GOVERNMENT NOTICES

DEPARTMENT OF HEALTH

No. 223 **6 March 2009**

National Directives and Instructions on conducting a Forensic Examination on survivors of Sexual Offence cases in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007

1. General

These directives, which are designed to provide standardized procedures for conducting forensic examination on sexual offence survivors in all health establishments in the Republic, must be read with the Department of Health's National Sexual Assault Policy, National Management Guidelines for Sexual Assault Care, the Victims Charter, the National Health Act, 2003 (No. 61 of 2003), Termination of Pregnancy Amendment Act, 2004 (No. 38 OF 2004), Children's Act, 2005 (No. 38 of 2005), and all other relevant legislation. The directives must be adhered to, in order to, amongst others, ensure a holistic, coordinated, efficient, and supportive response to survivors of sexual offence as well as to ensure the provision of a full range of comprehensive services to survivors who have made the decision to report a sexual offence by:

(i) Meeting the immediate needs of the survivor with crisis intervention and support services;
(ii) Provide a joint, effective, sensitive approach to survivors of sexual offence; and
(iii) Assist the police conducting an investigation of the crime by documenting and preserving forensic evidence for prosecuting the alleged sexual offender.

Directive 1

Section 66(3)(a)(i) the administering of Post Exposure Prophylaxis (PEP)

2. Survivors of sexual offence who present within 72 hours

PEP must be offered to all HIV negative patients presenting within 72 hours of a sexual offence that resulted in the patient coming into contact with the blood, semen or vaginal fluid of the alleged offender.

3. HIV testing

(a) PEP is provided to survivors of sexual offence who are HIV negative.

(b) HIV testing to establish status is therefore essential for PEP provision.

(c) Survivors of sexual offence must be counselled prior to being offered testing for HIV.

(d) In the case of children under 12 years, who do not have sufficient maturity to understand the benefits and mentally ill or disabled survivors of sexual offence, pre- and post-test counselling must be provided to the parent or legal guardian as they are persons who must give consent for HIV testing.

(e) Such parents or legal guardian must be treated as the "patient."

(f) If such persons are not available, the head of a health establishment, the court, child commissioner or social worker may sign the consent form for HIV testing

(g) Children over the age of 12 years, and younger children with sufficient maturity to understand the benefits, risks and implications of an HIV test, can legally consent for HIV testing.

(h) Use a rapid HIV test for all survivors of sexual offence who opt for PEP.

(i) If the test is negative inform the patient of the results and provide post-test counselling.

(j) If the first test is positive, this must be confirmed with a second rapid test. The survivor can be informed of the positive results after a confirmatory result that is also positive.

(k) If the second test is negative, a laboratory test (HIV-ELISA) is required.

(l) Further counselling on the use of ARVs as prophylaxis, the common side-effects, the importance of follow-up testing and the necessity to practice safe sex until all testing is completed at 3 months must be given.

(m) An anti-emetic should be given with PEP to prevent nausea and vomiting.

4. Post-Exposure Prophylaxis

(a) PEP must be administered within 72 hours of exposure.

(b) A 3-day starter pack must be offered to those patients who prefer not to test immediately, those who are not ready to receive results immediately or those who are unable to consent immediately due to severity of injuries or traumatisation.

(c) The rest of the treatment must be given when the HIV status of the patient has been established as negative.

(d) For those patients who cannot return for their one-week assessment due to logistical or economic reasons, a 28 day treatment supply with an appointment date must be given. This may be particularly relevant outside of the metropolitan areas.

(e) Patients who test HIV positive at the first test and those who sero-convert must be referred for long-term HIV and AIDS care.

(f) While on PEP and until the three-month visit showing the patient is HIV negative, the patient must be advised to use condoms with partner. Condoms should be provided to the survivor.

(g) The health care professional must inform the patient of other services available to the patient such as reporting the case to the police, counselling and management of sexually transmitted infections and other infectious diseases (tetanus and Hepatitis B).

