Manual for Medical Examination of Sexual Assault

Cehat
Centre for Enquiry into Health and Allied Themes

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Index

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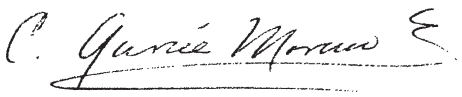
Foreward

Sexual assault can have long lasting emotional, physical and social effects on survivors and is a violation of a person's human rights. Survivors of sexual assault need comprehensive and caring services that address their physical and mental health needs and provide them with the necessary psychosocial and other support in order to help them recover from a traumatic event .

Health providers have an important role to play in this as they will often be one of the first points of contact after the event. In addition to providing the best possible health care, they are well placed to collect and document the evidence that is necessary to corroborate the assault and identify the perpetrator. This evidence is crucial for the prosecution of sexual assault cases. It is therefore essential that health providers have the knowledge and skills, as well as the understanding needed to respond appropriately and sensitively to sexual assault survivors.

This manual is an important contribution to strengthening the knowledge and understanding of providers in India on how to respond to sexual assault survivors. It should contribute to better care and better outcomes for victims/survivors, who are primarily women and children. The encounter with the health provider can contribute to the healing process or conversely can be an experience of revictimization. The more providers understand the issues surrounding sexual violence, and the psychological and physical needs of survivors and are able to provide the basic care and psychosocial support, and carry out a sensitive forensic examination when appropriate, the more likely they can help the survivor in the healing process. Where this is not possible, clear referral pathways should be established to ensure survivors can access the necessary care and support.

There is a need to invest in building the capacity of health providers to provide care and support to survivors of sexual assault. As we improve care for survivors of sexual assault, we must also continue our efforts to build more gender equitable societies and prevent sexual assault from happening in the first place.



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* The views expressed are those of the author and not necessarily those of the Organization

Preface

Women's liberation and emancipation, one of the most revolutionary changes that took place in the 20th century, has found a strong basis in international law. Several covenants and other human rights instruments emphasize the inalienable right of women to physical, mental and social autonomy, and freedom from servitude, discrimination and violence. For health workers, physicians, midwifes and nurses in particular, it is of paramount interest to understand the Right to Health, including the Rights to Sexual and Reproductive Health and to promote and monitor its implementation. In their daily work, health workers witness the violations of these rights, particularly of vulnerable and marginalised groups, women and children.

As sexual and reproductive rights are among the most controversial and sensitive issues in international law, they deserve particular attention by health professionals. Sexual and reproductive rights explicitly include the right to control one's health and body and freedom from sexual violence, such as rape, forced pregnancy, forced abortion and sterilization, female genital mutilation, forced marriage. They include the right to health protection, including accessible and affordable health care of good quality. While we may be conscious of these rights, we - especially health workers - are painfully unaware of the daily reality of millions of vulnerable groups.

A particularly disturbing form of violence is sexual assault and rape, of which mostly women and girls are the victim. Mass rape is increasingly being practised as a weapon of war, suppression and social destruction, and has been declared a war crime. As doctors and nurses we witness the magnitude of the suffering of women survivors, we see the physical and psychological wounds, we perceive the silent pain and fear of social exclusion after rape when kept secret. In cases of sexual assault which do reach health care or law enforcement (police), it is of utmost importance that the survivors are treated in a respectful and humane way, in line with medical ethics, and in line with the provisions of international law. Dignity of the survivor, professional secrecy, avoiding unnecessary, harmful, stigmatizing and disrespectful treatment are crucial. Especially in a sensitive area such as sexual assault, protocol approach is essential. International professional bodies of physicians (World Medical Association WMA), nurses (International Council of Nurses ICN) and gynaecologists (International Federation of Gynaecologists and Obstetricians FIGO) promote the use of a protocol that includes the above mentioned elements, and that is in line with medical ethics and international law.

Physicians, midwifes and nurses have a role to play in the implementation of the Right to Health and in Sexual and Reproductive Rights; society expects this from us, and as health care providers we owe this to our patients. This Manual, written and tested by CEHAT, meets these requirements, and should be recommended as a model protocol in all health facilities, police stations, and in the curriculum of medical and nursing schools.

Adriaan van Es, MD
Director, International Federation of Health and Human Rights Organisations (IFHHRO)

I. Introduction

There were an estimated 20,737 reported survivors of sexual assault in India in 2007 as compared to 15,847 cases in 2003 (National Crime Records Bureau). While there is evidence of a steady rise in the reporting of sexual assault, other forms of sexual violence such as sexual harassment at work place, eve teasing and marital rape go largely unrecorded. A National Study on Child Abuse conducted by the Ministry of Women and Children in 2007 showed that more than 53% children across 13 states reported facing some form of sexual abuse while 22% faced severe sexual abuse.[1] In spite of the rising numbers, these form only the tip of the iceberg and the crime remains largely hidden, given the stigma attached to sexual assault.

Sexual assault, like any other form of violence, results in physical and psychological consequences. Thus, health care providers have a dual responsibility vis-à-vis survivors of sexual assault. The first is to provide the survivor with the required medical and psychological treatment and care, while the second is to assist the survivors in their medico-legal proceedings by collecting evidence and doing good quality and thorough examination and documentation. However, it has been seen time and again that medical professionals carry certain biases about survivors reporting sexual assault similar to those in general society. Text books on medical jurisprudence continue to perpetuate these biases. Flavia Agnes, a leading advocate in her critique of the text books related to medical jurisprudence points out that these text books create a picture that women falsely allege rape and therefore doctors should exercise caution while conducting such examinations.[2] Neither medical text books nor medical education equips a doctor completely in understanding the issue of "sexual violence". Therefore the entire medico legal practice in cases of sexual assault hinges on defensive practice by health professionals. Further, the public health system lacks a uniform protocol for management of a sexual assault survivor whether it is about examination, documentation or treatment guidelines.

The SAFE (Sexual assault forensic and medical evidence collection) kit was developed by Center for Enquiry Into Health and Allied Themes (CEHAT) in 1998 to fill this gap. Though the kit was endorsed by several well known gynaecologists, forensic

[1] Ministry of Women and Child Development, Government of India, *Study on Child Sexual Abuse in India* April, 2007.
[2] Agnes F (2005) *To Whom Do Experts Testify? Ideological Challenges of Feminist Jurisprudence*, Economic and Political Weekly, 40(18): 1859-1866.

doctors, experts from the law enforcement agencies, forensic laboratories and women's rights activists, its use remained restricted to a teaching tool at the level of medical colleges.

In 2000, CEHAT collaborated with the Municipal Corporation of Greater Mumbai (MCGM) to set up India's first public hospital-based crisis centre to respond to women facing Domestic Violence. As a part of this project, health care providers (HCP) were trained to understand the association between Domestic Violence and its health consequences. Eventually a trained cadre of doctors, nurses and para medical staff emerged. Doctors trained as a part of this project felt that the current management of sexual assault patients also needs to change. Under the leadership of Dr. Seema Malik, the Project Director of Dilaasa and Chief medical superintendent (Peripheral Hospitals), a project for developing a comprehensive health care response to sexual assault was undertaken. This project was implemented in two municipal hospitals. The components of the implementation included training of health care providers in use of the kit and helping them acquire a perspective on sexual violence, providing assistance to doctors in conducting the examinations and in providing psychosocial support to survivors.

One of the important lessons learnt from this implementation was that doctors are adept at using the paraphernalia of the kit, but find it difficult to elicit history related to the sexual assault. In practice, most sexual assault survivors report non-penetrative sexual assaults. Though the SAFE kit proforma expects the doctor to probe for several forms of sexual assault such as forced oral sex, anal penetration, and masturbation of the child/woman, asking for such information was seen as a next to impossible task amongst doctors. When it came to eliciting such history from children, they found it all the more difficult. The experience of implementing the uniform proforma further demonstrated that sexual assault is looked at purely as a medico-legal issue with very little consideration to health consequences for the survivor of sexual assault. This attitude persists among health care providers, despite the well-documented fact that survivors require immediate medical attention coupled with psychosocial support in order to prevent long term sequelae.

This learning prompted us to develop a manual that would provide the examining doctor with a step-by-step approach to what should be done when a survivor of sexual assault reports to the hospital. This manual provides answers (with reference to relevant laws) to doctors about dilemmas that they encounter in day to day practice - such as what can be done when a survivor wants medical treatment but doesn't want to report the crime to the police. It provides detailed information on how history must be elicited, specific signs that should be noted during the examination, how

injuries must be recorded and dated, nature of evidence that needs to be collected, procedure for age estimation and much more. It also assists them with drafting an opinion at the end of such an examination. In addition to this, as annexures we have also provided a sample proforma and standard operating procedures that could be implemented at health facilities.

Given the absence of training on managing cases of sexual assault and the dearth of information on the issue in medical curricula, we hope that this manual will be able to fill a significant gap.

II. Scope of this Manual

This manual may be used:

- With the Sexual Assault and Forensic Evidence Kit (SAFE kit) and protocol.
- As a guide for examination and evidence collection in cases of sexual assault, even if you are using any other protocol or
- As a guide for examination and evidence collection if you are using only the kit without the protocol.

III. Definition of sexual assault:

The World Health Organisation (WHO) defines Sexual Violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments/ advances and acts to traffic, or otherwise directed against a person's sexuality, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim in any setting, including but not limited to home and work."[3] Sexual assault, a form of sexual violence, is a term often used synonymously with rape. However, sexual assault could include anything from touching another person's body in a sexual way without the person's consent to forced sexual intercourse (rape), sodomy (oral and anal sexual acts), child molestation, incest, fondling and attempted rape.[4]

Types of Sexual Violence include:

- coerced sex in marriage and dating relationships,
- rape by strangers
- systematic rape during armed conflict, sexual slavery
- sexual harassment,
- sexual abuse of children
- sexual abuse of people with mental and physical disabilities,
- forced prostitution and sexual trafficking,
- child marriage,
- denial of the right to use contraception,
- forced abortion and forced sterilization
- Violent acts against the sexual integrity of women, including female genital cutting and obligatory inspections for virginity
- forced exposure to pornography

[3] World Health Organization (2003) *Guidelines for medico-legal care for victims of sexual assault*, Page 6.
[4] National Centre for Victims of Crime (Washington DC).

Rape, as defined by Section 375 of the Indian Penal Code (IPC) is "Sexual intercourse by a man with any woman who is not his wife above the age of 16 years, against her will or without her consent." The inadequacy of the rape law lies in the fact that it does not include other forms of sexual assault like oral penetration, anal penetration, fingering and use of objects for penetration. Currently other forms of sexual assault are charged under sections having less severe punishments like Section 354 "criminal assault on a woman with intent to outrage her modesty" and Section 377 IPC, covering "carnal intercourse against the order of nature". Moreover, it does not recognize non-consensual sexual intercourse between a man and his wife as rape.

