ASFM

African Society Of Forensic Medicine

The ASFM **-** ***a pan African Society for Forensic Medicine & Science Practitioners***

Minimum Standards for Forensic Medicine Practice in Africa

Autopsy Practice

Mortuary Management

Disaster Victim Identification

Sexual Violence Management

AFP AUSTRALIAN FEDERAL POLICE ICRC

A publication of the
African Society of Forensic Medicine (ASFM)

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2. Mortuary Management
3. Disaster Victim Identification
4. Sexual Violence Management

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Foreward

To achieve a standard of forensic practice in Africa which meets at least a minimum standard without compromising basic ingredients of service, and which at thesame time takes into cognizance prevailing socioeconomic, cultural and other peculiar factors, the African Society of Forensic Medicine (ASFM) convened a special annual forensic conference by March 2013 in Johannesburg, South Africa to deliberate on the theme: Setting Minimum Standards for Forensic Medicine Practice in Africa with focus on the following service areas:

1. Autopsy Practice
2. Mortuary Management
3. Disaster Victim Identification (DVI)
4. Management of Sexual Violence

Forensic Medicine and Science practitioners from all parts of Africa participated in four teams; each team addressing one of the subject matters on various items that constitute acceptable minimum standards in Africa in serving our peoples in various jurisdictions across the continent. The teams also worked with mentors, international seasoned experts in the respective fields of practice, who provided general guideline where necessary. The product of this endeavour, this book on Minimum Standards, is truly a pan-African document.

This venture would have been impossible without the African projects sponsorship of the Australian Federal Police (AFP) and the support of our partners, the Victorian Institute of Forensic Medicine

(VIFM), International Committee of the Red Cross (ICRC) and the Argentine Forensic Anthropology Team (EAAF).

This manual is not intended to be a comprehensive text on Autopsy Practice, Mortuary Management, Disaster Victim Identification (DVI) and Management of Sexual Violence. Excellent texts abound on these subjects. However, it provides an African forensic practitioner even in remote places a general guide on appropriate approach to these issues in meeting medico-legal requirements in their various jurisdictions.

The effort of the editor, the reviewers and all the team members who contributed in this endeavour is highly appreciated. This manual will continue to evolve with time as more changes and progress in forensic medicine and science are achieved in Africa.

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ASFM Chairperson
February

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AUTOPSY PRACTICE

1. Preamble
2. Premises of Autopsy Practice
3. Clinical Vs Forensic Autopsy
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16. Workload and Autopsy Support
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PREAMBLE

All cultures and religions respect the body of the deceased.

An autopsy is a procedure of great ethical significance because it interferes with the human body.

Members of the ASFM take their responsibilities in relation to autopsies very seriously.

The ASFM has therefore produced these minimum standards, which have been presented in a simple format, to improve the quality of autopsy practice in Africa.

When an autopsy is undertaken by a pathologist / medical practitioner with sufficient training and experience, these are the minimum standards of performance required to:

- *Produce a reliable cause of death and other related conclusions in most cases;*
- *Allow some review of the autopsy results by another expert.*

PREMISES OF AUTOPSY PRACTICE

i. The autopsy should be carried out in a facility suitable for its proper performance (refer to Mortuary Management)
ii. Any facility MUST ensure that standards exist and are observed to optimize the OCCUPATIONAL HEALTH AND SAFETY of the staff. These standards relate to facilities, equipment and processes (universal precautions and dress regulations) and following them should be required by the responsible authorities.

CLINICAL vs. FORENSIC AUTOPSY

i. These should be defined within the legal framework of each country / jurisdiction but must include at least documented consent / authority from the appropriate persons / institutions.
ii. It is important to emphasize that no autopsy shall be carried out unless there is documented consent / authority as applicable in the various jurisdictions

LIMITED AUTOPSY

i. The ASFM recognizes that some circumstances may justify a "limited" autopsy, in which case the rationale for such shall be documented and the extent of the "limited" procedure clearly indicated.
ii. However, the limited autopsy is a medical procedure to be undertaken by a registered medical doctor with a history or documented circumstances of the death which underpins the rationale for the limited examination.

FULL AUTOPSY

- This involves external examination followed by removal and dissection of the organs from the three body cavities, with necessary deviations or additional dissection in particular circumstances, by a medically qualified practitioner who will be accountable for his / her decisions, actions, opinions and conclusions.

SCENE OF DEATH EXAMINATION

- The medically qualified practitioner shall ensure a consultative approach (with relevant agencies) with verifiable documentation describing the scene of death and / or an actual visit to the scene, if possible, with due consideration paid to the safety of the practitioner and his / her assistants.

ATTENDANCE AT AUTOPSY

i. The practitioner may allow those with clearly defined role(s) to attend the autopsy. Such person(s) should have appropriate qualifications, skills and competences.
ii. They shall be briefed to understand what it is they are about to observe and include:
    - those assisting in the procedure,
    - those with proper educational needs,
    - those representing relevant parties with an interest in the outcome of the autopsy
iii. The need for confidentiality shall be emphasized, particularly for non-medics and unsworn persons present.
iv. Such attendance should be in line with any formal rule, regulations or laws governing such attendance in the jurisdiction of practice

HISTORY AND CIRCUMSTANCES OF DEATH

i. The autopsy is a problem oriented exercise.
ii. Without good information about the circumstances (and scene) of death, it is difficult to know what the issues in the particular case are or might be.

iii. Documentation of the circumstances of death should be ensured, appropriate forms designed for the purpose of this documentation should be implemented, and where possible should be fully completed prior to autopsy and made available to the medically qualified practitioner prior to the autopsy.

