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NCK THE NATIONAL CENTRE
FOR KNOWLEDGE ON MEN'S
VIOLENCE AGAINST WOMEN

HANDBOOK

National Action Programme for
the Health Care and Medical Services'
Reception and Care of Victims of
Sexual Assault

COVERING LETTER

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To the Minister and head of the Ministry of Justice

On 22 February 2007, the National Centre for Knowledge on Men's Violence Against Women (Nationellt centrum för kvinnofrid in Swedish, abbreviated NCK) at Uppsala University was commissioned by the government to draw up a national programme for the reception and care of victims of sex crimes, to be used by the health care and medical services. The programme was to be presented to the government no later than 15 February 2008.

The purpose of the programme is to improve the health care and medical services' reception and care of victims of sex crimes. A further purpose is to develop routines for how medical samples should be taken and documentation carried out in order to provide the judicial system with as complete and expedient a basis for decisions as possible. It is important for health care staff to possess knowledge about how the question is best put to patients who may have been subjected to sexual violence. The national programme should include recommendations for how these questions should be asked and how the responses should be handled.

Specialist physician Dr. Steven Lucas, MD PhD, District Prosecutor Lotta Sundström and the Head of Patient Services at NCK, Åsa Witkowski, have participated in the commission as secretaries.

NCK hereby presents *Handbook. National Action Programme for the Health Care and Medical Services' Reception and Care of Victims of Sexual Assault*, along with a practical guide. The handbook is designed to be used as a learning aid by the health care and medical services as well as by authorities involved with the administration of justice.

The government's action plan against violence to women, honour-related violence and oppression, and violence in same-sex partnerships (Skr2007:08:39) includes instructions for NCK to implement the programme within the health care and medical services. NCK is currently proceeding with this task.

Gun Heimer

Professor, Head of the National Centre for Knowledge on Men's
Violence Against Women

List of government authorities, non-profit-making organisations and others that the working group has met with

In the course of drawing up the programme, meetings were held with representatives of various government authorities and non-profit-making organisations.

The reference group included Margareta Bergström, Director-General of the Crime Victim Compensation and Support Authority; Pia Johansson, Chief Judge at Blekinge District Court; Carin Götblad, Chief Commissioner at Stockholm County Police Department; Erna Zelmin, Director-General of the National Board of Forensic Medicine; Håkan Ceder, Deputy Director-General of the National Board of Health and Welfare; Ellen Hyttsten, Head of Division at the Swedish Association of Local Authorities and Regions; and Lisbeth Johansson and Birgitta Fernqvist, Director and Deputy Director, respectively, of the Public Prosecution Authority.

In order to make use of the specialist knowledge and experience of the subject area which exists all over the country, meetings were held with four focus groups. These groups were put together on the basis of participants' professions. The selection of participants was strategic in order to achieve a geographical spread and also to capture various large clinics.

The medical focus group included Birgitta Segerblad, Chief Medical Officer of the Swedish Society of Obstetrics and Gynecology; Lotti Helström, Chief Physician at the Emergency Clinic for Rape Victims (AVK), Södersjukhuset; Vilhelm Masreliez, Chief Physician at the Sachs' Children's Hospital; Ingemar Thibblin, Deputy Director-General at the National Board of Forensic Medicine and of the Forensic Medicine Unit at Uppsala University's Department of Surgical Sciences; Kajsa Westlund, secretary of the Swedish Association of Midwives; Bodil Kristiansson, a midwife at the Sahlgrenska University Hospital; and Elisabeth Tønnesen, District Medical Officer at the Swedish Association of General Practice. A representative who works with male victims of sex crimes at Södersjukhuset's emergency ward was also invited.

The psychosocial focus group included Gunilla Seflin, a counsellor at Södersjukhuset's Emergency Clinic for Rape Victims; Eva Wendt, Chairperson of the Forum for Swedish Youth Centres; Monica Mardell, a psychotherapist at the Crisis Centre for Women; Josefin Grände, Training Coordinator at the Stockholm County Administrative Board; and Monica Idestrom, Project Coordinator at the National Board of Health and Welfare.

The legal focus group included Abigail Choate, Project Coordinator at the National Police Board; Lisa Eriksson, District Prosecutor at Sundsvall's Office of the Public Prosecutor; Eva Wilhelmsson, Deputy Head of Division with Skåne County Police; Elvy Wicklund, a solicitor at the Kvinnojuristen legal firm; Karin Göransson,

Judge at Uppsala District Court; and Camilla Lyckman, Associate Judge of Appeal at the National Judiciary Administration.

The focus group for non-profit organisations included Katarina Bergehed, Campaign Coordinator at Amnesty International; Susanne Gullack Flyrén, Executive Head at RFSU, the Swedish Association for Sexuality Education; Carina Ohlsson, Chairperson of the Swedish Association of Women's Shelters; Lina Ploug, Chairperson for Roks, the National Organisation for Women's and Girls' Shelters in Sweden; Åsa Landberg, a psychologist with Save the Children Sweden; and Anneli Svensson, a counsellor at the Crime Victim Helpline of RFSL, the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights. Also invited were representatives from the Swedish Association for Victim Support, Män för Jämställdhet (Men for Equal Opportunities) and Alla kvinnors hus, a women's and children's shelter.

Visits were made to the Crime Victim Compensation and Support Authority, the emergency ward and Emergency Clinic for Rape Victims at Södersjukhuset, and to the Women's Clinic at the Sahlgrenska University Hospital.

The working group participated in seminars ("Assessing evidence in sex crimes cases" and "Joint inspection—an evaluative review of criminal investigations concerning rape and aggravated rape in which the victim was over 15") at the Swedish Prosecution Authority's Development Centre in Göteborg, at the Chairmen's Conference of the Swedish Medical Association and at the 2008 Annual Meeting of the Swedish Society of Obstetrics and Gynaecology.

In addition to these meetings, the working group met with Inga-Lis Adervall Åström, District Prosecutor at the Umeå division of the Office of the Public Prosecutor; Elisabet Karlsson, Detective Inspector, and Christer Sellström, a forensic laboratory technician at the Västerbotten County Police Authority; Marianne Göthberg, a psychotherapist at RFSU, the Swedish Association for Sexuality Education; Lotta Nilsson, an investigator, and Olivia Wigzell, Head of Unit at the National Board of Health and Welfare; Yvonne Stegeryd, a forensic laboratory assistant, Ricky Ansell, Head of Serious Crime DNA/Sex Crimes, and Tore Olsson, Laboratory Director, all at the Swedish National Laboratory of Forensic Science; and Annacarin Rathsman, a judge at Stockholm County Administrative Court.

Eva Hedlund, Honorary Doctor of social work and a registered psychotherapist, formerly at RFSU (the Swedish Association for Sexuality Education), contributed text on psychosocial work with the victims of sex crimes and their families.

Mariella Öberg, a research physician at NCK, contributed to the design of the handbook and the guide. Suggestions were made by Ingela Danielsson, Senior Physician at the Women's Clinic, Sundsvall Hospital.

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Table of Contents

- 1. Introduction** 9
- 2. Sexual assault**10
 - What is rape?10
 - Sex crimes legislation11
 - Changes to sex crimes legislation11
 - How common is sexual assault?12
 - Sex crimes reported to the police12
 - Prompt reporting crucial for an indictment13
 - Many sex crimes are not reported13
 - Why is sexual assault not reported?13
 - Who commits sexual assault?15
 - Vulnerability factors for being subjected to sexual assault among persons above the age of 15...16
 - Injuries16
 - Alcohol and other drugs16
- 3. Meeting the patient**19
 - The role of the health care services19
 - The patient's needs and rights19
 - Sexual assault brings out strong emotions in health care staff21
 - The victim's reactions21
 - Women who are raped by women; men who are raped by men23
 - Hate crimes23
 - Problems surrounding honour and virginity23
 - Young people's attitudes23
 - Where does a sex crime victim turn for help and care?24
 - What happens to those who don't seek immediate help?25
- 4. Asking the question**26
 - Who should be asked?26
 - Conditions for asking the question27
 - Procedure when instances of assault are discovered27
 - What happens if the question is not asked?28

5. The responsibility of the health care and medical services	30
Competence	30
Availability	31
Organisation	31
Equipment	31
Documentation	32
Safety	32
Quality assurance and further training	32
Collaboration	33
6. Medical care	34
Time factors	34
Anamnesis	34
Contraceptives and infections	35
Alcohol and drugs	35
Examination	36
The course of the examination	37
Handling of samples	42
Medical treatment and follow-up of screening	43
Infection treatment, prophylaxis and vaccination	43
Follow-up of screening after a sexual assault	43
Examinations of young people	44
Reporting to the social services	44
Patients without legal capacity	45
Unconscious patient	45
Other patients without legal capacity	46
7. Crisis counselling and psychosocial follow-up	47
Important factors in psychosocial treatment	47
An active approach	47
Recapitulation and processing of the sequence of events	48
The personal significance of the trauma	48
Reactions and support needs of family and friends	48
8. Documentation	49
Photography	50
Confidentiality	50
Breaching of confidentiality	51