IV. Health Consequences of Sexual Assault[5]

Sexual assault, in addition to being a violation of human rights, is also an important public health issue as it has several direct and indirect health consequences. As a health care provider one must be aware that survivors of sexual assault might present with varying signs and symptoms. For those survivors who do not reveal a history of sexual assault, these signs and symptoms should prompt one to suspect the possibility of sexual abuse/assault.

Physical Health Consequences:

- severe abdominal pain
- burning micturition
- sexual dysfunction
- dyspareunia
- menstrual disorders
- urinary tract infections
- unwanted pregnancy
- miscarriage of an existing fetus
- exposure to sexually transmitted infections (including HIV/AIDS)
- pelvic inflammatory disease
- infertility
- unsafe abortion
- mutilated genitalia, and
- self-mutilation as a result of psychological trauma

[5] Refugee guidelines, *Source: C. M. Renzetti, J. L. Edelson & R. Kennedy Bergen (Eds.)Pg 7., Sourcebook on violence against women and* of WHO guidelines for medico-legal care for victims sexual assault Pg 12

Psychological Health Consequences:

Short term psychological effects:
- fear and shock
- physical and emotional pain
- intense self-disgust, powerlessness
- worthlessness
- apathy
- denial
- numbing
- withdrawal and
- an inability to function normally in their daily lives

Long term psychological effects:
- depression and chronic anxiety
- feelings of vulnerability
- loss of control
- emotional distress
- impaired sense of self
- nightmares
- self-blame
- mistrust,
- avoidance and post traumatic stress disorder
- chronic mental disorders
- committing suicide or endangering their lives

Rape Trauma Syndrome:

"Rape Trauma Syndrome" was first described by Burgess and Holmstrom in the year 1974[6] . The identification of this syndrome by them was based on the analysis of 92 adult women rape survivors whom they interviewed and followed up. They delineated the symptomatology of this syndrome into two phases.

Phase 1, the acute phase, is one of disorganization. The survivor feels shock and disbelief regarding the rape. They may initially react in two ways:
(1) in the expressed style, patients display anger, fear, and anxiety, and often cry and (2) in the controlled style, the patient remains calm and composed and displays little outward emotion. Often, the controlled patient needs permission to express her

[6] Burgess and Holmstrom (1974) Rape Trauma Syndrome, Am J Psychiatry 131:981-986.

emotions. This phase can last from 6 weeks to a few months. Physicians should anticipate either reaction and provide appropriate support and encouragement.

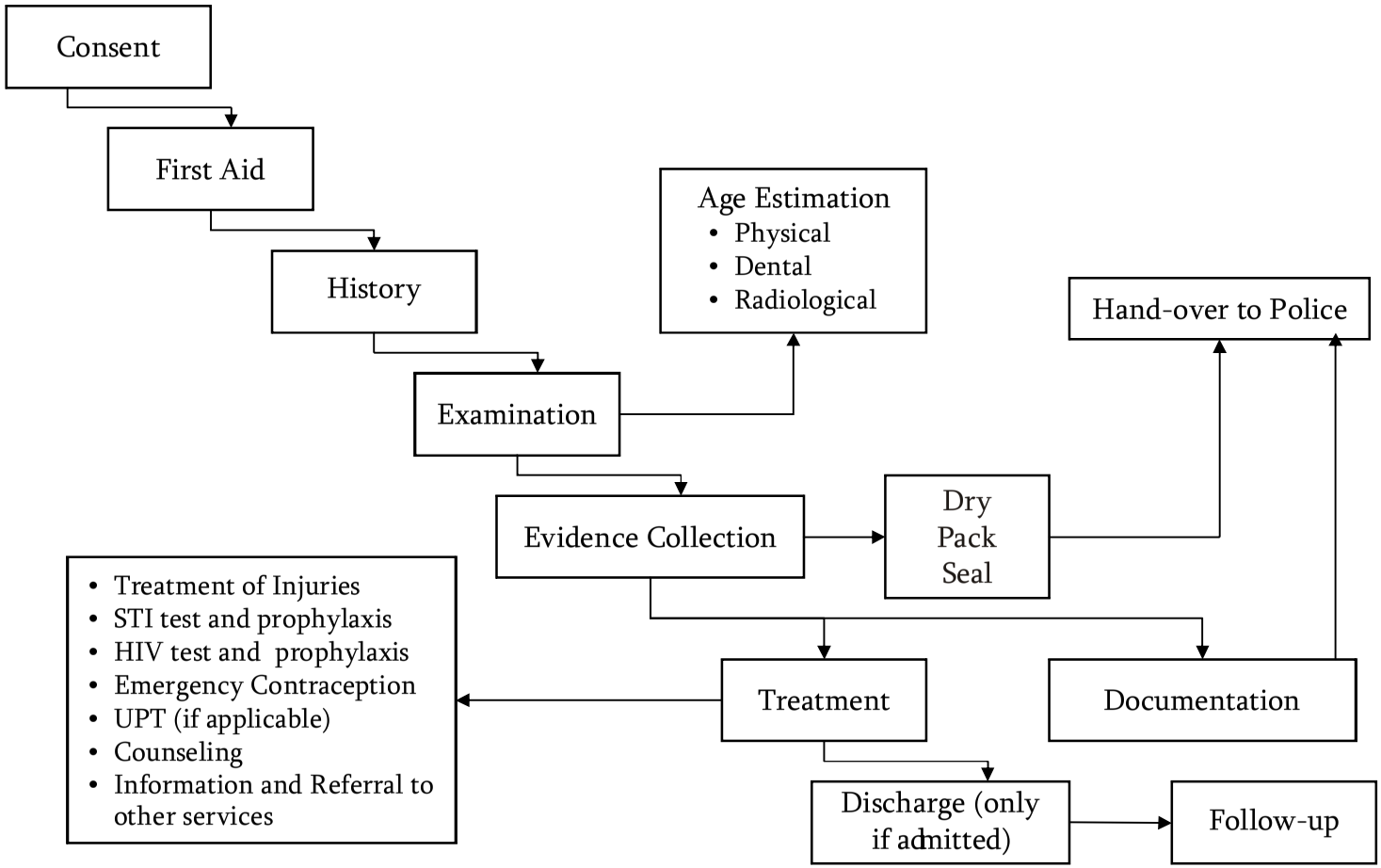
Phase 2, the reorganization phase, is a long-term process in which the survivor develops certain coping mechanisms. Reorganization may include stages of outward adjustment, personal integration. However it is important for doctors to realize that not all survivors will have similar kinds of symptoms. Some may exhibit more severe form of symptoms constituting the syndrome, some might have few and others might have no symptoms at all. Hence it is important for the doctor to treat each survivor on an individual basis.

V. Role of Health Care Providers

Health care providers play a dual role in responding to survivors of sexual assault. The first is to provide the required medical treatment and psychological support and the second is to assist the survivor in their medico-legal proceedings by collecting evidence and ensuring good quality documentation. After making an assessment regarding the severity of sexual assault, the first responsibility of the doctor is to provide medical treatment and attend to the survivor's needs. While doing so it may be pertinent to remember that the sites of treatment would also be examined for evidence collection later. The ultimate goal of the health care providers should be to establish a "Comprehensive Response to Survivors of Sexual Assault" .The components of the Comprehensive Response are as follows:

- Providing necessary medical support to the survivor of sexual assault
- Establishing a uniform method of examination, evidence collection by following the protocols in the SAFE kit
- Informed consent for examination and evidence collection and informing the police procedures.
- First contact psychological support and validation after the traumatic experience
- Maintaining a clear and fool-proof chain of custody and
- Referral to appropriate agencies for further help (eg. legal support services, shelter services etc.)

The diagram below represents the components of your role as a health care provider.



VI. Purpose of the Medical and Forensic Examination

The purpose of the medical and forensic examination of the survivor is to establish the following:

- Whether a sexual act has been attempted or completed. A sexual act may not only be penetration by the penis but also slightest penetration of the vulva by the penis, such as minimal passage of the glans between the labia with or without emission of semen or rupture of the hymen. Sexual acts include genital, anal or oral penetration by the penis, fingers or other objects as well as any form of non-consensual sexual touching.
- Whether such a sexual act is recent.
- Whether such an act was forcible. Signs of resistance to the assault are documented through examination. The history of resistance and/or evidence of struggle and injuries inflicted on the survivor by the accused and by the survivor on the accused provide evidence that the act was against his/her will. However, absence of signs of struggle does not imply consent.
- If validity of consent is questionable. Verifying age of the patient in case of pre-pubertal/adolescent girls/boys. Ascertaining influence of alcohol or drugs administered to the survivor.
- Providing treatment for sequelae of the assault and appropriate referrals for the patient.

VII. Prerequisites at the Health Facility

- The examination should be carried out in a non-threatening, quiet, well lit and private place.
- Adequate waiting space should be made available for relatives accompanying the survivor.
- Sufficient lighting and a comfortable examination table are necessary for a thorough examination.
- Sufficient space should be present on a table or platform for laying out all equipment required to conduct the examination and for taking notes.
- The facility should lay down clear procedures and protocols to be followed in cases of sexual assault and these should be made available to all providers. This includes assembling all the contents required for a medical examination in one place.
- The facility should designate staff for examination of survivors and collection of evidence. They should be trained on the issue of sexual violence and its impact on physical and mental health. They should also have the necessary training and experience to carry out an examination appropriately.

- It is not mandatory that only a gynaecologist must examine the survivor of sexual assault. As per 164 A Criminal Procedure Code (CrPC), any Registered Medical Practitioner can and should conduct the examination.
- In case a female doctor is not available for the examination of a female survivor, a male doctor should conduct the examination in the presence of a female attendant. In case of a minor/person with disability, his/her parent/guardian/ any other person with whom the survivor is comfortable must be present.
- Unless the patient requires indoor stay for treatment or observation admission should not be insisted upon.
- There must be no delay in conducting an examination and collecting evidence in cases of sexual assault as evidence is lost with time. The urgent nature of the examination cannot be over-emphasised.
- In a situation of mass violence (caste, communal or armed conflict) various forms of sexual assault are perpetrated against women and girls. Doctors working in such situations should therefore look for signs/evidence of sexual assault amongst all girls and women who come to the hospital, whether they are brought dead or alive. The State must provide security to its health professionals under such circumstances so that they may be allowed to carry out their duties without fear or external pressure.

