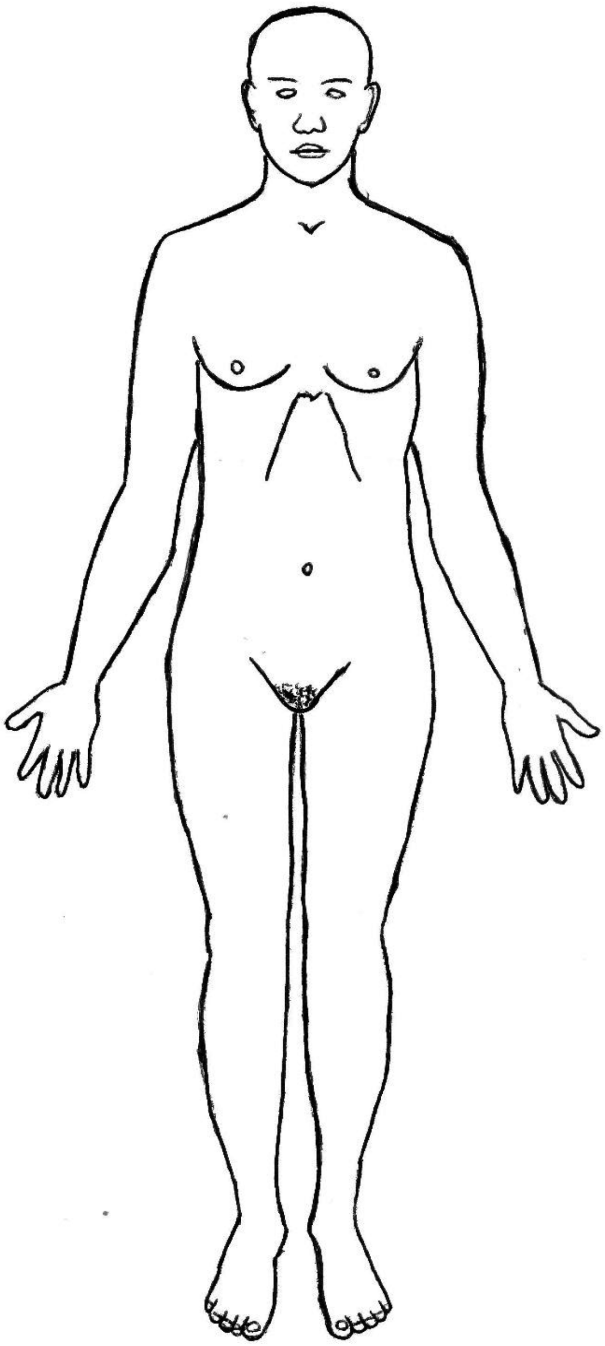
Delete where applicable

CONFIDENTIAL

Police report no:

Female

Right **Left**



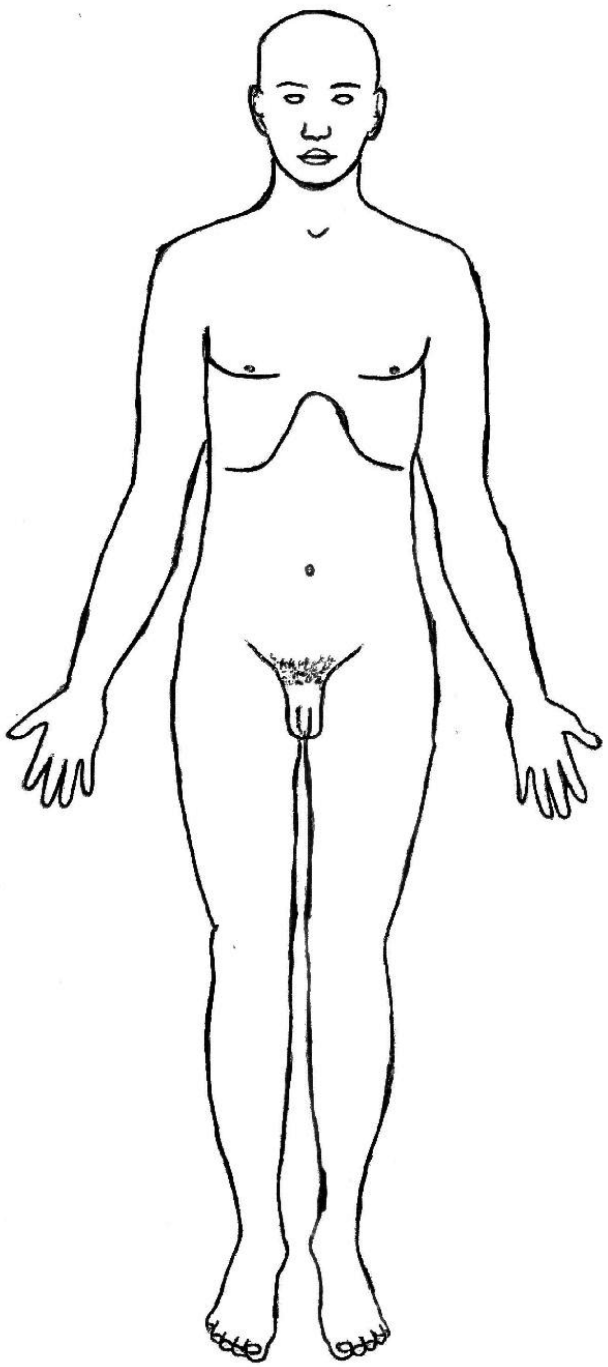
Delete where applicable

CONFIDENTIAL

Police report no:

Male

Right **Left**

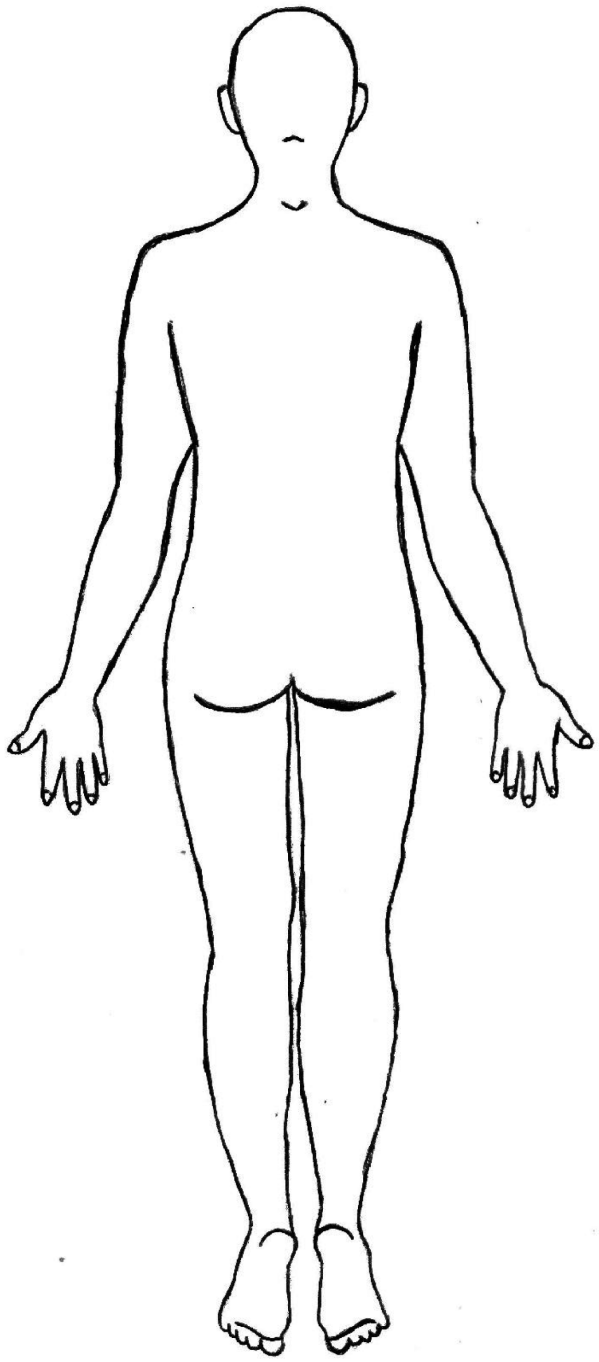


Delete where applicable

CONFIDENTIAL

Police report no:

Left **Right**

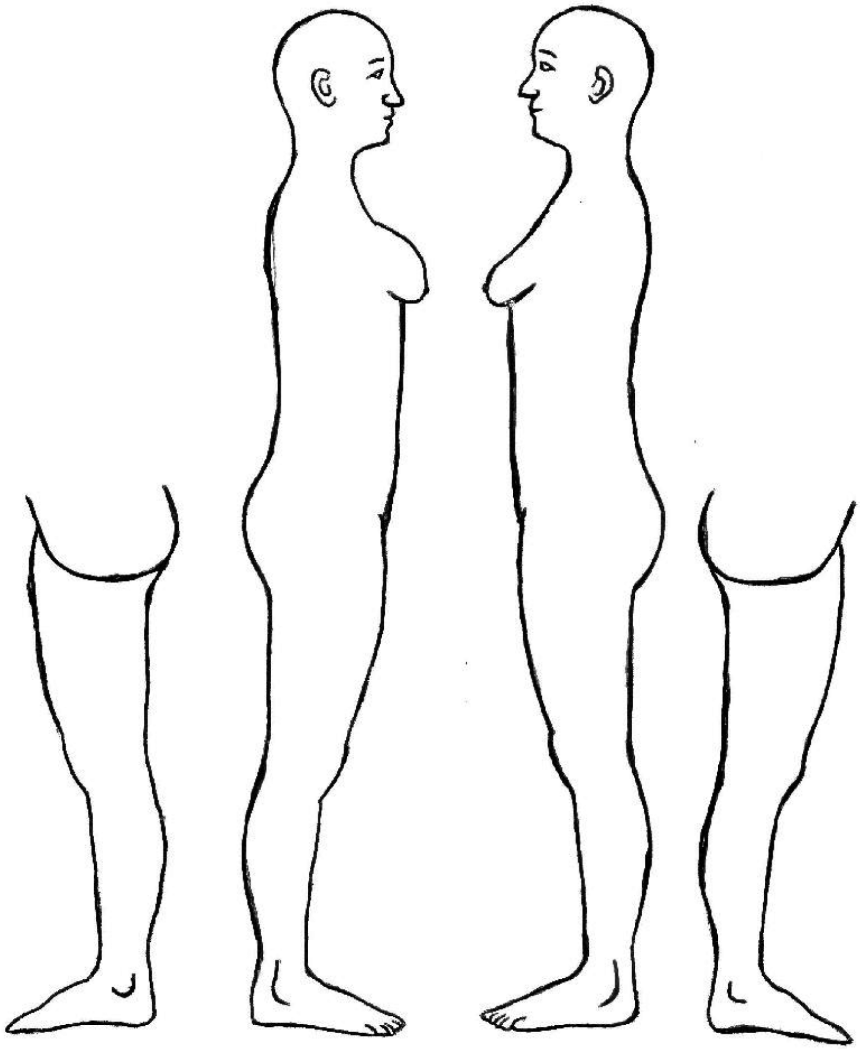


Delete where applicable

CONFIDENTIAL

Police report no:

Female

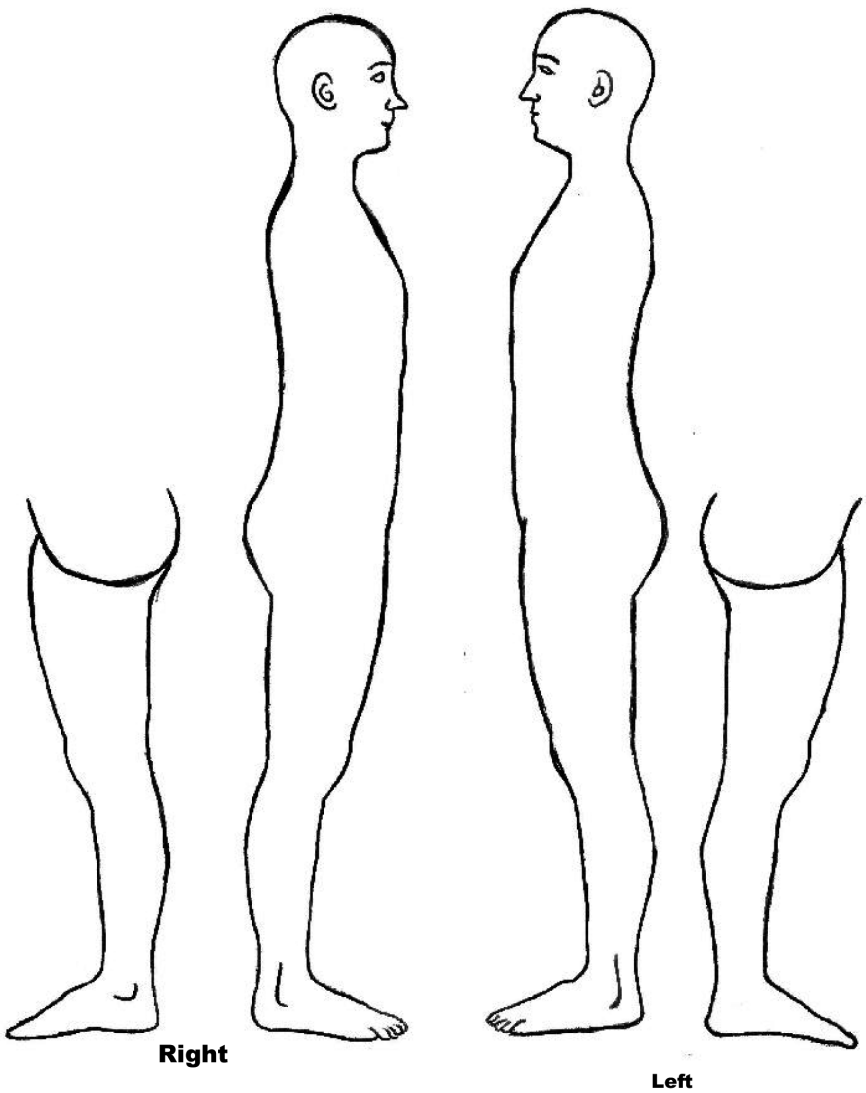


Delete where applicable

CONFIDENTIAL

Police report no

Male



Delete where applicable

CONFIDENTIAL

Police report no:

Initial History and examination done by :

Name of Dr ……..

