Abstract

Social Defence – The Protection of Children from Sexual Offences Act, 2012- Guidelines under section 39 of the Protection of Children from Sexual Offences Act, 2012 – Orders – Issued.

Social Welfare and Nutritious Meal Programme (SW8) Department

G.O.(Ms)No.17 Dated 18-03-2015
ஜய, பங்குனி **4,**
திருவள்ளுவர் ஆண்டு **2046**

Read:

Ref: From the Director of Social Defence Letter No. 59/SPSU/2013, Dated. 7.11.2013, 23.12.2013 and 13-01-2015.

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ORDER:

In the letter read above, the Director of Social Defence has sent the draft guidelines for the use of persons including Non-Governmental Organizations, professionals and experts or persons having knowledge of psychology, social work, physical health, mental health and child development to be associated with the pre-trial and trial stage to assist the child for approval of the Government.

2. Accordingly, in exercise of the powers conferred by section 39 of the Protection of Children from Sexual Offences Act, 2012 (Central Act 32 of 2012), the Governor of Tamil Nadu hereby issues the guidelines appended to this order, for use of Non-Governmental Organizations, Professionals and experts or persons having knowledge of psychology, social work, physical health, mental health and child development to be associated with the pre-trial and trial stage to assist the child.

(By order of the Governor)

P.M. Basheer Ahamed
Principal Secretary to Government

To
The Director of Social Defence, Chennai-10.
The Commissioner of Social Welfare, Chennai – 2.
The Secretary,
Tamil Nadu Commission for Protection of Child Rights, Chennai.

(P.T.O)

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The Ministry of Women and Child Development,
Government of India, New Delhi-110 001.
The Chairperson,
National Commission for Protection of Child Rights, New Delhi.
The Director General of Police, Chennai-4.
The Additional Director General of Police, CB-CID, Chennai -8.
The Director of Medical and Rural Health Services, Chennai.

Copy to:

All Sections in Social Welfare and Nutritious Meal Programme Department, Chennai -9.
All stake holders (Through the Director of Social Defence, Chennai-10.)
The Home Department, Chennai-9.
The Law Department, Chennai -9.
The Health Department,
Chennai – 9.

// Forwarded by Order //

Section Officer

APPENDIX

GUIDELINES FOR THE USE OF PROFESSIONALS AND EXPERTS UNDER THE PROTECTION OF CHILDREN FROM SEXUAL OFFENCES ACT, 2012

Introduction:-

The main objective of the guidelines is to handle the sexually abused children professionally with priority to address their medical and emotional needs and giving utmost care in the exercise of eliciting information without affecting their rights enshrined under the United Nations Convention on the Rights of Children. It is also aimed at facilitating and strengthening the trial by providing concrete evidences and witnesses by ensuring that the child is not subjected to secondary victimization at any stage. Further, it is felt that helping police in investigation and prosecution such as, gathering information in the own words of the child victim, collection of medical and forensic evidences would certainly ensure, to a greater extent, the prosecution of offenders who commit crime against children.

CHAPTER-I

Guidelines on Interviewing a Child

The United Nation's Convention on the rights of Children (1989) recommends that, wherever possible, children should be involved and consulted about all activities which affect their lives. The relevant portion is as hereunder:-

"In the arena of child protection, the focus has recently shifted from seeking information about children to collecting information directly from them. It is commonly agreed that the best source of information about children are children themselves".

Interviewing a child helps in collecting information directly from the child in his/her own version. In cases of child related sexual offences, there are areas where parents or other related persons are in a better position to provide information relating to the incidence than the child. However, there might be significant difference in the observation of a parent or related person and the child's own experience and sufferings. Hence, utmost care is always necessary in all cases of child sexual offences while interviewing a child to ascertain the sequences of the incidence such as place, time, frequency, persons present at the time, persons of whom the child could identify, the gravity of the abuse and the nature of intervention

required. Further, the facts in the own version of the child could later be corroborated with that of the information provided by parents and related persons to arrive at a clear picture of the incidence.

I. Interview Preparation:

The environment in which interviews are conducted is extremely important and should ideally be quiet and free from interruptions and distractions. It should be comfortable and child friendly. The more comfortable the child is, the more information he/she is likely to share. Following are some of the tips to be kept in mind while interviewing a child:-

1. Attention to the physical settings such as seating to maintain equal eye level and position at a reasonable distance.
2. Distractions like noise, ringing phones, conversation with others, watching something else may be avoided.
3. The timing of the interview is also important, as this can affect how children behave. For example, interviewing children prior to break of lunch time may result in less productive interviews as they may be hungry or thinking about their impending recreational time.
4. Quickly establishing rapport with children prior to the commencement of interview is essential, as it can help to put children at ease, improve trust and honesty and consequently may lead to more constructive dialogue.
5. Be friendly, informal and relaxed and use language that is easily understandable and meaningful to children.
6. Take time before the interview to find out whether the

child has special needs. If the child has needs related to developmental and / or physical disabilities, try to consult with a specialist who knows the child and can provide input into how disability may impact the child's ability to provide and receive information. Adjust interview accordingly.

7. If possible before the interview, find out about the neutral event (birthday/holiday/activity) in the child's life that may assist in establishing rapport, practicing narratives and assessing the child's memory and developmental level.
8. Take time before the interview to consider alternative explanations for the statements or behavior leading to concern about the possibility of abuse. This will enable to ask questions more freely and objectively. Explore what the child may have experienced. Keep an open mind.
9. Begin with self introduction and simply explain about job and role.

II. How to conduct Interview:

1. Assessing the Developmental Stage

At the beginning of the interview, it is important to assess the child's developmental level and to frame the interview so that age-appropriate interview techniques are used. It is important not to confuse chronological age with normal developmental stages. A child's developmental age may not match what may be expected for

the child's chronological age. We need to integrate our knowledge of child development with knowledge of the child's sense of time, temperament and language abilities. Some of this information may be obtained through interviews with the parents, either through questionnaires completed by the parents, consultations with school teachers, or our own observations. Once you have a sense of the child, it becomes easier to understand the child's thinking. What the child says and does can best be interpreted by understanding the child's developmental cognitive abilities and emotional state of mind. While formulating questions to ask a child, it is important that the questions be appropriate for the developmental level of the child.