Materials Required:

- Paper envelopes
- Sterile swabs and swab guards
- Bags for storing clothes
- Catchment Papers
- Comb
- Nail Cutter
- EDTA vaccutainer
- Plain vaccutainer
- Sodium fluoride vaccutainer
- Syringe and needle
- Distilled water
- Disposable Gloves
- Glass slides
- A pair of small scissors
- Lac Stick for sealing

Infrastructural requirements for the examination of survivor

- Torch
- Microscope
- Colposcope
- Disposable Speculum
- 2% 30 gm tube of sterile lignocaine jelly
- Cytofix spray
- Surgilube
- Spirit Lamp
- Toluidine Blue
- Polaroid camera
- UPT Kit

The Term 'Survivor': A person (male / female / transgender) against whom an assault is perpetrated is termed as a survivor. This term gives a positive hue to the self of the person; it conveys that s/he has managed to pull him/her self together in spite of what s/he went through. We have not used the term "victim" as this takes away from the person's agency. We also do not use "patient" as this is a general term used for a person with a disease. Sexual assault is not a disease but a violation of human rights.

VIII. Consent

- A survivor may approach a health facility under three circumstances:
    1. On his/her own;
    2. With a police requisition after police complaint;
    3. With a court directive.

  In all three circumstances, seeking informed consent for examination and evidence collection is mandatory (164 (A) CrPC).
- Consent of the patient should be taken for the following purposes:
    1. Examination
    2. Collection of the evidence
    3. Informing police for purposes of investigation
    4. Treatment
- The consent form must be signed by the person him/herself if s/he is above 12 yrs. of age. Consent must be taken from the guardian/ parent if the survivor is under the age of 12 years or if the survivor is unable to give his/ her consent by reason of mental disability. (Section 89 IPC)
- The consent form must be signed by the survivor, a witness as well as the examining doctor.
- Any major 'disinterested', mentally sound person may be considered a witness. In the hospital set-up this could be a nurse or other hospital employee.
- Please note that the survivor or guardian may refuse to give consent for any part of examination. In this case the doctor should explain the importance of examination and evidence collection. It should also be explained that refusal for such examination will not affect/compromise treatment. Such informed refusal for examination and evidence collection must be documented (164 (A) CrPC).
- Patient and her relative/ guardian should be explained that at any stage during examination and evidence collection she may ask the doctor to stop and that it will not have any effect on the quality of her treatment.
- Even if the survivor refuses consent to submit evidence to the Forensic Science Laboratory (FSL) and reveal information to the police for purposes of investigation, she should be made aware that if at a later date she changes her mind and wants to pursue a legal course of action, the collected evidence may be useful to seek justice.

- A survivor may come to the hospital only for treatment for effects of assault. Under 39 CrPC the doctor is not bound to inform the police. Informed refusal for not informing the police should be documented. Neither court nor police can force the survivor to undergo medical examination. It has to be with the survivor/parent/guardian's informed consent (depending on the age).
- Voluntarily reporting to health facility: In the past sexual assault survivor examination was only done after receiving a police requisition. Now the Supreme Court has clarified in case of Manjanna v State of Karnataka (2000) that police requisition is not mandatory for a sexual assault survivor to seek medical examination and care. The doctor should examine such cases even if the survivor reports to the hospital first without FIR.
- Requisition: Once the case is booked in a particular police station/court, the investigating officer (minimum rank of sub-inspector of police) of the case forwards a requisition for medical examination of survivor of sexual assault. The police constable may accompany the survivor as escort along with the requisition from the investigating officer.

IX. General Information:

- Start by recording the name, age, sex (male/female/transgender), address and contact number of the survivor.
- Information about the police case registered, such as Medico Legal Case (MLC) number, Crime Register (CR) number, U/S should also be recorded.
- Who the patient was brought by and relationship to accompanying persons must be recorded.
- Date, time and place of examination should be specifically written.
- Marks of identification (two in number), in the form of moles, scars, tattoos, preferably from the exposed parts of the body to be documented. While describing identification mark emphasis should be on size, site, surface, shape, colour, fixity to underlying structures.

X. Medical History

- Conventionally, obstetric history including past history of pregnancy, abortions etc is recorded. However, this may be considered an invasion of privacy as it forces survivors to reveal past sexual history/practice. Hence such history should not be routinely sought. (Section 146 of the Indian Evidence Act)

- Relevant medical history in relation to sexually transmitted infections (gonorrhea, HIV, HBV etc). This has a bearing on what gets transferred between survivor and accused of sexual assault. Such a history can be elicited by asking about discharge per-urethra/per-anus, warts, ulcers, burning micturition, lower abdominal pain etc. Based on this information reexamination including investigations can be done after incubation period of that disease.
- Relevant surgical history in relation to treatment of fissures/injuries/scars of ano-genital area should be noted.
- Information related to past abuse (physical/sexual/emotional) should be recorded. This is important in order to understand whether there are any health consequences related to the assault, which would also inform referral for further care. This information should also be kept in mind during examination & interpretation of findings.

XI. Sexual Assault History

- Keep in mind that narration of the history of sexual assault might be a traumatizing experience for the survivor. It is very difficult for most survivors to talk about this and s/he might not want to tell you all the details.
- Be very sensitive of this and explain to the survivor that the process of history taking is important for further treatment and for filing a case if needed.
- Talk to the survivor in a non-threatening environment.
- Do not pass judgmental remarks or comments that might appear unsympathetic and disbelieving. An accurate history can be obtained only by gaining the trust of the survivor and not by accusing him/her of lying.
- Police officers must not be present while history is being recorded. If the survivor is comfortable with a relative being around while recording the history then the relative could be present with the consent of the survivor.

- History of the incident, documentary specifically in the survivor's own words verbatim has evidentiary value in the court of law as this is being recorded by neutral and unbiased doctor. The doctor should record it completely as it may be the first opportunity for the survivor to narrate her history.
- Details of the place of the assault, time, nature of force used, areas of contact are recorded here. If the assailants are known, please ask and mention the names of the assailants.

- If any sensitive information is revealed (such as identity of assailants) it is better to have the identity (name) and signature of the informant (survivor or her parent/guardian in case of minor).
- Information collected on activities like bathing, washing genitals (in all cases) rinsing mouth, drinking, eating (in oral sexual assault) has bearing on the evidentiary outcome of trace evidence collected from these sites.
- Please specifically note history of injury marks that the survivor may state to have left on the assailant's body as it can be matched eventually with the findings of the assailant's examination.
- Pertinent data of the assault with regard to injuries, threats and weapons used must be recorded. While recording such data, please note the following:

  - Physical violence: mention weapons or objects used. Pushing, banging, slaps, kicks, blows with sticks, acid burns, gun shots, knife attacks etc. are examples of physical violence. Survivor may have had blunt trauma which should be looked for during examination.

  - Verbal threats should be recorded in survivor's words, eg. harming her or her near and dear ones. Threats to divulge information regarding occurrence of the assault to others will also amount to a threat.
- Information regarding attempted penetration or completed penetration by penis/finger/object in vagina/anus/mouth should be properly recorded along with information about emission of semen. Indicating that penetration was complete precludes the need to indicate that it was attempted.
- It is important to bear in mind that while 'rape' (Section 375 IPC) includes only peno-vaginal intercourse, there is a wide range of acts that amount to 'sexual assault'. These could be penetration of the vagina/mouth/anus by the penis/finger/object, or other acts such as masturbation of the assailant by the survivor, masturbation of the survivor by the assailant, oral sex by the assailant on the survivor or sucking, licking, kissing of body parts. While recording a history of sexual assault, it is important to probe whether these acts occurred or not.
- It is observed that generally doctors are awkward in asking for history of the sexual act. If details are not entered it may weaken the survivors' testimony. History of oral sex, anal sex and masturbation should be asked in simple language. In case of minor children, illustrative books or a doll can be used if available, to elicit the history of the assault. When it is difficult to elicit history from a child, please call an expert.

- Information about emission of semen outside the orifices should be elicited as swabs taken from such sites can have evidentiary value.
- Information regarding use and status of condom during the assault is relevant because in such cases, vaginal swabs and smears would be negative for sperm/semen.
- If there is a history of last consensual sexual intercourse in the week preceding the assault, it should be recorded because detection of that sperm/semen has to be ruled out. While seeking such history, explain to the survivor why this information is being sought, because the survivor may not want to disclose such history as it may seem invasive.
- If the survivor is menstruating at the time of examination then a second examination is required on a later date in order to record the injuries clearly.
- Some amount of evidence is lost because of menstruation. Hence it is important to record whether the survivor was menstruating at the time of assault/ examination.
- The same applies to bathing, douching, defecating, urinating and use of spermicide after the assault.
- If there is vaginal discharge, record its type, i.e., texture, colour, odour, etc.

XII. Forensic Evidence Collection

- Before you begin, make an assessment of the case and determine what evidence needs to be collected. This procedure cannot be done mechanically and will require some analysis. This assessment will have to be made on a case-to-case basis.
- The nature of forensic evidence collected will be determined by three main factors - nature of assault, time lapsed between assault and examination and whether the person has bathed/washed herself since the assault.
- If a woman reports within 96 hours of the assault, all evidence including swabs must be collected without fail, in keeping with the history of assault. The likelihood of finding evidence after 72 hours is greatly reduced, however it is better to collect evidence upto 96 hours in case the survivor may be unsure of the number of hours lapsed since the assault.
- Please keep in mind that spermatozoa can be identified only for 72 hours after assault. So if a survivor has suffered the assault more than three days ago, please refrain from taking swabs for spermatozoa. In such cases swabs should only be sent to FSL for tests for identifying semen.
- Evidence on the outside of the body and on materials such as clothing can be collected even after 96 hours.

- The nature of swabs taken is determined to a large extent by the nature of assault and the history that the survivor provides. The kinds of swabs taken should be consistent with the history. For example, if the survivor is certain that there is no anal intercourse, anal swabs need not be taken.
- Request the survivor to stand on a large sheet of paper, so as to collect any specimens of foreign material e.g. grass, mud, pubic hairs or scalp hairs etc. which may have been left on her person from the site of assault or from the accused. This sheet of paper is carefully folded and preserved in a bag to be sent to the FSL for trace evidence detection.
- Clothes that the survivor was wearing at the time of the assault are of evidentiary value if there are any stains/tears/trace evidence on them. Hence they must be preserved. Please describe each piece of clothing in the table provided. Presence of stains - semen, blood, foreign material etc - should be properly noted. Also note if there are any tears or other marks on the clothes. If clothes are already changed then the survivor must be asked if s/he has the clothes that were worn at the time of assault and these must be preserved.
- Always ensure that the clothes and samples are air dried before storing them in their respective packets.
- Ensure that clothing is folded in such a manner that the stained parts are not in contact with unstained parts of the clothing.
- Pack each piece of clothing in a separate bag, seal and label it duly.