5. AZT and 3TC Regimen for adults

(a) Dose of Zidovudine (AZT): 300mg 12 hourly (or 200 mg 8 hourly for 28 days).

(b) Dose of Lamivudine (3TC): 150mg 12 hourly for 28 days.

6. AZT and 3TC Regimen for children <14 years

(a) The maximum dose calculated per child should not exceed the adult doses, viz. Zidovudine 300 mg 12- hourly and Lamivudine 150mg 12-hours.

Paediatric dosage is based on height and weight and is calculated by the doctor.

(b) The standard dose for the lopinavir/ritonavir is 230mg Lopinar and 57.5mg Ritonavir per metre square twice daily.

Weight		Lamivudine(Epivir®, 3tc)		Zidovudine (Retrovir ®,ZVD, AZT)	
		4mg/KG Twice daily		240mg/m2 twice daily	
KG		Liquid 10 mg/ml	Tablet 150 mg	Liquid 10mg/ml	Capsule 100mg
5-6.9		2ml		7ml	
7-9.9-		3ml		6ml	1 Cap
10-11.9		4ml		12ml	1 cap
12-14.9		5ml		14ml	A cap
15-16.9		6ml		15ml	2 caps
17-19.9		7ml	½ tab	17ml	2 caps
20-24.9		9ml	½ tab	20ml	2 caps
25-29.9	25-27.9	11ml	1/2tab		3 cap or 300mg
	28-29.9	12ml	½	24ml	
30-34.9		13ml	1 tab	27ml	3cap or 300mg
		15ml	1tab	30ml	3cap or 300mg

7. High Risk Exposure

(a) A third drug lopinavir/ritonavir 400/100mg 12 hourly, can be added to the above is recommended in patients whose risk of infection is assessed to be high.

(b) The risk of HIV transmission is regarded high under the following conditions:

(i) Where there has been multiple perpetrators;

(ii) Anal penetration;

(iii) Obvious trauma to the genitalia; and/or

(iv) Known HIV positivity of one of the perpetrators.

(c) An assessment of the patient's ability to adhere to medication must be taken into account as lopinavir/ritonavir is a large capsule that cannot be crushed or opened and should be swallowed whole. It has a bitter aftertaste and requires a specific regimen.

(d) Not enough scientific evidence exists to support the three drug regimen, but it is considered best-practice in these circumstances.

8. Side effects/contra-indications

(a) Relative contra-indications to the use of AZT and 3TC include significant renal or liver impairment. Where a health care professional is in doubt about the use of AZT and 3TC in individual patients, s/he must contact his/her local physician or referral centre for advice.

(b) The health care professional must explain the common side effects of the drugs to the patient, which are, tiredness, headache, malaise, flu-like symptoms, muscle pains, nausea and vomiting.

(c) Most of these symptoms can be relieved with ordinary analgesia such as paracetamol and anti-emetics.

(d) The patient must be informed that these are temporary, vary in intensity and that they do not cause long-term harm.

9. Drug interaction and adherence

(a) Taking other medication such as those for pregnancy prevention and antibiotics may compound the side effects of AZT and 3TC.

(b) The health care professionals must advise the patient to return to the health facility if symptoms occur rather than stop the drugs.

(c) The health care professional must emphasize the importance of adherence.

(d) The health care professionals must improve adherence by employing a number of strategies such as:

(i) Encouraging patient to continue with counselling sessions;

(ii) How to identify each tablet;

(iii) When to take them;

(iv) Expected side-effects and management options for side-effects;

(v) Always providing an anti-emetic with the treatment;

(vi) Home visits;

(vii) Follow-up phone calls;

(viii) Pill diary;

(ix) Referral to NGOs; and

(x) Support groups.

(e) If the patient is taking lopinavir/ritinavir, she must be advised that the effectiveness of oral contraception is reduced.

