DOCUMENTATION OF ABUSE OR ASSAULT

Keeping good medical records is always important, but especially when you may later be required to write a statement for the police.

Notes should be:

- Contemporaneous – *written at the time or immediately afterwards*
- Detailed and legible
- Objective – *avoid injudicious language*
- Signed (signature and your name afterwards in block capitals or with a name stamp)
- Dated (date and time)
- What happened?
- Who else was there / their role? eg nurse, mother, interpreter

Recording history and examination

- Record information from third parties as such eg '*Ann Other, staff nurse on X ward, told me that . . .'*
- Record relevant information from patient verbatim eg *' he kicked me twice in the stomach'*
- Use accepted descriptions (eg abrasion) and anatomical nomenclature (eg epigastrium) but also provide translation eg vulva (outer genital area)
- The following classification is that used by forensic examiners:
    - ***Bruises*** *(sometimes called contusions)*
    - ***Abrasions*** *(scratches, grazes, superficial injuries)*
    - ***Lacerations*** *(cuts and tears caused by kicking or weapons such as sticks or bottles)*
    - ***Incisions*** *(clean-cut wounds made by a bladed weapon such as a knife)*
    - ***Stab wounds*** *(penetrating wounds)*
    - ***Burns*** *(caused by extremes of temperature, electrical or chemicals)*
- Use anatomical body sketches to record injuries. Measure the injury, mark it on the diagram and describe it eg oval purple bruise 2.8 x 1.2 cm, 5cm above the olecranon, on the posterior aspect of the right arm

Reports and statements

If you are asked to write a statement, do ask your clinical supervisor for advice

- A proforma may be available with the appropriate declaration which you must make sure you read in order that you understand your obligations;
    - *Statement of: Dr Iama Medic, MB BS, MRCGP.*

- *Occupation: Registered Medical Practitioner*
- *(CJ Act 1967, s9 MC Act 1980, ss5A (3) (a) and 5B; MC Rules 1981, r.70)*
- *This statement (consisting of X pages each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have willfully stated anything which I know to be false or do not believe to be true.*

- A statement is a legal document for Court purposes; N.B. you would be '*liable to prosecution if I have willfully stated anything which I know to be false or do not believe to be true.'*

- Type unless handwriting unavoidable
- Usually in report rather than letter form
- Check facts, spelling and grammar
- If long, number pages and paragraphs
- Include brief biography including qualifications, relevant experience and present position; it is good practice to include your GMC registration number.
- Contact details, such as bleep number and number for consultant's secretary (when you move on, ensure the secretary has details so you could be contacted later)
- Date, place etc
- Name, gender and DoB of patient (but **not** address)
- State why report is being written (eg requested by PC Officer)
- Be objective throughout – it is not your job to take sides
- A glossary may be necessary to explain medical terminology (or do so in the 'body' of the statement, e.g. ...the olecranon (point of the elbow)...
- Sometimes a police officer might attend to take a statement from you, which you will be asked to sign at the end.
- Whether you have typed the statement or 'dictated' it to the police officer, you must ensure that you have read it through and checked it carefully; make any changes that are necessary, signing and dating them if it is not possible to re-write the statement.

Jan Welch / Bernadette Butler May 2012