PROPERTY AND CLOTHING IDENTIFICATION

i. As much as possible and as applicable, all clothing and property on the body of deceased should be left intact , documented prior to autopsy, and preserved in the stipulated fashion as part of evidence in accordance with any relevant legislation or procedures of the jurisdiction.
ii. In many cases it will be reasonable to return the clothing and / or the property to the family if that is their wish, except when such material is helping in ongoing investigation.
iii. In the latter case, the family or concerned person(s) / institution should be informed of the need to retain such material.

EXTERNAL EXAMINATION

i. As forensic pathology is largely a visual exercise, if at all possible the external examination should be conducted with photo-documentation, scale and orientation. This provides the relevant record for the medically qualified person undertaking the examination, and allows for independent review, if and whenever necessary.
ii. External examination will include full physical examination involving, but not limited to identification markers items of

clothing, jewelleries and any other artefacts, weight, height, post-mortem changes, scars, deformities, tattoos, tribal marks, external injuries and / or diseases.

iii. NOTE: Physical descriptors of identification MUST be recorded

iv. All external injuries should be measured with scale and located in relation to anatomical markers (wound tracks in "internal findings")

v. All bodily orifices are to be inspected and findings documented.

INTERNAL EXAMINATION

i. All body cavities (cranium, chest and abdomen) are to be opened and inspected.

ii. All cavity fluid collections are to be described, collected and their volume measured where at all possible, or if this is not possible because of adhesions for example, the volume estimated.

iii. Special dissections will apply in some cases or circumstances e.g. neck dissection. In such cases, it is important that a standard text in forensic pathology is consulted for a general guideline. It is also a good practice to contact available colleagues who have experience in such procedures.

iv. All major solid organs including the heart, lungs, liver, spleen, kidneys and brain must be eviscerated, weighed and examined.

v. Stomach and bladder are to be opened, the contents described and their volume measured where at all possible.

vi. Major vessels should be examined including aorta, vena cavae, coronary arteries and vessels at the base of the brain.

SAMPLES FOR INVESTIGATION

- Appropriate samples must be taken at the discretion of the practitioner and with respect to available laboratory support for testing.
- Samples for investigation should be adequate (both in quantity and quality) for the specific tests required.

CHAIN OF CUSTODY

- Documented chain of custody processes must be maintained in all medico-legal / forensic cases.

AUTOPSY REPORTS

- All post mortem examination / autopsy findings must be documented and finalised in a signed report format. Autopsy templates which contain items of all necessary information required in a standard autopsy could be utilized for autopsy report to ensure consistency. However, there should always be room for additional information.

CAUSE OF DEATH

- The Cause of Death must be written in the World Health Organisation (WHO) format as set out in the "International Form of Medical Certificate of Cause of Death".

WORKLOAD AND AUTOPSY SUPPORT

I. The autopsy must produce reliable results.
II. Reliable results cannot be assured if the medically qualified practitioner does not have sufficient time.

III. The ASFM therefore considers it important to establish a standard in relation to the recommended number of full autopsies per pathologist per day:
   - *Not more than 3 cases per medically qualified practitioner per day, to a maximum of 300 full autopsy cases per practitioner per year.*

IV. Appropriate autopsy support should be available and rendered to the pathologist.

AUTOPSY AUDIT

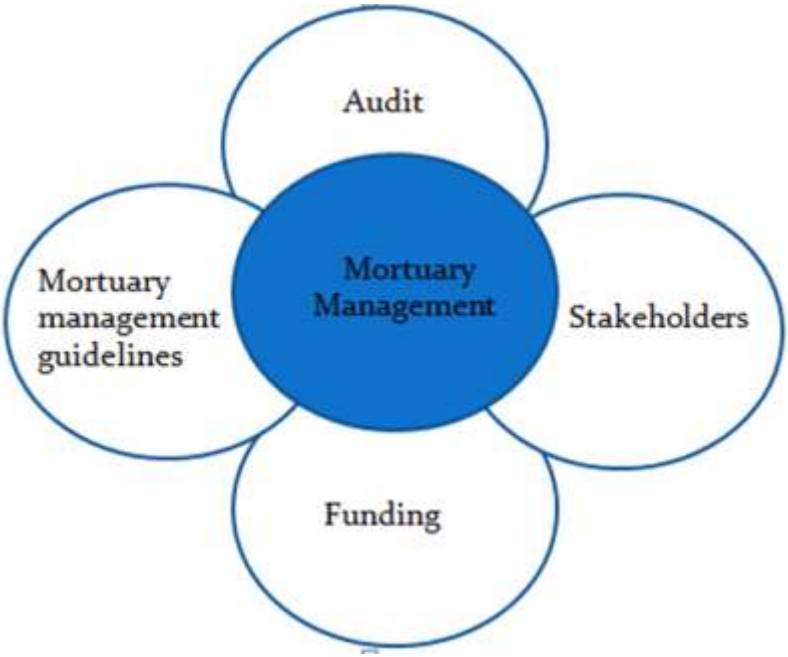
- At least one annual documented internal / external audit of autopsy reports should be performed against these minimum standards

SPECIFIC CASES REQUIRING ADDITIONAL MINIMUM STANDARDS

1. Gunshot cases
2. Burns
3. Sexual Homicides
4. Procedure-related deaths
5. Drowning
6. Decomposed bodies
7. Mutilated bodies, Fragment and Skeletal remains
8. Strangulation & hanging
9. Poisoning
10. Paediatric Deaths
11. Pregnancy-related
12. Aviation Deaths
13. Mining Deaths

MORTUARY MANAGEMENT

MORTUARY MANAGEMENT ISSUES



i. The management of forensic mortuaries requires a number of key elements; namely mortuary management guidelines, funding, stakeholder participation and audit.
ii. Management guidelines provide a foundation on which mortuary activities in a particular jurisdiction are based. They provide a means of standardization of service, which is desperately needed in many countries in Africa.
iii. This document strives to recommend the minimum standard of these guidelines. Mortuary guidelines must be formulated by relevant stakeholders to avoid bias and miscarriage of justice and to try and meet the needs of bereaved families.
iv. In most cases, stakeholders will be representatives from the ministries/ departments of health, justice and police. It is

important that all major activities are supported by the active participation of all stakeholders.

v. Stakeholders will also be responsible for mutually updating mortuary management guidelines, ensuring forensic mortuary funding needs are met as much as possible, and reviewed with annual audits. No single stakeholder should be seen to be having a "greater vote", so as to avoid perceptions of bias.
vi. Stakeholders must also ensure that there are no threats, political or otherwise to staff pertaining to the forensic work that they carry out.