(f)All survivors taking PEP should therefore be advised to practice safer sex until the 3 month HIV test.

(f) Patients who are using a condom, it is not necessary to adjust the dose of oral contraceptives.

(g) However, if she cannot use a condom, the patient must then be advised to increase the dosage of oral contraceptives when taking Kaletra.

10. Use in pregnancy

(a) PEP is not contra-indicated during pregnancy or lactation and the use of AZT and 3TC in the first trimester of pregnancy has not been shown to be teratogenic.

(b) However, there is no evidence on whether lopinavir/ritinavir is teratogenic and is therefore not recommended if the patient is pregnant.

11. Survivors Presenting after 72 Hours of Sexual Offence

(a) Survivors of sexual offence presenting after 72 hours should be provided with general counselling and be informed that there is no evidence that PEP will have any impact if taken more than 72 hours after exposure and that there is a potential risk of HIV infection.

(b) HIV testing should be offered at this visit with the prerequisite pre and post-test counselling. The window period should be explained to patients who

test negative at this time. The patients must be advised to return for a repeat HIV test at 6 weeks and again at 3 months. The necessity to practice safer sex should be explained.

12. Other Treatment

(a) The following should be given:

Anti-tetanus toxoid (ATT) for injuries covered by dirt, if the patient was last immunized against tetanus more than 10 years ago.

(b) Treatment for STIs should be provided to all patients.

(i) Treatment for adults:

- Cefixime 400mg stat po (alternative: Ceftriaxone 250mg IMI stat)
- Doxycycline 100mg bd po for 7 days
- Metronidazole 2g stat po (alternative: Metronidazole 400mg bd po for 7 days). Only for female patients or males who were sexually assaulted by females.

(ii) Treatment for pregnant women:

- Cefixime 400mg stat po (alternative: Ceftriaxone 250mg IMI stat or Spectinomycin 2g stat IMI)
- Erythromycin 500mg qid for 7 days
- Metronidazole 2g stat po (alternative: Metronidazole 400mg bd po for 7 days). Metronidazole 400mg bd po for 7 days should be used in the first trimester.

(iv) Treatment for children <14 years of age:

Ceftriaxone:

- If child weighs <25kg: 125mg IMI stat
- If child weighs ≥25kg: 250mg IMI stat
- In children >13 years of age can use Cefixime 400mg stat po

Erythromycin:

- If child <12 years: 50mg/kg body weight per day in 4 doses

- If child> 12 years: 250mg qid for 7 days

(v) Metronidazole (Only for female patients or males who were sexually assaulted by females):

- If child 1-3 years: 50mg tds for 7 days
- If child 4-7 years: 100mg bd for 7days
- If child 8-10 years: 100mg tds for 7 days
- In children> 10 years: Metronidazole 2g stat po (alternative: Metronidazole 400mg bd po for 7 days). Metronidazole 400mg bd po for 7 days is preferred for children.

(b) Emergency contraceptives pills (ECP) with an antiemetic, should be provided to all females in the reproductive age who have a negative pregnancy test and present within 5 days of the rape.

(c) This includes girls with signs of breast development and all women who have not had a hysterectomy or undergone menopause.

(d) The recommended regimen is levonorgestrel 1.5mg stat po.

(e) Alternative regimens include combined pills including ethinyl estradiol and levonorgestrel in various dosing combinations. These have to be taken immediately and repeated in 12 hours.

(f) Hepatitis immunisation can be provided to survivors who have not been completely vaccinated or previously infected. A complete course of vaccination i.e. 3 doses would be required to prevent future infections.

(g) Medication regimes may be routine and sound simple for health care professionals, however to patients who are traumatized and stressed, enormous difficulty may be experienced in relation to remembering what must be taken when and why etc.

(h) Patients should be given simple and clearly written instructions about taking medication.

13. Referral

(a) The patient should be given information about appropriate local support services.