2. Choosing Appropriate Interview Questions:

It is difficult to do an entire interview without asking any questions. It is more effective to use open-ended or indirect questions. Children provide more accurate information when they are freely narrating, rather than they are being asked direct questions. Open-ended questions allow children to expand on their ideas and give a better sense of thinking. Asking children to describe their home, their parents, or what they enjoy doing, allow them the freedom to elaborate as they choose. Indirect questions provide a margin of safety for the child. We have to try to find indirect ways to help the child share important information. If a child avoids an issue, then it may be necessary to try another approach. Encourage children to ask questions, and ask them to share whatever they would like about themselves or their family. Children enjoy having a sense of control over what they will be doing and saying.

3. Encourage Children to use their own Language: Encouraging children to use their own language includes

(1) Use of verbal prefaces (e.g. "It is important for you to tell me so that I can help you")

(2) Encourage Clarification: As the interview progresses, the child may often make a vague reference to "trouble at school" or "thing that happened after school". The interviewer might encourage clarification by paraphrasing the child's statement or by framing question such as "what kind of trouble at school do you mean?" or "Can you tell me about the thing that happened after School?"

(3) Do not use bribes or enticements: A child who has probably been told to be silent will only be further confused when offered an eatable or gift for revealing information.

(4) Try to decrease the child's anxiety. One way to do this is to let the child tell everything at her own pace.

(5) Acknowledge the child's embarrassment or reluctance to discuss troubles and issues. [Example: If the child suggests that the problem involves a specific person (step-father, neighbor, auto driver, family friend etc,) the interviewer may ask "what kind of problem are you having with that person" If the child indicates embarrassment and reluctance, one should acknowledge it, reassure the child and then restate the question. If the child is too embarrassed to answer or has difficulty in giving specific details relating to "private parts" in sexual abuse then the interviewer might consider the introduction of anatomically detailed dolls].

(6) In cases where a physical injury is associated with sexual abuse and if the child does not show the injury, then the investigator should ask specific questions to elicit the information (For example: "How did you get the injury?")

4. Establishing Details of Assault:

In establishing the details of an assault, the interviewer should move from general details to specific details of the assault. The interviewer needs to help the child to decrease anxiety and fear by using focusing techniques such as;-

(i) Child's Activity:- The interviewer should help the child to reconstruct his/her day. For example: "What were you doing that day?" Whether at play, going to nearby shop, returning from school, watching television at home etc.,);

(ii) Assailant's Activity:- The interviewer should try to learn what the assailant was doing. (For example: "As he comes for any of his/her help, offered some eatables, gifts etc.,)";

(iii) Family's Activity:- It is necessary to determine where the other family members are and what were they doing during the assault (Father was in office/Mother was in the kitchen or shopping etc.,).

Pictures may be used to make the child tell what happened during the incident. Child may be encouraged to draw his/her family, their home, or try to draw what happened. The interviewer must concern not only with the facts of what happened but also the child's feelings about the incident. On the back of the drawing, the interviewer should write what the child had stated while describing the picture.

If, during the interview, the child indicated that other individuals were present at the time of the incident, this gives information about potential witnesses or victims. If several incidents of abuse have taken place, the child needs to be questioned concerning the first incident that occurred. Talking about earlier incidents is often less threatening than discussing more recent ones. This procedure also helps establish the progression of sexual activity in sexual abuse cases.

5. Information cannot be gathered in a single attempt:

It should be remembered that not all victims will be able to disclose on the first interview nor will all children disclose the totality of their abuse on the initial interview. It may be necessary for the interviewer to go for second or third time interaction with the child by keeping him/her comfortable. The interviewer should always keep in mind that the child may initially deny any abuse and even deny it repeatedly over a period of time. Children may then begin to release bits and pieces of the abuse to test the reaction of the interviewer. Patience and skill are necessary in handling victim children and experience will be one of the key factors in developing one's competency in handling them.

6. Things to be kept in mind while interviewing a child:

(i) All children should be approached with extreme sensitivity and their vulnerability recognized and understood.

(ii) Try to establish a neutral environment and rapport with the child before beginning the interview. (For example: child's home, a private location away from parents or siblings that appears to be the most neutral spot.)

(iii) Ask the child why he/she had come to see you. Children are often confused about the purpose of the interview or worried that they are in trouble.

(iv) Do not express surprise, disgust, disbelief, or other emotional reactions to descriptions of the abuse.

(v) Avoid touching the child and respect the child's personal space and do not stare at the child.

(vi) Do not suggest feelings or responses to the child. For example "I know how difficult this must be for you."

(vii) Do not make false promises. For example "Everything will be okay" or "You will never have to talk about this again."

(viii) Permit the child to say he/she "does not know".

(ix) Allow the child to correct the interviewer if he/she desires so.

(x) The child may get exhausted frequently and easily, in such event, it is advisable not to prolong the interview. But rather to divert the child's mind and come back to the sexual abuse incident when the child is refreshed.

(xi) Let the child do the talking and answer any question the child may have in a direct manner.

(xii) Do not discuss the case in front of the child.

(xiii) Individuals who might be accused of influencing children (including parents in some cases) should not be allowed to sit with children during interview.

(xiv) A variety of non-verbal tools may be used to assist young children in communication, including drawings, toys, dollhouses, dolls, puppets, etc. since such materials have the potential to be distracting or misleading they should be used with care. They are discretionary for older children.

(xv) Storybooks, colouring books or videos that contain explicit descriptions of abuse situations are potentially suggestive and are primary teaching tools. They are typically not appropriate for information-gathering purposes.

7. Points to remember while handling Children with Special Needs:

(1) Better to have several shorter interviews

(2) They may need “Cues” to understand the topic of conversation

- Use of media can be helpful. Example: Photos of relevant people and places

(3) Limited expressive language skills and representational skills

- They often find it easier to ‘show’ than to ‘tell’
- Easier for them to use their own bodies rather than using dolls and properties

(4) Increased suggestibility and “Yes” Saying

(5) A neural professional who has worked with the child or with similarly disabled children can facilitate communication between the child and the evaluator. E.g. sign language, use of computer, communication board etc.,

(6) The evaluator and the professional assistant need to co-ordinate their efforts in advance before interviewing the child

(7) Keep questions short and simple

(8) Use proper names rather than pronouns

(9) Avoid asking leading questions

(10) Allow the child sufficient time to process the information (Slow Down)

(11) Keep in mind that children with special needs may be reluctant to report the crime or consent to the examination for fear of losing their independence.

Chapter - II

Code of Conduct for Support Persons, Interpreters, Special Educators and Translators

Support Person to be provided under sub-rule (7) of rule 4 of the Protection of Children from Sexual Offences Rules, 2012 may be a person or organization working in the field of Child Rights or Child Protection, or an official of a children's home or shelter home having custody of the child, or a person employed by the District Child Protection Unit to render assistance to a child through the process of investigation and trial in respect of an offence under the Protection of Children from Sexual Offences Act, 2012.