9. Forensic medical reports	55
Writing a forensic medical report	56
Obligation to inform	57
Consent	57
Quality assurance	57
Expeditiousness	57
10. How the judicial system works	59
The judicial chain	59
The judicial chain can be summarised in the following way	59
From report to indictment	60
The report	60
Preliminary investigation	61
The plaintiff	61
Apprehension, arrest and remand in custody	64
Expeditiousness requirement	65
Record of the preliminary investigation	65
Discontinuance of a preliminary investigation	66
Notification	66
Indictment decision	67
Main hearing and judgement	68
Oral, immediate, concentrated	68
Public.....	68
Witness support	68
The course of the main hearing	69
Experts.....	70
Forensic medical report	71
The prosecutor's burden of proof	71
Judgement	71
Appeal	72
Damages	72
Correctional treatment	73
11. Conclusion	75
Routines in health care and medical services for asking the question	75
New guide in the Sexual Assault Evidence Collection Kit.....	76
Review of the routines at other authorities	76

The health care and medical services' role in the continued judicial process	77
Other authorities' responsibility for improving quality.....	77
Implementation of the action programme.....	78
Quality register	79
Appendix A—Guide to Care Following Sexual Assault	80
Appendix B—The commission.....	95
Translation of Appendix B	98
Index	102

1. Introduction

Sexual assault is one of the most severe of all violations of human dignity. A sexual assault is about exercising power and about humiliation, as can be clearly seen in the frequently life-long traumas that victims suffer. Sexual assault is used as an act of war, as torture and as a means of oppression all over the world.

Sexual assault occurs at all times of the day and night, in all parts of the country. Anyone can become a victim. The stereotypical rape, in which the victim is a young woman who is attacked by an unknown man outdoors, only applies to a fraction of those who are actually subjected to sexual assault: young or old, woman or man, heterosexual or homosexual.

Victims can seek help anywhere in the health care chain—be it a specialised clinic for rape victims or a health centre in a rural district. It is therefore crucial that all those who may come into contact with sex crimes victims be able and prepared to meet the patient's medical, emotional and legal needs. This means that not just gynaecologists, but all doctors who may have to examine sex crimes victims, need to be able to carry out a complete examination, including the collection of samples as evidence.

The examination that takes place in the health care system following a sexual assault is not just about health and medical care. The doctors and nurses are also acting as the extended arm of the judicial system. That which is established by means of the patient history, examination, and the collection of samples may become supporting evidence in a future criminal process. This means that the demands for professionalism are very high on health care staff.

The handbook, together with the attached *Guide to Care Following Sexual Assault*, describes procedures for post-pubertal adolescents as well as for adults—both women and men. An age limit has been applied for practical reasons. The procedure is different in the case of sexual assault on younger children, and drawing up an action programme aimed at child victims is thus beyond the scope of this handbook.

By applying the recommendations in the handbook and following the routines it describes, health care and medical services staff will be able to live up to the rightful demands of patients and government authorities. This includes the entire chain of events, from asking questions about exposure to sexual assault to having legally correct and consistent routines for taking samples and for documentation.

2. Sexual assault

Many people who have suffered a sexual assault feel such a strong sense of guilt and shame that they cannot bring themselves to tell anyone about it. Others lack words and frames of reference for what they have experienced.

The health care and medical services have a unique opportunity to receive those who have been subjected to sexual assault. Besides providing the medical assistance and care that the patient needs, health care staff are often the patient's first link to the judicial system, and the results of the medical examination may become a significant aid in investigating the crime. It is a prerequisite for all this that health care staff possess knowledge about what sexual assault is and how it affects the individual.

What is rape?

The term "sexual assault" covers a spectrum of crimes ranging from sexual molestation to aggravated rape. The crimes vary in severity, which is reflected in the terms of punishment for each one. The crime which has been most studied in research and statistics, and which is most common in media reporting, is rape.

The law defines *rape* as forcing someone into sexual intercourse or other comparable sexual acts by the use of any of the following:

- assault or other violence
- threats
- improper exploitation of the victim's state of helplessness.

Sexual intercourse includes:

- vaginal intercourse
- oral intercourse
- anal intercourse.

Other comparable sexual acts include:

- inserting fingers or objects in the anus or into a woman's genitalia
- genital contact
- sexual intercourse-like acts in which direct contact is prevented by e.g. an item of clothing
- inducing the victim to masturbate.

Sex crimes legislation

Chapter 6 of the Swedish Penal Code contains the legislation on sex crimes. The first section deals with rape.

Chapter 6 of the Swedish Penal Code—On sex crimes

Section 1 A person who by assault or otherwise by violence or by threat of a criminal act forces another person to have sexual intercourse or to undertake or endure another sexual act that, having regard to the nature of the violation and the circumstances in general, is comparable to sexual intercourse, shall be sentenced for rape to imprisonment for at least two and at most six years.

This shall also apply if a person engages with another person in sexual intercourse or in a sexual act which under the first paragraph is comparable to sexual intercourse by improperly exploiting that the person, due to unconsciousness, sleep, intoxication or other drug influence, illness, physical injury or mental disturbance, or otherwise in view of the circumstances in general, is in a helpless state.

If, in view of the circumstances associated with the crime, a crime provided for in the first or second paragraph is considered less aggravated, a sentence to imprisonment for at most four years shall be imposed for rape.

If a crime provided for in the first or second paragraph is considered aggravated, a sentence to imprisonment for at least four and at most ten years shall be imposed for aggravated rape. In assessing whether the crime is aggravated, special consideration shall be given to whether the violence or threat was of a particularly serious nature or whether more than one person assaulted the victim or in any other way took part in the assault or whether the perpetrator having regard to the method used or otherwise exhibited particular ruthlessness or brutality.

Changes to sex crimes legislation

Over the past three decades, sex crimes legislation has been changed several times. On the whole, these changes reflect an adaptation of the law to a more modern view of the individual's sexual integrity. Earlier limitations to the definition of rape, such as the exclusion of rape within marriage, have been removed, as has the absolute requirement that violence or threats must have been used.

The legislation that came into force on 1 April 2005 brought two significant changes. First, the definition of rape was expanded to include sexual intercourse or other comparable acts with a person who is unable to give their consent. Second, the term "aggravated sexual abuse of a child" was replaced with the term "rape of a child under the age of 15", in which the act does not have to include threats or violence.

The evolution of sex crimes legislation

1984: Several changes which mean that the term “rape” becomes gender neutral and now also includes sexual acts which are comparable to intercourse. Furthermore, a special sentencing scale was added for aggravated crimes.

1992: A clarification of the penalty stipulation on aggravated rape, in which the criteria were particular ruthlessness or brutality in the way the crime was carried out, or the young age of the victim.

1998: A broadening of the crime of rape, allowing courts to consider the violation rather than the type of sexual act.

2005: The term rape applies even if there is no use of violence or threats, if the victim is in a state of helplessness, e.g. due to illness, intoxication or sleep. Special penalty stipulation on child rape, in which the coercion requirement is removed. The maximum sentences for certain sex crimes are increased.

It is not the task of health care staff, in an emergency situation, to define or classify what crime the patient has been subjected to.

The important thing is to highlight the fact that the patient has suffered a sexual assault, and to adapt the care effort to the patient's needs.

How common is sexual assault?

Sex crimes reported to the police

Over the past two decades, the number of rapes reported to the police has increased greatly in Sweden. Between 1985 and 2007, it increased fourfold, from 1,024 to 4,754 per year.¹ These statistics only cover rape; if all sex crimes are included, a threefold increase, from 4,098 to 12,466 reported sex crimes per year, has occurred over the same period.

When the Swedish National Council for Crime Prevention (Brottsförebyggande rådet in Swedish, abbreviated BRÅ) studied all instances of rape reported to the police in 2004, it found that almost all the victims were women. Only 4 per cent were men.² Most of the victims were young: almost half were between 14 and 24 years old, and 15 per cent were under 15. A large majority of them were either closely connected with the perpetrator (35 per cent) or acquainted with him (40 per cent). The assaults mostly took place indoors (79 per cent), and among these most took place in the victim's or the perpetrator's home (60 per cent). Rapes in which an unknown perpetrator attacked a woman outdoors made up only 9 per cent of reported assaults.

So-called gang rapes, a type of rape which has received much media attention, made up 11 per cent of all reported rapes.³ The victims in these cases were 95 per cent women, two thirds of which were under 25 years, half of these were under 18.

A large share—40 per cent—were unacquainted with the perpetrators, while 33 per cent knew them superficially.

Prompt reporting crucial for an indictment

The likelihood that a reported rape leads to an indictment is closely connected with how much time has elapsed between the crime and the report. A study of all reported rapes in Uppsala county in 2004, carried out by NCK together with the public prosecutor and the police, showed that 8 of 53 reported rapes (15 per cent) led to an indictment. In these 8 cases, 6 victims had reported the crime within 24 hours, and the remaining 2 within a month.

Many sex crimes are not reported

The hidden number, i.e. sex crimes which are not reported to the police and therefore are not included in official statistics, is large and difficult to estimate.⁴ In a Swedish study, 34 per cent of the women questioned said that they had been subjected to sexual assault after the age of 15.⁵ Studies from other parts of the world paint a similar picture: between one in four and one in two women state that they have been subjected to rape, attempted rape or sexual coercion at some point in their lives.