(b) Written referrals should be provided if the patient requests this. These services include:

(i) NGOs Support

(ii) Rape crisis centers

(iii) Shelters or safe houses

(iii) Legal AID

(iv) Support groups

(v) Social Services

(vi) Reproductive health services/TOP services for failed contraception

14. Follow up

(a) On discharging the patient ensure that the proper follow up arrangements are in place.

(b) Clinical follow up should be at a week, 6 weeks and three months. At the clinical follow up examinations check the following:

Clinical follow-up at a week Counselling and HIV test for those that did not take the test initially – discontinue ARV if test positive. Counselling should be continued at each visit especially for those not tested for HIV initially

- Results of HIV test
- Provide rest of ARV if HIV negative
- Assessment of general physical state, healing of injuries
- Assess completion of medications
- Assessment of emotional state
- Ask about psychological reactions and coping and provide appropriate support
- Contraception counselling if appropriate

Clinical follow-up at 6 weeks

- Repeat HIV test if tested negative at first visit
- Give results of HIV test
- Assessment of general physical state, healing of injuries

- Assessment of emotional state
- Assess completion of medications
- Ask about psychological reactions and coping and provide appropriate support
- Look for post traumatic stress disorder and treat
- Pregnancy testing and counselling- possible referral for TOP
- Contraception counselling if appropriate

Clinical follow-up at 3 months

- Repeat HIV test if 6 week test was negative
- Provide results of HIV test
- Assessment of general physical state, health of injuries
- Assessment of emotional state
- Ask about psychological reactions and coping and provide appropriate support
- Look for post- traumatic stress disorder and treat

Directive 2

(ii) The manner in which court orders for compulsory HIV testing contemplated in section 33 must be executed in order to ensure the security, integrity and reliability of the testing processes and test results

15. Compulsory HIV testing of alleged offender

(a) The health care professional must ensure that the survivor of the sexual offence or interested person have requested HIV testing of the alleged offender within 90 days of the sexual offence prior to conducting the HIV testing.

(b) The health care professional must offer the alleged sexual offender pre-test counselling or ensure that such pre-test counselling has been done .

(c) The health care professional must give the alleged sexual offender all the necessary information with regard to HIV and AIDS.

16. Blood specimens

(a) A blood specimen for ELISA testing must be collected.

(b) If Elisa test is positive, the results are conclusive and reported as such.

(c) If the ELISA test is negative, then the test result is reported as "negative".

(d) To ensure the security of the HIV test results, health care professionals must ensure that they are handled confidentially.

(e) All HIV test results of alleged sexual offenders must be kept in a locked cabinet/cupboard with access restricted only to the head of the health establishment or unit.

(f) Only the Investigating Officer has access to the results.

(h) Offenders will receive their sealed HIV results from the Investigating Officer, and a notice providing prescribed information on the confidentiality of and how to deal with the HIV test results.

(g) If necessary, the health care professional must explain the contents of the notice. One set of the HIV test results must remain at the health establishment for record keeping as prescribed or, where applicable, make the record of the HIV test results available to the prosecutor who needs to know the results for purposes of the prosecution of the matter in question or any other court proceedings.

Directive 3

(iii) The manner in which the HIV test results contemplated in section 37 must be dealt with in order to ensure confidentiality

17. The obligation of the health care professional with regard to the HIV test results of the alleged offender

(a) The health care professional must maintain and guarantee confidentiality about the conducting of the HIV test.

(b) To ensure the security, integrity and confidentiality of the HIV test results, the health care professional must ensure that they are handled confidentially.

(c) All HIV test results of alleged sexual offenders must be kept in a locked cabinet/cupboard with access restricted only to the head of the health establishment or unit.

(d) These results must be made available only to the Investigating Officer responsible for the case.

(e) The health care professional must hand the Investigating Officer the record of the result of the HIV test with duplicate sealed separate envelopes marked "confidential with:

(i) The case number;

(ii) Name and rank of the Investigating Officer;

(iii) Name of the survivor; and

(iv) Name of the alleged offender.