I. Eligibility for a Support Person, Interpreter, Special Educator and Translator:

(i) Any person not below the age of 21 years

(ii) Reference letters from three persons who shall endorse the conduct, character and competency of Support Persons (this includes communication skills in the required field etc).

(iii) Should have a clear communication skills. Knowledge of the unique modes of communication for children with disability shall be an added advantage.

(iv) Should not have been convicted by a court for any criminal offences (This will exempt minor traffic fines etc.)

(v) Should furnish a self declaration by such person confirming the foregoing eligibility criteria.

(vi) The services of the support person may be terminated upon request by the child or his parent or guardian or person in whom the child has trust and confidence and the child or the above said person requesting the termination shall not be required to assign any reason for such request.

(vii) District Child Protection Units should prepare and maintain a list of support persons, interpreters, special educators and translators, with names, addresses, qualifications, experience and other contact details. The list shall be made available to the Child Welfare Committee, Special Juvenile Police Unit, Local Police, Magistrate or Special Court or other authority concerned as and when required. The list has to be reviewed once in every two years.

  - The list should have Persons of all genders.
  - Persons who have special skills in handling children with different disability.

- Person having health issues that make him/her difficult to perform as support person should not be selected.
- Support Person cannot be a person who could be called as an expert to give evidence/ advice to the court.

- Support Person shall be nominated with the consent of the child and his parents or guardian or other person in whom the child has trust and confidence.

II. A. CODE OF CONDUCT SPECIFIC TO SUPPORT PERSONS, INTERPRETERS, SPECIAL EDUCATORS AND TRANSLATORS

(1) Should not be alone with the child.

(2) Should not have physical contact.

(3) Should not reveal the personal details of the child

(4) Should not record on any electronic devices.

(5) Should not have any personal contact with the child other than his role assigned.

(6) No gifts to be given to the child.

(7) No favours to be asked from the child or from his/her family.

(8) Should not give the child any electronic devices to play with or use.

(9) While assisting the child, the person should not be under the influence of alcohol or any Psychotropic drugs.

(10) Support Persons/Interpreters/Special Educators/ Translators should relay the information exactly and accurately (should not embellish or add/modify) to all persons involved in the Criminal Process – Child Welfare Committee, Child Prosecutor, Police etc.

(11) Should not disclose to media any information relating to the child in subject.

(12) The person should not share any sexual explicit material either print or electronic to the child.

(13) Relationship between the support person and the child ceases when Child Welfare Committee or the family discontinues the services or when the case is concluded but confidentiality shall be maintained at all times even after the completion of the case.

(14) If the Support Persons/Interpreters/Special Educators/Translators do not keep his/her commitment and fail to attend two consecutive appointments then his/her services can be terminated.

(15) If the person is likely to miss an appointment due to unforeseeable circumstances, he/she should inform the Child Welfare Committee and take permission.

(16) The Support Persons'/ Interpreters'/Special Educators'/Translators' commitment is only to the child and should not favour any other person.

(17) Support Persons / Interpreters / Special Educators/ Translators cannot invite the child to his/her house, cannot take them out for any personal programme or cannot stay overnight with the child.

(18) Support Persons/Interpreters/Special Educators / Translators cannot act as a Counsellor and should not be interviewing or preparing the case study report.

(19) If the District Child Protection Units or any other Institution /organization (Private or Government) is involved in any child abuse or any case related to the child, no functionary of that organization can be

designated as the Support Person/ Interpreter/Special Educator/Translator for that case.

(20) During the course of the case, if the Support Persons/ Interpreters/Special Educators/Translators develop a health problem, he/she should inform the Child Welfare Committee.

(21) Inappropriate language and ridiculing the child, his/her family and family background or any other subjective comments by the support person is not permissible.

(22) Support Persons/Interpreters/Special Educators/ Translators assigned by the Child Welfare Committee are answerable only to the Child Welfare Committee to furnish a report.

(23) The Support Persons/ Interpreters/Special Educators/ Translators should be committed to the case at least for a year or till the case is completed.

(24) The Support Persons/ Interpreters/Special Educators/ Translators should treat the child and his/her family with dignity and respect.

(25) Children should not be engaged in any errands or personal work.

(26) Support Persons/ Interpreters/Special Educators/Translators should be accommodative of the convenience of the child and his/her family.

B. Responsibilities

(i) After every contact with the child, the Support Persons/ Interpreters/Special Educators/Translators shall give a

report in the format as prescribed in the Chapter-VI.

(ii) Support person will have to work or liaise with other persons involved in the case such as Experts, Interpreters, Translators, Special Educators, Police Personnel, Judiciary etc., for a common objective of enabling the process of justice.

(iii) All observations of the Support Persons/ Interpreters/Special Educators/Translators regarding the case and information communicated by the child should only be reported.

C. BASIC ETIQUETTES TO BEAR IN MIND WHILE HANDLING CHILDREN WITH DISABILITY

(i) A child who has a disability is a child -- like anyone else.

(ii) Allow the child who has a disability to help you at ease, if you don't know what to do or say.

(iii) Offer assistance if asked or if the need seems obvious, but don't overdo it or insist on it. Respect the children's right to indicate the kind of help needed.

(iv) Be considerate of the extra time it might take for a child with a disability to get things said or done. Let the child set the pace in walking or talking.

(v) Speak directly to a child who has a disability. Don't consider a companion to be a conversational go-between.

(vi) Don't move a wheelchair or crutches out of reach of a child who uses them.

(vii) Never start to push a wheelchair without first asking the occupant if you may do so.

(viii) When pushing a wheelchair up or down steps, ramps, or curbs, or other obstructions, ask the child how he or she wants you to proceed.

(ix) Don't lean on a children's wheelchair when talking.

(x) Give whole, unhurried attention to the child who has difficulty in speaking. Don't talk for the child, but give help when needed. Keep your manner encouraging rather than correcting. When necessary ask questions that require short answers or a nod or shake of the head.

(xi) Speak calmly, slowly, and distinctly, to a child who has a hearing problem or other difficulty in understanding. Stand in front of the child and use gestures to aid communication. When full understanding is doubtful, write notes.

(xii) Explain to a child who has a visual problem about the surroundings and people who are present.