Themes

- Legal framework
- Facilities
- People management
- Administration
- Procedures
- Ethics and respect

1. Legal framework

1.1 Relevant country specific legislation must govern the practice of forensic mortuaries.

1.2 These legal statutes:

i. Should be familiar to all personnel.
ii. Should be available on site for easy reference.
iii. Should be adhered to without fear or favour.
iv. Where legislation is outdated, forensic pathologists / relevant medically qualified practitioners in consultation with relevant stakeholders must be advocates for change, to ensure contemporary community standards are met and justice prevails.

2. Facilities

- Level Of Forensic Pathology Service

  2.1 Should be specified for each facility.

- Location

  2.2 Must be accessible to members of the public.

  2.3 Should be in proximity of support services e.g. the police, hospital, legal authorities etc.

- Security and access

  2.4 The facility must be secure.

  2.5 Access must be controlled and restricted.

- Structure

  2.6 The design must meet local building standards.

  2.7 There must be segregation of processes- clean, transitional and dirty areas.

  i. Clean area includes area for administration, equipment and consumable storage area.

  ii. Transitional area includes body viewing area, body reception and release area, and personnel changing rooms.

  iii. Dirty area includes body storage area, autopsy suite, waste storage area.

  2.8 Clean Areas

  2.8.1 Administration area

  i. Must include a visitor's reception area and toilet, an office space for mortuary technicians and support staff and office space for forensic pathologists/ medical officers.

2.8.2 Storage area

i. An area must be provided for storage of stock items.

2.9 Staff Amenities

i. Should include toilets, showers and a resting / kitchen area.

2.10 Transitional

2.10.1 Body Viewing Area

i. Entrance is from the clean area.

ii. Should not provide a view of the autopsy area.

iii. Hand washing facilities should be provided within the view area.

iv. Relations to be accompanied and assisted by a member of staff at all times.

v. Should only allow viewing and not touching of the body by family, where this does not infringe on the last-rites of family members in accordance with local customs.

2.10.2 Body Reception- Release Area

i. Should be out of view of the public.

ii. The body loading area should provide access to all types of vehicles.

iii. Relevant registers, together with body rules and body scales must be available.

iv. Tagging and weighing of bodies should be done on reception of the body.

v. The body should be shrouded or bagged before storage

vi. Staff must be informed if a body is harbouring a biohazard risk, and the body bag must be labelled appropriately.

2.11 Dirty Area

2.11.1 Body storage area

i. There should be a refrigerated body store.

ii. Temperatures of refrigerators should be maintained at 2-6° C.

iii. There should be daily monitoring and recording of refrigerator temperatures.

iv. There should be adequate space for all bodies. No bodies should be stored on the floor.

v. A single body should be stored on each trolley or body tray.

2.11.2 Autopsy Suite

i. Autopsy processes must be out of view and out of sight of visitors.

ii. Personal protective equipment (PPE) should be worn at all times.

iii. There must be at least one autopsy table or one fixed trolley.

iv. There should be a continuous supply of running water and good drainage system to clear biological fluids from the dissecting field.

v. There must be adequate space to allow staff to work without being crowded.

vi. Only authorised persons must be present in the autopsy room.

vii. Organ scale must be provided.

viii. Dissection kits must be provided as per local protocols.

ix. Special sharp disposal box or at least safe improvised plastic boxes should be provided to received sharps

x. There must be an adequate supply of appropriate specimen containers and specimen collecting kits.

xi. An emergency eye- wash facility should be provided.

xii. Electrical outlets must be protected from splashing.

xiii. Fully equipped first aid box must be placed in easily accessible position

xiv. Fire extinguishers including buckets filled with dry sand must be provided

- Power supply

  2.12 Must be reliable.

  2.13 Must be protected outlets in wet areas.

- Water supply

  2.14 Must be available in all operational areas of the facility.

- Lighting

  2.15 Must be adequate in all areas.

  2.16 The light fittings in the autopsy suite and wet areas should be sealed and waterproof

- Ventilation

  2.17 Natural ventilation may be used, but must ensure that no odours escape from the autopsy suite into public areas.

  2.18 Windows must be insect proof

  2.19 Where mechanical ventilation is used, the autopsy suite must have negative ventilation and a separate supply and exhaust from the rest of the building. Technical details will be provided by building experts.

- Rodent proofing

  2.20 Facilities must be rodent proof and pest- control measures should be instituted where necessary.

- Drainage
  - 2.21 The floors should be sloped or graded and curved at the periphery; suitably trapped floor drains must be provided.
  - 2.22 Drainage of waste water must be directly into the sewer system
  - 2.23 Drainage must be adequate for the facility and relatively easily accessed to facilitate management of blockages.
- Fire plan
  - 2.24 All facilities must have a fire plan, including regularly serviced fire extinguishers, and well-marked, accessible fire exits to assembly points.
  - 2.25 A nominated staff person should be responsible for ensuring that staff are aware of the plan and know what to do in the event of a fire.
- Finishes and Surfaces
  - 2.26 The floors and walls must be impervious and washable, especially in the autopsy suite.
  - 2.27 The floors must be non-slip
  - 2.28 The ceilings should be washable
- Communication
  - 2.29 There must be at least one telephone line (mobile or fixed) or satellite communication (two way radios in areas with no such).
- Transportation
  - 2.30 Facilities that are involved in transporting bodies must only use authorized clearly marked vehicles which have

been designated to transport bodies. The vehicles must be suitably modified as per specification for body transport vehicle.