(f) The HIV results must be handed to the Investigating Officer in a sealed record with a notice containing information on confidentiality as contemplated in form 9.

(g) The survivor or the interested person should be counselled prior to receiving the HIV results of the alleged sexual offender. The investigating officer must ensure that the survivor or interested person has been counselled before handing over the sealed record of the HIV results to the survivor or to the interested person, as the case may be.

Directive 4

(iv) The manner in which the reporting of an alleged sexual offence is to be dealt with if the offence is reported to a designated public health establishment

18. Patients who do not want to report the incident to the police

(a) There is no statutory obligation to report the sexual offence if the patient is an adult, except if the survivor is an older person in need of care and protection in terms of the Older Persons Act, 2006 (Act No. 13 of 2006), minors in terms of the Children's Act 38, 2005 (No. 38 of 2005) and mentally ill persons as defined in the Mental Health Care Act, 2002 (No. 17 of 2002).

(b) In case of a patient who is uncertain about reporting the alleged offence, the health care professional should address the patient's fears and concerns to assist the patient make the decision about reporting.

(c) However, uncertain patients should be encouraged to report the case to the police within 24 hours of the sexual offence.

(d) The patient must also be encouraged to allow the collection of non-degradable evidence to be preserved in case she/he decides to report the case at a later date.

(e) The patient must be informed that the evidence will only be retained at the health care establishment for a minimum of 6 weeks.

(f) The health care professional must ensure that such evidence is properly secured.

(f) Amongst others, the patient should be offered the following health care services:

(i) Counselling;

(ii) treatment of any physical injuries;

(iii) STI's and HIV and AIDS prevention;

(iv) In case of female patients of reproductive age, pregnancy risk evaluation and prevention; and

(v) Other infectious diseases prevention and treatment.

(g) The patient's right to decide should always be respected and honoured.

(h) The patient, including minors, should never be coerced or forced to report the sexual offence or to undergo medical forensic examination.

(i) If the patient consent to be examined, but refuses biological evidence to be collected, diagrams, photographs and completion of J88 form is still recommended.

(j) By law children under the age of 16 years cannot consent to intercourse. Therefore, health care professionals have a legal obligation to report sexual offences cases involving minors under the age of 16 to the police irrespective of the patient's choice.

(k) If the patient is willing to report the alleged offence, but is unable to do so due to injuries, the head of the designated unit or health care establishment must request the police to interview the patient on site for statement recording.

(l) The patient who is willing and able to go and report the matter to the police must be encouraged to do so.

Directive 5

(v) The manner in which assistance in the investigation and prosecution of sexual offences, generally must be conducted

19. Investigations/Examination of sexual offences patients

(a) The Sexual Assault Evidence Collection Kit (the kit) must be utilized in conducting forensic medical examination in sexual offence cases. There are different kits for both adults and children under the age of 12 years.

(b) The kit has a checklist of all the evidence needed to be collected for forensic purposes as well as instructions, which should be followed meticulously.

(c) The rights of the patient must be respected at all times.

(d) Informed consent is vital in the examination of patients of sexual offence. Therefore, a required consent form SAP308 must be completed prior to physical examination.

(e) Complete history of the patient should be taken.

(f) Physical examination by experienced and skilled forensic health care professional must be performed in all forensic examination.

(g) Special consideration should be taken in the examination involving children.

(h) Correct positioning of patients and techniques is very important during the examination.

(i) Forensic health care professionals must adequately complete the required documentation (including the J88 form) and sound conclusions be made.

(j) The box and all items in the kits are bar coded with their unique number. As a result, component of different kits should not be swapped or mixed.

(k) Unused components of each kit must be discarded.

(l) The collection of forensic evidence should immediately follow medical examination.

(m) Only medically stabilized patients should be referred for forensic medical examination evidence collection.

(n) Emergency treatment enjoys precedent over forensic medical evidence collection.

