



Recommendations for the documentation of injuries

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The clinician's role

The documentation, management and interpretation of injuries are core activities of a forensic clinician whether working in the field of general forensic medicine (GFM) or sexual offence medicine (SOM).

It is vital that these basic skills are performed to a high standard so that the best interests of patients (complainants, complainers, suspects, and police officers/staff injured on duty) and the criminal justice system are served. This clinical activity has been described as 'body mapping'. This term is inappropriate: the documentation of injuries requires much more, including knowledge of:

- Anatomy, including surface anatomy
- The structure of the skin
- The tissue response to injury and the healing process.

In addition, the ability to interpret the findings, taking into account other relevant factors.

Introductory training courses, (ITCs), for forensic clinicians should cover the documentation, interpretation and management of injuries, including non-fatal strangulation and anogenital injuries.¹

Forensic Science Regulator (FSR)

In March 2023 the FSR issued a Code of Practice² which came into force on 2nd October 2023. The FSR has defined discrete forensic science activities (FSA).

FSA – BIO 100 is the Forensic examination of sexual offence complainants

This is defined as the recovery of items and/or samples believed to be relevant to an alleged sexual offence from a complainant in a dedicated facility (our emphasis).

The following sub-activities are considered to constitute 'Forensic medical examination of sexual offence complainants':

Physical examination of an individual for biological and trace material which may be evidence or give rise to evidence in an alleged offence under investigation: 'Recording of information' may include the use of image capture devices (including colposcopes) for specialist image capture/photo-documentation in general and intimate images, and/or the use of body diagrams/maps to record the presence, location and measurements of injuries and marks, or the apparent absence of injuries and marks.

Material believed to be biological or non-biological (which includes particulate trace material).

Examinations carried out in other facilities, e.g. hospitals, care homes, are not currently covered by this Code.

FSR-GUI-0020 Forensic medical examination of sexual offence complainants

This provides more detailed guidance on the examination and recording of injuries, particularly paragraph 5.5.6.³

FSA – INC 200 – Forensic examination of detainees

The current version of the FSR Code does not apply to this FSA therefore this FSA has no requirements set for compliance, including any for accreditation.

However, recommended best practice is that the forensic medical examination of a detainee, police officer/staff injured on duty, or complainant of assault should be of the same standard as for sexual offence complainants.

Why do injuries need to be documented and classified in criminal cases?

Accidental or inflicted?	To compare accounts of causation
Defence or offence	(To determine cause of death)
Determine cause of injury	To determine consistency of accounts
How old is the injury?	To exclude normal anatomic variants
How was the inflicting object or implement used or wielded?	What was the nature of the inflicting object or implement?

From: Payne-James J. Injury documentation & Assessment. Chapter 75. pp 712-726 In Payne-James J & Byard R. Eds Forensic and Legal medicine. Clinical and Pathological Aspects. CRC Press, Boca Raton, 2024



Initial contact

Consent for the assessment, physical examination and documentation of any findings should be obtained.

The role of the forensic clinician⁴ is to:

- provide first aid and, where necessary, refer for secondary care
- accurately record the injuries in contemporaneous records
- be able to suggest a possible aetiology, or range of aetiologies, for the injuries
- be able to offer an estimate (no matter how broad) of the age of an injury
- be able to make a statement (a streamlined forensic medical report is not suitable).

History

A general medical history should be obtained. The specific history which informs this type of assessment includes:

- How and when the injury occurred (this may reveal memory problems)
 - Use open ended questions
 - Record critical components verbatim
 - Do the injuries fit with the history given by the patient?
 - Are there injuries in different stages of healing?
 - Was a weapon used?
 - Document whether the patient is right or left-handed
 - What clothing was worn?
 - Factors that limit the provision of a full & accurate account include:
 - Pain & circumstances of the interview
 - Impaired mental function, psychological factors and fictitious
- What treatment has occurred since the injury
- Current symptoms and signs including those which could suggest internal complications or underlying bony problems
- Recent injuries (including sporting or occupational) that may be relevant to the management and interpretation of this injury
- Past or current medical conditions which may cause bleeding problems or indicate the patient may be immunocompromised
- Past or current infectious diseases
- Past and current skin conditions

- Relevant prescribed or over the counter medication e.g. warfarin, aspirin, steroids
- Drug allergy
- Congenital condition/anomaly
- Recent substance use including alcohol (in relation to head injuries);
- Immunisation history (tetanus and Hepatitis B);
- Where, and with whom, they live (may be important both in explaining any chronic stigmata of deprivation and in considering the care that may be at home after the patient leaves).

Examination

The examination findings should be recorded in detail. A full body examination should be offered as there may be injuries underneath clothes.

This should include a general examination pertinent to the particular evaluation and then more specific findings. Good lighting is essential. Examination should include the mouth and may require the use of an ophthalmoscope and/or otoscope/auroscope.

There are multiple factors that may affect how injuries present and how easily they are seen. An individual's general health, age, medication, etc. may affect how a bruise develops, and it is more difficult to see bruises in individuals with darker skin tones. The documentation and interpretation of injuries is performed by inspection and palpation – you may not be able to see something, but you may be able to feel something. If concerned, as the examining clinician, you should ask the patient to return for a review visit.



Inspection of body surfaces should result in a record being made that indicate the absence as well as presence of injury.