Body Evidence:

- Based on Locard's principle of exchange there is exchange of bodily evidence between accused and survivor.
- Collect oral swab for detection of semen and spermatozoa. Oral swabs should be taken from the posterior parts of the buccal cavity, behind the last molars where the chances of finding any evidence are highest.
- Swabs are used to collect bloodstains on the body, foreign material on the body surfaces seminal stains on the skin surfaces and other stains.
- Detection of scalp hair and pubic hair of the accused on the survivor's body (and vice-versa) has evidentiary value. Collect loose scalp and pubic hair by combing. Intact scalp and pubic hair is also collected from the survivor so that it can be matched with loose hair collected from the accused. All hair must be collected in the catchment paper which is then folded and sealed.
- If there is struggle during the sexual assault, with accused and survivor scratching each other, then epithelial cells of one may be present under the

nails of the other . Examine nail scrapings and nail clippings for epithelial cells (this can also be used for DNA detection). Clippings and scrapings must be taken for both hands and packed separately.

- Ensure that there is no underlying tissue contamination while clipping nails.
- Blood is collected for grouping and also helps in comparing and matching blood stains at the scene of crime.
- Collect blood and urine for detection of drugs/alcohol as the influence of drugs/alcohol has a bearing on the outcome of the entire investigation. If such substances are found in the blood, the validity of consent is called into question. In a given case, for instance, there may not be any physical or genital injuries. In such a situation, ascertaining the presence of drug/alcohol in the blood or urine is important since this may have affected the survivor's ability to offer resistance.
- Venous blood is collected with the sterile syringe and needle provided and transferred to 3 colour coded vaccutainers for the following purposes:

Colour Code	Contents	Purpose
Red	Plain Vaccutainer	Blood grouping and drug estimation
Grey	Sodium Fluoride	Alcohol estimation
Purple	EDTA	DNA Analysis

- Blood group and HIV, VDRL should be sent to the hospital laboratory.
- Urine sample may be collected in a container to test for drugs and alcohol levels as required.
- Note the time drugs/metabolites remain in the body.
  1. Alcohol - Found up to 10 hours.
  2. Rohypnol (Flunitrazepam) - Found up to 36-72 hours.
  3. GHB (Gamma Hydroxybutyric Acid) - Found up to 10-12 hours.
  4. GLB (Gamma Butyrolactone) - Found in urine up to 6 hours and in the blood up to 24.

Genital and Anal Evidence:

- In the case of any suspected seminal deposits on the pubic hair of the woman, clip that portion of the pubic hair, allow to dry in the shade and place in an envelope.

- Pubic hair of the patient is then combed for specimens of the offender's pubic hair. A comb must be used for this purpose and a catchment paper must be used to collect and preserve the specimens. Cuttings of the pubic hair are also taken for the purpose of comparison or to serve as control samples. If pubic hair has been shaved, do not fail to make a mention of it in the records.
- Take two swabs from the vulva, vagina, anal opening for ano-genital evidence. Swabs must be collected depending on the history and examination. Swabs from orifices must be collected only if there is a history of penetration. One vaginal smear is to be prepared on a glass slide provided, air-dried in the shade and placed in an envelope. This extra wet smear prepared should be examined for spermatozoa under the microscope. This will aid the doctor in writing opinion with more certainty.
- Often lubricants are used in penetration with finger or object, so relevant swabs must be taken for detection of lubricant.
- Swabs for microbiological tests for infections may be sent as per institutional policy and availability.
- Swabs must not be dried in direct sunlight.
- Always ensure that all the envelopes containing the samples are labeled

XIII. General Examination

- Record the mental status of the survivor after the incident accurately. This may offer evidence of ingestion or injection of drug / alcohol voluntarily or forcibly or ignorantly.
- Rape trauma syndrome is an entity with both physical and emotional components with acute and chronic symptoms. To arrive at a diagnosis of Rape trauma syndrome mention of mood is important.
- Make an assessment of the emotional and mental state of the woman and record it (one may mention the mood in terms like shock, scared, numbed, etc. Please note that "the patient is indifferent, detached or controlled" may be used against her by the defense hence such reference may be avoided).
- Height and weight are relatively important in assessing physical age.
- A general examination begins with the inspection of the body surface for bruises, scratches, bites and other injuries. Specifically look for marks on the face, neck, shoulders, breast, upper arms, buttocks and thighs.
- Note and describe all injuries. Describe the type of injury - abrasion, laceration, incised etc.

- Mention possible weapon of infliction in the words such as - hard, blunt, rough, sharp, etc.
- It is important to keep in mind that injuries might not always be seen. There may be circumstances in which the survivor may have been threatened with bodily harm, physically restrained, or afraid to resist for other reasons, thus explaining absence of injuries. In fact, only one-third of cases of sexual assault have visible injuries.[7] But cases of assault have been proved even in the absence of injuries.
- Injuries are best represented when marked on body charts. They must be numbered on the body charts and each injury must be described in detail. Photographic evidence is even better than body charts, provided the survivor consents to it.
- Actual measurements, site, shape, with time since injury should be described.
- Time since injury calculation is as follows:

Abrasion:

Fresh	Bright Red
12 to 24 hours	Reddish scab
2 to 3 days	Reddish brown scab
4 to 7 days	Brownish black scab
After 7 days	Scab dries, shrinks and falls of from periphery

Contusion:

Fresh	Red
Few hours to 3 days	Blue
4th day	Bluish-black to brown (haemosiderin)
5 to 6 days	Greenish (haematoidin)
7 to 12 days	Yellow (bilirubin)
2 weeks	Normal

Note : This is a reference chart only, as many external and internal factors contribute in the healing of injuries

[7] Bowyer L, Dalton ME. Female victims of rape and their genital injuries. Br J Obstet Gynaecol. 1997;104:617-620

If there is deep bruise or contusion, signs of injury will usually show after 48 hours. In case you see signs of injury on the follow-up, please record them and attach the documentation to MLC papers.

Laceration: It becomes difficult to estimate exactly the time since injury based on the size and contamination. However a rough estimate can be done based on signs of healing.

Incised injury:

Fresh	Haematoma formation
12 hours	Edges - red, swollen
24 hours	Scab of dried clot covering the entire area
After this rough estimate can be based on signs of healing.	

Please do not mention old scars as they are identification marks rather than new injuries due to assault. If mentioning those seems pertinent, add a note on when they were acquired.

Stains on the body:

- Describe the type of stain - blood, semen, lubricant, etc.
- Describe the actual site and size and colour.
- Mention the number of swabs collected and their sites.

XIV. Genital Examination

- A careful observation of the perineum is made for evidence of injury, seminal stains and stray pubic hair.
- In case of female survivors, the vulva, labia, fourchette, hymen and introitus are inspected likewise. A note is made of any swelling, bleeding and tearing, these being signs of recent injury.
- Bleeding/swelling/tears/discharge/stains/warts around the anus and anal orifice must be documented. Examine the anal sphincter tonicity and document findings. Per-rectal examination to detect tears/stains/fissures/hemorrhoids in the anal canal must be carried out and relevant swabs from these sites should be collected.
- Examination of the vagina of an adult female is done with the help of a sterilised speculum. Gentle retraction allows for inspection of the vaginal canal. Look for bruises, redness, bleeding and tears, which may even extend into the perineum, especially in the case of very young girls. In case injuries are not

visible but suspected; 1% Toluidine blue is sprayed and excess is wiped out. Micro injuries will stand out in blue.

- Do not perform two-finger test of admissibility in cases of sexual assault as information about past sexual conduct has been considered irrelevant to the case in several judgments. (Section 146 of the Indian Evidence Act)
- The examination and treatment as needed may have to be performed under general anaesthesia in case of minors and when injuries inflicted are severe.
- Micro injuries are better appreciated under a colposcope. Per vaginal and per speculum examination is not a must in the case of children when there is no history of penetration and no visible injuries. Per speculum examination should be done with a sterile water/ saline (preferably warm) lubricated speculum.
- Routinely, there is a lot of attention given to the status of hymen. However it is largely irrelevant because the hymen can be torn due to several reasons such as cycling, riding or masturbation among other things. Even if the hymen is intact, forceful sexual penetration cannot be ruled out.
- If there is vaginal discharge, comment on the characteristics ie. texture, colour, odour, etc.
- As with general examination, genital findings must also be marked on body charts and numbered accordingly.

XV. Opinion:

- Opinion has to be given on following issues

1. Any clinical evidence that the survivor is mentally incapable of giving consent, or under the influence of ethyl alcohol/narcotic drug/ psychotropic substance.
2. Any means by which the assailants can be identified.
3. Evidence of penetrative or non-penetrative sexual assault:

A. Non-penetrative sexual assault

Non-penetrative sexual assault like fondling, sucking, forced masturbation, etc. Properly eliciting history in this regard is vital. Examination for any injuries caused by these acts must be documented and marked on body charts. Relevant swabs must be collected.

B. Penetrative sexual assault

- Evidence of vaginal, anal or oral intercourse.
  - Evidence of vaginal intercourse is in the detection of spermatozoa in the

wet vaginal smear, semen in the vaginal swabs/smears detected by FSL.

- Evidence of anal intercourse is in the detection of spermatozoa in the wet anal smear, semen in the anal swabs/smears detected by FSL.
- Evidence of oral intercourse is in the detection of spermatozoa in the wet oral smear/semen in the oral swabs/smears detected by FSL.

- Whether there is evidence of vaginal, anal penetration by finger or object.
  - Vaginal penetration: presence of injuries and lubricant - detection of lubricant in the swabs by FSL.
  - Anal penetration: presence of injuries and lubricant - detection of lubricant in the swabs by FSL.
- Whether there are signs of use of force.
  - based on both physical and genital injuries;
  - based on physical injuries over body like abrasions, contusions, lacerations, incised injuries, fractures, nail scratches, bite marks, etc;
  - based on genital injuries like tear on fourchette, introitus, in the vagina, fresh hymen tears or lacerations, urethral lacerations, anal lacerations, abrasions.
- Whether intercourse was a recent act or not.
  - based on time since injuries.

4. Actual age of the survivor in case of minor (< 18 yrs).
   - medical age is mean of physical age, dental age and radiological age.

- Drafting of provisional opinion should be done immediately after examination of survivor and wet smear examination.
- The opinion must state the number of days after which examination and evidence collection was carried out, after the incident.
- The following section gives the reader some scenarios about ways to draft a provisional and final opinion. However, this list is not exhaustive and readers are advised to form provisional opinions based on the examples given below.

Provisional opinion PENETRATIVE Assault by PENIS			
Genital injuries/ disease	Physical injuries	Wet smear vaginal/ anal	Opinion
present	present .	positive	There are signs suggestive of recent forceful vaginal/anal intercourse
present	absent	positive	There are signs suggestiv of recent forceful vaginal/anal intercourse
present	present/ absent	absent	There are signs of use of force/forceful penetration of vagina/anus: however opinion regarding penetrative inter-course is reserved pending availability of FSL reports.
absent	present	absent	There are signs of use of force, however opinion regarding penetrative intercourse is reserved pending availability of FSL reports
absent	absent	absent	There are no signs of use of force, however opinion regard-ing penetrative intercourse is reserved pending availability of FSL reports.