Sweden ⁶	34%
Nordic countries ⁷	24%
USA ⁸	27%–47%
England ⁹	24%

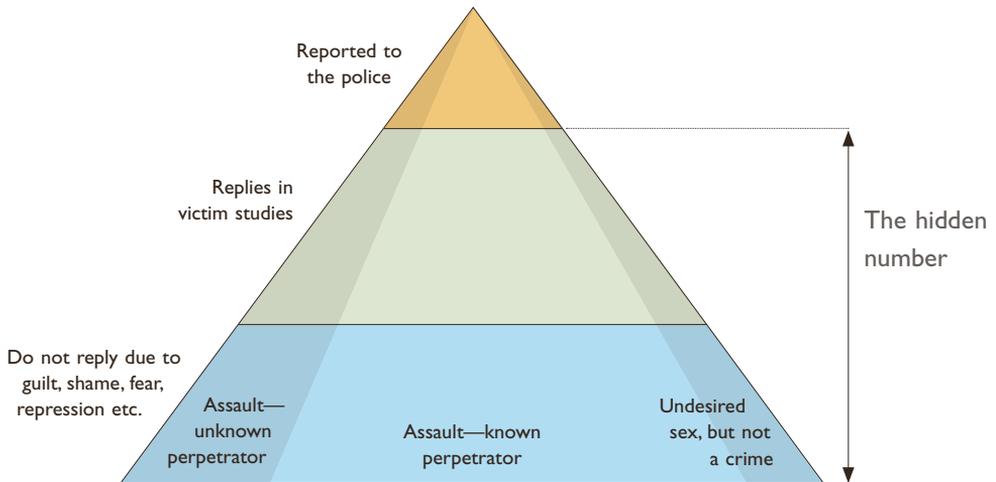
Several Swedish sources claim that between 5 and 10 per cent of all instances of sexual assault are reported to the police.¹⁰ Based on Swedish crime statistics from 2007, that would mean that the actual number of rapes committed every year is between 40,000 and 80,000, or between 110 and 220 cases of rape every 24 hours. If this is correct, rape is at least as common as cardiac infarctions (40,000 cases every year).¹¹

Why is sexual assault not reported?

In a large Swedish poll, women were asked about reporting sexual assault.¹³ Of those who had not reported it, 51 per cent said that it was too insignificant an incident, 11 per cent said they felt too ashamed, 6 per cent said that the police would not be able to do anything, and 5 per cent said they did not want to involve the police. Only 2 per cent of non-reporting respondents stated that they were afraid of retaliation or that they were worried the perpetrator might end up in prison.

Similar factors feature in international studies, in which women say that they are unwilling to report the incident because it is too private or personal, because they feel guilt or shame, accuse themselves or are fearful or distrustful of the police.¹⁴

The tip of the iceberg



Based on: Krug EG et al.¹²

Common reasons why victims of sexual assault do not report the incident to the police:

- The victim does not believe that reporting would lead to any legal action
- The victim does not perceive the incident as an assault
- Feelings of guilt and shame
- Self-accusations
- Unwillingness to identify oneself as a victim of sexual assault
- Unwillingness to subject oneself to a legal process
- Distrust of the judicial/the health care system
- Inability to act due to e.g. social vulnerability, functional disability or mental illness.

Under-reporting

Sexual violence in close relationships, where sexual assault is part of a pattern of physical and psychological violence, is under-represented among reported rapes.¹⁵ The threshold for admitting to a violent relationship is high, since the woman often suffers from particularly strong feelings of powerlessness, guilt and shame. If sexual assault is part of a pattern and therefore occurs repeatedly, as is often the case, it becomes an everyday event in the woman's life and thus a normalisation occurs.

Sex crimes against children and young people are also under-reported. In 2007, a total of around 4,000 sex crimes against persons under the age of 15 were reported, of which 1,271 were rapes.¹⁶ However, studies of adults in the Nordic countries suggest that between 9 and 19 per cent of women and between 3 and 9 per cent of men had been subjected to sexual assault before they turned 18.¹⁷ For children as for adults, a close relationship with the perpetrator is a major obstacle to reporting the crime. Those who have been subjected to sexual assault during their childhood are at markedly greater risk of being subjected to sexual assault as adults as well.¹⁸

Studies of male victims of sex crimes are very few in number, but several polls from other countries indicate that men report sexual assault to an even lesser degree than women do.¹⁹ Nevertheless, studies from venereal disease clinics suggest that experiences of sexual assault are a big problem among male patients: 18 per cent of those questioned stated that they had been subjected to it as adults, while 12 per cent reported childhood experiences of sexual assault.²⁰ The share is greater among homosexual men and among those who were subjected to it as children. In comparison with women victims, men who report sexual assault to the police have more often been subjected to serious physical violence, and more often perpetrated by more than one offender.²¹

Who commits sexual assault?

In the overwhelming majority of sexual assault cases, the perpetrators are men. According to Swedish crime statistics, 99.95 per cent of perpetrators are men when the victim is older than 15. For victims who are 15 years old or younger, the corresponding figure is 98 per cent. Women perpetrators are more often seen in rapes which happen in homosexual/bisexual relationships, in connection with gang rapes (together with male perpetrators), and in child rape.²² In rare instances of reported rapes, a woman is the sole perpetrator and the victim is a man.²³ A number of international agencies and organisations have begun to focus on factors that increase the risk of becoming a sex crimes offender, such as alcohol and drug abuse, subjection to or witnessing violence or sexual violence at home, a strongly patriarchal family structure or social norm, and a social environment in which judicial support for victims is weak.²⁴ To a great extent, these factors overlap with the vulnerability factors of many victims.²⁵

Vulnerability factors for being subjected to sexual assault among persons above the age of 15:

- a physically violent partner or ex-partner
- chronic alcohol or drug abuse
- homelessness or other social problems
- childhood experiences of sexual assault or care neglect
- mental illness
- physical or psychological functional disability.

Injuries

In most rape victims, genital injuries are not proven with certainty. Injuries to or around the genitals or the anal area are only seen in about 20 per cent of victims, and are principally swelling and superficial injuries to mucous membranes and to the perianal skin.²⁶ Redness in these areas is more common, but is usually regarded as an unspecific finding and cannot be distinguished from the effects of voluntary sexual intercourse. In a small number of victims, however, genital injuries are more serious, with e.g. perforation of the vagina or the rectum, or injuries to the internal genitalia. Overall, about half of all rape victims have bodily injuries. These are mainly found on the arms and thighs and consist of bruises and abrasions which occurred when the victim tried to defend her- or himself.

Alcohol and other drugs

Alcohol is very commonly a factor seen in conjunction with rape. According to a study by BRÅ, 83 per cent of victims and 86 per cent of perpetrators had consumed alcohol in connection with the assault.²⁷ Similar figures are reported in international studies.²⁸ Involuntary drugging is sometimes suspected in cases of sexual assault, for instance when the victim wakes up with incomplete recollections of the incident. Despite strong suspicions, however, drugs other than alcohol are rarely proven in forensic chemistry analyses.²⁹ Several drugs, such as benzodiazepines and GHB, are metabolised quickly, which might explain negative test results in cases where more than 24 hours have elapsed between the incident and the taking of samples. It nonetheless appears that alcohol is the most commonly used drug, voluntarily or involuntarily, in connection with sexual assault.

- ¹ Brottsförebyggande Rådet (BRÅ) statistics 2007 (Electronic) <http://statistik.bra.se/solwebb/action/index> (Läst 2008-01-25)
- ² BRÅ 2005:7
- ³ Ibid
- ⁴ BRÅ: "The hidden number gives the relationship between the actual number of crimes and the visible or reported number of crimes. If, for instance, the hidden number is 1, all committed crimes are reported. If the hidden number is 2, the actual number of crimes is twice as large as the visible number of crimes."
- ⁵ Lundgren E et al. *Slagen Dam. Mäns våld mot kvinnor i jämställda Sverige—en omfattningsundersökning*. Stockholm, Fritzes Offentliga Publikationer, 2001
- ⁶ Ibid
- ⁷ Wijma et al. Emotional, physical, and sexual abuse in patients visiting gynaecology clinics: a Nordic cross-sectional study. *Lancet* 2003;361:2107–13
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- ²⁴ Krug EG et al., eds. *World report on violence and health. Chapter 6. Sexual violence* Geneva, World Health Organization, 2002, *Sexual Violence Prevention—Scientific Information: Risk and Protective Factors*. (Electronic) Centers for Disease Control and Prevention. http://www.cdc.gov/ncipc/dvp/SV/svp-risk_protective.htm (2008-01-21)
- ²⁵ Kushel MB et al. No door to lock: victimization among homeless and marginally housed persons. *Arch Intern Med*. 2003 Nov 10;163(20):2492–9, Bengtsson-Tops A. The prevalence of abuse in Swedish female psychiatric users, the perpetrators and places where abuse occurred. *Nord J Psychiatry*. 2005;59(6):504–10, Martin SL et al. Physical and sexual assault of women with disabilities. *Violence Against Women*. 2006 Sep;12(9):823–37, Stermac L et al. Childhood Risk Factors for Women's Sexual Victimization. *J Interpers Violence*. 2002;17(6):647–670
- ²⁶ Sugar NF et al. Physical injury after sexual assault: findings of a large case series. *Am J Obstet Gynecol*. 2004 Jan;190(1):71–6, Hilden M et al. Genitoanal injury in adult female victims of sexual assault. *Forensic Sci Int*. 2005 Nov 25;154(2–3):200–5, Palmer CM et al. Genital injuries in women reporting sexual assault. *Sex Health*. 2004;1(1):55–9
- ²⁷ BRÅ 2005:7