The following information should be recorded for each injury:

Site	The site of the injury should be recorded. This may be measured from a suitable landmark.
Size	The dimensions (length and width) of the injury should be measured and recorded in centimetres. Widths may vary along an injury and this range should be measured and recorded. If there are a large number of very similar lesions within an area, it is perfectly reasonable to represent that as a single collection. So, it is reasonable to say, for example, that there were about 25 small round bruises between 0.5 cm and 1 cm in diameter in an area 10 cm by 18 cm over the left upper back with the medial edge 1 cm from the centre of the spine and the upper edge running horizontally along a line 2 cm below the 7th cervical vertebra. Clearly, some injuries, e.g. lacerations and incisions have depth, but this can only be measured in an anaesthetised patient, (or by pathologists in a postmortem examination).
Shape	Where relevant the shape (oval, triangular, elliptical etc) of the injury and the appropriate dimensions should be recorded.
Orientation	It may be useful to ask the patient to assume the position they were in when they sustained the injury e.g. a flexed arm or a hand over the head.
Colour	The colour of the damaged skin or bruising should be noted; this may be different for each of the injuries and so should be recorded for each injury.
Specific features	Specific features should be noted, e.g. direction of skin tags in abrasions; features specific to lacerations so as to be able to demonstrate later that this is not an incised wound.
Subjective features	These will include pain or tenderness, and function of injured area. It may be necessary to perform these assessments using distraction testing techniques to ensure an accurate opinion is obtained.
State of healing (if appropriate) Not precise and depends on: Extent of injury Health of the individual Post wound care	Early changes may include bleeding, swelling After 12-24 hrs there may be a reddened margin, scab formation After 24-72 hrs there maybe granulation tissue 24-72 hrs 3 weeks onwards there may be healing with scar formation (lacerations and incisions)

Body charts/diagrams may be used to document the injuries.⁵ There is no requirement to write 'not to scale' on a body diagram as clearly injuries will not be documented to scale.

Lesions with a particular pattern or unusual shape should usually be shown in detail. However, this can be done separately from the body chart/diagram where it is adequate to indicate the site of the injury by a simple cross. A separate sheet of paper may be used, appropriately labelled and exhibited, to provide more information.

Facilities for examination may not be ideal and it may not be possible to move patients. Consider lighting (torch) and other equipment, such as an appropriate measure,⁶ e.g. forensigraph.⁷



Forensic investigations/sampling

The samples required will depend on the history and examination of the injury.⁸ The following investigations should be considered for each injury:

- removal and preservation of foreign bodies within the injury
- collection of foreign bodies amongst the hairs
- swabbing bloodstains on the skin (they may be from a third party)
- swabbing an injury that may be a bite using Forensic DNA Grade (FDG) swab(s) moistened with FDG sterile water
- obtaining any necessary control swabs.

Photo-documentation

Consideration should be given to the photo-documentation of injuries⁹ this includes intimate images.¹⁰ It is essential that if clinicians are involved in the taking of photographs, they have appropriate training for the role. Specific consent should be sought for the taking of photographs.¹¹

Statements

All forensic clinicians involved in documenting injuries should be trained in writing statements. The statement provides independent evidence for the court (takes the place of giving evidence in court on many occasions) and should reflect the contemporaneous notes. It is, therefore, essential that the forensic clinician makes clear, comprehensive, contemporaneous notes.

Common types of injuries¹²

As noted above, the definitions and features of these must be covered in an ITC in GFM and SOM.¹

Abrasions

Bruises

Lacerations

Incised wounds

Self-inflicted injuries

Defensive injuries

Non-fatal strangulation¹³

Bites¹⁴

Burns: Low or high temperature burn injuries; acid and chemical burns

It is important to note other features, including transient findings, when these are present, e.g. erythema and oedema, as these may be associated with injury (and other conditions, such as infection).

Intimate and ano-genital examination

In all aspects of clinical forensic practice, clinicians must have a sound knowledge of anatomy and physiology and the changes which occur throughout childhood growth and development, including puberty, and an understanding of the changes which occur during pregnancy and the menopause. An awareness of congenital conditions and anomalies is also important. As noted above, the examination must be explained, consent obtained, and a chaperone offered. The development of the required knowledge and skills in this area is supported by suitable introductory training courses and supervised practice.¹

The principles of the description of injuries and how to record them is similar, including noting the absence of injury, but the tissue surfaces affected may not be a keratinised squamous epithelium.

In an ano-genital examination, as well as acute injuries, it is important to be able to describe other findings:

- congenital anomalies
- anatomical changes, e.g. prolapse, urethral caruncle, haemorrhoids
- non-recent effects of trauma, for example, genital cutting, surgery and healed injuries.

In particular, reference should be made to the guidance contained in the Physical Signs of Child Sexual Abuse.¹⁵

In describing the position of ano-genital and hymenal findings, including injuries, reference is made to a clock-face whatever the position of the patient:

- Anterior = 12 o'clock
- Posterior = 6 o'clock
- Patient's left = 3 o'clock
- Patient's right = 9 o'clock

Findings can be related to other 'times' on the clock face, as necessary.

In addition, it is essential to correctly describe ano-genital findings, including those of the hymen, whether the finding is an acute injury, or the appearance of an injury once healed.

Depth of disruption to the hymen	Description if acute	Description if not acute
Partial	Laceration	Notch (further described as superficial or deep)
Complete, i.e. to the base of the hymen	Laceration	Transection



Auditable standards

Standard		Notes
All body diagrams have patient ID and/or name and/or clinic number	100%	Name will be absent if patient not identified or is a non-police referral at a SARC
All body diagrams are dated	100%	In standard UK format
All body diagrams have the name(s) of the clinician(s)	100%	Two names for a joint examination, e.g. with a paediatrician, or a trainee and their supervisor
All documents include the site, size, description and type of injury	95%	Allows for group of injuries
Specific consent required for photography	100%	

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