- Instruments And Equipment

2.31 The following should be provided as a minimum:

i. Body trays / trolleys
ii. Body scales / rules
iii. Organ weighing scales
iv. Dissection kits
v. PPE (caps, masks, goggles, scrubs, gowns, double gloving, mid- calf waterproof, non- slip boots, and waterproof aprons)
vi. Photographic equipment and body diagrams
vii. Body bags / shrouds
viii. Cleaning equipment
ix. Regular servicing of equipment with documentation of servicing and dates in equipment registers.

- Health and environmental control

2.32 Wastes from the mortuary must be handled by competent persons or certified companies or authorities.

2.33 Waste management involves segregation of waste generated, followed by containment and disposal.

2.34 Health care risk waste or hazardous biological waste must be separated from general mortuary waste:

i. Hazardous biological waste is that which contains pathogens of sufficient virulence that may cause an

infectious disease if someone susceptible is exposed to it.

a. Liquid- body fluids, water used for autopsy and cleaning of "dirty" areas.
b. Solid human tissue, disposable waste e.g. gloves, used sharps etc.

ii. General household waste is generated in the clean / dry areas e.g. used stationery.

2.3.5 Use Of International Colour Coding for Waste Disposal Bags / Containers;

Container	Use
Red bags Labelled "Infectious"	Solid medical waste
Black bags	General household waste
Yellow rigid containers Labelled "Danger: contaminated sharps"	Used sharps
Dark green container / bag Labelled "Infectious"	Hazardous chemical and pharmaceutical waste

2.36 Containment- – placement into appropriate containers should be done at the point of generation.

2.37 Storage / Disposal

i. Solid medical waste- *medical waste management companies (incineration/ burial)*

ii. Liquid medical waste- *into sewer system via trapped drains. Never into storm drains.*

iii. There should be timely removal of solid waste.

iv. If removal / collection not possible on the same day, waste to be stored in a secure, ventilated, washable waste storage area.

2.38 Infection Control

i. There should be standard operating procedures developed and available at each facility.

ii. One person should be appointed as a Safety Officer. He / she should be trained in first aid.

iii. First aid kits must be available on the premises and should be adequately stocked with viable materials (not expired).

iv. Occupational post- exposure prophylaxis must be available as per local protocols.

v. Medical surveillance in the form of pre- employment medical examinations, annual chest x-rays, vaccinations (hepatitis B and tuberculosis) and exit medical examinations must be done.

vi. An employee assistance programme including psychological support must be in place.

vii. Appropriate disinfectants must be used and regular disinfection of the facility and equipment therein must occur.

3. People management

3.1 Mortuary Management Structure

There should be a well- defined mortuary management structure in place. This must include a Forensic Pathologist/ medically qualified practitioner in a permanent or advisory capacity.

3.2 Job Descriptions

Detailed descriptions should exist for each employee post.

3.3 Signed Confidentiality Agreement

All employees should sign a confidentiality agreement prior to working in mortuary facilities. Confidentiality regarding the deceased, family relations and the entire process must be guarantee for the integrity of mortuary service.

3.4 Staff establishment

The staff establishment should correlate with the level of forensic service provided at that facility.

3.5 Training for staff

All staff should receive in- service training, and an assessment prior to being allowed to work in the mortuary.

3.6 Workplace Skills Development Programme

A programme should be in place to ensure that staff members have the opportunity to progress in their career.

3.7 Performance management

Staff performance must be regularly reviewed and appropriate action taken.

3.8 Peer review system

Medical personnel should have their work submitted to a peer review system to ensure compliance with quality standards especially with regards to autopsy practice in the mortuary.

4. Administration

4.1 Operating hours

The level of service provided after- hours should be clearly defined. The main city mortuaries should operate on a 24 hour per day basis for the receipt of bodies.

4.2 Documentation

The following documentation must be kept, as a minimum:

i. Incident/ occurrence register (will include workplace injuries)
ii. Death register- case file
iii. Reports accompanying the body
iv. Statistical register
v. Legal authorisation for autopsy (together with specimen and organ removal)
vi. Property register
vii. Exhibit register
viii. Interview questionnaire
ix. Chain of custody documentation

x. Identification and release documents
xi. Specimen register and specimen request forms
xii. Visitors log book
xiii. Autopsy register
xiv. Autopsy report
xv. Register for issuing of the autopsy report
xvi. Unidentified persons registers
xvii. Photography register

4.3 Records in the mortuary should be well kept to cover against loss.
4.4 There should be a documented policy about who can access what documents.
4.5 A document archive and document disposal system should be in place.

5. Financial management
5.1 The mortuary manager is responsible for ensuring prudent financial management of mortuary resources together with the production of annual reports subject to audit.
5.2 The following registers must be kept, as a minimum:
i. Asset register
ii. Stock registers
iii. Revenue register (where applicable)

6. Audit
6.1 Facilities must be subject to regular internal and external audits. The audits to be conducted should be set out at the beginning of each financial or calendar year.

6.2 These include financial, equipment, safety, body handling, storage and autopsy processes and body count audits.

6.3 Reports must be provided in a timely fashion, after audits, and reviewed with an aim to improving facility processes and management.

7. Procedures

7.1 Standard Operating Procedures

There should be standard operating procedures governing all mortuary processes. Any deviation from them must be authorised by the mortuary manager or concerned authority and documented.

7.2 Organ and Tissue Retention for Transplantation

Documented procedures around organ and tissue retention for transplantation must be in place, dictated by relevant legislation and / or best practice.