Rationale why forced penetrative sex cannot be ruled out	What can FSL detect
This could be because a condom was used or because the assailant may have had a vasectomy or diseases of the vas deferens	Evidence of semen except when condom was used
This could be because, there was use of condom or the assailant may have had a vasectomy or diseases of the vas. The lack of genital injuries could be because of use of lubricant	Evidence of semen or lubricant
This could be because, there was use of condom or the assailant may have had a vasectomy or diseases of the vas. The lack of genital injuries could be because of use of lubricant. The lack of physical injuries could be because of the survivor being unconscious, under the effect of alcohol/drugs, overpowered or threatened.	Evidence of semen, lubricant and drug/alcohol

Provisional opinion PENETRATIVE Assault by FINGER/OBJECT			
Genital injuries/ disease	Physical injuries	Wet smear vaginal/ anal	Opinion
only genital injuries present	absent	negative	There are signs of use of force/forceful penetration of vagina/anus, however the opinion regarding lubrication is reserved pending availability of FSL reports.
no genital injuries	absent	absent	There are no signs of use of force/forceful penetration of vagina/anus, however the opinion regarding lubrication is reserved pending availability of FSL reports

Rationale why forced penetrativesex cannot be ruled out	What can FSL detect
This could be because, there was fingering or penetration by object with or without use of lubricant	Evidence of lubricant
This could be because, there was fingering or penetration by object with use of lubricant	Evidence of lubricant

FINAL OPINION AFTER RECEIPT OF FSL REPORT

Genital injuries/ disease	Physical injuries	Evidence of spermatozoa on wet smear	FSL report
present	present	negative	positive for presence of semen
present	absent	negative	positive for presence of semen
absent	present	negative	positive for presence of semen
absent	absent	absent	positive for presence of semen
absent	absent	absent	positive for drugs/alcohol and semen
present	present	absent	negative for presence of semen/ alcohol/ drugs/ lubricant
genital injuries present	absent	absent	negative for presence of semen/ alcohol/ drugs/ lubricant
absent	only physical injuries	absent	negative for presence of semen/ alcohol/ drugs/ lubricant
absent	absent	absent	negative for presence of semen/ alcohol/ drugs/ lubricant
absent	absent	absent	positive for presence of lubricant only

Final opinion

There are signs suggestive of forceful vaginal/anal intercourse.

There are signs suggestive of forceful vaginal/anal intercourse.

There are signs suggestive of forceful vagina/anal intercourse.

There are signs suggestive of vagina/anal intercourse.

There are signs suggestive of vagina/anal intercourse under the influence of drugs/alcohol.

There are no signs suggestive of vagina/anal intercourse, but there is evidence of assault.

There are no signs suggestive of vagina/anal intercourse, but there is evidence of genital assault.

There are no signs suggestive of vagina/anal intercourse, but there is evidence of assault.

There are no signs suggestive of vagina/anal intercourse.

There is a possibility of vaginal/anal penetration by lubricated object.

OPINION FOR NON-PENETRATIVE ASSAULT

1	Bite marks present and /or FSL detects salivary stains	There are signs suggestive of evidence of bite mark/s on _____ site (time the injury)
2	Sucking marks (discoid, subcutaneous extra-vasation of blood, with or without bite marks) present and /or FSL detects salivary stains	There are signs suggestive of sucking mark/s on _____ site (time the injury).
3	Forceful fondling, with presence of bruises or contusions with or without fingernail marks	There are signs suggestive of forceful physical injuries on _____site (time the injury) (which may be due to fondling)
4	Only forceful kissing and FSL detects salivary stains	There are signs suggestive of salivary contact (which may be due to kissing)
5	If the history suggests forced masturbation of the assailant by the survivor and if there is evidence of seminal stains detected on the hands of the survivor	There are signs suggestive of seminal fluid contact (which may be due to masturbation)
6	In case there are no signs of sucking, licking..... detected, but the history suggests some such form of assault	It is still important to document a good history because the survivor may have had a bath or washed herself.

XVI. Signature and seal

- After the examination the medical practitioner should draft the report, formulate the opinion, sign the report and handover report and sealed samples to police under due acknowledgement.
- On the last sheet, please mention how many pages are attached. It is imperative that the doctor signs each page of the report so as to avoid tampering.
- It is important that one copy of all documents be given to the survivor as it is his/her right to have this information. Copies must also be given to the police and FSL and one copy must be kept for hospital records. It is hence preferable that all documentation be filled out in quadruplicate.
- All evidence needs to be dried, packed and sealed in separate envelopes. The responsibility for this lies with the examining doctor.
- Each envelope must be labeled as follows

Packet number……

Name of the hospital & Place……..

Hospital Number & Date ……

Police station with Crime number & Sections (if any)…….....

Name of the person with age & Sex ……..

Sample collected……..

Examination required……..

Date & Time **Signature of doctor with seal**

XVII. Treatment Guidelines and Psychosocial Support

- Urgent medical needs must be prioritized.
- At the end of the first examination the patient is assessed and treated, advised or referred for conditions like injury, sexually transmitted diseases and pregnancy that may result from the assault. Counselling and psychosocial support should be offered. In the absence of such expertise kindly refer the patient to the nearest competent personnel.

1. **Sexually Transmitted Infections:** If clinical signs are suggestive of STD, collect relevant swabs and start PEP. If there are no clinical signs, wait for lab results.
   - For non-pregnant women, the preferred choice is Azithromycin 1gm stat or Doxycycline 100mg bd for 7days, with Metronidazole 200mg (7days) with antacid.
   - For pregnant women, the preferred choice is Amoxycillin/ Azithromycin with Metronidazole (NO METRONIDAZOLE TO BE GIVEN IN THE 1ST TRIMESTER OF PREGNANCY)
   - Hepatitis B. Draw a sample of blood for HBsAg and administer 0.06 ml/kg HB immune globulin immediately (anytime upto 72 hours after sexual act). This is not mandatory and is subject to availability and the capacity of patient to pay for the treatment.

2. **Pregnancy Prophylaxis (Emergency Contraception)**
   - The preferred choice of treatment is 2 tablets of Levonorgestrel 750 μg (Norlevo), within 72 hours. If vomiting occurs, repeat within 3 hours.

     Or

     2 tablets COCs Mala/ Ovral

     Mala/Ovral G => 2 tablets stat repeated 12 hours within 72 hours

     Novelon/Femilon/Ovral L => 4 tablets stat repeated after 12 hours within 72 hours.
   - Although emergency contraception is most efficacious if given within the first 72 hours, it can be given for up to 5 days after the assault.
   - Pregnancy assessment must be done on follow up and the survivor must be advised to get tested for pregnancy in case she misses her next period.

3. **Lacerations:** Clean with antiseptic (Savlon/Dettol) or soap and water. If survivor is already immunised with Tetanus Toxoid or if no injuries, TT not required. If there are injuries and survivor is not immunised administer ½ cc TT IV. If lacerations require repair and suturing, which is often the case in minor girls, refer to the nearest centre offering surgical treatment.

4. **Post Exposure Prophylaxis (PEP) for HIV** should be given if a survivor reports within 72 hours of the assault. Before PEP s prescribed, an assessment of HIV risk must be done.[8]

[8] For further details on HIV risk assessment, please refer to *Post-Exposure Prophylaxis to Prevent HIV Infection: Joint WHO/ILO guidelines*, WHO 2007.

5. **Follow-up:** Because sexual assault survivors have multiple needs (medical as well as psychosocial), follow-up is essential at 3 and 6 weeks. Please emphasize the importance of follow up to the patient. It is ideal to call the patient for re-examination 2 days after the assault to note the development of bruises and other injuries. All follow ups should be documented.
    - Within 72 hours after initial assessment to record developing bruises
    - Repeat test for gonorrhoea if possible.
    - Test for pregnancy.
    - Repeat after six weeks for VDRL.
    - Assess for psychological sequelae. Re-iterate need for psychological support.

6. **Psycho-social Support**

- **Establishing rapport** with the survivor is an extremely crucial part of providing services. This is particularly important because s/he has come after a traumatic episode and has crossed several hurdles in order to report the crime. It must be emphasized that coming to the hospital is an act of courage, given the stigma attached to the crime of sexual assault. Appreciating the survivors' strength in this regard can serve to build a bond of trust. Gaining the trust of the survivor will make it easier for them to talk about the episode which is essential to recording a good history.
- **Facilitating and demystifying procedures:** All the procedures, reasons/ rationale needs to be explained to the survivor in a language that s/he understands. Ensure confidentiality and explain to the survivor that s/he must reveal the entire history to you without fear and not hide anything. The fact that this process requires internal examination must also be explained. Genital examination may be uncomfortable, but that it is for his/her benefit needs to be stressed. Often survivors are shuttled from one department to the other for carrying out various tests and procedures such as x-rays etc. The need for these also needs to be explained as survivors are often confounded by the number of procedures being performed.
- **Conveying messages of validation and addressing feelings of self-blame:** The most important message that needs to reach the survivor is that rape or sexual assault is an act of violence. This drives home the point that the survivor is not responsible for precipitating the act of rape by any of her actions or inactions. It is a tool used to exert power over women/girls to establish control.

It needs to be emphasized that this is a crime/violence and not a sexual act. It is not a loss of honour but a violation of his/her rights and it is the perpetrator who should be ashamed.

- **Addressing suicidal thoughts:** Feelings of shame and guilt often lead to thoughts of wanting to end one's life. It should be conveyed to the survivor that such thoughts are common and that there are ways to over come them. You must encourage him/her to engage in activities that help to deal with negative feelings. In case s/he has too many intrusive negative feelings, encourage her to seek help.
- **Involving the family/friends:** Friends and families may be equally traumatised with the episode and may feel completely lost so it is important for you to explain the procedures to them as well. At the same time they may have common perceptions/myths about rape that could lead to victim blaming, isolation or even desertion of the survivor. Explain to them that rape is an act of violence and not an act that the survivor has precipitated; that she is not to be blamed for what has happened. Dealing with the aftermath of sexual assault requires a great deal of support from the family and society. It is important to involve the family so as to create an enabling environment for the survivor once she goes back home.
- **Dealing with Children:** In cases of child sexual abuse, it might be difficult to talk to the survivor about the incident. At such times, it is best to speak to the mother. Often it is the mother who is the immediate carer for a child; but also invariably faces the brunt for not taking adequate care of the child. It is pertinent to talk to the mother and deal with her feelings too. At the same time you must also educate the mother about ways to deal with the child and explain the meaning of good and bad touch. It should also be stressed that the child should be allowed to go about his/her daily activities and should not be subject to restraint (such as preventing him/her from going to school, to play etc) as a result of the assault.
- **Refer** to the hospital social worker if available in the hospital or a counselling centre. While making such a referral convey to the survivor that such incidents cause long term psychological trauma and may re-surface over a period of time It is hence important to address the psychological impact through counselling.