CHAPTER-III

Standard Operating Procedures for Medical Practitioners while Examining Child Victims of Sexual Abuse

This chapter on Standard Operating Procedure for Medical practitioners on how to handle child victims of sexual abuse took into account the Code of Criminal Procedure, 1973, the Provisions of Protection of Children from Sexual Offences Act, 2012 and the Criminal Law (Amendment) Act, 2013.

I. Role of Health Care Providers:

Health care providers play a dual role in responding to children subjected to sexual assault. The first is to provide the required medical treatment/assessment and psychological support and the second is to assist the child 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 child's needs. While doing so it may be pertinent to remember that the sites of treatment on the body would also be examined for evidence collection later. The ultimate goal of the health care providers should be to establish a "Comprehensive Response to children of Sexual Assault".

II. The components of the Comprehensive Response are as follows:

(1) Providing necessary medical support to the child victim of sexual assault.
(2) Establishing a uniform method of examination, evidence collection by following the protocols in the SAFE kit.
(3) Informed consent for examination and evidence collection and informing the police procedures.
(4) First contact psychological support and validation after the traumatic experience.
(5) Maintaining a clear record of handing over and taking over of material evidences collected till it is sent to forensic lab (fool-proof chain of custody).
(6) Referring to appropriate agencies for further help (e.g. legal support services, shelter services etc.).

III. Purpose of the Medical and Forensic Examination:

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

(1) To ascertain 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 glands between the labia with or without emission of semen or rupture of the hymen. Sexual acts not limited to genital, anal or oral penetration by the penis, fingers or

other objects as well as any form of non-consensual sexual touching.

Two finger tests is a form of virginity test. It involves testing for laxity of vaginal muscles with fingers (the "two-finger test"). A doctor performs the test by inserting a finger into the female's vagina to check the level of vaginal laxity, which is used to determine if she is "habituated to sexual intercourse". However, the usefulness of these criteria has been questioned by medical authorities and opponents of virginity testing because vaginal laxity and the absence of a hymen can both be caused by other factors, and the "two-finger test" is based on subjective observation. In virginity tests, the presence of a hymen is often used to determine if a woman is a virgin.

The period passed over after the incident need to be mentioned, whether such a sexual act is recent or sometime back.

(2) <u>To ascertain whether such an act was forcible:-</u> Any harm caused to the child's body is documented through examination. This could include injuries inflicted on the survivor by the accused and by the survivor on the accused (if the accused is available for examination).

(3) <u>If validity of consent is questionable:-</u> The age of the survivor in case of pre-pubertal/adolescent girls/boys has to be ascertained.

(4) To ascertain the influence of alcohol or drugs, if any administered to the child.

(5) To provide treatment for squeal of the assault and appropriate referrals for the child.

IV. Prerequisites at the Health Facility:

(1) The examination should be carried out in a non-threatening, quiet, and private place.

(2) Adequate waiting space should be made available for parents, relatives accompanying the child.

(3) Sufficient lighting and a comfortable examination table are necessary for a thorough examination.

Infrastructural requirements for the examination of Child:

Torch	Microscope	Colposcope
Surgilube	Cytofix spray	Spirit Lamp
Camera	Toluidine Blue	Disposable Speculum

(4) Sufficient space should be present on a table or platform for laying out all equipment required to conduct the examination and for taking notes.

(5) It is the prime responsibility of the medical facility to provide proper care, examination and psychosocial treatment to the child victim of sexual assault.

(6) Section 164 A of the Code of Criminal Procedure, 1973 explains the legal requirements for medical examination of a victim of rape. 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.

(7) The facility should designate staff for examination of child sexual victims 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.

(8) It is not mandatory that only a gynecology must examine the child of sexual assault. As per section 164 A

of the Code of Criminal Procedure, 1973, any Registered Medical Practitioner can conduct the examination.

(9) In case a female doctor is not available for the examination of a girl child, a male doctor should conduct the examination in the presence of parent/guardian/ person of trust and in their absence the examination shall be conducted in the presence of a women nominated by the head of the medical examination.

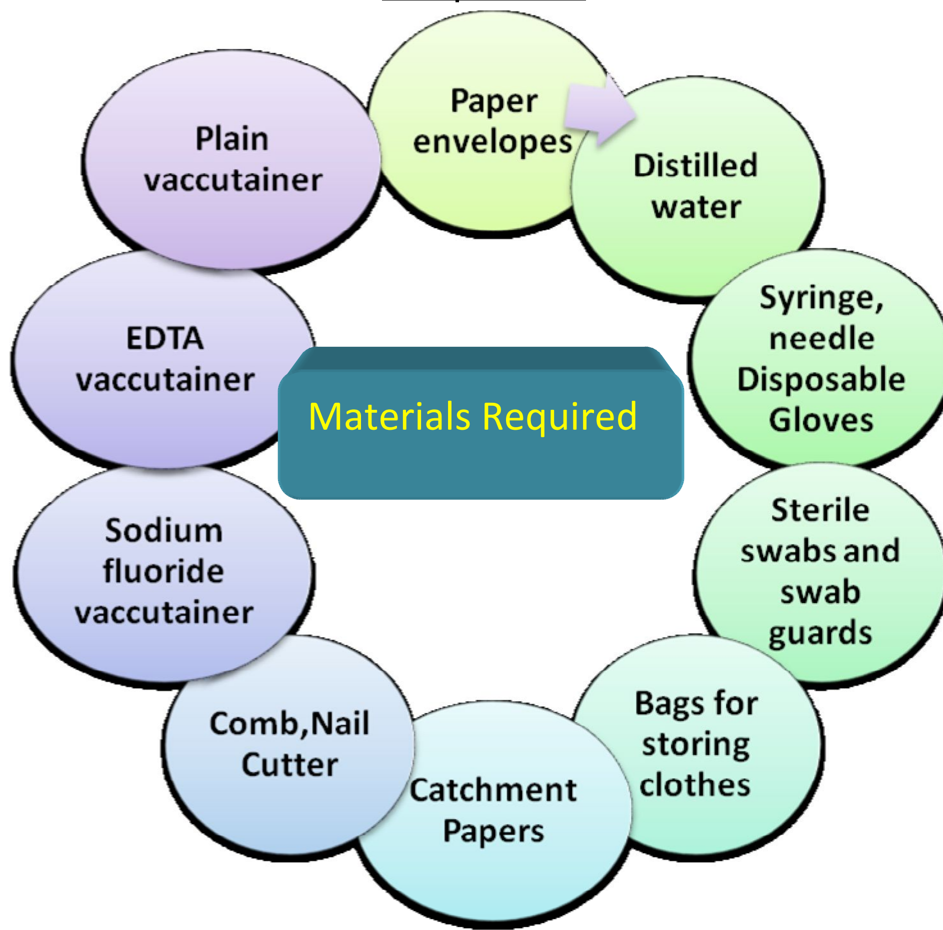
(10) In case of a child with disability, his/her parent/guardian/ any other person with whom the child is comfortable must be present.

