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Medico Legal Aspects of Sexual Violence: Impact on Court Judgments

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Background

Health professionals play a critical role in responding to survivors of sexual violence. The Indian law, Sec 164 (A) CrPC specifically vests medico legal responsibility in health professionals and provides them guidelines to carry it out in a systematic manner [1]. Additionally recent laws related to sexual violence namely 'Protection of Children from Sexual Offences, 2012' and 'Criminal Law Amendment to Rape, 2013' specify dual roles for health professionals; therapeutic and medico legal vis- a -vis survivors of sexual violence [2-3]. Both laws emphasize that sexual violence must be considered as a medico legal emergency and immediate care must be offered to survivors irrespective of whether the health facility is a government one or a private one. The right to emergency medical care existed in other statute and has been also mentioned in high court orders [4]. However; the recent changes in law have brought a strong focus on health systems to operationalize both these roles. The medico legal role comprises of forensic examination, sample collection, and documentation of history along with dispatch of the evidences to the forensic science laboratories. This role assists the investigation machinery related to prosecution. The therapeutic role comprises provision of medical care along with psychosocial support. This role seeks to mitigate the health consequences sustained as a result of sexual violence along with psychological first aid. Despite the criticality of both roles - forensic and therapeutic - health professionals' response in India continues to be suboptimal [5].

The current medico legal procedure is fraught with lack of uniformity, medieval biases against women, and unscientific practices which act as a barrier in survivor's struggle for justice [6]. Forensic science textbooks used by medical students comprise several biases against women such as "well-built woman cannot be raped", "working class women cannot be raped as they can offer resistance" and "most rape cases are false"[7]. The changes in the laws on rape have not been incorporated in to the forensic textbooks. The teaching of forensic medicine, therefore, continues to emphasize aspects such as two finger test conducted to determine if the survivor is sexually active, hymenal status recorded to assess virginity, and height-weight measured to determine the extent of resistance offered by the survivor to prevent the attack. There is also an overriding emphasis on presence of injuries.

Evidence from hospital-based studies show that the medico legal examination of survivors is conducted in a mechanical manner [8]. More often than not, history of sexual violence is not given any importance; health professionals collect forensic evidence without any thought e.g. anal, oral and, vaginal swabs are routinely collected from all survivors whether or not there is any history of such forms of violence. Health professionals do not seek information on circumstances of sexual violence. Fail to acknowledge reasons for survivors being unable to resist the act of sexual violence: they may be scared, or may be drugged, or may just be in a state of terror to react to the forced act. Besides circumstances of sexual violence, health professionals also do not document specific activities undertaken post assault by survivors which lead to loss of evidence. Time lapse in reporting to a hospital, activities such as urinating, gargling, bathing, defecating, and menstruation lead to loss of evidence. It is evident that health professionals are not equipped to understand the limitations of medical evidence [9]. In a study conducted in a tertiary care hospital in India, it was found that the hospital was equipped with the state of art facilities, but did not have a treatment protocol for sexual violence survivors. Health professionals left the follow up care and referrals for treatment to the discretion of police. As a result, if the police

perceived referral as important for their case they would take the survivor to the specified department, but if they did not find it important they would neglect the medical care. Therapeutic care did not figure in the first line of care for survivors of sexual violence even in this state of the art tertiary care hospital [10].

The current paper presents learnings related to establishing a comprehensive health care model for survivors of sexual violence. Within this context the paper seeks to explore whether a systematic medico legal response plays any role in the court trials of sexual violence. This is done through analysis of court judgments. Findings from the analyses of court judgments suggest that police, prosecution, and judiciary continue to subscribe to unscientific aspects of medico legal examinations. The paper presents an analysis of 14 judgments in the light of medico legal evidence and presents factors that led to conviction and acquittals. The paper concludes that it is critical for all the systems to understand the scope and limitations of medico legal evidence if justice has to be secured for sexual violence survivors.