- ²⁸Mohler-Kuo M et al. Correlates of rape while intoxicated in a national sample of college women. *J Stud Alcohol*. 2004 Jan;65(1):37-45, Read KM. Population-based study of police-reported sexual assault in Baltimore, Maryland. *Am J Emerg Med*. 2005 May;23(3):273-8
- ²⁹Hurley M et al. The epidemiology of drug facilitated sexual assault. *J Clin Forensic Med*. 2006 May;13(4):181-5, Slaughter L. Involvement of drugs in sexual assault. *J Reprod Med*. 2000 May;45(5):425-30 Hindmarch I et al. Forensic urinalysis of drug use in cases of alleged sexual assault. *J Clin Forensic Med*. 2001 Dec;8(4):197-205

3. Meeting the patient

The role of the health care services

In receiving and caring for the victims of sex crimes, the health care and medical services have dual role. Besides fulfilling its normal functions, health care also serves as the first link in the judicial chain and as a resource in the investigation of the crime.

Sample collection includes medical tests in order to identify sexually transmitted infections or pregnancy, as well as forensic tests to collect evidence and document alcohol or drug intoxication. An examination is conducted to identify injuries that may require treatment, but also to document injuries in text and images, as evidence. The meeting with the patient is documented in the medical record. The forensic medical report contains specialist reports on the findings from the examination of the victim.

Patients often end up in a no-man's-land between health care services and the judicial system. A lack of communication leads to forensic samples not being picked up for analysis. When provision of a forensic medical report is delayed, the judicial system instead requests access to sensitive medical records.

In order for sex crimes victims to receive dignified, competent and correct treatment throughout the entire process—from the emergency ward to the police report and criminal investigation, to a possible indictment—each person along the way must act professionally. This means that staff in the health care and medical services must be aware of their role and responsibilities. Among the latter is knowing what duties of the police, the prosecutor and the courts have and what they expect from the health care services.

The patient's needs and rights

A person who has suffered a sexual assault has several fundamental needs, both immediate and long term. The patient must be given a professional reception no matter where the contact takes place—at the emergency ward, the health centre, the youth centre, the venereological clinic, the gynaecological clinic or the special unit for victims of sex crimes. The fact that the patient is also the victim of a crime adds a further dimension, in that the examination carried out and samples collected may also become the basis of a criminal investigation.

In caring for the victims of violence, the focus is on their human rights. In its publication “Clinical Management of Rape Survivors”¹, the World Health Organisation (WHO) defines human rights for individuals who have suffered sexual assault. These may be summarised as follows:

Health

Survivors of rape and other forms of sexual abuse have a right to receive good quality health services, including reproductive health care to manage the physical and psychological consequences of the abuse, including prevention and management of pregnancy and sexually transmitted infections. It is critical that health services do not in any way “revictimize” rape survivors.

Human dignity

Persons who have been raped should receive treatment consistent with the dignity and respect they are owed as human beings. In the context of health services, this means, as a minimum, providing equitable access to quality medical care, ensuring patients’ privacy and the confidentiality of their medical information, informing patients and obtaining their consent before any medical intervention, and providing a safe clinical environment. Furthermore, health services should be provided in the mother tongue of the survivor or in a language she or he understands.

Non-discrimination

Laws, policies, and practices related to access to services should not discriminate against a person who has been raped on any grounds, including race, sex, colour, or national or social origin. For example, providers should not deny services to women belonging to a particular ethnic group.

Self-determination

Providers should not force or pressure survivors to have any examination or treatment against their will. Decisions about receiving health care and treatment (e.g. emergency contraception and pregnancy termination, if the law allows) are personal ones that can only be made by the survivor herself. In this context, it is essential that the survivor receives appropriate information to allow her to make informed choices. Survivors also have a right to decide whether, and by whom, they want to be accompanied when they receive information, are examined or obtain other services. These choices must be respected by the health care provider.

Information

Information should be provided to each client in an individualised way. For example, if a woman is pregnant as a result of rape, the health provider should discuss with her all the options legally available to her (e.g. abortion, keeping the child, adoption). The full range of choices must be presented regardless of the individual beliefs of the health provider, so that the survivor is able to make an informed choice.

Privacy

Conditions should be created to ensure privacy for people who have been sexually abused. Other than an individual accompanying the survivor at her request, only people whose involvement is necessary in order to deliver medical care should be present during the examination and medical treatment.

Confidentiality

All medical and health status information related to survivors should be kept confidential and private, including from members of their family. Health staff may disclose information about the health of the survivor only to people who need to be involved in the medical examination and treatment, or with the express consent of the survivor.

The conditions for heeding these rights and needs exist in the health care system, but it requires forethought and planning to ensure that these resources are always available and easy to call on. This is partly a question of a professional attitude towards the patient, and partly one of organisation of the health care system's resources. These aspects are dealt with in greater depth in Chapters 5 and 6.

Sexual assault brings out strong emotions in health care staff

Listening to descriptions of sexual assault brings out strong emotions. Individuals who meet a victim of a sex crime may indirectly feel subjected to assault themselves, and may without realising it protect themselves against the victim's emotions and story. Even experienced health care staff react strongly. Assessments may become emotionally coloured in a way that does not occur in contacts with other types of patients. This can easily lead to confusion and evasive behaviour. In order to be able to act professionally as care provider, it is important to be aware of the possibility that you will be affected, and to be aware of these reactions as and when they occur. The concrete guidelines in Chapter 6 and the attached Guide to Care Following Sexual Assault are intended to facilitate working in these emotionally charged situations.

The victim's reactions

People who have suffered a sexual assault can react in many different ways. The reaction pattern can vary from despair to relative calm or complete isolation, and even to laughter. The absence of reactions normally associated with trauma is not a contradiction of the patient's having suffered a sexual assault. The task of health care staff is to listen to the patient's story and to offer professional care.

The immediate crisis reaction often includes:

- anxiety and fear
- feelings of guilt and shame
- feelings of insecurity and powerlessness
- sleeping problems, palpitations, nausea, freezing, diarrhoea.

People in this condition are often described as being in a state of shock. Their sense of time may be disrupted and they may have difficulties in giving a coherent description of events. Providing the patient with comprehensive care at this point may have a significant positive effect later.² If the victim feels that she has been believed and well cared for, this may increase her readiness to file a police report, to return for follow-up appointments and to process her crisis in a positive way.³

“Two young women were seated in the waiting room of the emergency ward. They were giggling and were clearly drunk. One of them had reported at the reception desk that she had just been raped by two men at a party. ‘Can that really be the case?’, I thought.”

In the longer term, sexual assault may lead to both psychological and physical complications:

- irritableness and anger
- depression
- anxiety
- chronic pain—headaches, aching muscles, abdominal pain
- eating disorders
- relational disorders
- sexual disorders—lack of interest, promiscuity, fear
- reactivation of earlier traumas
- difficulties in connection with gynaecological examinations, pregnancy and childbirth
- Post-Traumatic Stress Syndrome (PTSD).

Men who are subjected to sexual assault react in much the same way as women do. One of the main differences is that men more often experience confusion about their own sexual orientation: heterosexual men wonder if they “allowed” the assault to happen, which may then be perceived as evidence of homosexuality, while homosexual men may distance themselves from their sexual orientation due to feelings of disgust. Men also feel that their masculinity is deeply hurt by the assault, and that they will be seen as weak and incapable of defending themselves. Myths that men cannot be raped are still rife. If a man gets an erection or ejaculates during an assault, it may be perceived as evidence that he actually

wanted to have sex. However, studies show that even as they are being threatened, both women and men can react with physical signs of arousal. This leads the victim to further confusion and feelings of shame.⁴

Women who are raped by women; men who are raped by men

The mechanisms behind rape are the same, irrespective of both the perpetrator's and the victim's gender. The purpose of a rape is to dominate, to maintain power and to control the victim. Thus homosexual victims show the same range of reactions as heterosexual ones. One difference is in how high the threshold is for reporting the assault or seeking help. Despite today's greater openness in society and stronger legal protection, many homosexuals are sceptical toward the judicial system and health care.⁵ Homosexuals still describe how they encounter prejudices and disparaging attitudes when they seek help.⁶

Hate crimes

There is no unified definition of the term hate crimes, which instead is an umbrella term for crimes with xenophobic, homophobic, islamophobic or anti-semitic motives. What distinguishes them all is that they constitute an attack on human rights and that they are contrary to society's fundamental belief in the equal worth of all people. It is the motive behind the crime which makes it a hate crime, not the criminal offence itself. Sexual assault can also be a hate crime. The victim may then experience a deeper violation, as the assault is an open expression of hatred against her/his identity.