7.3 High Risk Autopsies

7.3.1 Facilities that are not equipped to deal with group 4 biological hazard agents should not admit such bodies to their facilities

7.3.2 Group 4 Hazardous Biological Agents (HBAs) will require quarantining procedures and NO post-mortem examination will be performed. The diagnosis of Group 4 HBA (e.g. Ebola virus) is confirmed in the laboratory.

7.3.3 The protocol for dealing with bodies with contagious diseases clearly defines the responsibilities of the different agencies, the rapid disposal of the corpse without releasing it to the family, the decontamination of the facility and the monitoring of all

persons that had contact with the body. There are only about four P4- facilities in the world where post-mortems are performed on these cases

7.3.3 There should be a high index of suspicion for bodies harbouring group 3 biological hazard organisms and a means of communicating this suspicion to the rest of the mortuary staff.

8. Ethics and respect

8.1 There must be respect for the dignity of the deceased and empathy shown to the relatives.

8.2 There must be respect for all cultures and religions.

8.3 Bodies must be handled and presented in a dignified / respectful way. For example, they should be covered when not being subject to formal examination.

8.4 There must be efforts to try to restore the body best cosmetic appearance as possible especially as applicable to fresh bodies.

8.5 Bodies with hazardous infections (Group 3 / 4) should be labeled and handled in isolation.

9. Challenges Faced In Formulating Mortuary Minimum Standards

9.1 Rural vs. urban facilities

9.2 Hospital vs. police / forensic mortuaries

9.3 Different levels of service of different mortuaries

9.4 Private mortuaries and ensuing potential conflict of interest

9.5 Transportation of bodies from scenes

9.6 Admission photographs for every case admitted to the mortuary

Glossary of terms

1. Definition of biological hazard groups:

   Group 1- a biological agent that is unlikely to cause human disease.

   Group 2- a biological agent that can cause human disease and may be a hazard to employees. It is unlikely to spread to the community and effective prophylaxis or treatment is usually available.

   Group 3- a biological agent that causes severe human disease and presents a serious hazard to mortuary personnel. Effective prophylaxis / treatment may only be available for some of these e.g. hepatitis B & C, HIV, tuberculosis etc.

   Group 4- a biological agent that causes severe human disease and presents a serious hazard to mortuary personnel. There is a high risk of spread in the community and usually there is no effective prophylaxis or treatment e.g. Ebola

2. Mortuary- in this document refers to a facility where dead bodies or human remains are temporarily kept for storage or storage and autopsy. It may be a hospital, forensic or police mortuary. The minimum standards outlined are intended to apply to all such facilities.

3. Clean area- parts of the mortuary where there is no risk of acquiring an occupational infection e.g. the administration area.
4. Dirty area- parts of the mortuary where there is risk of acquiring an infectious organism e.g. the autopsy room.
5. OH & S- occupational health and safety.
6. PPE- personal protective equipment.

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DISASTER VICTIM IDENTIFICATION (DVI)

INTRODUCTION

1. The ASFM aspires to achieve international standards for DVI. The Interpol DVI Guide is the principal guide for Disaster Victim Identification (DVI).
2. It is important to recognize that in larger disasters, it is not possible to implement Interpol DVI guidelines in all its details, and the approach must be to manage dead remains in a way that promotes the likelihood of later identification. This approach is also well described in a booklet entitled: "Management of Dead Bodies after Disasters: a Field Manual for First Responders" by the *ICRC, International Federal of Red Cross and Red Crescent Societies, WHO* and *Pan American Health Organization*. In any disaster it is a crucial expert decision to decide very early which approach applies in the circumstances.
3. This document focuses on the minimum standards required for disaster victim identification.
4. We understand that this situation should not be deemed resource dependent
5. Under this we define a disaster as two or more fatalities in the one incident. In such incidents, the risk of misidentification of the deceased is high if DVI procedures are not followed.
6. All measures to contribute to the positive identification of victims should be implemented.
7. Practitioners should work to respond to relatives' need for identification as soon as possible.
8. Victims are to be treated with dignity and respect.
9. DVI teams work in an interdisciplinary manner and engage the services of experts in various different fields, as needed.

10. The success of the DVI operation is in direct proportion to preparation. The responsible authorities must make preparations for DVI operations.
11. Cooperation with other DVI teams, for support in times of need, should be in place.

Summary of Important Considerations:

i. Need for disaster preparedness
ii. Need to constitute a standing DVI team
iii. Need to have formal authority for DVI procedure.
iv. Multi - disciplinary approach
v. Need to have proper labelling system early in the process.
vi. Importance of use of Interpol standard as applicable
vii. Use of Interpol forms for the process of DVI as applicable
viii. Need for availability of all methods of scientific identification
ix. Available resources should be taken in to consideration in DVI operations
x. Cultural and religious needs are important
xi. Quality assurance
xii. Quality Management Systems.

The following are considered the recommended minimum standards of the African Society of Forensic Medicine (ASFM) in each member country :

1. A national mass disaster plan should be in place, within which should exist a DVI committee.
2. The DVI team must have the different sub-teams within the

victim identification unit: Recovery and Evidence Collection Team, AM Team, PM Team, Reconciliation Team, Identification Team.

3. Debriefing of staff should be done during and after the DVI process.
4. Every country must have a resource list of human capital/infrastructure and equipment that is available to handle the DVI situation
5. Security to personnel and materials is a key factor to DVI operation.