Establishing a Comprehensive Health Care Model for Responding to Sexual Violence

In order to address the gaps in the forensic and therapeutic response of the health sector as stated earlier, CEHAT a research centre of the Anusandhan trust collaborated with the Municipal Corporation of Greater Mumbai (MCGM), in 2008, to establish an intervention model to respond to sexual violence survivors in 3 Municipal hospitals of Mumbai. The model aimed at changing the practice of health professionals from a purely medico legal evidence perspective to a medico legal care perspective. Elements of comprehensive health care model for sexual violence survivors were evolved from the perspective of science, medicine, ethics, and law.

The model comprised of the following aspects

- Operationalising informed consent for survivors of sexual violence
- Carrying out systematic documentation of history of sexual violence
- Using gender sensitive protocols for examination and collection of relevant forensic evidence
- Recording a reasoned medical opinion
- Providing first contact psychological support and free medical support
- Maintaining a clear and fool-proof chain of custody

This hospital-based model was operationalized through a systematic training of Health Professionals on developing communication skills to speak to survivors of all ages and sexes. Efforts were made in the training programs to replace clinical terms used by the health providers with colloquial terms to speak to about the incident. Trainings also provided them with information on dynamics of sexual violence and an understanding of scope and limitations of medical evidence. Discussion with health professionals enabled them to replace the archaic medico legal practices with use of gender sensitive and scientific methods of examination. It also equipped them to formulate medical opinion and explain the reasons for lack of medical evidence on the survivors. Mock sessions were offered to health professionals in order to prepare them for court appearances and defend their clinical observations. An important component of the model was the provision of crisis intervention services. These ranged from providing psycho-social support, preparing a safety assessment and safety plan, demystifying and facilitating various institutional procedures and providing counseling services to family members [11].

A total of four hundred and forty four survivors were responded to in the period of 2008 to 2014 in the three hospitals where the model was implemented. Four hundred and eleven survivors were considered for analysis as the rest of the survivors reported consensual sexual activity and did not want to pursue a case. A threefold increase was seen in the reporting of sexual violence during the period 2012-14 as compared to 2008-12 (94 from 2008-2012, and 354 in 2012-2014). The sudden increase in reporting could be attributed to the enactment of a new law on Protection of children from sexual offences in 2012 (POCSCO), campaigns against the brutal physical and sexual violence of a young woman in New Delhi in 2012 that created mass awareness on reporting of sexual violence and Criminal law amendment to rape law 2013 [2,3]. The campaign and outcry against sexual offences through media reports may have provided survivors and their families the courage to report sexual violence.

Profile of Survivors

Most survivors reporting sexual violence were under the age of 18 years (65%), where as the rest of them were adults. Under the age of 18 years, 42% were under 12 years of age (Table 1). In 77% cases, the survivors knew their perpetrators. Documentation by health professional brought forth that the assault took place when survivors were going about their routine such as grocery shopping, traveling home after school, relatives visiting the survivor's family, and being in the care of a known adult while parents were away at work. These circumstances clearly show that while the perpetrator planned the act, for the survivor these were unsuspecting circumstances.

A quarter of the survivors voluntarily reported to the hospital (Table 2). These survivors expressed concerns about their health and feared having HIV/STI infections, unwanted pregnancies and reached the hospital for treatment. In instances of child sexual abuse, caregivers brought them to the hospital fearing negative health consequences and worries about the child's ability to lead a normal life.

40% survivors reported sexual violence in the nature of penovaginal penetration, additionally 17% reported penetration

of the anus and mouth by penis and 14% reported penetration of the vagina by use of fingers. 36% survivors reported a range of non-penetrative forms of sexual violence such as fondling of sexual organs, kissing and licking. This is an important learning as "Rape" is often associated only with penovaginal penetration. However, when trained health professionals elicit details of sexual violence, survivors are able to report a range of sexually violent acts (Table 3).