(11) Unless the child victim requires indoor stay for treatment or observation admission should not be insisted upon.

(12) 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-emphasized.

(13) 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.

Materials Required:



V. Victim of child sexual abuse:

Victim of child sexual abuse may approach the hospital/clinic under three ways; namely (1) by the victim, (2) through police after a complaint is made and (3) by the direction of a court.

In all the above cases, seeking informed consent for examination and evidence collection is mandatory (Section 164 A CrPC).

VI. 1. Consent of the survivor should be taken for the following purposes:

(i) Examination

(ii) Collection of the evidence

(iii) Informing police for purposes of investigation

(iv) Treatment.

(2) The consent form must be signed by the person himself/herself if he/she is above 12 years. of age. Consent must be taken from the guardian/ parent if the child is under the age of 12 years or if the child is unable to give his/ her consent by reason of mental disability. (Section 89 IPC).

(3) The consent form must be signed by the child, a witness as well as the examining doctor.

(4) Any major 'disinterested', mentally sound person may be considered as a witness. In the hospital set-up this could be a nurse or other hospital employee. The police or a relative of the child cannot be considered as a witness.

(5) In case the child or guardian of the child refuses to give consent for any part of examination, 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 (Section 164 A CrPC).

(6) Child victim of sexual abuse and his/her relative/ guardian should be explained that at any stage during examination and evidence collection he/she may ask the

doctor to stop and that it will not have any effect on the quality of her treatment.

(7) Even if the child refuses to give consent to submit evidence to the Forensic Science Laboratory (FSL) and reveal information to the police for purposes of investigation, she/he should be made aware that if at a later date she/he changes her/his mind and wants to pursue a legal course of action, the collected evidence may be useful to seek justice.

(8) A child victim of sexual abuse may come to the hospital only for treatment for effects of assault. Under section 39 of the Code of Criminal Procedure, 1973 the doctor is bound to inform the police about the Commission of such offences. Justification for not informing the police should be documented. Neither court nor police can force the child to undergo medical examination. It has to be with the child/parent/guardian's informed consent (depending on the age).

VII. Voluntarily reporting to health facility:

In the past, in case of sexual assault, child examination was only done after receiving a police requisition. Now the Supreme Court has clarified in the case of Manjanna vs State of Karnataka (2000) that police requisition is not mandatory for a sexual assault victim to seek medical examination and care. The doctor should examine such cases even if the victim reports to the hospital first without First Information Report (FIR).

VIII. 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 to Superintendent/Incharge for medical examination of child of sexual assault. The requisition form of the investigating officer, must be handedover directly to the Superintendent/Incharge. This may be done while accompanying the parent and of the child during the medical examination.

General Information:

- Start by recording the name, age, sex (male/female/transgender), address and contact number of the Child subjected to sexual abuse.
- Information about the police case registered, such as Medico Legal Case (MLC) number, Crime Register (CR) number; under section should also be recorded.
- Who the child 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.

Medical History:

- Relevant medical history in relation to sexually transmitted infections (gonorrhea, HIV, HBV etc). This has a bearing on what gets transferred between victim 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 is any health issue.
- ❖ Consequences related to the assault, which would also inform referral for further care. This information should also be kept in mind during examination and interpretation of findings

Note:-

(1) Keep in mind that narration of the history of sexual assault might be a traumatizing experience for the survivor. It is very difficult for the child to talk about this and she/he might not want to tell you all the details.

(2) Be very sensitive of this and explain to the child that the process of history taking is important for further treatment and for filing a case if needed.

(3) Talk to the child in a non-threatening environment.

(4) 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 child and not by accusing him/her of lying.

(5) Police officers must not be present while history is being recorded. Parents/ guardian/ a person of trust have to be around while recording the history.

Sexual Assault History:

History of the incident, documented specifically in the child's own words has evidentiary value in the court of law as this is being recorded by neutral and unbiased doctor. Whenever possible the police can be present during the medical examination of the sexually abused child/victim. It could reduce the traumatization of the child/victim. This can be done in the presence of doctor and police. The doctor should record it completely as it may be the first opportunity for the survivor to narrate her / his history.

Details of the place of the assault, time, nature of force used and areas of contact are recorded here. If the assailants are known, 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 (child 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.

Specifically note history of injury marks that the child 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, 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. Child may have had blunt trauma which should be looked for during examination.
- Verbal threats should be recorded in child's words, eg. Harming her/him or her/his 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 of IPC) includes only peno-vaginal intercourse, but 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 child, masturbation of the child by the assailant, oral sex by the

assailant on the child 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 child's testimony.
- ❖ History of oral sex, anal sex and masturbation should be asked in simple language, using terms that the child understands. Pictorial representation may be used as an aid.
- ❖ In case of children having difficulty in verbalizing, illustrative books, body charts or a doll can be used, to elicit the history of the assault. Assistance of the support person, translator, or special educators may be sought to elicit history from a child with a special need.
- ❖ 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 the child victim 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 child was menstruating at the time of assault/ examination.
- ❖ The same applies to bathing, touching, defecating, urinating and use of spermicide after the assault.

- If there is vaginal discharge, record its type, i.e., texture, colour, odour, etc.
- In case there are any cancellations while recording anything on the pro forma, it is important for the doctor to countersign next to the correction.

Forensic Evidence Collection:

- Make an assessment of the case and determine what evidence needs to be collected, even before the beginning. 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 child reports within 96 hours (4 days) 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 (3 days) is greatly reduced; however it is better to collect evidence up to 96 hours in case the child may be unsure of the number of hours lapsed since the assault.
- Keep in mind that spermatozoa can be identified only for 72 hours after assault. So if a child has suffered the assault more than three days ago, 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 child provides. The kinds of swabs taken should be consistent with the history. For example, if the child is certain that there is no anal intercourse; anal swabs need not be taken.
- Request the child 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 him/her by the 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 child was wearing at the time of the assault are of evidentiary value if there is any stains/tears/trace evidence on them. Hence they must be preserved. 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 child must be asked if she/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 may be a possibility of exchange of bodily evidence between accused and victim of sexual abuse.
- 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 evidences 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 child'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 child victim 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 child victim 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 (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 child's ability to offer resistance.