THE WORK PLAN :

1. DISASTER MANAGEMENT AUTHORITY/REGULATOR (Initial Response consideration, Arrival at the scene, Processing the scene, Administrative set up of the mortuary operation)
2. RECOVERY AND EVIDENCE COLLECTION
3. METHODS OF IDENTIFICATION
4. AM DATA COLLECTION
5. PM DATA COLLECTION
6. RECONCILIATION AND IDENTIFICATION
7. IDENTIFICATION BOARD

1. DISASTER MANAGEMENT

Principles

Coordination of the following activities:

i. Implementing a clearly defined command structure and standard channels of communication is required.
ii. Each member country establishes one or more permanent Disaster Victim Identification (DVI) Teams. They should have a responsibility for disaster response, but also for the vital functions of pre-planning and training of key personnel.
iii. Priority should be given to:
    a) First-aid for injured victims
    b) Personal and property security measures.
    c) Family assistance and public relations.
iv. Initial action at the disaster site:
    a) Obtain an overview of the scope of the disaster.
    b) An authoritative body must assume command of the operation.
v. An advance team should be sent to the scene to evaluate:
    a) Extent of area of the scene
    b) State of the corpses
    c) Duration of the process
    d) Medico-legal institute able to respond
    e) Methodology to remove the bodies
    f) Transportation of corpses
    g) Storage
vi. Organization of a disaster response operation
vii. Operational units should be formed to carry out remaining disaster response measures.

ROLES

Victim Identification units

Recovery and Evidence Collection Team

- Recovery of bodies at the disaster site and the collection and preservation of evidence and property at the site.

AM Team

- Collects ante mortem information.
- Composition: police and other relevant personnel

PM Team

- Collects all relevant dental medical and forensic information obtained from the bodies of deceased victims.
- Composition: Forensic pathologists, Forensic Odontologists, and Forensic Anthropologists, Fingerprint experts and Forensic scientists.
- Any forensic specialists as may be required by a particular circumstance

Reconciliation Team

- Responsible for matching AM and PM data records.

Identification Board

- Makes final decisions regarding the identification of given victims and certifies these decisions on the DVI form.

Debriefing

- Responsible for the Care and counselling need of those involved in the DVI exercise
- This aspect of DVI may often be neglected.
- It is important that adequate care is made available for participants in a DVI operation.

PROCESS

- Objects should not be removed objects from victims' clothing before thorough documentation by evidence collection personnel.
- A DNA sample should be obtained from the victims if condition of bodies in envisaged changing and where bodies are fragmented.

COLLECTION POINTS

Recovery Command Centre

- In consultation with the operations sector commander, the Recovery Command Centre is to be set up in the immediate vicinity of the disaster site.

Evidence/Property Collection Centre

- Examination of property items for information of relevance to identification and classification as evidence.

METHODS OF IDENTIFICATION

All possible scientific methods of identification should be employed.

i. Finger Prints
ii. Dental Records
iii. DNA
iv. Radiographs

Numbering of bodies

- A single number is assigned to each body or body part.

Cooling of bodies

- Appropriate cooling modalities should be developed in consultation with local authorities.

Examination of bodies

- During Post Mortem examination of bodies it is essential to ensure that only unavoidable changes are made to the bodies examined.

Mortuary

- Wherever possible, the morgue station should be established in consultation with the head of the Victim Identification unit.

HUMAN CAPITAL

PM Team leader

- Ensures that sufficient personnel are available for examination of bodies, supervises PM activities and checks for compliance with safety and health requirements.

Body registrar

- Assigns PM numbers and enters PM numbers on PM forms.

Fingerprint specialists

- Determine the method of fingerprint collection to be used.

Forensic Anthropologists

- *Assist the forensic medical personnel in examination of skeletal elements.*

(Forensic) Photographers

- *P*hoto documentation of the body.

Radiologists and Radiographers

- Use X-rays and other applicable radiological procedures for identification purposes.

Forensic pathologists

- The forensic pathologist performs the external and internal examination of the body and enters appropriate data in the PM record.

Forensic Odontologist

- Assessment of dental status of deceased persons for the purpose of identification.

Autopsy assistant:

- The autopsy assistant assists the forensic pathologist in the external and internal examination of bodies.

Quality control officer

- The quality control officer reviews all documents for completeness and legibility.

Reconciliation and Identification

- The team analyses data from both AM and PM teams and helps to reconcile data for the purposes of assisting the identification process

Identification Board

- Final identification of a disaster victim is made with the approval of the Identification Board

Debriefing

- Care for operational personnel.

- All personnel assigned to victim identification duties should have access to a comprehensive programme of medical and psychological care.

KEY CONSIDERATIONS

Safety and Special Clothing

- Personnel assigned duties at the disaster site are to wear appropriate personnel protective gears (PPE)

Communication

- Clear lines of communication must be established between operational units at the disaster site and the command centre.

Legal Standards

- Every DVI operation is subject to the laws of the country in which the disaster in question has occurred
- Agreements regarding the integration of international DVI teams in cases of need should also be worked out.

Special Operations

Biological Substances/ Chemical Weapons

- Victims should not be autopsied, unless the autopsy can be conducted in a mortuary that has appropriate facilities.
- DVI practitioners will need to work with other response agencies such as military, fire, scientific officers and radiological experts to accomplish the task safely and effectively.

Natural Disasters (earthquakes, floods, tsunamis, etc)

Mass Graves

- Burial of bodies in mass graves is not permissible and must be discouraged.

Marking of Bodies/Body Parts

- Everybody or body part is assigned a unique number / code.

Photographic documentation of bodies/body parts

- The following photos should be taken: entire body, face, torso and lower body.

Documentation

- The recovery record in the Interpol Forms should be filled out completely.

Identification

- Visual identification of bodies or photographs should only be used as a preliminary identification tool.

Cooperation with International Organizations

- Cooperation with international organizations is encouraged.

Recommendations

- Human resource and geo mapping facilities is critical.
- Local customization to different areas and circumstances is encouraged.
- Periodic review of procedures in line with international best practices and in response to local realities

MINIMUM STANDARDS FOR THE CARE OF SEXUAL ASSAULT SURVIVORS

DEFINITION OF SEXUAL ASSAULT VIOLENCE: (adopted WHO guidelines)

Sexual violence is defined as: "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work".