20% survivors sustained genital injuries and 22% suffered physical injuries. This is in keeping with global evidence, where it has been found that only 33% survivors suffer any injury.11 other health consequences were found to be unwanted pregnancies, burning micturition, pain in abdomen, sleep disturbances, attempted suicide, and bedwetting (Table 4).

Table 1: Age of survivor reporting sexual violence

Age-range	Frequency	%
0-12 years	174	42.3
13-17 years	95	23.1
18 & above	142	34.5
Total	**411**	**100.0**

Table 2: Pathway to hospitals for survivors of sexual violence

Pathway	Frequency	Percentage
Hospital 1st contact	100	24
Police 1st contact	300	73
No information	3	1
Came to the Hospital based counseling centre	8	2
Total	411	100

Table 3: Nature of sexual violence reported by survivors

Nature of assault*	Frequency	Percentage
Penetration of vagina by penis	164	40%
Penetration of vagina by finger	57	14%
Penetration of anus by penis	37	8%
Penetration of mouth by penis	39	9%
Non-penetrative sexual violence (Kissing, touching, masturbation)	148	36%

Table 4: Health consequences faced by survivors of sexual violence

Health Consequences	Frequency	%
Genital injury	81	20%
Physical injury	91	22%
Burning micturition	19	5%
Pain in genital area	18	4%
Pain in rectum	11	3%
Pain in other body parts	29	7%
Unwanted pregnancy	39	9%
Other health consequences (attempted suicide, bet wetting, sleep disturbances	27	7%
No health consequence	138	33%

Analysing Legal Outcomes

All survivors received medical care and psychosocial support. Having ensured a comprehensive health care, the question remained about legal justice to the survivors. For this, court judgments were procured for fourteen survivors. The contents of the judgments were segregated in an excel sheet on the basis of age, nature of sexual violence, health consequences sustained, and results of forensic science results. These judgments were found between the period of 2010-2012 The survivors of the period 2010-12 could not benefit from the expanded definition of rape as per Protection of Children from Sexual Offences' (2012) and 'Criminal Law Amendment to Rape' (2013). The previous laws on rape did not consider penetration of mouth and vagina, penetration by parts other than penis and non-penetrative forms of violence as rape.

Of the fourteen case judgments, only six convictions were secured, while the rest were acquittals. Factors such as age of the survivor, type of sexual violence, nature of health consequences, forensic findings and health professional's deposition were considered for analysing the outcomes of fourteen judgments. The table (Table 5) presents specific components from the fourteen judgments that played a role in convictions and acquittals.

Table 5: Profile of fourteen survivors where court judgments are available

Age		0-12	13-17	18 and above
No. of survivors		5	2	7
Relationship with Perpetrator	Known	4	2	5
	Unknown	1	0	2
	Total	**5**	**2**	**7**
Type of sexual violence	Penetration	4	1	7
	Non- penetration	1	1	0
	Total	**5**	**2**	**7**
Presence of physical injuries		0	0	3
Presence of genital injuries		5	0	2
Presence of intoxicant	Yes	0	1	2
	No	5	1	5
	Total	**5**	**2**	**7**

Age		0-12	13-17	18 and above
Semen/ blood	Yes	1	0	4
	No	4	2	3
	Total	**5**	**2**	**7**
Health consequences	Physical	3	0	3
	Psychological	0	1	3
	Total	**3/5**	**1/2**	**6/7**
Judgement	Conviction	2	2	2
	Acquital	3	0	5
	Total	**5**	**2**	**7**

Factors Leading to Convictions

Ensuring availability of medico legal documentation and Health professionals to the courts

Availability of medico legal records and detailed documentation by health professionals seems to have played an important role in the trial process. The court took cognisance that documentation was nuanced and included forms of non-penile penetration as well as attempt to penetration. The law before 2012 recognized only penovaginal penetration as rape, but despite the limitations of legal provisions health professionals carried out comprehensive history seeking and documentation pertaining to non-penile penetration as well as non penetrative sexual violence.