XVIII. Age estimation

- Age estimation is required when examining minor survivors. Assaults on minors are punishable with more severe sentences and therefore age assessment is critical.
- If there is enough documentary proof, age determination is not recorded. If the age is at the borderline, the doctor can make a judgment regarding need for age determination test.
- Medical age is the mean of physical age, dental age and radiological age of the person.
- Physical age is estimated based on physical growth like height, weight, chest circumference etc and also based on secondary sexual characteristics.
- Tanner staging of breast and pubic hair should be used to determine stage of growth

Breast Development using Tanner's Index:		
Stage 1	Pre-adolescent: Elevation of papilla only	Less than 9 years
Stage 2	Breast bud stage: Elevation of breast and papilla as a small mound. Enlargement of areola diameter	10-11 years
Stage 3	Further enlargement and elevation of breast and areola with no separation of their contours	12 years
Stage 4	Projection of areola and papilla to form a secondary mound above level of breast	13-14 years
Stage 5	Mature stage: projection of papilla only due to recession of the areola to general contour of breast	15-16 years

Pubic Hair Staging		
Stage 1	Preadolescent: Vellus over pubes is not further developed than that over the abdominal wall (ie. No pubic hair)	Less than 12 years
Stage 2	Sparse growth of long, slightly pigmented downy hair, straight or slightly curled, chiefly along the labia	12-13 years
Stage 3	Considerably darker hair, coarser, more curled. Hair spreading sparsely over the junction of the pubes	13-14 years
Stage 4	Hair now adult in type, but area covered is still considerably smaller than in adult. No spread over medial surface of thighs.	14-15 years
Stage 5	Adult in quantity and type with distribution to horizontal pattern. Spread to medial surface of thighs.	More than 15 years

- Dental age is estimated by identifying the total number of teeth, how many and which among them are temporary and which are permanent. It is also essential to identify which is the last tooth erupted and based on charts we can estimate the dental age by noting the age corresponding to the tooth last erupted.
- Count the total number of teeth and also differentiate which of them are temporary or permanent. Accordingly, mark them in the chart provided.
    1. P - for permanent
    2. T - for temporary
    3. ? - for erupted
    4. X - not erupted

Note: Below is a reference chart only, as many external and internal factors contribute in the eruption of teeth.

Eruption of teeth

- Temporary teeth (Rule of halves)
  - Lower central incisors - 5 to 6 months
  - Upper central incisors - 6 to 7 months
  - Upper lateral incisors - 7 to 8 months
  - Lower lateral incisors - 8 to 9 months
  - First molars - 1 year
  - Canines - 1 ½ years
  - Second molars - 2 to 2 ½ years

- Permanent teeth
  - First molars - 6 to 7 years
  - Central incisors - 7 to 8 years
  - Lateral incisors - 8 to 9 years
  - First premolars - 9 to 10 years
  - Second premolars - 10 to 11 years
  - Canines - 11 to 12 years
  - Second molars - 12 to 14 years
  - Third molars - 17 to 25 years

Differences between temporary & permanent teeth

Temporary teeth	Permanent teeth
Smaller	Larger
Shiny	Lusterless
Vertical upper incisors	Forward & downward upper incisors
Smooth incisor edge	Serrated incisor edge
Worn out cusps in molars	Prominent cusps in molars
Twenty - 2102 (Incisor, Canine, premolar, molar)	Thirty two - 2123 (Incisor, Canine, premolar, molar)

- Radiological Age:

  Radiological age is estimated by looking for appearance of ossification centers, fusion of those with the shaft, fusion of sutures etc. for this we have to take radiographs of various joints to look for these findings of ossification centers.

- Important changes at various ages in joints visible radiologically

12 years	Hip joint (center for lesser trochanter appears 10 to 12 yrs) Elbow joint (center for lateral epicondyle appears 11 to 12 yrs) Wrist joint (center for pisiform appears 10 to 12 years)
14 years	Hip joint (center for iliac crest appears 14 yrs) Elbow joint (center for radial tuberosity appears 14yrs)
16 years	Hip joint (center for ischial tuberosity appears 16 yrs)
18 years	Shoulder joint (all centers of upper end of humerus fuse with shaft) Wrist joint (all centers of lower end of radius and ulna fuse with shaft) Hip joint (center for iliac crest fuses with ilium)
21 years	Hip joint (center for ischial tuberosity fuses with the ischial body)

Note: This is a reference chart only, as many external and internal factors contribute in the fusion of ossification centers

XIX. Requisitions for Forensic Science Laboratory / Pathology / Microbiology

- Once samples are collected, they must be sent to the Forensic Science Laboratory for testing. Pack all samples separately, seal and label them before handing over to the appropriate authority. While handing over, a requisition letter addressed to the FSL, stating what all samples are being sent and what each sample needs to be tested for should be stated. For example, "Vaginal swab to be tested for semen". This form must be signed by the examining doctor as well as the officer to whom the evidence is handed over.
- Specimens sent to the Forensic Science laboratory will not be received unless they are packed separately, sealed, labeled and handed over maintaining proper chain of custody under due acknowledgement.

- Wet smears for spermatozoa evidence and smears for detecting bacteria or parasites causing STI's and histo-pathological evidence of such tissue smears for evidence of STI's - send samples to Pathology / Microbiology departments under due acknowledgements.
- All blood samples must ideally be refrigerated until handed over to next in chain of custody.
- Chain of custody: The hospital must designate certain staff responsible for handling evidence and no one other than these persons must have access to the samples. This is done to preclude the possibility of mishandling and tampering.

ANNEXURE 1:
RELEVANT LAWS & RESEARCH

IPC	
Section 375	• A man is said to commit "rape" who, has sexual intercourse with a woman under circumstances falling under any of the six following descriptions: 1. Against her will. 2. Without her consent. 3. With her consent, when her consent has been obtained by putting her or any person in whom she is interested in fear of death or of hurt. 4. With her consent, when the man knows that he is not her husband, and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married. 5. With her consent, when, at the time of giving such consent, by reason of unsoundness of mind or intoxication or the administration of any stupefying or unwholesome substance, she is unable to understand the nature and consequences of that to which she gives consent. 6. With or without her consent, when she is under sixteen years of age. Even the slightest penetration of the vulva by the penis is sufficient to constitute the sexual intercourse necessary to the offence of rape.
CRITIQUE:	Section 375 is restrictive as it recognises only forced peno-vaginal intercourse (rape). It excludes other forms of sexual assault such as use of instruments, fingering, anal sex, oral sex etc. These offences are currently charged under section 354 and section 377 which have lesser punishment than 376. This reflects a traditional concern with virginity because of which greater punishment is given for rape, than other forms of sexual assault.

Section 375/376:	• Sexual intercourse by a man with any woman who is not his wife above the age of 16 years, against her will or without her consent • Sexual intercourse by a man with any woman below the age of 12 years • Sexual intercourse by a man with his wife if she is below the age of 15 years
Section 376 A	• Sexual intercourse by a man with his wife without her consent or against her will at a time when there exists a legal separation.
Section 376 B	• Sexual intercourse by a male public servant with a woman in his custody (consent not in consideration)
Section 376 C	• Sexual intercourse by a male superintendent/ manager of a jail or other place of custody with a woman in his custody (consent not in consideration).
Section 376 D	• Sexual intercourse by a man of the management of a hospital or nursing home with any woman in the precincts of hospital (consent not in consideration).
Section 354	• Assault or use of criminal force to outrage a woman's modesty
Section 377	• Unnatural sexual intercourse 'against the order of nature' which includes anal/oral penetration.
Section 89	• Consent of parent/guardian is necessary for anyone under the age of 12 years
CrPC	
Section 164 A	• Examination of a case of rape shall be conducted by a registered medical practitioner (RMP) employed in a hospital run by the government or a local authority and in the absence of such a practitioner, by any other RMP • Examination to be conducted without delay and a reasoned report to be prepared by the RMP.

	• Record specifically consent obtained for examination. • Exact time of start and close of examination to be recorded. • RMP to forward report without delay to IO, and in turn IO to Magistrate
Section 53 A	• Elaborates on medical examination of a person accused of rape. It clearly states what includes medical examination. It also states that medical examination of accused must be carried out without any delay and can be conducted by any RMP.
Section 157	• Deals with procedure of investigation in relation to the offence of rape. The 2008 amendment of the Act says that the recording of the statement of the survivor shall be conducted at her residence or a place of her choice as far as possible by a woman police officer.
Section 327	• Mandates an in-camera inquiry and trial of rape and that as far as practicable, the trial would be conducted by a woman judge or magistrate.
Section 173	• Mandates that investigation in relation to rape of a child may be completed within three months from the date on which the information was recorded by the officer in charge of the police station. When the report is forwarded to the magistrate, it must also contain the report of medical examination.
Section 176 (1 A)	• Mandates Judicial Magistrate to investigate all custodial rape and deaths.
Section 357 (A)	• Victim Compensation Scheme - all state governments in consultation with the central government are required to prepare a scheme for victim compensation.
Section 39	• Doctor is not required to inform the police of a case of sexual assault.

Indian Evidence Act	
Section 114 (A)	• If sexual intercourse by the accused is proved and the question is whether it was with or without out the consent of the woman and if she testifies before the court that she did not consent, the court shall presume that she did not consent.
Section 146	• Not permissible to put questions in cross examination of the prosecutrix as to her general immoral character.
Case Laws	
State of Karnataka v Manjamna (2000 SC (Crl) 1031/CriLJ 3471/2006(6) SCC 188	• Police requisition not necessary for forensic examination by hospital or doctor.
Bharwada Bogibhai Hirjibhai vs State of Gujarat (1983)	• Corroboration with medical evidence not required to prove a charge of rape. Circumstantial evidence and the survivor's own statement are crucial pieces of evidence notwithstanding the results of medical evidence.
State of H.P. v. Tara Chand and Anr 2008 (3) Shim LC1	• Past sexual conduct is irrelevant to a case of sexual assault. The Himachal Pradesh High Court while overruling the decision of the trail court stated: *"Thus in our considered opinion the learned trial Court unnecessarily attached too much importance to the subsequent statement of Kanti Kumari and wrongly gave the benefit to the respondents on the observation of the doctor that the prosecutrix was habituated to the sexual intercourse, the absence of spermatozoa on the vaginal swab and the absence of injuries on genital organs of the prosecutrix and the respondents. Whereas, we have found the testimony of the prosecutrix worth inspiring confidence and it also finds corroboration in its material particulars as a*

	stated above. There is no material defect in the investigation of the case, which makes the testimony of the prosecutrix unbelievable."
Delhi Commission for Women V Delhi Police, Delhi HD W.P. (CRL) 696/2008, Order 23rd April, 2009.	• Hospitals must have special rooms for examination of survivors of sexual assault • A uniform method of documentation and evidence collection to be adopted in all Delhi Hospitals - SAFE kit to be used • Requisite infrastructure for such an examination has been described that must be available at all facilities • Proper & safe storage of evidence is the responsibility of the hospital
Research Evidence	
Rape may not leave obvious signs of injury	• A retrospective study of case records of women who reported rape showed that less than 30% of them had genital injuries (Bowyer L, Dalton ME. Female victims of rape and their genital injuries. Br J Obstet Gynaecol. 1997;104:617-620) • Genital injury is absent in more than 50% of cases of sexual assault, even among victims presenting to a hospital based service. (McGregor MJ, Du Mont J, Myhr TL. Sexual assault forensic medical examination: is evidence related to successful prosecution? Ann Emerg Med. June 2002; 39:639-647)
The survivor need not show extreme emotional reactions to the incident when s/he presents at the hospital	• Emotional responses to sexual assault are varied ranging from emotive to controlled. McGregor in her study found even distribution of victims who presented as emotive (44.4%) versus controlled (47.6%).