Venous blood is collected with the sterile syringe and needle provided and transferred to three 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	Ethylenediaminetetraacetic Acid (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.

Duration of time drugs/metabolites remain in the body.

Found up to 10 hours
- Alcohol

Found up to 36-72 hours
- Rohypno (Flunitrazepam)

Found up to 10-12 hours
- Gamma Hydroxybutyric Acid (GHB)

Found in urine upto 6 hrs, in blood 24 hrs
- Gamma Butyrolactoe (GLB)

Genital and Anal Evidence:

- ❖ In the case of any suspected seminal deposits on the pubic hair of the child, clip that portion of the pubic hair, allow to dry in the shade and place in an envelope.
- ❖ Pubic hair of the child 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.
- Other pieces of evidence such as tampons (may be available as well), which should be preserved.
- Swabs for microbiological tests for infections may be sent as per institutional policy and availability.
- Swabs must be air dried, not dried in direct sunlight. Drying of swabs is absolutely mandatory as there may be decomposition of evidence which can render it un-usable.
- Always ensure that all the envelopes containing the samples are labeled

General Examination:

- Make an assessment of the general mental condition of the child.
- Observations on the general mental condition of the child should include whether he/she was agitated, restless, numb, anxious, whether he/she was able to respond to all the questions asked by the doctor. A doctor can also record his/her feelings in his/her words for ensuring accuracy.

- Any signs of intoxication by ingestion or injection of drug/alcohol must be noted.
- 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 child 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. (Bowyer and Dalton, 1997). Moreover, mucosal injuries heal rapidly. They may not be visible during examination and may not leave any scars either. (McCann et. al, 2007). Even so, 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 child and parent's 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 off from periphery

Contusions:

Fresh	Red
Few hours to 3 days	Blue
4th day	Bluish-black to brown(hemosiderin)
5 to 6days	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

If there is deep bruise or contusion, signs of injury will usually show after 48 hours. In case signs of injury are seen on the follow-up, it has to be recorded and has to be attached with 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	Hematoma formation
12 hours	Edges-red.swollen
24 hours	Scab of dries clot covering the entire area
After this rough estimate can be based on signs of healing	

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.

Genital Examination:

- A careful observation of the perineum is made for evidence of injury, seminal stains and stray pubic hair.
- In case of female child, 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.

- 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.
- The examination and treatment as needed may have to be performed under general anaesthesia especially 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.
- Do not perform two finger test of admissibility in case 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), (girl children married before the age of 18yrs)
- 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. Research shows that an intact hymen does not rule out sexual assault, and a torn hymen does not prove previous sexual

intercourse. Hymen should therefore be treated like any other part of the genitals while documenting examination findings in cases of sexual assault. Only those that are relevant to the episode of assault (findings such as fresh tears, bleeding, edema etc.) are to be documented.

- ❖ 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.

Opinion:

Opinion has to be given on following issues;

1. Any clinical evidence that the child subjected to sexual abuse 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. *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.

- o Evidence of oral intercourse is in the detection of spermatozoa in the wet oral smear/semen in the oral swabs/smears detected by FSL.
- o Whether there is evidence of vaginal, anal penetration by finger or object.
- o Vaginal penetration: presence of injuries and lubricant - detection of lubricant in the swabs by FSL.
- o Anal penetration: presence of injuries and lubricant - detection of lubricant in the swabs by FSL.
- o 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.
- o Whether intercourse was a recent act or not.
  - Based on time since injuries.

b.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.

4. Actual age of the child (< 18 yrs).

- Medical age is meant of physical age, dental age and radiological age.
- Drafting of provisional opinion should be done immediately after examination of child victim and wet smear examination.
- The opinion must state the number of days after which examination and evidence collection was carried out, after the incident.

CHAPTER-IV

Role of the Tamil Nadu Commission for Protection of Child Rights with regard to Protection of Children from Sexual Offences (POCSO)Act, 2012

The role of the State Commission for Protection of Child Rights is prescribed in Section 44 of the POCSO Act, 2012 and Rule 6 of the POCSO Rules, 2012.

Monitoring of implementation of the Act:

(1) The SCPCR may collect information and data on its own or from the relevant agencies regarding reported cases of sexual abuse and their disposal under the processes established under the Act, including information on the following:-

(i) number and details of offences reported under the Act; Sources will be Police, Child Welfare Committees (CWCs), Special Courts, District Child Protection Units (DCPUs), State Child Protection Society (SCPS), District Social Welfare Officers (DSWOs), Directorate of Social Welfare and Social Defence.

(ii) Details of the number of cases filed under IPC/ POCSO, or exclusively under POCSO alone etc - The details of section, along with the sub-sections synopsis of the case, context of abuse cases, gender variables etc., for better understanding of the reported cases across the State.

(iii) To monitor whether the procedures prescribed under the Act and rules were followed including those regarding timeframes. Time frames to be monitored by State Commission for Protection of Child Rights (SCPCR).

(iv) Police to inform Child Welfare Committee (CWC) and Special Courts within 24 hours.

(v) If police believe emergency medical care is needed then they have to take the child for this care within 24 hours of complaint.

(vi) Police to ask for Child Welfare Committee (CWC) assessment if they believe a child needs care and protection within 24 hours.

(vii) Child Welfare Committee (CWC) assessment to be done within 3 days.

(viii) If child is ascertained by Child Welfare Committee (CWC) as in need of care and protection and is assigned a support person, the Child Welfare Committee (CWC) should inform the police/Special Juvenile Police Unit (SJPU) who in turn should inform the Special courts within 24 hrs of making assignment.

(ix) Evidence to be obtained by Special Courts, 1 month from the time of committal.

(x) Trial to be over in 1 year.

(xi) State Government should pay compensation ordered by Special court within 30 days of receipt of order.

(2) Details of arrangements for care and protection of victims of offences under this Act, including arrangements for emergency medical care and medical examination;

(3) The Child Welfare Committee (CWC) can decide on the place of staying of the Child/Victim i.e either family or institutions;

(4) Details regarding assessment of the need for care and protection of a child by the concerned Child Welfare Committee (CWC) in any specific case. – The State Commission for Protection of Child Rights (SCPCR)

request has to be in writing and acknowledged when received.

(5) The State Commission for Protection of Child Rights (SCPCR) may use the information so collected, to assess the implementation of the provisions of the Act. The report on monitoring of the Act shall be included in a separate chapter in the Annual Report of the State Commission for Protection of Child Rights (SCPCR) Sec. 44 (3) of the POCSO Act.