Reasonable explanation for lack of Injuries

Amongst the six cases, where convictions were secured, it is important to note that all survivors did not sustain injuries. Health professionals were able to substantiate reasons for lack of injuries. Aspects such as delay of more than a month in reporting to the hospital, being offered a drink comprising of a stupefying substance and hence inability to resist the attack were cited as reasons for lack of injuries. Health Professionals brought forth the documentation of health consequence in the form of pain in urination, lower abdominal pain, and attempt to end one's life as post sexual violence consequences. Such explanations by them drew the attention of the courts to consider such health consequences as medico legal evidence.

In one particular instance, health professional had noted inflammation in the genital region in a child survivor of five years. The court questioned the medico legal evidence asking the health professional to explain if inflammation could be an outcome of a sexually transmitted infection. The Health Professional explained that her examination findings noted that inflammation was a result of injury. She also drew attention to the fact that presence of a STI in a five year old is a sign of sexual violence.

Effective explanation for negative forensic reports

Of the six survivors where conviction was secured, forensic evidence was collected from five. This was because one survivor had reported to the hospital after a month, hence no evidence could be located from the body of the survivor. WHO guidelines clarify that medico legal evidence cannot be located on the body after a period of seventy two hours. For the five survivors reporting before that period of seventy two hours, forensic evidence was collected in the form of blood samples, urine samples, nail cuttings, swabs for detection of semen/sperms etc.

Medico legal evidence analyzed by forensic science laboratory (FSL) tested positive in case of two survivors as semen stains found on body of the survivor matched the perpetrator. In instances where the forensic reports were negative, health professionals were able to explain it in the court. In one instance despite the survivor reaching the hospital immediately after the episode of sexual violence, swabs collected for seminal stains did not test positive. The Health professional explained that because survivor was menstruating at the time of sexual violence and at the time of examination, it is possible that evidence was lost with menstrual blood. Such an explanation was admitted by the court. In another instance, doctor was also able to explain that many a times survivors are not able to recall whether there was emission of semen, if semen is not emitted or ejaculation has occurred outside the body swabs would not test positive. Such explanations were given credence by the courts.

Well-equipped prosecution

For all six survivors, prosecution was well prepared and had reviewed the medico legal documentation along with the health professionals. They had also ensured that doctors were called as expert witnesses. Out of six cases, doctors could come in four cases to depose evidence. In two instances that the doctors could not be present, medico legal documentation was presented appropriately by the Public Prosecutor (PP). PPs in all the six convictions were aware that even negative medical evidence needs to be presented to the court to ensure that non-disclosure of status of medico legal evidence is not looked by the court in a negative manner.

Factors Leading to Acquittal

Deficiencies in presentation of injuries as evidence

Amongst the cases where acquittals had taken place, there was presence of medico legal evidence in the form of injuries. Three survivors sustained physical injuries and four sustained genital injuries. Despite deposition by the doctor in the court, the prosecution was unable to link these injuries to the episode of sexual violence. Prosecution could not offer an explanation when the defense counsel raised questions such as whether injuries may have emerged from consensual sexual activity. In cases, where there was absence of injuries on the survivors, PPs assumed that health professionals need not be called to depose in the court. When questions were raised by the court on absence of injuries Prosecution could not adequately respond as they were not aware of the limitation of medical evidence. Had they summoned the doctors, the situation could have been different with the possibility of doctors bringing clarity on this issue to the Court.

Inconclusive presentation of trace evidence

Amongst the eight survivors, trace evidence was found in four survivors in the form of semen traces and presence of alcohol in blood. Due to the fact that three of the four survivors were adults and in a relationship, the court raised the possibility of the semen evidence being of the partner from the consensual relationship and asked the prosecution to explain it. Prosecution could have disputed such an argument based on the case narration of the survivor. Survivors had clearly stated that the perpetrator was a known person but they were not in

a relationship with them. Further directions could have been sought from the court to assess whether the semen evidence of the consensual partner matched that of the perpetrator. The prosecution however could not bring these aspects to the notice of the court. DNA examination and matching could have been sought to assess whether the semen traces belonged to the consensual partner but even such a direction was not sought, leaving the survivors at a disadvantaged position.