ANNEXURE 2:
SAMPLE STANDARD OPERATING PROCEDURES

This is a proposed SOP developed at mid-sized public hospitals in Mumbai.

1. Any survivor 12 years of age or above may give consent for sexual assault examination (as per Section 89 of the IPC). If the survivor is younger than 12 years, the parent/ guardian's consent must be taken.
2. It is not mandatory to admit the patient in case of sexual assault, if her medical condition does not warrant admission. Every effort should be made to ensure that all evidence collection and examination is completed within a few hours and the patient is allowed to leave immediately, without admission. In case some investigations (such as radiographs) are pending, the patient must be informed of their importance, and explained that it would be preferable if she stayed admitted in the hospital so that these investigations may be completed. If she still refuses admission after being informed, then she must be asked to come the next day for the relevant investigations and this must be taken in writing from the woman . The responsibility thereafter, rests on the woman herself. In case the woman doesn't come the next day, the examining doctor must make a note of the investigations that were not completed and then dispatch the sealed SAFE kit to the MRO.
3. The responsibility of preserving and sealing the collected evidence lies with the examining doctor. Assistance can be sought from the nurse who is the witness in the course of examination / or any other nurse on duty for air drying evidence and sealing the evidence. Each piece of evidence must be sealed and signed individually by the examining doctor.
4. Each sealed evidence requires the hospital stamp which should be taken from the MR department.
5. Once evidence is sealed, it should be handed over to the MRO.
6. In case the evidence needs to be preserved in a refrigerator, it must be kept in the labor ward.
7. The evidence will be handed over to the police by the MRO.
8. Once the evidence is handed over by the examining doctor to the MRO, it is the responsibility of the MRO to ensure that it is collected by the police. This might require following up with the police station. In case follow up is required, the CMO may be called upon to contact the relevant police station through the police constable on duty.
9. It is the responsibility of the MRO to make sure that the evidence is preserved until collected by the police.
10. In case the evidence remains uncollected by the police, the MR department has to preserve the evidence for 15 years or till the time that it is collected by the police.

ANNEXURE 3:
SAMPLE PROFORMA FOR EXAMINATION OF A SURVIVOR OF SEXUAL ASSAULT

SEXUAL ASSAULT SURVIVOR EXAMINATION PROFORMA

I) Information:

Hospital Name & Place .....

Out Patient Dept./In Patient Dept. No. .....

MLC Reference Number/ Outward Number .....

Survivor's name ..... M/F/TG .....

Address .....

Telephone number/Contact number if available .....

Age ..... Date of birth ..... Married / Single / Divorced .....

Name of accompanying female nurse/ attendant/ relative .....

Identification marks (1) ..... (2) .....

Date and Time of survivor's arrival at the hospital .....

Received Request From *(tick or write if any other)* Self/ Police/ Magistrate/.....

Letter number ..... Dated .....

Crime Registration No. ..... Under section .....

Brought by ..... (Name and signature)

Relation: .....on ..... (Date) at .....

PC/ HC/ PN/ WPC Number ..... Police Station: .....

Date, Time and Place of examination .....

Examined in presence of ..... (Name & Signature of Witness)

II) MEDICAL HISTORY

Relevant medical/surgical history .....

Past History of Abuse .....

History of allergies ..... Current medication .....

Menarche ..... Menstrual Cycle : ..... LMP

Obstetric history : G P L A D

Contraception Yes/ No ..... If yes - Method used .....

Was the survivor pregnant at the time of assault? ..... If Yes, Length of Gestation .....

III)SEXUAL ASSAULT HISTORY

Narration of incident in survivor's own words *(In case this space is insufficient, please use notes page attached at the end)* :

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Location of assault ..... Date and time of assault .....
Number of assailants and name/s .....
Whether known to survivor Yes/ No ..... if yes- Relationship to survivor .....
Is there any history of drug or alcohol being given to the survivor before or during the assault? .....
Since assault has the survivor changed clothes?- Yes/ No .....
If yes, are they available?..... Were they washed / repaired? .....
Since assault has the survivor, *(tick)* 1. Eaten food 2. Ingested fluids 3. Smoked 4. Brushed 5. Gargled
Has the survivor left any marks of injury on the body of the assailant during the assault? If yes, enter details .....
.....
Describe pertinent data of the assault with regard to :
Verbal threats .....
Body Areas touched .....
Physical violence .....
Weapons or objects used (or threatened with) .....

Details regarding penetration: Was penetration attempted by penis, fingers or other object? (Write (Y), No (N), or Don't know (DK))									
	Attempted Penetration			Completed Penetration			Emission of Semen		
Orifice	By Penis	By Finger	By Object	By Penis	By Finger	By Object	Yes	No	Don't know
Vagina									
Anus									
Mouth									

Was oral sex performed by assailant on survivor?	Y	N	DK
Masturbation of survivor by assailant	Y	N	DK
Masturbation of assailant by survivor	Y	N	DK
Did ejaculation occur outside body orifice?	Y	N	DK
Describe Location			
Kissing, licking or sucking of breasts or parts of survivor's body?	Y	N	If Yes, describe-

Was condom used? ..... Y / N / DK .....
If yes - Status of the condom ..... Untorn / Torn / DK .....
Was lubricant used? ..... Yes / No / DK .....
If penetration was attempted by object, describe object: .....
Was last previous intercourse within one week prior to the assault? ..... Yes / No / Do not remember .....
Was survivor menstruating at the time of the assault? .....
Was survivor menstruating at the time of the examination? .....

Between the assault and the time of the examination did the survivor:			
	Yes	No	Don't know
Bathe			
Douche			
Void Urine			
Defecate			
Use Spermicide			
Since the assault has there been any vaginal/anal/oral bleeding/discharge?			
Prior to the assault has there been any vaginal/anal/oral bleeding/discharge?			

IV) FORENSIC EVIDENCE

- Debris Collection Paper (on which survivor is undressed) to be placed in envelope .....
- Is the clothing worn now the same as worn during the assault? ..... Yes/ No .....
  (If not, request clothes worn during the assault to be submitted)
- Clothing evidence to be air dried and placed in BAG 1 .....

Clothing Evidence	Description

Body evidence samples duly labeled to be placed in BAG 2. Each sample to be packed, sealed, labeled separately & sent to FSL for further examination. (Use Distilled Water provided for moistening swab sticks)

BODY EVIDENCE	List sites where applicable. If not collected, give reason.
Oral Swab	
Blood Stains on body	
Foreign material on body	
Seminal Stains on body	
Other stains (specify site and suspected nature of material)	
Head Hair Combing	
Scalp Hairs (5-10 strands)	
Take nail scrapings of both hands separately	
Nail clippings of both hands separately (Write if deeply cut already)	
Blood for grouping/Drug estimation (Plain Vaccutainer)	
Blood for alcohol levels (Sodium Fluoride Vaccutainer)	
Blood for DNA analysis (EDTA Vaccutainer)	
Any other sample (collect in sterile container)	

Genital and Anal evidence samples to be placed in Bag 3. Each sample to be packed, sealed, labeled separately & sent to FSL for further examination (Use Distilled Water provided for moistening swab sticks)

GENITAL AND ANAL EVIDENCE	List sites where applicable. If not collected, give reason.
Matted Pubic Hair	
Combing of Pubic Hair (mention if shaved)	
Cutting of Pubic Hair of survivor (5-10, mention if shaved)	
Vulval Swabs (2)	
Vaginal Swabs (2)	
Anal Swab (2)	
Vaginal Smear (2)-1 for immediate examination & 1 for FSL	
Vaginal Smear (for detecting spermatozoa)	
Vaginal Smear (for evidence of STD)	

V) GENERAL EXAMINATION

Height: ..... Weight: .....

Emotional / mental status .....

Physical Examination: Examine the following areas for assault related findings

- Gait of survivor .....
- Scalp examination for areas of tenderness (if hair pulled out/dragged by hair) .....
- Facial bone injury: orbital blackening, tenderness .....

- Petechial haemorrage in eyes and other places .....
- Lips and Buccal Mucosa / Gums .....
- Behind the ears .....
- Ear drum .....
- Neck, Shoulders and Breast .....
- Wrists and forearms .....
- Medial aspect of upper arms .....
- Inner aspect of thighs .....
- Buttocks .....
- Other, please specify .....

VI) Genital examination - Examine the following areas for assault related findings

(Note- PV & PS examination not to be performed in children unless required to detect injuries)

State of the sphincters : .....

Labia Majora : .....

Labia Minora : .....

Fourchette and introitus : .....

External urethral meatus: .....

Hymen (only if relevant): .....

Anus and Rectum: .....

Per Speculum examination: YES / NO .....

If yes, findings: .....

.....

Per Vaginum Examination : YES / NO .....

If yes, findings: .....

.....

Any other findings to be noted: .....

.....

VII) Opinion

After examining …….. bearing identification marks as described above, ... day/s after the incident.

I am of the opinion that .....

.....

.....

.....

.....

Date

Time **Signature of Examining Doctor**

Place

Name of Examining Doctor with Seal

This report contains _____ (number of) Sheets.

SURVIVOR CONSENT FORM

I, ... *(Name of the person giving consent)* hereby give voluntary consent to:

1. Examine and treat .....*(Survivor's name)* (myself / my ...../ specify other relationship .....) for the effects of sexual assault.
2. Conduct a medico-legal investigation for the purpose of assisting the police in apprehending and/or prosecuting the persons who committed the assault. This investigation will include a physical examination which may involve an examination of the mouth, breasts, vagina, anus and rectum; in addition it may include the removal and isolation of articles of clothing, scalp hair, foreign substances from the body surface, saliva, pubic hair, samples taken from the vagina, anus, rectum, and the collection of a blood specimen.
3. Inform the police the history as recorded and the findings of the examination, and provide them with any substances collected during the course of the medical investigation and / or any information and observations that might assist them in apprehending and/ or prosecuting the person(s) who committed the assault.