Problems surrounding honour and virginity

Sexual assault may lead to particular problems in communities where the concept of honour plays a central role. The fact that such communities are frequently marginalised in Swedish society complicates the situation even further. A woman's virginity before marriage can be crucial to the honour of her extended family. In the case of sexual assault, this can mean that the reaction of the victim and her kin to her loss of virginity overshadows the actual assault. For fear of reprisals by her extended family, the victim may request a certificate of her virginity or ask for surgical measures to "restore her virginity". Strong feelings of guilt and shame over having lost her virginity, and fear of punishment or rejection by the extended family may constitute insurmountable obstacles to the victim's seeking care or reporting the assault to the police. If a man from such a community is subjected to sexual assault, his feelings of shame may make it impossible for him to tell anyone at all about it.

Young people's attitudes

Young people's attitudes to sex and sexual assault are not always in tune with adult's views. In interviews with teenagers, a grey area emerges between "good" sex—which is voluntary and mutual—and "bad" sex—which happens as a result

of persuasion, forcible insistence, or in a state of drunkenness.⁷ Many teenage girls who had negative experiences of sexual events which could be classed as crimes were still unsure of what to call them. They blamed themselves, for having drunk too much, for example, or for having shown an interest in someone who then forced them to have sex. Boys who expressed the view that of course a “no was a no” if a girl did not want to have sex still thought that girls had only themselves to blame if they drank too much or got someone excited and then said stop. These attitudes may to a great extent explain why many sexual assaults against young people go unreported.

Where does a sex crime victim turn for help and care?

In the acute phase, it is most common for victims of sex crimes to seek help within the health care system. The initial contact most often occurs at an emergency ward, a gynaecological clinic or at one of the specialised clinics for rape victims that exist in some areas. However, the geographical distance to such clinics for many victims means that primary care centres also play an important role.

Youth centres receive a large number of young people for testing and sex counselling. Sometimes information about assaults comes out during these visits, in which case the staff must make an informed judgement about how to proceed.

Some victims contact the police immediately following the assault, while others do so a long time afterwards. Sometimes the victim contacts psychiatric care or non-profit-making organisations in order to break the silence and process the psychological trauma.

Victims of sexual assault turn to the following for help and care:

- **The health care system**
 - Specialised rape clinics
 - Emergency wards
 - Gynaecological clinics
 - Venereological clinics
 - Youth centres
 - Primary care centres
 - Psychiatric emergency wards
 - Psychiatric out-patient services
 - Crisis centres
- **The police**
- **Non-profit organisations**
 - Women's helplines and shelters
 - Crime victim helplines or similar
- **The social services**
- **The church**

What happens to those who don't seek immediate help?

The vast majority of victims of sexual assault do not seek immediate help. Later on, however, many tell someone close to them—a partner, friend, family member or colleague—and may thus get help in processing the event and moving on.⁸ Some victims seek psychiatric help. Since the psychological injuries following a sexual assault can remain unhealed and affect a victim's daily life for years, even decades, psychosocial treatment is important even if an assault is discovered long after it happened (see Chapter 7). In such cases, a medical examination may be significant for identifying possible lasting injuries, or confirming that everything looks normal. However, many victims do not seek professional help, and instead remain invisible.

¹ *Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons — Revised ed.*, Geneva, World Health Organization/United Nations High Commissioner for Refugees, 2004

² Ullman SE. Social support and recovery from sexual assault: a review. *Aggression and Violent Behavior*. 1999;4(3): 343-58

³ *Anmälan och utredning av sexualbrott. Promemoria av sexualbrottsofferutredningen*. Ju 2004;1 pp. 75-6. Ullman SE. Social reactions, coping strategies and self-blame attributions in adjustment to sexual assault. *Psychology of Women Quarterly*. 1996;20:505-26

⁴ Walker J et al. Effects of rape on men: a descriptive analysis. *Arch Sex Behav*. 2005 Feb;34(1):69-80. Stermac L et al. Stranger and acquaintance sexual assault of adult males. *J Interpers Violence*. 2004 Aug;19(8):901-15. Rentoul L, Appleboom N. Understanding the psychological impact of rape and serious sexual assault of men: a literature review. *J Psychiatr Ment Health Nurs*. 1997 Aug;4(4):267-74. Davies M. Male sexual assault victims: a selective review of the literature and implications for support services. *Aggression and Violent Behavior*. 2002;7:203-214

⁵ Gärdfeldt Lars, personal correspondence, November 2007

⁶ *Kvinna slår kvinna, man slår man, Homosexuell partnermisshandel*. Nationellt Råd för Kvinnofrid, Stockholm 2003

⁷ Jeffner S. *Liksom våldtäkt, typ...* Stockholm, Utbildningsförlaget Brevskolan, 1998

⁸ Ullman SE. Social support and recovery from sexual assault: a review. *Aggression and Violent Behavior*. 1999;4(3): 343-58

4. Asking the question

Most people who suffer sexual assault do not report the matter to the police and do not seek health care immediately following the assault. However, later on—sometimes several years after the incident—many seek medical care for reasons other than the actual assault. It has been documented in several large studies that women who have been subjected to sexual assault, as children or as adults, seek care for conditions such as depression and chronic pain much more frequently than other women.^{1,2} There are no corresponding studies of men.

Many opportunities for offering help present themselves within health care. In order to seize on these opportunities, health care staff must expressly ask if the patient has been subjected to sexual assault, and must know how to deal with an affirmative response.

Who should be asked?

Should patients only be asked when the likelihood of sexual assault is high, e.g. when someone comes to the emergency ward with injuries? This approach carries with it a considerable risk that many vulnerable patients will be overlooked, or that the patient who is asked will feel singled out.

In several large polls, an overwhelming majority of women have said that they are positive to being asked questions about sexual assault in connection with visits to health care services.² Younger women and adolescents were also positive to being asked in connection with such visits.³ These polls were based on a small number of direct questions about sexual assault and/or violence. The small number of respondents who were negative to being asked such questions justified their responses above all by saying that the questions could produce feelings of shame, or bad memories from earlier events.

Since the potential gains from asking patients questions about their exposure to sexual assault may reasonably be assumed to outweigh the potential risks (patient discomfort, reprisals by the perpetrator, jeopardising the patient-health care relationship) for the individual patient, all patients who consult the health care and medical services should be asked. As sexual assault and violence frequently coincide, the questions should cover both.

All patients should be asked about sexual assault and violence

Conditions for asking the question

The best results in asking patients about sexual assault and violence are achieved when the following criteria are fulfilled.⁴

- A clear policy for how and when health care staff should ask a patient about sexual assault and violence.
- Routines for asking questions about sexual assault and violence. It is the management's responsibility to ensure that routines are established, while it is the employees' responsibility to follow them.
- A prepared questionnaire (see page 29) with short multiple choice questions for staff to use. A form is also easy to administer and document. Staff should have the possibility of adding open-ended questions which are directed to the patient as an individual and based on her or his specific situation.
- A clear division of responsibility as to who should be asking questions about sexual assault and violence.
- Community resources and cooperation between organisations in taking care of victims of violence.
- Training programmes to increase staff competence regarding patients who have been subjected to violence and to increase awareness of the fact that people who have been subjected to violence visit health care services every day.

Procedure when instances of assault are discovered

If a patient describes experiences of sexual assault or violence, the care provider must be prepared to listen and act. This includes giving the patient information, offering relevant medical treatment, carrying out a risk assessment and facilitating contacts with the judicial system and the social services.

Information

- Sexual assault is a crime.
- The patient is entitled to receive help in reporting the incident to the police and the social authorities.
- The patient and her children are entitled to protection.
- Support and crisis management help are available.

Risk assessment

- Where is the perpetrator?
- Have the assaults/violence recently increased in scope and severity?
- Has the perpetrator threatened to kill the patient?
- Does the perpetrator threaten or hit the patient's children?
- Does the perpetrator know that the patient has sought care?
- Has the patient ever thought about committing suicide?
- Can the patient return home?

What happens if the question is not asked?

Failing to draw attention to patients' exposure to sexual assault leads to thousands of people passing through health care services without having their needs properly met. The care provider misjudges the underlying cause of the patient's health problems, thereby delaying or rendering impossible both a processing of the event and any legal process, with the risk of continued ill health and, in the worst case, death, which could have been avoided if the underlying problem had been identified in time.