Even instances where no trace evidence was found on survivors, medico legal records provided clarifications for it. Medical opinion of the Health Professional was recorded for lack of trace evidence. Such an opinion stated that perpetrator had not emitted semen on the survivor's body, survivor reported to the hospital after delay of a week and survivor being assaulted by finger penetration; hence semen could not be found. Despite such clear medical interpretation, prosecution was not able to present these findings in the Court.

Inconsistencies in survivor deposition and medico legal documentation

An important responsibility of the Public Prosecutor is preparation of the survivor before making court appearances. Each potential evidence to be presented by the PP has to be examined and verified. If this is not done and contradictions appear, then it can mar the chances of successful prosecution. In one instance, contradiction appeared in the medical evidence presented by the health professional in the court and questions raised by the survivor against medico legal documentation. Survivor stated that she had sustained genital lesions after the violent episode which the HP had not recorded. The HP maintained that at the time of examination no lesion was found on the genitals. The PP was not able to salvage the situation, and resulted in an issue indicating inconsistency in the statements of the survivor and the Health professional. The court upheld that a health professional is a disinterested party and hence there is no reason to record false reports. The court stated that had the survivor sustained genital lesions post the assault, she could have visited another HP and that medical record could have been brought to the court. Such a record was not sought by the prosecution. Unfortunately such inconsistencies were used by the defense counsel to discredit survivor's narrative. Hence proactive prosecution is needed to bring medical evidence to clarify any suspicion observed by the Court in relation to acceptance of any evidence and testimony.

Overambitious prosecution

Eagerness on the part of prosecution also affected the chances of conviction. In one instance police prepared a charge sheet of gang rape despite the survivor stating that there was only one perpetrator. The focus of the prosecution became proving the offence of gang rape, but required evidence was found to be lacking. In another instance, the survivor reported assault from the perpetrator by insertion of fingers in the vagina but the police had included charge under rape. The law on rape till 2012 required an attempt to penetration by penis and did not prosecute use of objects, fingers etc. When non-penetrative assault charge was brought under rape sections of the law, it allowed the defense an upper hand in squashing the prosecution's case. If appropriate sections of Indian penal code were charged for the offence on insertion of fingers in the vagina, the chances of getting conviction would have certainly increased. Even if the charges (which provided higher punishments) were leveled with an intention to punish the perpetrator with a severe sentence, it backfired when the prosecution failed to prove its point and with the accused going scot-free and the victim denied justice for no fault of hers.

Fear of social incrimination

Amongst the eight survivors where acquittals were declared, three survivors withdrew from court appearances during trial as they did not want to pursue the legal battle any longer. Survivors and their families cited reasons such as wanting to move on, not wanting the survivor to be labeled fear of future prospects of survivor's marriage amongst others. Amongst the survivors who withdrew period of trial ranged from 1.5 years to 3 years.

Discussion

Through the analysis of fourteen judgments an effort was made to understand how courts interpret medico legal findings and whether these findings have any role to play in conviction and acquittal. An important insight that we gained was about the gaps in the understanding of the medico legal evidence by courts. Medico legal evidence was largely understood in the form of injuries. Presences of genital and physical injuries were found to be an important factor in the process of conviction as was seen in the findings. But inconsistencies were found in accepting injuries as evidence in cases of adolescent survivors. Courts raised questions on whether the injuries were related to consensual sexual activities. Further biases were reflected in court proceedings when health professionals were asked for results of the two finger test - such a test was used in the past by health professionals to determine the past sexual conduct of a survivor, but in recent times it has been banned by a Supreme Court order [12]. Yet such questions were asked in the court.