Signature :

Time:
Date:

Reminder on Further instructions:

1. If any forensic samples are taken please refer to Section 5.0 Collection of forensic samples to be filled in appropriately.
2. Any treatment given to patient please fill up Section 4.0 Treatment and Aftercare
3. Case referred to other appropriate specialties, to state the specialty and the name of Dr referred to. (Section 4.6)

Delete where applicable **CONFIDENTIAL**

Police report no:

3. Case of alleged rape/molest to be seen by Gynaecology team

Name of Doctor (Gynae Examination): 1.	Name of Doctor (Gynae Examination): 2.
Designation:	Designation:
I/C no:	I/C no:

Please note what the patient/guardian has consented for initially and kindly ensure before your examination of patient, the appropriate explanation and counseling is given to the patient first.

If further consent is needed for any other specific procedures, kindly obtain written consent below before proceeding.

CONSENT FORM FOR MEDICAL CONSULTATION

I ……

(I/C No. ……..) have been informed and explained by Dr ……..

I/C No: ……Designation…… on the details of the forensic medical examination and evidence collection. I understand and agree that the findings and evidence collected will be released to the police and will be used in court.

I hereby consent to the following procedures:…….. to be conducted on myself / my son / my daughter / the named person…….. (I/C / Passport / Birth cert no:……..)

Patient's/Parent's/Guardian's/Protector's Signature or fingerprint:

Name: Date:

Witness's signature:

Name: Date:

Delete where applicable

CONFIDENTIAL

Police report no:

SURAT KEBENARAN UNTUK MENERIMA KHIDMAT NASIHAT PERUBATAN

Saya……
(nombor I/C:……) telah dimaklum dan diterangkan oleh Dr…… yang berjawatan ..... dengan nombor I/C…… berkenaan dengan penjelasan pemeriksaan perubatan forensik dan pengumpulan bahan bukti. Saya faham dan setuju bahawa sebarang hasil pemeriksaan dan bahan bukti yang dikutip akan diberi kepada pihak polis untuk digunakan dalam mahkamah nanti.

Saya di sini memberi kebenaran supaya prosedur-prosedur : ..... berikut dijalani ke atas saya sendiri / anak lelaki saya / anak perempuan saya / orang yang bernama ……
(No I/C / Passport / Sijil Kelahiran: …….).

Tandatangan/cap jari pesakit/ibubapa pesakit/penjaga pesakit/pelindung pesakit:

Nama:
Tarikh:

Tandatangan saksi:

Nama:
Tarikh:

Any further relevant clinical history / details / notes to be added :

……
……
……
……
……

Delete where applicable

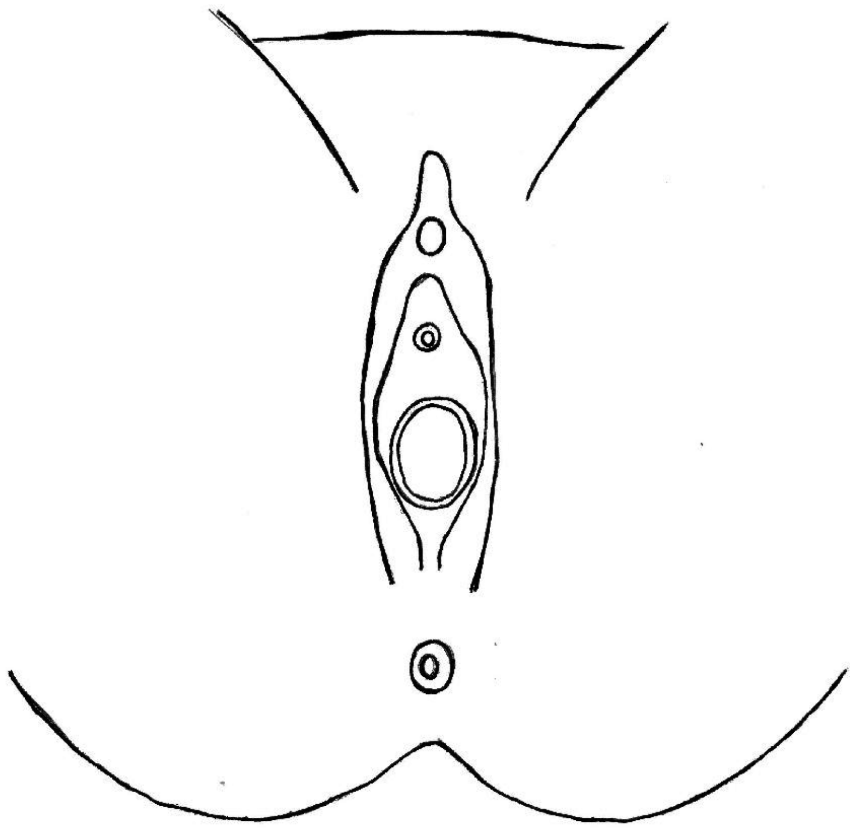
CONFIDENTIAL

Police report no:

3.1	<u>Genito-anal Examination (Female)</u> Record all findings and injuries (place notes here; all injuries found must be described in detail, location, type, measurements, severity. Use body charts for diagrams. Use Specimen Collection Pack for collection of samples from these areas)

3.1.1 Inner thigh, external genitalia and perineal area. Findings present/No findings

Right **Left**



Delete where applicable **CONFIDENTIAL**

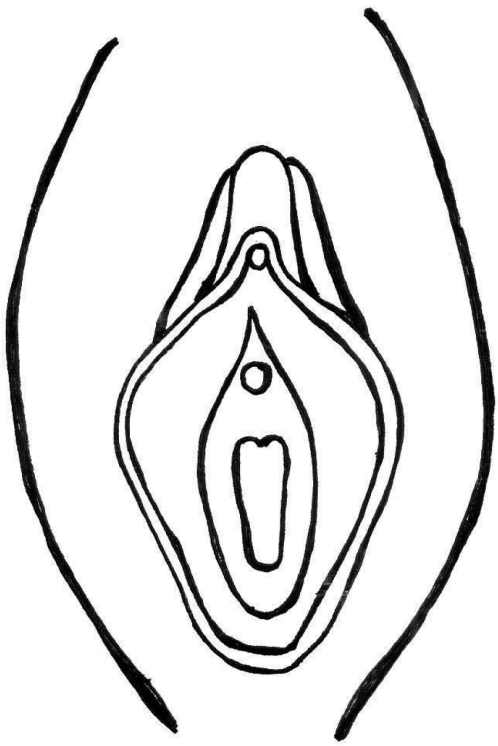
Police report no:

3.1.2 Examine the vulva, hymen and vagina.

(External and/or Colposcope examination, Use Specimen Collection Pack for collection of vaginal swabs where indicated)

Findings Present/No findings

Right **Left**



Delete where applicable **CONFIDENTIAL**

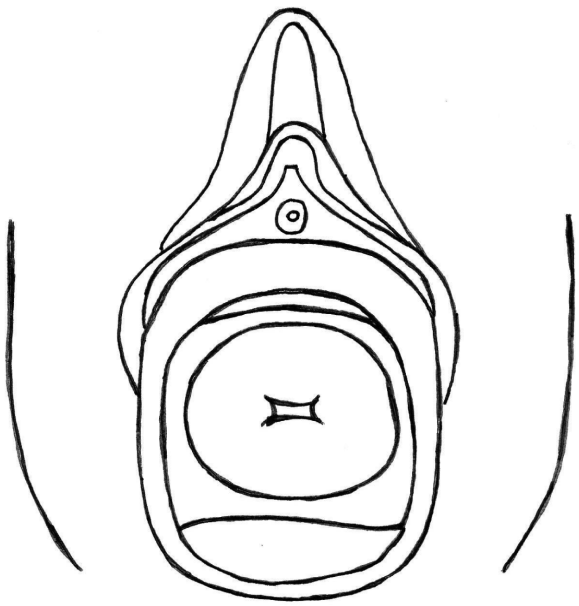
Police report no:

3.2	Vaginal speculum examination (Female) If hymen intact, do not proceed with speculum examination, use Specimen Collection Pack for samples from these areas)

3.2.1 Vaginal speculum examination — Indicated/Not indicated

Findings — Present/No findings

Right **Left**



Delete where applicable

CONFIDENTIAL

Police report no:

3.3 Collection of medicolegal samples in acute cases will include:
- Swabs from the vulva (please fill Section 8.11) and vagina (please fill Section 8.12)
- Urine samples for UPT, UFEME and C&S (please fill Section 8.15)

Any other samples taken also to be recorded in Section 8

3.4 Treatment given to patient :

……
……
……

3.5 Examiner's findings:

3.5.1	Are there any body injuries?	Yes / No
	3.5.1.1 Do these injuries indicate force has been used on patient?	Yes / No
	3.5.1.2 Are these signs of violence applied to the patient?	Yes / No
	3.5.1.3 Are there defense injuries?	Yes / No
	3.5.1.4 Are they signs of restraint?	Yes / No
3.5.2	Can you specify the type of violence used? Specify: …… …… (Indicate whether this is strangulation, blunt trauma sharp weapon, gun shot injuries or combination)	Yes / No
3.5.3	Are there any genital injuries?	Yes / No
3.5.4	Do the genital injuries indicate 3.5.4.1 Signs of blunt object penetration of the vagina?	Yes / No
	3.5.4.2 Are they acute injuries?	Acute/Non acute/Both
3.5.5	Is the history given consistent with examination findings?	Yes / No
3.5.6	Are there any signs of abuse/torture?	Yes / No
3.5.7	Does the patient's physique correspond with his/her age?	Yes / No
3.5.8	Are there any mental abnormalities? Specify: …… ……	Yes / No
3.5.9	Is the patient mentally retarded? Specify: …… ……	Yes / No

Delete where applicable

CONFIDENTIAL

Police report no:

3.5.10	Are there any signs of intoxication? Specify:…… ……	Yes / No

Delete where applicable

3.6. PRELIMINARY REPORT TO THE POLICE

(The doctor when asked to, will now give a brief preliminary report to the police to assist with their investigations. Answers to the above questions, not necessarily all, are sufficient at this stage.}

Is the report:	Verbal / Written

The report given should be attached to this form.

Name of doctor who gave the report	1.
	2.
	3.
	4.
	5.
Name of Police Officer:	
Rank No./Police Station:	
Date of report:	

Delete where applicable **CONFIDENTIAL**

Police report no:

4. Case of alleged sodomy to be seen by Surgical team

Name of Doctor (Genito-anal Examination): 1.	Name of Doctor (Genito-anal Examination): 2.
Designation:	Designation:
I/C no:	I/C no:

Please note what the patient/guardian has consented for initially and kindly ensure before your examination of patient, the appropriate explanation and counseling is given to the patient first.

If further consent is needed for any other specific procedures, kindly obtain written consent below before proceeding.

CONSENT FORM FOR MEDICAL CONSULTATION

I …….

(I/C No. ……..) have been informed and explained by Dr…… I/C No. …….. Designation…… on the details of the forensic medical examination and evidence collection. I understand and agree that the findings and evidence collected will be released to the police and will be used in court.

I hereby consent to the following procedures:…….. to be conducted on myself / my son / my daughter / the named person

……. (I/C / Passport / Birth cert no:……..)

Patient's/Parent's/Guardian's/Protector's Signature or fingerprint:

Name: Date:

Witness's signature:

Name: Date:

Delete where applicable

CONFIDENTIAL

Police report no:

SURAT KEBENARAN UNTUK MENERIMA KHIDMAT NASIHAT PERUBATAN

Saya
……..

(nombor I/C:……) telah dimaklum dan diterangkan oleh Dr……yang berjawatan

…….. dengan nombor I/C…… berkenaan dengan penjelasan pemeriksaan perubatan forensik dan pengumpulan bahan bukti. Saya faham dan setuju bahawa sebarang hasil pemeriksaan dan bahan bukti yang dikutip akan diberi kepada pihak polis untuk digunakan dalam mahkamah nanti.

Saya di sini memberi kebenaran supaya prosedur-prosedur :

..... berikut dijalani ke atas saya sendiri / anak lelaki saya / anak perempuan saya / orang yang bernama

……
……

(No I/C / Passport / Sijil Kelahiran:……).

Tandatangan/cap jari pesakit/ibubapa pesakit/penjaga pesakit/pelindung pesakit:

Nama:
Tarikh:

Tandatangan saksi:

Nama:
Tarikh:

Any further relevant clinical history / details / notes to be added :

……
……
……
……

Delete where applicable

CONFIDENTIAL

Police report no:

SURAT KEBENARAN UNTUK MENERIMA KHIDMAT NASIHAT PERUBATAN

Saya
……..

(nombor I/C:……) telah dimaklum dan diterangkan oleh Dr……yang berjawatan

…….. dengan nombor I/C…… berkenaan dengan penjelasan pemeriksaan perubatan forensik dan pengumpulan bahan bukti. Saya faham dan setuju bahawa sebarang hasil pemeriksaan dan bahan bukti yang dikutip akan diberi kepada pihak polis untuk digunakan dalam mahkamah nanti.