RATIONALE FOR MINIMUM STANDARDS

- Increase in Sexual Assault violence
- Specialised care for Sexual Assault victims
- Support for medico-legal processes

PURPOSE OF MINIMUM STANDARDS

- Human resources
  - Certification of Staff
  - Training
- Infrastructure
  - Facilities
- Equipment
  - Evidence Kits
- History taking
- Clinical Examination
  - Medical Care
  - Forensic Evidence
- Treatment
  - Physical
  - Psychosocial
  - Follow up: Medical and Counselling
- Documentation
- Networking wit Stakeholders
- Funding
- Statistics (data)

- Court Testimony
- Monitoring and Evaluation
- On-going safety and prevention of re-occurrence

HUMAN RESOURCES

i. Attaining of skill and competency certification of the clinical examiner.
ii. Doctors and Nurses would be used at the discretion of health ministry of the country.
iii. Training must be included in both the Undergraduate and Postgraduate curricula of both doctors and nurses.
iv. Training manual ought to be modified to be country-specific.
v. On-going in-service training to update and maintain skills of examiners.
vi. Ad hoc training and in-service training (presentations, lectures, tutorials, talks, videos).
vii. A two (2) week duration stand-alone course including practical component on sexual violence management.
viii. Medical Institutes be in line with curriculum
ix. Sexual assault training during internship program
x. Mentorship and practical supervision
xi. Guidelines and protocols to be developed and adapted for each country

INFRASTRUCTURE

i. Dedicated facilities with provision for adults and children – can be within existing structures. For children, the facility must be child-friendly
ii. Basic requirements must be present:
a. Privacy
b. Safety
c. Security
d. Cleanliness
e. Accessibility

EQUIPMENT

- The ASFM adopts WHO guidelines as minimum standard
- Evidence / Rape Kits used where resources are available

HISTORY TAKING

- Informed Consent should be obtained in writing from a person(s) legally capable of giving that consent (this will be based on chronological age, developmental level, maturity, mental illness, mental retardation, drug, and alcohol intoxication)
- Treat all victims of sexual violence with respect and dignity throughout the entire examination irrespective of their race, social status, religion, culture, sex, occupation, sexual orientation or lifestyle.

ADULTS: General medical history, Gynaecological history & Assault history

- History taken to direct:
  - Examination
  - Evidence collection
  - Treatment
  - Information sharing (police, court)
  - Record purposes
- Confidentiality

CHILDREN:

- Child- friendly environment
- Limited single assessment

CLINICAL EXAMINATION:

- Consider acute serious or life threatening medical needs first'
- Head-to-toe examination
- Examination of all orifices
- Country specific and use of WHO guidelines
- Avoid lubricants prior to evidence collection
- Interpretation of clinical findings

Adults:

- Clinical findings and history taking to formulate informed conclusion

Children:

- Adopt ADAMS classification system
- Full examination including pubertal development (Tanner staging)
- Genital examination (without internal examination)
  2 positions
  2 techniques

- Note the extent of external trauma
- If required age estimation to be based on clinical and radiological examination with recognition that this is an estimation only

1. SAMPLE COLLECTION

- Forensic Evidence
  - Biological (within 24 hours for children and 72 hours for adults)
  - Non-Biological (within 72 hours)
  - Apply WHO or National guidelines
  - Ensure chain of custody and retain copies of documentation in secure place
  - Retain forensic specimens / kits for at least 3 months, longer if practical, secure storage under lock and key

- MEDICAL INVESTIGATIONS
  - Sexually Transmitted Infections, HIV and Hepatitis B
  - Pregnancy
  - Physical Injuries

2. Laboratory support:

- Forensic laboratory:
  - DNA support where available: this should be aimed for.
- Hospital / Health facility laboratory:
  - HIV, Hepatitis B screen, Pregnancy test, STI, semen analysis.

- According to WHO and National guidelines.

TREATMENT – ADULT AND CHILDREN

- Physical and Psycho-social care
- Preventative, Promotive and Curative
- Follow up care
  - Medical Review
  - Counselling
- According to WHO and National guidelines

DOCUMENTATION

- Written consent for assessment, photographs, disclosure, investigation and treatment
- Sexual Assault pro- forma document - comprehensive medical records meeting medico-legal requirements (e.g. Form J88 used in South Africa) (WHO-Sexual Violence Examination Record). Practitioners should create similar pro-forma documents, where not in existence, through processes in line with medico-legal requirements in their jurisdictions.
- Holistic care (medical care and legal requirements)
- Maintain confidentiality
- Storage, Security and Access to medical records
- Photography
  - Consent
  - Sensitivity
  - Date and Time
  - Chain of custody
  - Storage and Security

STAKEHOLDERS

To ensure coordination, prevention, sensitization, multidisciplinary-team approach (roles and responsibilities of all role players need to be clearly defined). The identified role players would include the following:

- Police

- Social workers
- Local community
- Media
- Courts
- Governments
- NGOs
- Private Sector
- Churches, mosques and religious groups
- Traditional leaders
- Laboratories
- Health care facilities
- Education / schools
- State Department of Social Development

FUNDING

- Partnership - government, international, NGOs
- Free service: this must be emphasised at patient contact level
- Comprehensive funding must be made available
- Covers multi–disciplinary needs
- According to local national policies

STATISTICS AND DATA

- Comprehensive and accurate statistics for all sexual violence cases.
- Important to identify an existing or emerging trends and this will inform decision-making for sexual assault management.