¹ Samelius, L. *Abused women. Health, somatization and posttraumatic stress*. Doctoral thesis at Linköping University, 2007, Alander T, et al. Abuse in Women and Men with and without Functional Gastrointestinal Disorders. *Dig Dis Sci*. 2008 Jul;53(7):1856-64

² Coid J et al, Sexual violence against adult women primary care attenders in east London. *Br J Gen Pract*. 2003 nov;53(496):858-62, Stenson K et al. Women's attitudes to being asked about exposure to violence. *Midwifery*. 2001 Mar;17(1):2-10

³ Wendt E et al, Young women's sexual health and their views on dialogue with health professionals. *Acta Obstet Gynecol Scand*. 2007;86(5):590-5

⁴ *Woman abuse: screening, identification and initial response*. Toronto, Registered Nurses Association of Ontario (RNAO), 2005

⁵ McFarlane J et al. Assessing for abuse during pregnancy. Severity and frequency of injuries and associated entry into prenatal care. *JAMA*. 1992 Jun 17;267(23):3176-8

Questions about violence and sexual assault

1. Have you been emotionally or physically abused by your partner or anyone else close to you?

Yes

No

2. Over the past year, have you been beaten, kicked or otherwise physically hurt by someone?

Yes

No

If you replied yes, by whom?

Spouse/co-habitee

Ex-spouse/co-habitee

Boyfriend/girlfriend

Unknown person

Other

3. Have you ever been forced into sexual acts?

Yes

No

4. Over the past year, have you been forced into sexual acts?

Yes

No

If you replied yes, by whom?

Spouse/co-habitee

Ex-spouse/co-habitee

Boyfriend/girlfriend

Unknown person

Other:

5. Are you afraid of any of the people mentioned above, or of anyone else?

Yes

No

Complementary information:

.....

.....

.....

5. The responsibility of the health care and medical services

The health care and medical services' statutory responsibility clinically to prevent, analyse and treat illness and injury puts particularly high demands on staff caring for patients who have suffered sexual assault.

The Health and Medical Services Act (1982:763)

Requirements to be met by health and medical services

Section 2a. Health and medical services shall be conducted so as to meet the requirements of good care. In particular this means that they must

1. be of good quality and cater to the patient's need for security in care and treatment,
2. be readily available,
3. be founded on respect for the self-determination and privacy of the patient,
4. promote good contacts between the patient and health and medical personnel,
5. satisfy the patient's need for continuity and safety in care.

Care and treatment shall as far as possible be designed and conducted in consultation with the patient. Different care efforts for the patient shall be coordinated in an expedient way.

Every patient having recourse to health and medical care shall, except where manifestly unnecessary, be given a prompt medical assessment of his or her state of health.

Competence

All staff categories in health care should be competent to act in the event of the suspicion that a patient has been subjected to sexual assault. It is important that the patient is professionally cared for and that the examination is carried out correctly. A high level of competence in the examining doctor is always desirable, but requirements for extensive experience or particular competences may not

be an obstacle to the examination. All doctors who may need to examine both female and male victims of sexual assault must be capable of conducting a full body examination and gynaecological and/or proctological examination, of collecting all the necessary samples and of knowing how further care for the patient may be initiated. Chapter 6 provides a detailed run-through of all these steps, and the attached *Guide to Care Following Sexual Assault* is a support resource when meeting the patient.

Availability

Sexual assault may occur at all times of the day and night, anywhere in Sweden. The patient should be examined as soon as possible for a medical assessment, protection against undesired pregnancy and sexually transmitted infection, and to collect evidence. This means that community health care resources must be organised such that sex crimes victims can be cared for in the best possible way in all parts of the country. The patient is entitled to health care which is secure and in keeping with her or his legal rights, regardless of where she or he lives.

For this reason, primary care plays an important role in rural areas, while specialist clinics for women victims of rape exist in several major urban areas. A patient's ability to seek and receive help must not be dependent on the distance to the nearest hospital. Similarly, a large number of victims in one specific area must not lead to long waiting times and to patients therefore declining to seek care. Swedish women's clinics have routines for and experience in meeting female sex crimes victims. By contrast, similar competence for male victims is very limited.

Organisation

Competent and comprehensive reception and care require a well-functioning organisation in which care providers act on the basis of clear, written instructions. An action plan that describes the division of responsibilities is required in order for the patient to receive adequate care from the right provider. Such plans are best formulated at the local level, where knowledge exists about available resources. The action plan is also a prerequisite for the staff to pose questions about sexual assault to all patients who seek care, and to act professionally when patients describe experiences of sexual assault or violence.

Equipment

All hospitals and most health centres in Sweden possess the basic equipment required to carry out a complete gynaecological and/or proctological examination, including infection testing and evidence collection.

The Sexual Assault Evidence Collection Kit is a pre-packaged set for examining both women and men. It should always be used, regardless of whether the incident has been reported to the police or not. The patient may decide to report it at a later stage, and the opportunity to collect evidence when the patient seeks medical care must not be wasted.

A digital camera should be available for the photographic documentation of injuries.

Documentation

The documentation of an examination following a sexual assault includes information which is sensitive for the patient. Photographs, copies of police reports, medical records and certificates require complete confidentiality and careful handling. Each health care district individually determines how confidentiality is to be maintained. Some districts have chosen to keep separate medical records or to limit access to electronic patient records.

Transferring medical records, photographs and samples from the health care and medical services to the judicial system requires strict routines that include ID checks and written receipts. This is to be documented on the patient's record.

Digital images require particularly careful handling in order to prevent their being spread.

Safety

The patient's safety is a central concern for the health care services. A person seeking help following a sexual assault must be offered the possibility of receiving care secluded from a possibly violent partner. Health care staff must be able to perform a risk assessment, i.e. establish the patient's situation in relation to possible dangers. However, staff should also list positive resources in the form of help and support. Routines must be in place for contacting the police about possible protection measures if the perpetrator is deemed to pose a potential threat to the patient (see Chapter 10).

Quality assurance and further training

In working with sex crimes victims, there are several possible quality indicators for the follow-up and evaluation of results:

- How long is the waiting time for patients who have suffered sexual assault, from arrival to examination?
- How does the patient perceive her or his reception by health care staff?

- What proportion of patients who have suffered sexual assault come back for a follow-up appointment?
- What proportion of the staff knows about existing and applicable care programmes and routines?
- How long is the delay between the request for and the issuing of a forensic medical report?

Staff training is key to good patient reception and care. It is important that routines for receiving victims of sexual assault are continuously developed based on current research and on the needs of patients and health care staff.

Collaboration

Collaboration is not just a prerequisite for the professional reception and care of victims of sex crimes; it is also a legal requirement under the Administrative Procedure Act.¹ The purpose is for government authorities to become more efficient, less disconnected and easier for individuals to deal with.²

One element of acting professionally is to know what areas of responsibility other organisations have and where these responsibilities overlap. Differences between the various organisations' duties should not be effaced. On the contrary, differences are the basis and strength of collaboration. In health care, this involves communication between different clinics and specialities as well as between different personnel categories.

When the health care and medical services care for patients who have been subjected to sexual assault, communication with the judicial chain is essential. Clear routines, established through a dialogue between clinically active staff in health care and operatively active staff in the judicial system, create conditions conducive to collaboration and minimise the risk of misunderstandings. A prerequisite for this is formal and regular meetings. During these meetings, the involved parties can provide feedback about previous matters, exchange experiences and plan continued collaboration. To a large extent, the health care services and the judicial system have hitherto acted on separate levels, but the future requires that they meet on a common level.

¹ Section 6 of the Administrative Procedure Act (1986:223)

² Govt. bill 1985/86:80 *New Administrative Procedure Act*, p. 62

6. Medical care

Time factors

The likelihood of finding evidence of sexual assault is directly dependent on the amount of time that has elapsed between the assault and the examination. The collection of evidence should therefore be performed as early as possible. However, there is no absolute time limit for collecting evidence. The first 72 hours are often regarded as the crucial time window, but DNA from the perpetrator can sometimes be found on the victim even after seven to ten days. A full collection of evidence should therefore be carried out if fewer than ten days have passed since the assault—but may also be meaningful if more time has elapsed.

For questions about and advice on collecting evidence, contact:
The Swedish National Laboratory of Forensic Science (Statens kriminaltekniska laboratorium, or SKL in Swedish) on +46-13-24 14 00 (during office hours), or Kvinnofridslinjen on 020-50 50 50 (24 hours, only domestic phone calls)

Anamnesis

A person seeking care after a sexual assault may behave in many different ways (see Chapter 3). A state of shock, or the effects of alcohol or drugs, may make the account fragmented or incoherent. The patient may be reticent or even totally shut off from her/his surroundings. Thus conditions will vary for obtaining the information necessary in order to make a global assessment of the patient. This is particularly true when circumstances make health care staff suspect a sexual assault, but the patient does not volunteer any information.

The best conditions for a full account are created by asking open-ended questions and giving the patient time to talk without interruptions. If necessary, more questions about details can be asked in order to obtain information which may determine elements of the examination or collection of evidence. Sometimes specific questions are needed if the patient cannot or will not describe what happened. Avoid leading questions, emotive expressions and complicated medical terms. It is a good idea to take notes and to recapitulate what has been established—that gives the patient a chance to render events concrete and also offers an opportunity to check the facts.

If the patient does not speak Swedish, the history should be taken in the patient's mother tongue, with the help of an interpreter. Never use a member of the patient's family as an interpreter.

It is important to record if the patient has had a shower or a bath, changed tampons or underpants, changed clothes, brushed her/his teeth, or eaten or drunk anything after the assault, as this may explain a possible absence of expected evidence.