Saya di sini memberi kebenaran supaya prosedur-prosedur :

..... berikut dijalani ke atas saya sendiri / anak lelaki saya / anak perempuan saya / orang yang bernama

……
……

(No I/C / Passport / Sijil Kelahiran:…….).

Tandatangan/cap jari pesakit/ibubapa pesakit/penjaga pesakit/pelindung pesakit:

Nama:
Tarikh:

Tandatangan saksi:

Nama:
Tarikh:

Any further relevant clinical history / details / notes to be added :

……
……
……
……

Delete where applicable

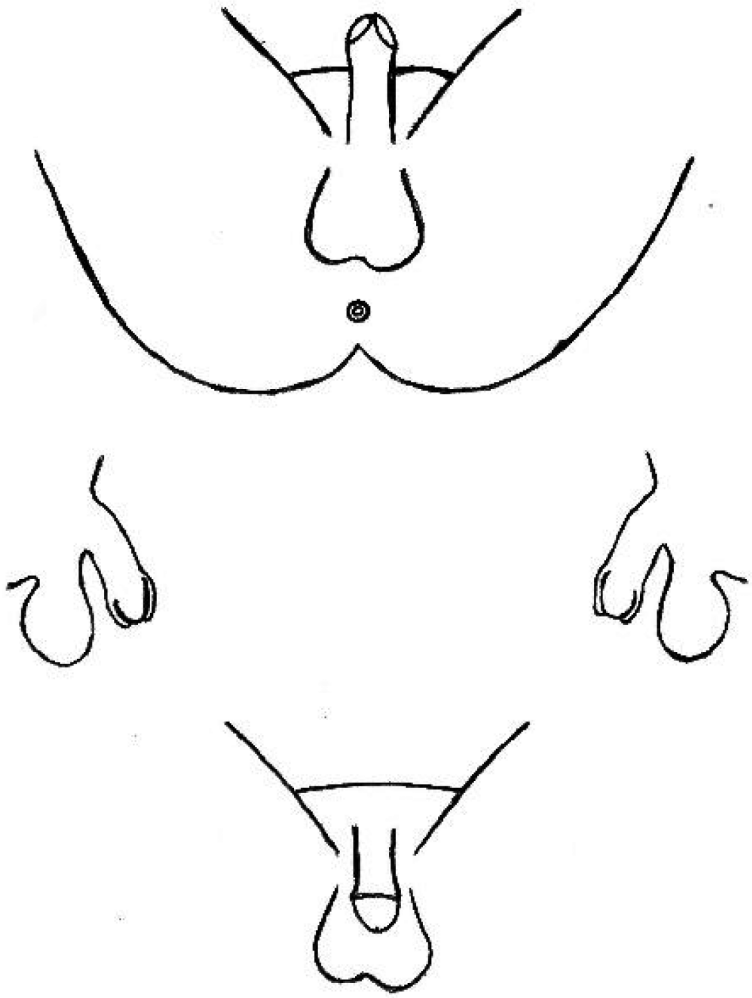
CONFIDENTIAL

Police report no:

4.1	<u>Genito-anal Examination</u> Record all findings and injuries (place notes here; all injuries found must be described in detail, location, type, measurements, severity use body charts for diagrams, Use Swab Collection Pack for collection of samples from these areas)

4.1.1. Inner thigh, external genitalia and perineal area. Findings present/No findings

Right **Left**

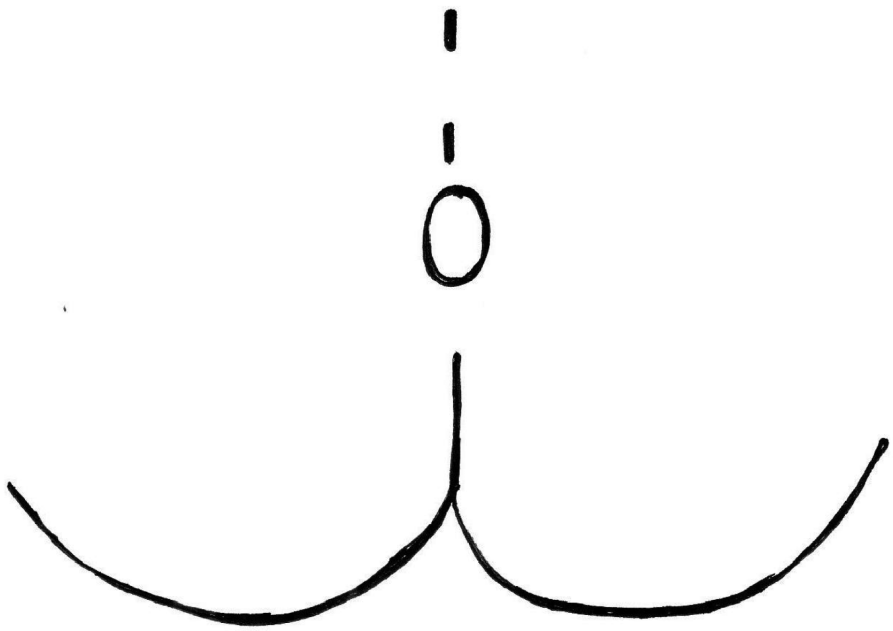


Delete where applicable **CONFIDENTIAL**

Police report no:

4.2.	Anal examination (if indicated in the history) (Use anoscope/proctoscope if indicated, use Swab Collection Pack for collection of samples from this area) Injuries Present/no findings

Right **Left**



Delete where applicable **CONFIDENTIAL**

Police report no:

4.3. Rectal examination
Anus/Anal Canal

4.3.1	Anus/Anal Canal	
	4.3.1.1 Are there any scratches?	Yes / No
	4.3.1.2 Are there any muscle tears?	Yes / No
	4.3.1.3 Is there any faecal staining on buttocks?	Yes / No
	4.3.1.4 is there any swelling?	Yes / No

4.3.2	Anal sphincter	
	4.3.2.1. Muscle tone	Good/Loose

4.4 Collection of medicolegal samples in acute cases will include swabs from the anus (please fill in Section 8).
Any other samples taken also to be recorded in Section 8

4.5 Treatment given to patient :
……
……
……
……
……

4.6 Examiner's findings

4.6.1	Are there any body injuries?	Yes / No
	3.1.1 Do these injuries indicate force has been used on patient?	Yes / No
	3.1.4 Are these signs of violence applied to the patient?	Yes / No
	3.1.3 Are there defense injuries?	Yes / No
	3.1.4 Are they signs of restraint?	Yes / No
4.6.2	Can you specify the type of violence used? Specify: …… …… (Indicate whether this is strangulation, blunt trauma sharp weapon, gun shot injuries or combination)	Yes / No
4.6.3	Are there any genital injuries?	Yes / No

Delete where applicable

CONFIDENTIAL

Police Report No.:

4.6.4	Do the genital injuries indicate 3.4.1 Signs of blunt trauma?	Yes / No
	3.4.2 Are they acute injuries?	Acute/Non acute/Both
4.6.5	Are there any anal injuries?	Yes / No
4.6.6	Do the anal injuries indicate 3.6.1 Signs of blunt object penetration into the anus?	Yes / No
	3.6.2 Are they acute injuries?	Acute/Non acute/Both
4.6.7	Is the history given consistent with examination findings?	Yes / No
4.6.8	Are there any signs of abuse/torture?	Yes / No
4.6.9	Does the patient's physique correspond with his/her age?	Yes / No
4.6.10	Are there any mental abnormalities? Specify: …… ……	Yes / No
4.6.11	Is the patient mentally retarded? Specify: …… ……	Yes / No
4.6.12	Are there any signs of intoxication? Specify:…… ……	Yes / No

Delete where applicable

CONFIDENTIAL

Police Report No.:

4.7 PRELIMINARY REPORT TO THE POLICE

(The doctor will now give a brief preliminary report to the police to assist with their investigations. Answers to the above questions, not necessarily all, are sufficient at this stage.}

Is the report:	Verbal / Written

The report given should be attached to this form.

Name of doctor who gave the report	1.
	2.
	3.
	4.
	5.
Name of Police Officer:	
Rank No./Police Station:	
Date of report:	

Delete where applicable

CONFIDENTIAL

Police report no:

5. RESULTS OF ALL AVAILABLE LABORATORY INVESTIGATIONS

All results must be attached to this page.

Delete where applicable

CONFIDENTIAL

Police report no:

6. FULL MEDICAL REPORT

(Based on history, physical finding and laboratory investigations)

Once the laboratory results are available the doctor should submit the full medical report.

Name of the doctor who wrote the medical report:	
Designation of the doctor:	
Date of report:	

The report must be attached to this section.

Delete where applicable **CONFIDENTIAL**

Police report no:

7. TREATMENT AND AFTER CARE

	Treatment and medication Specify:
	Antibiotics given Specify:
	STD prophylaxis/treatment given Specify:
	Contraception prescribed Specify:
	Immunization (ATT or Hep.B) Specify:
	Referral to appropriate specialist (Gynaecologist, Paeditrician, Psychiatrist/ surgeon etc)
	Referral to Counselors
	Referral to Welfare Department
	In sexual assaults and domestic violence, Referral to WCC

Delete where applicable **CONFIDENTIAL**

Police report no:

8. COLLECTION OF FORENSIC SAMPLES

8.1	**Collection of clothes (Use Physical Evidence Pack)** **Indicated / Not indicated**			
	No.	Type of clothes		
8.2	**Collection of foreign materials and/or swabs from the body** **Indicated / Not indicated** (Use Physical Evidence Pack)			
	No.	Location	Nature of items	No. of swabs/items
	Finger nails **Indicated / Not indicated** (Use Physical Evidence Pack)			
	Right Finger nails	Nail Scrapings/ Cut Fingernails/ Not taken		
	Left Finger nails	Nail Scrapings/ Cut Fingernails/ Not taken		
8.4	**Collect head hair combings** (Use Physical Evidence Pack) **Indicated / Not indicated** (Place a piece of paper on the desk and comb from behind and forward with the head leaning forward)			
	Hair combings	Taken/ Not taken		
8.5	**Plucked/cut head hair** **Indicated / Not indicated**			
	Plucked/cut head hair	Taken/ Not taken		
8.6	**Collect 3 swabs from oral cavity** **Indicated / Not indicated**			
	No.	Location	Analysis requested	

8.7	**Pubic hair combings** **Indicated / Not indicated** (any matted hair or dried suspected semen should be cut and collected)	
	Pubic hair combings	Taken/ Not taken
8.8	**Pubic hairs cuttings** **Indicated / Not indicated** (pubic hairs should be cut and collected)	
	Pubic hair cuttings	Taken/ Not taken

Delete where applicable

CONFIDENTIAL

Police report no:

8.9	**Collection of samples from the genitalia and anus** (Use the Specimen Collection pack)		**Indicated / Not indicated**
8.10	**Swabs from the penis** (take 3 swabs from the glands, prepuce and shaft – external swabs, 1 microbiology, 2 DNA) inner part of the vulva – external swabs, 1 microbiology, 2 DNA)		**Indicated / Not indicated**
	No.	Analyses required	Laboratory
8.11	**Swabs from the vulva** (take 2 swabs from LVS (DNA)		**Indicated / Not indicated**
	No.	Analyses required	Laboratory
8.12	**Collection of samples from the vagina** (Use the Specimen Collection Pack when conducting speculum examination) (2 swabs from cervical introitus for semen(DNA), 2 swabs from posterior fornix for semen (DNA), 2 swabs from cervical introitus for bacteriological examination, 2 swabs from posterior fornix for bacteriological examination)		**Indicated / Not indicated**
	No.	Analyses required	Laboratory
8.13	**Collection of samples from the external anus** **(3 external swabs – 1 microbiology, 2 DNA)**		**Indicated / Not indicated**
8.14	**Collection of samples from the internal anus** (With/without anoscopes. 3 internal swabs, 1 microbiology, 2 DNA)		**Indicated / Not indicated**
	No.	Analyses required	Laboratory

Delete where applicable

CONFIDENTIAL

Police report no:

8.15	**Collection of Blood and Urine samples**		
	Sampling for alcohol and toxicology analyses (Use Toxicology Pack) **Indicated / Not indicated** (Blood samples for alcohol in NaF container and blood for toxicology in plain container, 1 urine sample)		
	No.	Analyses required	Laboratory
	Reference Samples for DNA analyses (Use Blood DNA Pack) **Indicated / Not indicated** (Blood for DNA in FTA Card and/or Blood Grouping in EDTA containers)		
	No.	Analyses required	Laboratory
	Samples for Baseline UPT and STI **Indicated / Not indicated** (Serum for HIV, VDRL, Hepatitis B & C in Plain containers, 3 Urine samples for C&S and UFEME and UPT)		
	No.	Analyses required	Laboratory

Total No of Samples	**No. of Samples to the Chemistry Department Laboratory**	**No. of Samples to the Hospital Forensic Medicine/Pathology Laboratory**

All samples handed over to Police Officer name :……

Rank No :……

Police station :……

Delete where applicable

CONFIDENTIAL

Police report no:

9. FOLLOW UP IN HOSPITAL

First follow up visit : _____

Date : _____

Name of doctor : _____

I/C No. : _____

Designation : _____

History :

LMP :

Any vaginal discharge? Yes/No

Any pregnancy symptoms? Yes/No

Any psychological symptoms noted? Yes/No

Clinical Examination :

Repeat Investigations:

Urine Pregnancy Test	
Urine Culture	
Blood HIV	
Blood Hepatitis B	
Blood VDRL	
Others (specify)	

Referral:

Name of clinic : _____

Date and time : _____

Delete where applicable

CONFIDENTIAL

OSCC FORENSIC EXAMINATION KIT

The kit is presented in a bag containing the following items:

1. **1 Copy of Medical Examination guidelines**
2. **1 Copy of Medical Examination form**
3. **1 sheet of brown/white paper measuring 45" X 28" folded in a polythene bag**
4. **Physical Evidence Pack:**
    - 1 polythene bag for collected fallen debris
    - 4 polythene bags for clothing
    - 2 combs each in Polythene bag for head and pubic combing
    - 2 polythene bags, each for plucked head and pubic hairs
    - 2 polythene bags for fingernails scraping each with brown stick
    - 1 polythene bag for any trace evidence recovered from the victim/body
    - Nail clipper
5. **DNA Pack : (to be sent by police to the chemistry lab)**
    - 1 EDTA bottle for blood sample OR 1 FTA ® card
    - 2 plain cotton with stick for vaginal swabs to be placed in plain container
    - 6 plain cotton swabs for oral, rectal and body swabs to be placed in plain container, when indicated.
6. **Microbiology Pack: (to be sent to hospital lab)**
    - 2 cotton swabs for high vaginal swabs for gonococcus culture to be placed in 2 Amie's transport media container
    - 1 plain blood bottle for VDRL blood sample
    - 1 plain blood bottle for HIV antigen Test
    - 1 Plain blood bottle for Hepatitis B/C Ag Test
7. **Toxicology and Alcohol Pack**
    - 1 Na citrate/Fluoride/Oxalate bottle for alcohol blood sample
    - 1 plain glass bottle for toxicology and drug of abuse blood sample
    - 1 urine container for cannabiniods/morphine urine sample

8. Clinical Pack (cold case)

- 2 Urine Container for Urine Pregnancy Test
- 1 Plain Blood Grouping Sample
- 1 EDTA bottle for blood sample

9. Examination Equipment Pack

- Disposable Vaginal Speculum set
- Elastoplast dressing
- Two 10 ml syringes with two 21 G needles and two 23G needles
- Spirit swabs
- 2 pairs of disposable glove
- Camera
- Aprons
- 2 Foley Catheter
- 1 extra Brown/Chinese paper
- Masks
- Proctoscope

A. SPECIMEN LIST (Fresh Sexual Assault)

Specimens in ***italic*** should be sent to the hospital Pathology Laboratory. All these specimens need to be ordered according to the format below. The results will be reviewed by the O&G team during follow up.

Other specimens should be given to the police officer in charge. The list of these specimens and the particulars of the police officer must be documented in a Medico-legal Specimen Book.

1. PHYSICAL EVIDENCE SPECIMENS

- Fallen loose debris and trace evidence from the body
- All clothing worn during the incident
- Nail Clippings/Nail Scrapings
- Hairs
  - Combed hair - pubic and scalp hairs
  - Plucked hairs - 10 strands of scalp hairs
  - Cut-pubic hairs or any hairs matted by dried semen

2. BLOOD

- DNA
- *VDRL*
- *HIV*
- *Hbs Ag*
- Toxicology and Drugs (if necessary)
- Alcohol (if necessary)

3. URINE

- *Urine Pregnancy Test*
- *Urine FEME*
- *Urine Culture*
- Urine for Toxicology and Drugs (when indicated)

4. VAGINAL SWABS

- Low / external Vaginal Swabs (LVS)
  - *Culture*
  - DNA
- High / internal Vaginal Swabs
  - *Culture*
  - DNA

- Swab from introitus -
  - *Culture*
  - DNA

5. RECTAL SWABS (for sodomy cases)

- DNA

6. ORAL SWABS (if oral sex occurred)

- DNA

7. BODY SWABS (when indicated eg: bite marks, blood stain, semen stain)

- DNA

B. SPECIMEN LIST (Cold Sexual Assault)

Specimens in ***italic*** to be sent to hospital Pathology laboratory.

1. BLOOD

- DNA
- ***VDRL***
- ***HIV***
- ***Hbs Ag***

2. URINE

- ***Urine Pregnancy test***
- ***Urine FEME***
- ***Urine Culture***

3. VAGINAL SWABS

- ***Culture***

SPECIMENS TO BE GIVEN TO POLICE OFFICER IN CHARGE:

1. PHYSICAL EVIDENCE PACK

(Department of Chemistry, Malaysia)

- Clothing > Physical evidence
- Nails > Physical evidence
- Hairs and fibres – physical evidence and DNA profiling

2. DNA PACK

(Department of Chemistry, Malaysia)

- Blood DNA
- LVS for DNA
- HVS for DNA
- Rectal / Oral / Body swabs for DNA

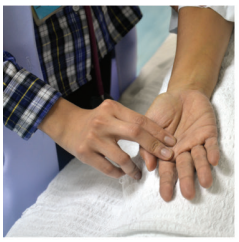
3. TOXICOLOGY & ALCOHOL PACK - when indicated

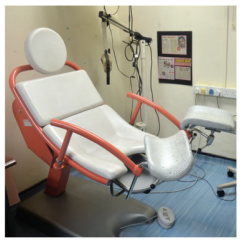
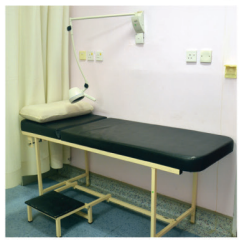
(Department of Chemistry, Malaysia)

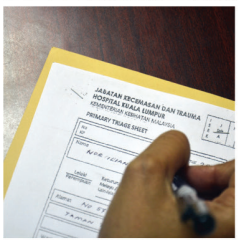
- Blood for alcohol
- Blood for drugs
- Urine for drugs

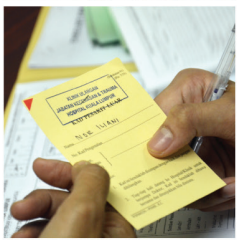
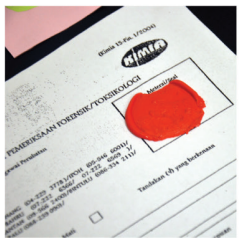

