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Injury Examination and Medico-Legal Report

Practical 01 / Clinical or documentation case

Aim

Describe injuries objectively and write a simulated medico-legal injury report.

Principle

Observed findings, reported history and expert opinion have different evidential weight. Wound terminology and reproducible location help a later reviewer understand the report.

Materials and Requirements

- Fictional clinical record and de-identified injury images
- Body chart, scale and institutional training form

Procedure

1. Check the purpose, identity, authority and consent process with the supervisor. Prioritise required clinical care.
2. Verify the simulated request, examinee identifier, date, time, place and examiner role. Explain the examination scope and record the permitted parts before beginning the model assessment.
3. Record the patient's account in their own words where useful and mark who supplied each history item.
4. Create a brief time line separating the examinee's reported event, attendance and treatment from verified events in the chart. Record a direct quotation only where wording matters.

Continue with step 5 on the next page.

Procedure Continued

Injury Examination and Medico-Legal Report

5. Describe every represented injury by type, side, site relative to landmarks, measurements and observed features. Mark findings on a diagram.
6. On the model or photograph number lesions in a consistent anatomical order. Record exact position, shape and measured dimensions using the supplied scale and mark each number on the body chart.
7. Compare simulated symptoms with objective findings and state which regions could be assessed. Describe the margins, surrounding change and any supplied imaging without assigning unsupported timing or intent.
8. Record investigations, treatment and limitations. State only an evidence-supported opinion and mark any part that is deferred.
9. Review the record against the mock form and state the supported medical interpretation and its limits. Date the entry and identify pending results and who will review them.

Precautions

- Do not estimate bruise age from colour alone.
- Use only authorised images and records. Preserve privacy and chain of custody.

Observations and Interpretation

Injury Examination and Medico-Legal Report

Observations and Record

Item	What to record	What it tells you
History	Source, date and patient account	Separates reported events from examination
Injury	Type, size, site and diagram	Documents observable facts
Opinion	Supported inference and limitations	Preserves uncertainty for later review

Worked Example

A teaching image shows a superficial linear abrasion 2.0 cm long over the left forearm. Record the actual site and appearance. Shape alone does not identify a unique object or exact time.

Result and Interpretation

Produce a completed fictional report with time, observations, diagram and a limited opinion.

Viva Questions and Answers

What distinguishes a laceration from an incision as a description?

Laceration refers to tearing and can show bridging tissue. Assess an actual wound in context.

Why use fixed landmarks?

They make later location and comparison more reliable.

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