(o) Forensic evidence collection includes:

(i) Biological samples;

(ii) Trace evidence;

(iii) Physical injuries;

(iv) Psychological behaviour;

(v) Photography;

(vi) Diagrams; etc.

(p) The specimens should be properly packaged (and stored for a minimum of 6 weeks, if necessary) and transferred.

(q) Mismanagement of the evidentiary chain may result in the court ruling it as inadmissible.

(r) Similarly, evidence collected by a non-expert will be rejected by the court.

20. Samples to be collected on a sexual offence patient

(a) The following samples should be collected:

(i) Oral specimen;

(ii) Clothing collection;
(iii) Evidence on patient's body;
(iv) Fingernails;
(v) Saliva on skin;
(vi) Semen or other stains on body;
(vii) Head hair;
(viii) Pubic area specimen;
(ix) Ano-rectal specimen;
(x) Genital specimen; and
(xi) Reference blood sample as per instruction in the kit.

(b) During the forensic examination, only parts under examination should be exposed and be covered before proceeding to the next site of concern.

21. Precautionary measures during the collection of forensic medical evidence

(a) Take care not to damage the hymen in the sexually inactive females.
(b) Obtain the required swab from the genital area.
(c) Refrain from a speculum examination in a person who was a virgin prior to the sexual offence.
(d) Speculum examinations in pre-pubertal females are discouraged.
(e) The members of the forensic team must avoid cross-contamination of biological substances, including their own.
Patients must be informed that confiscated clothing is being sent for forensic analysis.
(f) The following persons must be granted assistance during forensic medical examination:
(i) Children;
(ii) The disabled;
(iii) Psychological traumatized; and
(iv) The elderly

22. Drugs and alcohol

(a) In suspected drug facilitated sexual offences, collect blood for alcohol in the prescribed blood tube.

(b) Urine for metabolite screening should also be collected in the case of suspected drug facilitated sexual offence as this can be detected in the urine for longer periods after ingestion than in blood.

23. HIV test

(a) Blood for HIV testing should be collected if patient consent to testing.

(b) This may be done immediately on presentation after the reported sexual offence or after three days.

(c) For the procedure and management thereof, see Directives 1, 2 and 3.

24. Urine for pregnancy test

(a) The health care professional must collect urine for pregnancy test in female children and women of child-bearing age who are otherwise sexually active and not adequately covered by a contraceptive as it is important to rule out pregnancy.

(b) Presence of a pregnancy might affect the type of treatment given and the woman will want to know whether the pregnancy preceded the sexual offence.

25. Products of conception

(a) Products of conception that resulted from a sexual offence can be collected using the Human Tissue Collection Kit.

(b) This may be collected at birth or after an abortion.

(c) The specimens may include placental tissue, fetus or fetal tissue.

26. Additional diagnostic tests

If there is any necessity for any additional diagnostic tests to be done, the required samples should be taken.

27. Additional investigations for children: screening for STIs

(a) Although investigations for sexually transmitted infections are no longer recommended for the management of sexual offences in adults, in children the presence of STIs may be diagnostic of sexual abuse and therefore investigations are required.

(b) The following specimens should be taken:

(i) A vaginal swab for microscopy and/or culture .

(ii) Blood for STIs and HIV.

28. Maintaining chain of evidence/reporting to the police

(a) Until a trial takes place, access to the confidential information contained in the J88 form is legally privileged to the investigating officer and the Department of Justice and Constitutional Development.

(b) The information may, however, be disclosed to the defence lawyer after obtaining a court order from the Magistrate or Prosecution.

(c) The original J88 form should be handed to the Investigating Officer after obtaining his/her signature. A copy should be filed in the patient's file for record purposes and subsequent court proceedings.

(d) If the Investigating Officer is not present, the forensic health care professional should clearly mark and registered the forms and kit, and keep them under lock and key. These should only be given to the investigating officer and not just any person.