Contraceptives and infections

Ask specifically about contraceptives, pre-existing pregnancy and any knowledge of sexually transmitted infections. Also ask if the perpetrator used a condom.

If there is any uncertainty about contraceptives, emergency contraceptives should be offered. These may be obtained at the clinic. It is very unusual for rape victims to be infected during an assault, but testing must always be done in order to discover a possible infection and offer treatment or prophylaxis. If the perpetrator is unknown or suspected of belonging to an HIV/hepatitis risk group, prophylaxis should be considered in consultation with a clinic for infectious diseases (see Treatment, page 43).

Alcohol and drugs

It is important for several reasons to ask about use of alcohol and other drugs in connection with the assault, both by the victim and the perpetrator. Alcohol and/or drug intoxication may affect both medical care and judicial procedures.

Recommendations for patient history after a sexual assault

Allow the patient to recount freely what happened, but be prepared to follow up with specific questions. It is important to obtain information which will affect the content of the examination, tests and collection of evidence, for example

- Was violence used? How, and on what parts of the body?
- Were weapons or blunt objects used?
- Had the patient drunk alcohol and/or taken other drugs? If so, were they taken voluntarily or involuntarily?
- Were there any other circumstances which may have rendered the patient helpless (illness, sleep, functional disability)?
- What type of sexual acts were committed: vaginal, anal or oral intercourse; penetration using fingers or objects; licking; kissing; touching of genitals or of other parts of the body? Did the perpetrator ejaculate? If so, where? Was a condom used?
- Has the patient had a shower or a bath, changed tampons, changed clothes, brushed her/his teeth, eaten or drunk anything since the assault?

Based on: *Clinical management of rape survivors*, WHO¹

Examination

Anyone who seeks health care immediately after having been subjected to a sexual assault must be offered a full bodily examination including:

- an examination of the entire body, with any injuries recorded
- a gynaecological and/or proctological examination, with any injuries recorded
- tests for pregnancy, drug use and sexually transmitted infections
- collection of forensic evidence.

Note that this applies irrespective of whether the incident has been reported to the police or not. It is not unusual for the victim to be unwilling to report the incident initially, but to then change her/his mind. If evidence is not collected on the first visit, the opportunity to do so is lost.

As described earlier, a full examination which fulfils all these requirements can be carried out anywhere in Sweden where the following are available:

- a doctor
- equipment for gynaecological and/or proctological examinations
- material for taking samples
- a digital camera.

The Sexual Assault Evidence Collection Kit (swabs, envelopes, paper bags, lengths of adhesive film, tubes for blood and urine samples) is a pre-packaged kit developed by the National Laboratory of Forensic Science and Nordkrim to facilitate evidence collection in an emergency situation. It has existed since 1995, and its contents were reviewed most recently in 2007.² *The Guide to Care Following Sexual Assault* is included with the kit, and is also available on www.nck.uu.se.

www.nordkrim.se

However, most hospitals and health centres have this type of material for taking samples among their standard equipment. The absence of a *Sexual Assault Evidence Collection Kit* should therefore never be an obstacle to a full examination.

A colposcope is a magnifying instrument which is used at many gynaecological clinics for diagnostics and treatment of gynaecological diseases. It can also be used in an examination following a sexual assault. Studies of whether colposcopy offers clear advantages over examination without magnification have produced conflicting results. More injuries are discovered when a colposcope is used, but it is difficult or impossible to determine whether such injuries are the result of an assault or of voluntary sexual intercourse.³ For this reason, colposcopes are not included here in the basic equipment required for an examination following a rape.

The Guide to Care Following Sexual Assault (see the Appendix) contains directions for taking a patient history, a checklist for examinations and sample collection, and a template for forensic medical reports. It is also included with the *Sexual Assault Evidence Collection Kit*, and can be accessed on www.nckuu.se. Use the Guide for every examination!

The course of the examination

Use a systematic approach. This ensures a full examination and facilitates documentation. The examination follows the general pattern for detailed medical examinations. Record injuries on pictograms and photograph all suspected deviations (see the section on photography, page 50). Explain to the patient what you are going to do and ask her/him to tell you if anything feels unpleasant or painful.

If the assault has not been reported to the police at the time of the examination, the patient should be informed of the care provider's routines for storing evidence (see Handling of samples below).

The assistant should prepare the collection of samples and the examination equipment in accordance with the template on page 81, and should be present throughout the examination.

General

Record the patient's weight, temperature, blood pressure and pulse. It may be a good idea for clinic staff to carry out these tasks before the medical examination begins.

The police will determine if the patient's clothes are to be collected as evidence. If the incident has not been reported to the police, underpants may be collected by the health care services and the patient advised to store the rest of her/his clothes in their existing condition in separate paper bags, to be used as evidence if the incident is reported to the police later.

Samples

Blood samples

- EDTA tube (purple stopper) for DNA analysis at the National Laboratory of Forensic Science
- Potassium oxalate/sodium fluoride tube (grey stopper) for alcohol and drugs analysis at the National Laboratory for Forensic Chemistry
- HIV, hepatitis and syphilis serology
- Serum ethanol tube (red stopper)
- Other clinical samples depending on the patient's medical needs, as necessary

Urine samples

- Urine samples for forensic chemistry analysis (2 samples)
- Pregnancy test (hCG)
- Urine test strips (dip sticks) for blood cells and nitrite
- Urine samples for chlamydia (only male patients)

Samples for other sexually transmitted infections (STI)

Chlamydia

Collect samples when penetration or attempted penetration has occurred.

At least two samples during the examination.

Women: throat, cervix/posterior fornix, rectum

Men: throat, rectum, urine sample

Gonorrhoea

Collect samples when penetration or attempted penetration has occurred.

Sensitivity increases with the number of samples taken during the examination.

Women: throat, urethral meatus, cervix, rectum

Men: throat, urethral meatus, rectum

Samples collected as evidence

- A full evidence collection as described in the Guide is recommended.
- An extended evidence collection may be done based on the patient's account (areas of contact).
- Use NaCl to dampen swabs as directed.
- Store swabs in labelled bags.
- Use lengths of adhesive film to collect foreign fibres, hairs and similar material found on the body.

General condition

Check the degree of wakefulness and check for any signs of major trauma or blood loss, any signs of alcohol and/or drug use, fever if any, and any signs of a severe crisis reaction (anxiety, fear, palpitations, nausea, chills, diarrhoea).

Head and neck

Examine and palpate the entire area—the scalp, outer ears, behind the ears, the auditory canals, eardrums, conjunctivae, facial bones, nose, throat and neck. Take note of any signs (bruises, redness, abrasions, swelling, open wounds, haemorrhages/ecchymoses, petechiae) of possible violence, such as blows, knife wounds or throttling.

Evidence collection

- Damp swab sample if any areas of contact.

Mouth and throat

Look for injuries to the teeth and gums, mucosal bleeding, injuries to the tongue and frenula and to the lips and labial frenula.

Evidence collection

- Two dry swab samples from the mouth (rub against teeth and gums, and on top of and under tongue)
- Two damp swab samples from the lips and around the mouth
- Possibly damp swab samples from around the ears if the perpetrator ejaculated in or around the mouth.

Testing and samples for screening

- Point-of-care rapid test for chlamydia (IMPORTANT: The chlamydia sample must be taken before the gonorrhoea sample)
- Culture for gonorrhoea.

Chest, back and abdomen

Take note of any signs of trauma. Look for marks along the spine or the shoulder blades from contact with the surface on which the assault occurred. Look for bite and suction marks. Carefully palpate the abdomen and make note of any tenderness as a sign of organ injury from e.g. kicking.

Evidence collection

- Damp swab sample for any areas of contact.

Arms and hands

In just over half of all rape cases there are demonstrable injuries, the most common being restraining marks on the upper arms. Thoroughly look over and feel

arms and hands, including the joints. Check fingernails for breakage, foreign material or blood, and note any findings.

Evidence collection

- Swab fingers and under fingernails with a damp, pointed swab.

Buttocks, legs and feet

Look in particular for restraining marks and abrasions on the inside of the thighs and buttocks.

Evidence collection

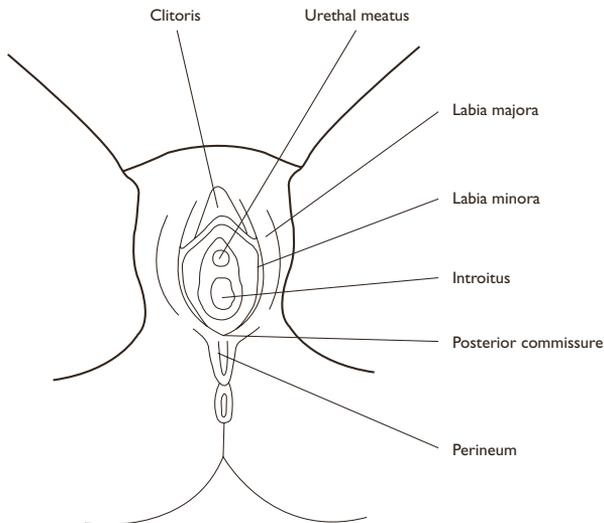
- Damp swab sample for any areas of contact.