I give my consent to the above fully and freely. I also understand that I have the right to refuse either a medico-legal investigation or information to be given to the police or both, but that my refusal will in no way result in denial of treatment for the effects of the assault.

I also understand that I am free to revoke all or any part of this consent at any time during the examination.

The content of above is explained to me in ..... language which I understand and hence I sign.

.....	.....
.....	.....
(Name & Signature of Witness)	(Name & Signature of Survivor)
.....	.....
(Date, Place and Time)	.....
	(Name & Signature of Guardian or Relative of the Survivor when s/he is unable give her consent due to mental disability, or if s/he is under the age of 12 years.)

ESTIMATION OF AGE IN CASE OF MINORS

Kindly fill in a request for X-rays and attach a copy to this form.

Height Weight

Breast Staging (Please refer manual)

Axillary Hair

Pubic hair (Please refer manual)

Dentition:

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Teeth: Permanent / Deciduous / Mixed

Whether space formed behind second molar Yes ☐ No ☐

Ossification test -

1. X-rays advised .....

.....

2. Observations .....

.....

.....

Opinion on Age .....

Date Signature of Examining Doctor

Time

Place Name of Examining Doctor with Seal

REQUISITION FOR LABORATORY EXAMINATION BY FORENSIC SCIENCE LABORATORY

From

To,
The Director Forensic Science Laboratory
_____

Sir/ Madam,

Sub: Requisition for laboratory examination of material evidence collected

Submitting herewith material evidence collected from……

age…….. sex…….. .

Concerning OPD/IPD No…… MLC No .....

Cr. No. ..... U/S ..... of Police Station ..... .

Please examine the following sealed packets and opine on

1. …… For Evidence of …… .
2. …… For Evidence of …… .
3. …… For Evidence of …… .
4. …… For Evidence of …… .
5. …… For Evidence of …… .
6. …… For Evidence of …… .
7. …… For Evidence of …… .
8. …… For Evidence of …… .

Yours sincerely
Dr…… Hospital name ..... .

Signature Seal

Received intact, sealed, labelled samples by

…….. (Signature)

PC No: ..... Police Station: .....

Date:

REQUISITION FOR LABORATORY EXAMINATION BY PATHOLOGY/ MICROBIOLOGY DEPT

(To be used if a pathology/microbiology laboratory is not available in the hospital)

From

To,

The HOD

Dept of _____

Sir/ Madam,

Sub: Requisition for laboratory examination of material evidence collected

Submitting herewith material evidence collected from……

age…….. sex…..... .

Concerning OPD/IPD No…… MLC No .....

Cr. No. ..... U/S ..... of Police Station ..... .

Please examine the following sealed packets and opine on

1. …… For Evidence of …….. .
2. …… For Evidence of …….. .
3. …… For Evidence of …….. .
4. …… For Evidence of …….. .
5. …… For Evidence of …….. .

Yours sincerely

Dr…… Hospital name ..... .

Signature Seal

Received intact, sealed, labelled samples by

……(Signature)

PC No: ..... Police Station: .....

Date:

DISCHARGE / SUMMARY SLIP

Survivor's name : ..... .

Date of examination : ..... .

Doctor's name : ..... .

Sexully transmitted diseases	Test done	Treatment given /	Follow up on .....
Gonorrhea			
Chlamydia			
Syphilis			
HIV testing (after counselling and if consent given)			At 3 mths & 6 mths
Routine prophylaxis for HIV			
Hepatitis B			At 1 mth & 6 mths

	Tests done	Post-coital contraception given	Follow up on .....
Pregnancy			

Injuries	Surgery	Follow up on .....
1.		
2.		
3.		
4.		
5.		

Injection Tetanus Toxoid (T.T.) Yes ☐ No ☐

Psychological assessment and counselling .....

Immediate referral to .....

Advise on discharge (including follow up dates) .....

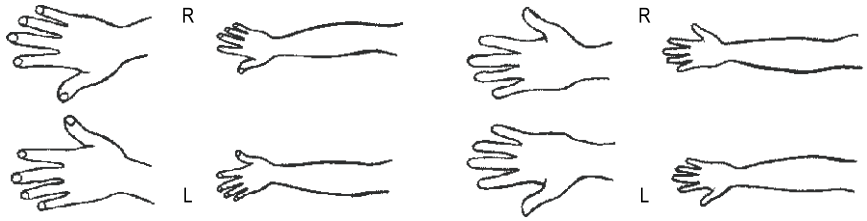
Date :

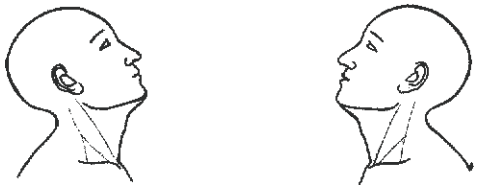
Time :

Signature of Examining Doctor

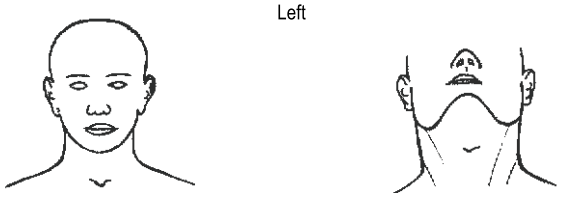
Name of Examining Doctor with Seal

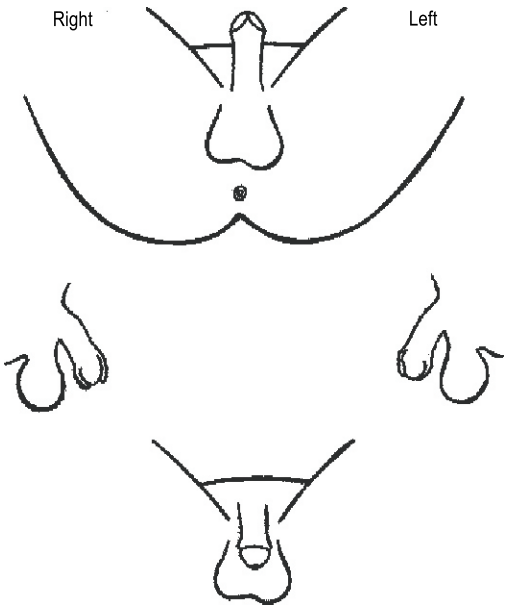
Mark all injuries on the diagram provided on next page, indicating type of injury, size (length, breadth and depth as relevant), shape, colour, borders, age and content. Opinion regarding cause of injury for each injury - - - e.g; sharp object, cloth, rope, cigarette butt, metal/wood, nails/ fingers to be recorded. Nature of force used - - - very aggressive, violent, restraint, etc. to be recorded.





Right Left

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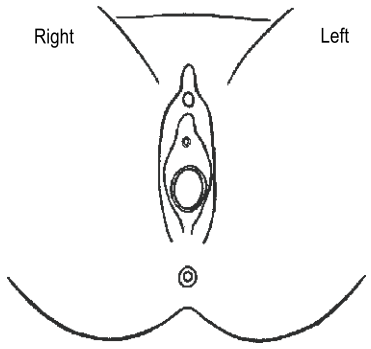
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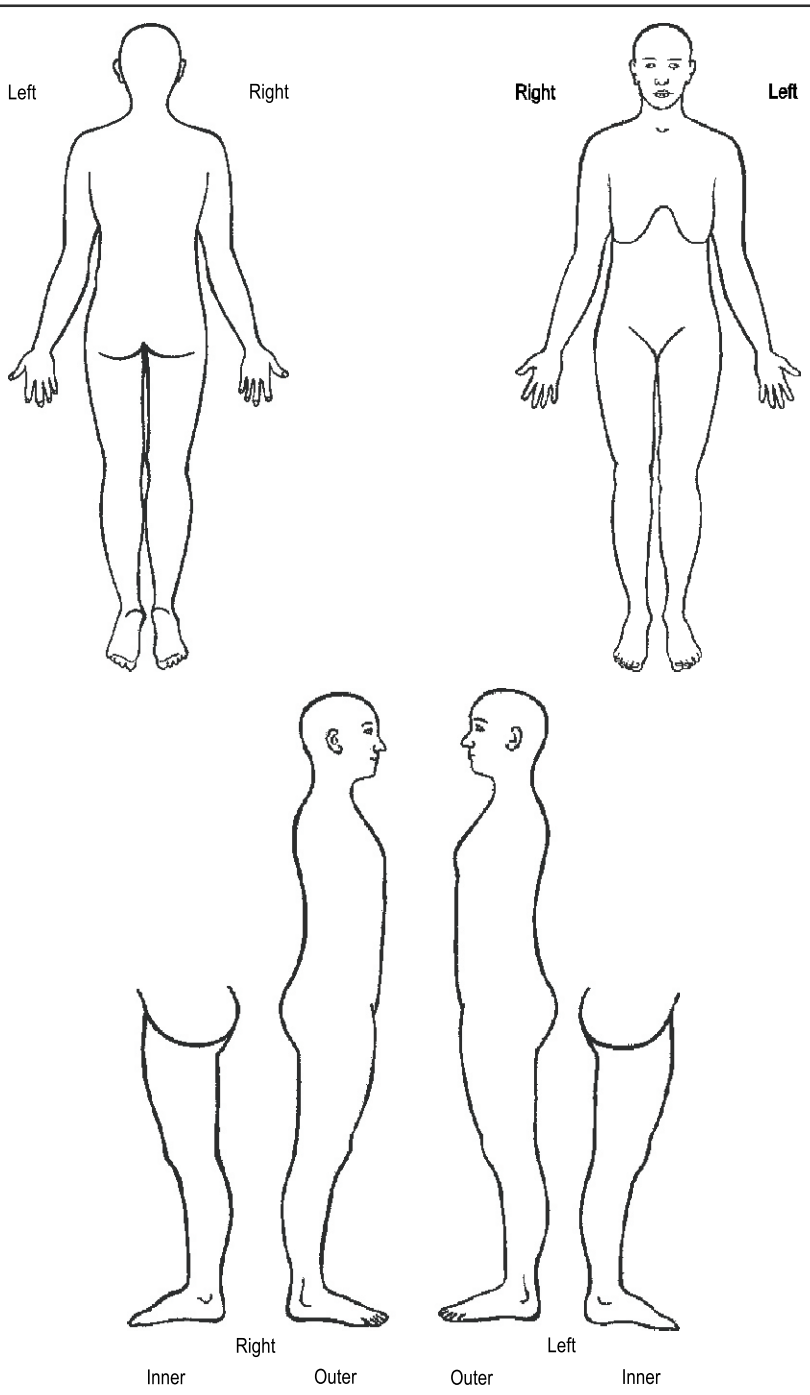

Figures courtesy WHO document 'Guidelines for Medico-Legal Care for Victims of Sexual Assault'

Centre for Enquiry into Health and Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Investigation and Treatment of Psycho-Social Trauma.