(e) The storage period should be very short. Non-degradable evidence can be kept for a longer period.

(f) The transfer of forensic medical evidence specimen from official to official should be recorded and confirmed by the signature or statement by the recipient. Failure to obtain acknowledgement may result in the rejection of the evidence.

(g) Evidence is like a chain and should not be broken. Evidence must be passed directly from one custodian to another.

(h) Ideally the specimens should be handed over to the police immediately after the examination.

(i) Dispatching forensic medical samples is strictly police responsibility.

(j) Collected samples should be handed to the investigating officer as soon as possible.

29. Giving evidence in court: Expert evidence

(a) A forensic health care professional should factually and confidently present evidence in court.

(b) A forensic health care professional should interpret his/her findings within the parameters of his/her expertise.

(c) Both Doctors and Nurses are recognised experts.

(d) Expertise is based on education, training, skills and experience.

(e) Experts are called as witnesses in order to assist the court in coming to a proper decision on complex technical or scientific matters.

30. The South African court procedure

(a) The South African court procedure is based upon an adversarial legal system. This means that the opposing sides (the prosecution and defence) may each call their own witnesses (including experts) to provide evidence in court.

(b) Each side is also given the opportunity to test the other's through the process of cross-examination.

(c) Once both sides have presented their evidence and argument, it is then up to the judge or magistrate to pass judgement on whether or not the state has proven its case against the accused beyond reasonable doubt.

(d) It is essential for the forensic health care professionals to prepare their testimony by reviewing all records and notes, consult with other non-involved experts and refer to relevant research regarding their examination of the sexual offence patient.

(e) Ideally the forensic health care professional should also consult with the state prosecutor beforehand. This will enable them to explain the findings and

their significance and date of giving evidence to avoid delays and waiting for long periods in court.

(f) When called to the stand, the prosecutor will begin leading evidence by asking the forensic health care professional to describe her/his expertise to the court. This may include qualifications, training and experience of examining sexual offence patients.

(g) Thereafter the provider will be asked to describe her/his:

(i) Findings/opinion/results;

(ii) The process used/scientific criteria applied and reliability; and

(iii) Reasons for the findings/results.

(h) After the prosecutor has led the forensic health care professional's evidence, it is then the turn of the defence attorney to cross-examine the provider. The purpose of the cross-examination is:

(i) To separate truth from lies;

(ii) To separate opinions from fact;

(iii) To establish what the witnesses heard as opposed to what they know; and

(iv) To establish things that actually happened as distinct from what the witness thought happened."

(i) Defence lawyers may dispute expertise by questioning the qualification and/or experience of the forensic health care professional.

(j) The defence lawyers may also put statements to the witness and then attempt the expert to agree with that statement.

(k) This is done to obtain concessions in the expert's testimony and narrow or eradicate any conflict between the expert's testimony and the defence's case. In this way, the defence attempts to create reasonable doubt.

(l) The expert witness must be prepared to defend the integrity of their findings and opinions against the questions of the cross-examiner.

31. Tips for giving evidence in court

(a) The attire of the testifying forensic health care professional should reflect professionalism.

(b) Avoid medical terminology. Explain in lay terms the details of their examination, findings and conclusions as required or requested. .

(c) Do not provide more information than you are asked.

(d) Do not venture beyond your field of expertise, and answer of "I don't know" is acceptable.

(e) Try to distinguish factual statements from opinions.

(f) Limit information to what is requested/required.

(g) The expert witness should be unbiased and be a servant of science and research only.

(h) Opinion evidence may be confirmed with the aid of relevant recognised research articles and books.

(i) After presenting factual evidence, the expert witness is entitled to opinion evidence.

(j) The forensic health care professional does not represent the State nor the defence, but should be considered independent.

(k) Consultants with the defence lawyer should be done with the permission and the presence of the State Prosecutor.

DIRECTOR-GENERAL: HEALTH