(6) The following are the other suggestions regarding the tasks to be undertaken with regard to the Act by the State Commission for Protection of Child Rights;

(a) One member of Tamil Nadu Commission for the Protection of Child Rights needs to be assigned to deal exclusively with POCSO Act.

(b) A standard format has been developed for the State Commission for Protection of Child Rights (SCPCR) to get the information from relevant agencies like Child Welfare Committee (CWC) and Police etc., on monthly basis (subject to modification as required). It will assist the State Commission for Protection of Child Rights (SCPCR) to keep track of the reporting of cases and monitoring of the same by State Commission. A standard format is given in the *Annexure-I.*

(c) Monthly reports from the police can be sought in cases relating to sexual violence against children to

tally with cases being informed to Child Welfare Committees (CWCs).

(d) A clear protocol should be developed (the necessity, and the process,) so that there will not be duplication, replication, overlapping of any inquiry process. This will then ensure the seamless integration of all protection structures, systems and personnel involved in child protection with the best interests of the child as the paramount factor.

CHAPTER- V

This chapter is further subdivided into three units

UNIT – ONE

Recommendations of the Supreme Court of India on Compensation

(1) The right to compensation has now been determined as a constitutional right. In *Delhi Domestic Working Women's forum v. Union of India and others WP (crl) No 363/1993,* (AIR 1995 SCC vol 1 pg 14) while issuing

various other directions for rape victims the Supreme Court has held:

"It is necessary, having regard to the Directive Principles contained under Article 38(1) of the Constitution of India to set up Criminal Injuries Compensation Board. Rape victims frequently incur substantial financial loss. Some, for example, are too traumatized to continue in employment.

Compensation for victims shall be awarded by the court on conviction of the offender and by the Criminal Injuries Compensation Board whether or not a conviction has taken place. The Board will take into account pain, suffering and shock as well as loss of earnings due to pregnancy and the expenses of child birth if this occurred as a result of the rape."

(2) In *State Of Rajasthan & Ors. v. Sanyam Lodha* (available on: http://indiankanoon.org/doc/516463/), the apex court has observed, Civil Appeal No 7333/2011 out of arising (SLP) No. 12721/2009.

"The need to treat equally and the need to avoid discrimination arise where the claimants/beneficiaries have a legal right to claim relief and the government or authority has a corresponding legal obligation. But that is also subject to the principles relating to reasonable classification. But where the payment is ex-gratia, by way of discretionary relief, grant of relief may depend upon several circumstances. The authority vested with the discretion may take note of any of the several relevant factors, including the age of the victim, the shocking or gruesome nature of the incident or accident or

calamity, the serious nature of the injury or resultant trauma, the need for immediate relief, the precarious financial condition of the family, the expenditure for any treatment and rehabilitation, for the purpose of extension of monetary relief. The availability of sufficient funds, the need to allocate the fund for other purposes may also play a relevant role. The authority at his discretion may or may not grant any relief at all under Relief Fund Rules, depending upon the facts and circumstance of the case."

(3) In *Chairman, Railway Board and others vs. Chandrima Das (Mrs) and others (*2000 (2) SCC 465) the Supreme Court in a case relating to gang rape of a foreigner, has observed as follows;-

"Where public functionaries are involved and the matter relates to the violation of fundamental rights or the enforcement of public duties, the remedy would be avoidable under public law. It was more so, when it was not a mere violation of any ordinary right, but the violation of fundamental rights was involved- as the petitioner was a victim of rape, which a violation of fundamental right of every person guaranteed under Article.21 of the Constitution." The court held that the relief can be granted to the victim for two reasons- firstly, on the ground of domestic jurisprudence based on the Constitutional provisions; and secondly, on the ground of Human Rights Jurisprudence based on the Universal Declaration of Human Rights, 1948 which has international recognition as the 'Moral Code of Conduct'- adopted by the General Assembly of the United Nation."

UNIT – TWO

Guidelines to be Considered while Determining the Compensation in Cases of Child Sexual Abuse

Based on various decisions of the Supreme Court and the guidelines of various statutory bodies the following guidelines have been extracted:-

I. Interim and Final Compensation

The Special court shall take note of any of the several relevant factors to decide the compensation, including:-

a) Where death results as a consequence of the sexual abuse. This compensation will not depend on whether the victim was an earning or non-earning member of the family.
b) Age of the victim
c) Nature and severity of the bodily injury suffered by the victim and expenditure incurred or likely to be incurred on medical treatment and psychological counselling to the victim.
d) Financial condition of the family
e) Expenditure consequential on pregnancy, if resulting from rape including expenses connected with abortion, if it is resorted to, in consequence to rape.
f) Expenses incurred or likely to be incurred in connection with any education or professional or vocational training or training for self employment to the victim.
g) Loss caused to the victim by cessation or interruption of

gainful activity or employment on the basis of an assessment made by the Board;

h) Non pecuniary loss or damage for pain, suffering mental or emotional trauma, humiliation or inconvenience.

i) Expenses incurred in connection with provision of any alternate accommodation in cases where the victim belongs to any other place other than the place where the offence took place.

j) Expenditure for any other form of treatment and / or rehabilitation.

II. Guidelines to fix the Compensation with Regard to the_Offences Booked Under Various Sections of POCSO Act

Each case would involve adopting a different yardstick for compensation. For example an act that results in loss of employment would have a different consequence to a child compared to a child that is not employed. Similarly a child harassed by an offender may be pulled out of school while another child facing a similar situation may continue its education. Given the socio economic disparity that exists and the nature of the specific act of sexual assault the minimum and maximum amount as compensation will be decided by State on case to case basis depending on the facts.

Under rule 7 of the Protection of Children from Sexual Offences Act, the Special Court has the powers to direct payment of compensation taking note of various parameters many of which have been extracted in the previous chapter.

The POCSO Act details various categories of offences and grades them in different ways. Any child that has faced sexual assault may require treatment for mental trauma. All sexual offences may involve some form of mental trauma to be caused to the child even when there is no physical injury.

The expenses for addressing and treating the mental trauma of the child in all the categories of offences will be borne by the Government.

Under the definition of Penetrative sexual Assault in Section 3 there are four distinct categories all of which involve a form of penetration that can be extremely traumatic.

Under section 3 (a), (b) (c) and (d) of POCSO Act an act of sexual assault could result in grievous hurt that could require vaginal reconstruction, colostomy, repeated reconstructive surgery, both body and genitals.