Courts displayed a lack of understanding of health consequences of sexual violence such as burning micturition, pain in abdomen and possibility of sexually transmitted infection in children. Despite medical records indicating the nature of treatment offered to these survivors in the form of analgesics for pain relief, antibiotics for treatment of sexually transmitted infections and provision of emergency contraception to avoid an unwanted pregnancy - the prosecution was not able to link the health consequences as outcome of sexual violence. Evidence from different countries has established physical and psychological health consequences of sexual violence [13]. However, the courts in India have not taken cognizance of the same.

Another issue of concern is the inconsistent interpretations of biological evidence (presence of semen stains, alcohol in blood) - whether positive biological evidence plays any role in the conviction or acquittal could not be determined in these judgments. Similar evidence was found by other studies assessing the impact of forensic evidence on legal outcomes [14]. These studies in fact discussed that more than biological evidence, factors such as prosecutorial screening, and chances of convictability of a crime were instrumental in how the courts operate. These studies thus showed that presence of biological evidence was not obligatory to secure convictions. Hence the impact of biological evidence and its impact on legal outcomes have been unclear [15].

The court judgments also reflected stereotypical beliefs and biases existed against survivors of sexual violence. If the survivor knew the perpetrator, court drew inferences that the possibility of the act being a consensual one cannot be ruled out. Such inferences proved to be damaging to the survivor and also to the outcome of the court trial. When the perpetrator was a known person or a partner, such cases were seen to be less deserving of justice as against survivors who resisted sexual violence and tried hard to physically resist the attack [16].

Besides the long process of court trials, an important factor for survivors was also how societies and communities perceived them. Unfavorable attitudes by neighbors, fear of another attack by perpetrators, concern about future of the survivor and concerns around impact of the legal processes on family and friends led survivors to drop out of the court trials as evidenced in the analysis of the judgments. Similar findings were seen in a report undertaken by the Home department of England and Wales 15. Their study showed similar findings where survivors stated that they wanted to move on in their lives by dropping from the trial process. In order that a survivor of sexual violence continues with the legal processes, there is a critical need for multiplicity of stake holders to work in coordination with one another and also in the best interest of the survivors. Aspects such as compensation, counseling and therapeutic services along with strong support mechanisms for navigating the criminal justice system and commitment to protect and support survivors are critical to prevent attrition [16].

Conclusion

Medico legal evidence has been considered an important component in the prosecution of crimes, especially those related to sexual violence. The courts heavily rely upon it. However it is important to understand that forensic science itself is a new and emerging discipline. No forensic method has rigorously been able to demonstrate a definitive connection between a specific individual and a sample/source .Far more research is required to arrive at definitive conclusions as stated by global research on forensic sciences [17].

In the Indian context, the medico legal practice was fraught with medieval practices and lacked a scientific approach. This paper has presented efforts made in order to change the age old medico legal practice in hospitals by a scientific, survivor centric gender sensitive approach. Efforts were made through the model to look beyond the forensic role of health professionals and harness therapeutic care for survivors. While providing therapeutic and medico legal care to survivors and assisting them with rehabilitation services, there was also an While doing so, there was also an interest in understanding if medico legal practice of health professionals can assist the courts in interpretation of medico legal evidence. Medical opinions by health professionals documented circumstances of sexual violence and highlighted reasons for loss of medical evidence in instances where it was not found. Such findings were expected to assist the courts in interpreting medico legal evidence. But analysis of case judgments in this paper brought forth serious gaps in how the police, prosecution and courts understand medico legal evidence. Despite several judgments of the apex court stating medical evidence only as corroborative evidence , courts continued to believe that medico legal examination and evidence collection will inform them whether rape occurred or not . Efforts must be made to acknowledge that health systems have a therapeutic [18].

This paper highlights that training of health professionals to carry out systematic and scientific medico legal examination and care must be supported with training of the police, prosecution and judiciary to explain the scope and limitations of medical evidence. Interface amongst these stakeholders is pertinent in order to enable survivors in their pursuit for justice.

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