COURT APPEARANCE:

- All health professionals must be aware of the potentially being called to court to provide expert testimony and must be prepared to attend court
- All health professionals must be aware of local legislation
- Court preparation for victims and witnesses
- All health professionals are expert or professional witnesses and must provide an objective opinion

MONITORING AND EVALUATION:

- Monitoring & Evaluation framework – country-specific, will be measured against guidelines and protocols for sexual assault.
- Continuing Professional Development must be provided for health care workers involved in sexual assault management to keep up with contemporary management issues and to improve skills.
- Regular stakeholders meetings must be held to improve services.
- Feedback and on- going outreach amongst service providers, communities, relevant NGOs, concerned government agencies and other stakeholders.
- Annual update/ review of statistics to identify gaps and overlaps and improve efficiency.
- Peer review of medico-legal reports.
- Peer review of court testimony.
- Court outcomes (finalization of cases); not necessarily based on conviction rates but rather on the number of cases finalised and the reasons for acquittals.

SAFETY AND PREVENTION OF REOCCURRENCE OF SEXUAL ASSAULT

- Shelters for adults as obtainable in a few African countries is a model for addressing peculiar needs of survivors of sexual violence in Africa
- Separate victim from perpetrator when being transported for medical examinations
- Children:
  - Separate children from perpetrator if indicated and in line with service protocol in your jurisdiction.
  - Retain children in secure and supportive environment, preferably within the extended family as applicable.
  - Empower caregivers to prevent on-going abuse using relevant and available agencies.
  - Institute parenting programs that encourage communication

MINIMUM STANDARDS FOR THE CARE OF SURVIVORS OF CHILDHOOD SEXUAL ASSAULT

RATIONALE

i. Childhood sexual abuse is common – almost half of all reported cases of sexual assault occur in children and 1 in 3 girls and 1 in 5 boys will be sexually assaulted before the age of 16 years.
ii. Childhood sexual abuse is not restricted to rape but encompasses a wide range of sexual activities.
iii. The process of abuse influences the clinical features, physical and psychological sequelae as well as the process of disclosure and presentation.
iv. Spontaneous disclosure is uncommon and invariably delayed.
v. It is normal for the genital examination to be normal following sexual assault and a normal examination does not mean that nothing has happened.
vi. The diagnosis of sexual abuse is based on history and the clinical examination may confirm this; identify sequelae; and guide health care.

PRINCIPLES

i. Children are not small adults and must not be treated as such. Children are children.
ii. The care of children following sexual assault must be guided by the best interests of the child.
iii. The participation of the child is an essential element in the care of sexual abuse.
iv. Care must be initiated on the allegation of sexual assault not the confirmation of such assault. Preventing sexual violence to a child should be the goal.
v. Assume the worst and aim to minimize secondary trauma to the child.

STANDARDS

These should be based on and applied to a standardized framework for the management of childhood sexual abuse.

1. Suspect Abuse.

   Given the low rate of disclosure, poor communication skills of children and diverse presentation of sexually abused children, the minimum expected of health professionals working with children are that they:

   - Maintain a high index of suspicion and include sexual abuse in their list of differential diagnoses.
   - Learn to read between the lines when consulting with children and adolescents.
   - Listen to and believe stories provided by children.
   - Take a complete medical and social history in addition to a comprehensive history of the sexual abuse.

2. Investigate All Suspicions.

   The investigation of allegations of sexual assault must focus on the needs of the child and should:

   - Include a medical assessment, psychological evaluation and forensic examination.
   - Be conducted by a suitably qualified health professional.
   - Only occur with the consent or assent of the child if more than 3 years of age or caregiver for those younger than 3 years.
   - Be limited to a single medical assessment.
   - Always occur in a child friendly setting.
   - Involve processes that recognise the developmental needs of the child.
   - Always involve a full examination including a genital examination:
     - In two positions – supine and prone knee-chest or left lateral;
     - Using two techniques – labial traction and labial separation;

- Without internal examinations.

- An examination under anaesthesia should be reserved for the confirmation and treatment of internal injuries not for the primary assessment.

3. Validate Findings and Support the Legal Processes.

The clinical assessment includes support for legal processes provided these are secondary to the best interest of the child. Such support includes:

- Reporting all suspected cases of sexual abuse irrespective of the intentions of the caregivers.
- Completion of a medico-legal report in all cases regardless of the time interval between the alleged sexual assault and the clinical assessment.
- The collection of forensic evidence in cases presenting soon after the assault with the restriction of:
  - 24 hours for the collection of biological specimens – internal swabs are never indicated in pre-pubertal children;
  - 72 hours for the collection of foreign matter.
- Provide court testimony when required.

4. Treat the child.

i. Whilst only a few cases of childhood sexual assault are associated with abnormal clinical findings, all cases have the potential to cause physical and psychological sequelae.

ii. The treatment of children therefore needs to be holistic and:

- Adopt a worst case scenario based on the history, irrespective of clinical findings.
- Address both physical and psychological needs.
- Cater for prophylaxis and curative elements focusing on:
  - Acute injuries.
  - Sexually Transmitted Infections and HIV.
  - Pregnancy prophylaxis which should be provided to all girls with Tanner stage 3 or more thelarche regardless of

their menstrual history. However, the intended treatment must be explained to the victim, and they should be allowed to decide whether or not to accept them.

- Include follow up to at least 3 months after the last reported incident of abuse for assessment of psychological wellbeing, safety and the exclusion of pregnancy and sexually transmitted infections.

5. Ensure On-Going Safety of the Child.
   Children need to be protected from on-going abuse and cared for in a supportive environment this is best achieved by:

   - Leaving the child within the family setting including the extended family in cases of intra-familial abuse;
   - Separation of child and perpetrator;
   - Empowering caregivers to understand and improve the supervision of the child as the primary mode of protection.

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Autopsy Practice

Mortuary Management

Disaster Victim Identification

Sexual Violence Management

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