SELAMAT DATANG
KE JABATAN KECEMASAN
HOSPITAL KUALA LUMPUR


O.S.C.C.
BILIK KHIDMAT BERSEPADU

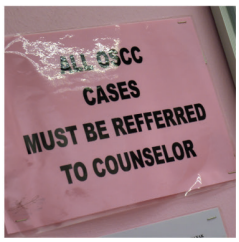


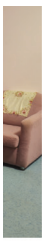

- ONE STOP CRISIS CENTRE -
O.S.C.C. MALAYSIA
PROVIDER
SPECIMEN MANAGEMENT KIT





PEMERIKSAAN FORENSIK/TOKSIKOLOGI

TCA CARD
BORANG 9
TOXICOLOGY FORM
CONSENT FORM

Sexual assaulted
Scan case
Domestic violence

ALL OSCC
CASES
MUST BE REFFERRED
TO COUNSELOR

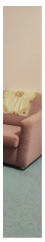
REFERENCES



REFERENCES

1. Clinical Management of Rape Survivor. Revised edition. World Health Organization Headquarters Departments of Reproductive Health and Research, of injury and Violence Prevention, of Gender, Women and Health. 2004.
2. Rape - the Malaysian scenario. Kasinathan NADESAN .Departments of Pathology and Obstetrics & Gynaecology, Faculty of Medicine,
3. University of Malaya. Malaysian J Path01 2002; 24(1): 9 – 14
4. UK National guidelines on the management of adult and adolescent complaints of sexual assault 2011.
5. www.wao.org.my
6. ATLS Student Course Manual 8th Edition
7. National Report on Violence and Health in Malaysia WHO Kobe Centre 2006
8. Law Of Malaysia, Domestic Violent Act (Amendment) 2012
9. Guidelines For The Hospital management of Child Abuse and neglect
10. Child Act 2001

TECHNICAL COMMITTEE ON GENERAL POLICY OF ONE STOP CRISIS CENTER SERVICES IN MALAYSIA



TECHNICAL COMMITTEE ON GENERAL POLICY OF ONE STOP CRISIS CENTER SERVICES IN MALAYSIA

Advisor:

- **YBhg. Datuk Dr. Jeyaindran Tan Sri Sinnadurai**
  Deputy Director of General of Health Malaysia (Medical)
- **YBhg. Dato' Dr. Azman Bin Haji Abu Bakar**
  Director of Medical Development Division
- **YBhg. Datin Dr. Nor Akma Binti Yusuf**
  Deputy Director Medical Development Division

Chairman:

- **Dr. Sabariah Faizah Binti Jamaluddin**
  Head of National Emergency Medicine and Trauma Services
  Ministry of Health Malaysia

Drafting Members:

- **Dato' Dr. Zahari Noor**
  Consultant Forensic
  Head of Forensic Medicine Department
  Hospital Pulau Pinang
- **Tuan Hj. Mohamad Fazin**
  Legal Advisor
  Ministry of Health Malaysia
- **Dr. Rosidah Binti Ibrahim**
  Consultant Emergency Physician
  Head of Emergency and Trauma Department
  Hospital Serdang
- **Dr. Seah Lay Hong**
  Director
  Department of Chemistry Malaysia
  Sarawak Branch
- **Dr. Irene Cheah Guat Sim**
  Consultant Pediatrician
  Pediatric Institute
  Hospital Kuala Lumpur
- **Dr. Wan Khamizar Binti Wan Khazim**
  Consultant Colorectal Surgeon
  Hospital Sulatanah Bahiyah
  Alor Setar

- **Dr. Shamala Devi A/P Karalasingam**
  Consultant Obstetric and Gynaecologist
  Clinical Research Center
  Kuala Lumpur

- **Dr. Nurliza Binti Abdullah**
  Consultant Forensic
  Forensic Department
  Hospital Kuala Lumpur

- **Dr. Patimah Binti Amin**
  Senior Principal Assistant Director
  Medical Development Division

- **Dr. Noor Aziah Binti Zainal Abidin**
  Senior Principal Assistant Director
  O&G Pediatric Services Unit
  Medical Development Division

- **Dr. Noor Azleen Binti Ayop**
  Emergency Physician
  Head of Emergency and Trauma Department
  Hospital Seberang Jaya, Pulau Pinang

- **Dr. Khairul Nizam Bin Hassan**
  Emergency Physician
  Head of Emergency and Trauma Department
  Hospital Putrajaya

- **Dr. Muhammad Arif Bin Mohd Hashim**
  Consultant Pathologist
  Head of Pathology Department
  Hospital Kuala Lumpur

- **Dr. Siew Sheu Feng**
  Forensic Medicine Specialist
  Forensic Department
  Hospital Kuala Lumpur

- **Dr. Norhaya Binti Abdullah**
  Emergency Physician
  Hospital Sultanah Fatimah, Johor

- **Dr. Farina Binti Mohd Salleh**
  Emergency Physician
  Hospital Sungai Buloh

- **Dr. Anisah Binti Adnan**
  Emergency Physician
  Hospital Melaka

- **Dr. Azhana Binti Hassan**
  Emergency Physician
  Hospital Tuanku Jaafar, Seremban

- **Dr. Ranjini A/P Sivaganabalan**
  Emergency Physician
  Hospital Tengku Ampuan Rahimah Klang

- **Dr. Faisal Bin Salikin**
  Emergency Physician
  Hospital Kuala Lumpur

- **Dr. Mohamad Fadhly Bin Yahya**
  Emergency Physician
  Emergency and Trauma Department
  Hospital Melaka

- **Dr. Kasuadi Bin Hussin**
  Senior Principal Assistant Director
  Medical Development Division

- **Dr. Rosnah Binti Ramly**
  Senior Principal Assistant Director
  Violence and Injury Prevention Unit
  Disease Control Division

- **Dr. Sharifah Fetom Binti Mohd Salleh**
  Emergency Physician
  Hospital Ampang

- **Dr. Siti Suhaila Binti Hamzah**
  Emergency Physician
  Hospital Sungai Buloh

- **Puan Nor Azura Binti Abd Majid**
  Medical Social Worker
  Hospital Kuala Lumpur

- **Puan Noraini Binti Mohamad Zahid**
  Medical Social Worker
  Hospital Kuala Lumpur

- **Dr. Nor Mashitah Binti Hj Jobli**
  Principal Assistant Director
  Medical Development Division

- **Dr. Abdul Hakim Bin Abdul Rashid**
  Principal Assistant Director
  Medical Development Division

Review Panel

- **Dr. Sabariah Faizah Binti Jamaluddin**
  Head of National Emergency Medicine and Trauma Services
  Ministry of Health

- **Dato' Dr. Abdul Jamil Bin Abdullah**
  National Head of Surgical Services
  Ministry of Health

- **Dato' Dr. Hussin Imam Bin Hj Muhammad Ismail**
  National Head of Pediatrics Services
  Ministry of Health

- **Dr. Ravichandran Jeganathan**
  National Head of Obstetrics and Gynecology Services
  Ministry of Health

- **Dr. Mohd Shah Mahmood**
  National Head of Forensic Services
  Ministry of Health

Secretariat / Coordinator

- **Dr. Nur Ana Nasirah Binti W Mahmood**
  Assistant Deputy Director
  Medical Development Division

- **Mohd Arif Bin Mohd Yusoff**
  Assistant Medical Officer
  Medical Development Division

- **Ahmad Waziruddin Bin Abdul Hamid**
  Assistant Medical Officer
  Medical Development Division

- **Mohd Faiz Bin Johari**
  Assistant Medical Officer
  Medical Development Division

- **Noor Azmah Binti Ahmad Zaki**
  Medical Development Division

- **Hendra Irawan Bin Hamdani**
  Medical Development Division