- ✓ *The expenses of the medical treatment for offences under section 3 will be borne by the Government.*
- ✓ *The minimum amount of compensation to be paid to the child for an offence under section 3 should be two lakhs rupees subject to a maximum of ten lakhs rupees.*
- ✓ *Any further amount to be paid could take note of the parameters laid down by rule 7 of the Statute.*
- ✓ *The half of the said sum shall be paid when the FIR has been filed as contemplated under Rule 7.*

Section 5 of POCSO Act defines aggravated penetrative sexual assault and includes violence as defined under section 3

being committed by police, armed forces, public servant, managements of institutions, gang rape, using deadly weapons, causing grievous hurt etc.

It lists 21 categories of offences that include custodial violence and violence that may have a serious impact on the child such as assault, pregnancy, needs surgical intervention and psycho-social support for psychological trauma and communication of HIV etc.

- ✓ *The expenses of the medical treatment for offences under section 5 shall be borne by the Government.*
- ✓ *The minimum amount of compensation to be paid to the child for an offence under section 5 should be five lakhs rupees subject to a maximum of twenty five lakhs rupees.*
- ✓ *Any further amount to be paid could take note of the parameters laid down by rule 7 of the Statute.*
- ✓ *The half of the said sum should be paid when the FIR has been filed as contemplated under Rule 7.*

Section 7 of POCSO Act defines sexual assault of a non penetrative nature where there is a touch with sexual intent.

- ✓ *The minimum amount of compensation to be paid to the child for an offence under section 7 is fifty thousand rupees subject to the maximum of three lakhs rupees.*
- ✓ *Any further amount to be paid could take note of the parameters laid down by rule 7 of the Statute.*

- ✓ *The half of the said sum should be paid when the FIR has been filed as contemplated under Rule 7.*

Section 9 of POCSO Act defines aggravated sexual assault listing 21 categories of acts constituting the offences. These are similar to aggravated penetrative sexual assault as defined in section 5 of the said Act.

- ✓ *The minimum amount of compensation to be paid to the child for an offence under section 9 is one lakh rupees subject to a maximum amount of 5 lakhs rupees.*
- ✓ *Any further amount to be paid could take note of the parameters laid down by rule 7 of the Statute.*
- ✓ *The half of the said sum should be paid when the FIR has been filed as contemplated under Rule 7.*

Section 11 of POCSO Act defines sexual harassment. Six (6) different categories are elaborated for this offence some of which include using the electronic or enticing the child for pornographic purposes.

- ✓ *The minimum amount of compensation to be paid to the child for an offence under section 11 (i) and (ii) is twenty five thousand rupees subject to a maximum of one lakh rupees.*
- ✓ *The minimum amount of compensation to be paid to the child for an offence under section 11(iii,iv,v,and vi) is fifty thousand rupees subject to a maximum of two lakhs rupees.*

- ✓ *Any further amount to be paid could take note of the parameters laid down by rule 7 of the Statute.*
- ✓ *The half of the said sum should be paid when the FIR has been filed as contemplated under Rule 7.*

Section 13 of POCSO Act treats the use of a child for pornographic purposes as an offence. Given the very serious nature of the offence and the impact it can have on the child as every time the picture is used or transmitted would constitute another offence

- ✓ *The minimum amount of compensation to be paid to the child for an offence under section 13 is two lakhs rupees subject to a maximum of five lakhs rupees.*
- ✓ *Any further amount to be paid could take note of the parameters laid down by rule 7 of the Statute.*
- ✓ *The half of the said sum should be paid when the FIR has been filed as contemplated under Rule 7.*
- ✓ *The minimum amount recommended here would in no way pre close the State from granting enhanced amount.*

UNIT - THREE

Enhancement of Compensation in Special Cases

The Special Court may also take the following into consideration while determining the enhancement of compensation in special cases (not limited to those described

below).

(a) Offences against children below 12 years of age, which may involve specialized treatment and care
(b) Offences against mentally challenged children or children with special needs which may involve specialized treatment and care
(c) Victim becomes infected with STDs including affected by HIV/AIDS as a consequence of rape;
(d) Victim gets pregnant as a consequence of rape and due to circumstances beyond her control delivers the child;
(e) Where severe medical problems is faced by the victim including both physical and mental.

Chapter - VI

Reports of the Support Person

1. Case

Profile No -----------------------------

Under section of POCSO Act, 2012 --------------------------

Title of profile----------------------

Police Station----------------------

FIR number ----------------------

2. Case History

Type of sexual assault:

Place of assault:

Date & Time:

Witness if any:

3. Details of the Child(Victim):

Name of the child(Victim) ----------------------, Age --------

Sex ------------------, Date of Birth ----------------------

Educational Status: Student/Dropout ----------------------

Religion ----------------------, Caste ---------------------

Disabilities, if any -------------------- Any other Social habits ------------

Education qualification-----------------------------------,

Permanent Address: --

Any Relationship between the child/victim & the support person

Yes/No [ ]

4. Parents/Guardian Details

Father's/ Guardian's Name ---------------------- Age -------

Qualification ----------------------- Occupation ----------------------

Mother's Name----------------- Age ---------

Qualification ----------------------- Occupation ----------------------

Address --

-- --

5. Need Assessment done on the part of support person

----

6. Medical Treatment Details:

Mental condition (Present & past) ----------------------------

Physical condition (Present & past) ---------------------------

Habits, interests (moral, recreational) ----------------------

7. Opinion of doctor on the Child/victim ----------------------------

----

Doctor Signature (seal)

----

8. Accused Details:

Name ----------------------, Age ----------, sex-----------------

Qualification -------------------------

Address --

Name village town city ---------------------, District -----------------------

9. Immediate needs of the victim:

Individual Action/ Care plan:

Signature of the

Support person

Annexure-I

State Commission for Protection of Child Rights

Standard/Monitoring Format for Enforcement of POCSO Act, 2012-(District Wise)

Month.. Year................................ Agency...

S. No	No. of Cased Filed									Offender			No. of cases reported to CWC	No. of cases for which Emergency Medical Care Provided.	No.of cases for which medical examina tion one.	Assess ment report of CWC Obtai ned	Inform- ation sent to spl. Court (Yes/ No)	No.of Cases Disposed	No.of Cases pending
	Under IPC only			Under POCSO Only			IPC & POCSO												
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Male	Female	Total							

P.M.Basheer Ahamed,
Principal Secretary to Government.

//True Copy//

Section Officer