Female outer genitalia

Collect the patient's underpants in a labelled bag. Give the patient replacement underpants after the examination.

Make note of the extent of pubic hair and the presence of any foreign hairs or other foreign material. Carefully comb through the patient's pubic hair, using lengths of adhesive film to collect any foreign material. Apply the adhesive film directly to the patient's skin if she is shaved or has little pubic hair. Clip off any hairs which are stuck together and seal in a length of adhesive film. Examine the labia majora and minora, the urethral meatus, the introitus including the hymen, the posterior commissure of the labia minora and the perineum.

The most common genital injuries connected with rape are reddening, abrasions, bruises, swelling and small fissures in the skin of the outer genital area, and small fissures in the mucosa around the introitus.



Evidence collection

- Damp swab samples, one each from the introitus and the perineum.

Samples for screening

- Gonorrhoea culture from the urethral meatus.

Female inner genitalia

Using a speculum lubricated with water only, examine the entire vagina, the cervix and posterior fornix. Injuries to the inner genitalia are unusual after rape, and mainly occur during particularly violent assaults such as gang rapes or the insertion of foreign objects into the vagina.

Evidence collection

- Two dry swab samples, one each from the cervix and posterior fornix
- Wet smear from the posterior fornix for direct microscopy to detect the presence of sperm.

Testing and samples for screening

- Point-of-care rapid test samples for chlamydia from the cervix and posterior fornix, on the same stick
- Gonorrhoea culture from the portio (IMPORTANT: The chlamydia sample must be taken before the gonorrhoea sample).

Male genitalia

Collect the patient's underpants in a labelled bag. Give the patient replacement underpants after the examination.

Make note of the extent of pubic hair and the presence of any foreign hairs or other foreign material. Carefully comb through the patient's pubic hair, using lengths of adhesive film to collect any foreign material. Apply the adhesive film directly to the patient's skin if he is shaved or has little pubic hair. Clip off any hairs which are stuck together and seal in a length of adhesive film. Examine the shaft of the penis, the foreskin including the frenulum (the most common location of genital injuries in men) and the glans. Examine the skin of the scrotum and palpate the testicles.

Evidence collection

- Two damp swab samples, one each from the glans and the foreskin, and two swab samples from the shaft of the penis.

Samples for screening

- Urine sample for chlamydia
- Gonorrhoea culture from the urethral meatus.

The anal area and rectum (women and men)

Examine the perianal skin and gluteal groove for signs of abrasions, fissures, bruises and swelling. Sperm from vaginal assaults may seep backwards after the assault and may therefore be present outside the anus.

Evidence collection

- Two swab samples, one dry and one damp, from the area around the anus.
- If an anal assault is suspected, examine the rectum. Carefully wash the perianal skin with water. Palpate the anal canal carefully with a finger and assess possible injury to the anal sphincter by asking the patient to pinch. Examine the lower rectum and the anal canal using a proctoscope.

Evidence collection

- Two dry swab samples from the rectum, taken through a proctoscope.

Testing and samples for screening

- Point-of-care rapid test for chlamydia from the rectum, taken through a proctoscope.
- Culture for gonorrhoea from the rectum, taken through a proctoscope (IMPORTANT: The chlamydia sample must be taken before the gonorrhoea sample).

Handling of samples

Medical samples

Immediately send medical samples to the appropriate laboratory for analysis:

- Blood samples HIV/hepatitis
 Syphilis
 Ethanol
- Urine samples uhCG
 U-test strip
- PCR test/culture Chlamydia
 Gonorrhoea

Forensic samples

If the incident has been reported to the police, they will collect the forensic samples for further processing. If the incident has not initially been reported to the police, dry samples and material (swab samples, lengths of adhesive film, under-

pants) may be stored together, labelled, at room temperature in a locked archive accessible only to authorised staff.

Samples can be analysed even if many years have passed since they were taken.⁴ It is therefore reasonable that they be kept in the health care services' possession for at least two years. Blood and urine samples for DNA, labelled with the patient's identity, should be analysed within two weeks, but may be kept in a refrigerator for up to two years. The refrigerator must be locked and accessible only to authorised staff.

Medical treatment and follow-up of screening

Infection treatment, prophylaxis and vaccination

General prophylaxis against sexually transmitted infections following a sexual assault is not recommended by infection specialists and venereologists. However, it is very important to take samples for screening. Chlamydia treatment can be carried out at most units, while treatment for gonorrhoea and syphilis is reserved for infectious disease or venereology specialists.

If the perpetrator is unknown or suspected of belonging to a risk group for HIV or hepatitis, an infectious disease clinic must be contacted immediately to decide whether HIV prophylaxis (anti-retrovirals) and/or hepatitis B prophylaxis (immunoglobulin and vaccination) should be administered. Any prophylactic treatment should begin within 2 and no later than 72 hours after the suspected contagion took place. Hepatitis B vaccination is broadly recommended if the patient has not been vaccinated or exposed earlier.

Follow-up of screening after a sexual assault

A follow-up appointment should be offered within a few weeks of the sexual assault. A follow-up visit is important for answering the patient's questions, informing about screening results and doing any further examinations or tests.

Screening of the samples taken during the first examination will show if the patient already had an infection at the time of the assault. If these samples prove negative, further samples are taken in order to rule out transfer of infection during the assault.

Samples for chlamydia, gonorrhoea, syphilis and pregnancy should be taken two to four weeks after the initial examination/taking of samples.

Samples for syphilis, HIV and hepatitis should be taken three months after the first samples were taken.

Examinations of young people

Almost one in three victims of rapes reported to the police is under 18 years old. A large proportion of young people who seek care following sexual assault belong to particularly vulnerable groups, in particular teenage girls who have mental problems, behavioural disorders or are exposed to social problems such as substance abuse or violence at home. Young people sometimes find it very difficult to put into words what they have been through in connection with an assault, and may therefore need help in putting the events into perspective and processing the incident.

Care management following sexual assault of persons under 18 should be carried out in consultation with a paediatrician, who should preferably be chiefly responsible for the patient. For teenage girls, it is a good idea for history-taking and a full examination to be done by a gynaecologist; that way, the patient will not need to tell the same story twice and be examined by two different doctors. Teenage boys should be examined by a paediatrician. If anal assault or genital injuries are suspected, a surgeon and/or a forensic examiner should be consulted. Emergency circumstances may make it necessary to deviate from these principles and require other doctors to make the initial assessment and documentation.

Routines for history and examination are the same as for adults, but remember to explain everything very carefully, to give the patient time and to have patience. It is a good idea to meet the patient without her/his family at some point during the consultation, but make sure that parents or guardians are called in to the greatest possible extent. Young people often protest against having their parents contacted. In such cases, explain why it is important to have one's parents there as support. In most cases, a report must be filed with the social services, which means that parents will need to be informed anyway in connection with the social services' investigation. Exceptions to the rule of contacting guardians occur when the patient is in the care of the social authorities and when either of the parents is suspected of being the perpetrator. In the latter case, the social services must be contacted immediately to consider protective measures.

Psychiatrists specialising in children and adolescents should be consulted at an early stage in order to process the immediate crisis following an assault, to assess vulnerability factors for the patient and her/his surroundings, and to assess the need for longer-term treatment.

Reporting to the social services

All staff in the health care and medical services are required by law to report to the social services any suspicion that a person under 18 years of age is coming to harm. Sexual assault may be a sign of abuse or neglect. In the acute situation, an assessment must be made of the patient's immediate need for care and protection, which is best done by a doctor with paediatric competence. Social emergency services are available in many places and may be contacted for consideration

of emergency social measures, such as placement in care or an emergency foster home, or to discuss whether a report should be made to the social services. Young people are sometimes drunk or affected by drugs in connection with an assault, requiring an assessment of whether the patient needs to be admitted to hospital for observation. This may also warrant a report to the social services.

Social Services Act (2001:453)

Chapter 12. Reporting of abuse

Section 1

Any person receiving information of a matter, which can imply a need for the social welfare committee to intervene for the protection of a child should notify the committee accordingly.

Authorities whose activities affect children and young persons are duty bound, as are other authorities in health care, medical care and other forensic psychiatric investigation services and social services, prison and probation services to notify the social welfare committee immediately of any matter which comes to their knowledge and may imply the need for the social welfare committee to intervene for the protection of a child. The same applies to persons employed by such authorities. The same duty of notification also applies to persons active within professionally conducted private services affecting children and young persons or any other professionally conducted private services in health and medical care or in the social services field.

Patients without legal capacity

Unconscious patient

Examination

If a patient is unconscious, all medically relevant examinations which may benefit her/him should be carried out. This also applies in cases where sexual assault is suspected. All samples which may be regarded as important for the patient's own health should be taken. Examinations for medico-legal purposes require the patient's consent.⁵ If the patient due to unconsciousness cannot give her/his consent, a court may appoint a legal representative at the request of the prosecutor.⁶ The legal representative may then give consent in the patient's stead.

Forensic medical report

The principal rule is that the patient's consent is required for completing a forensic medical report, and this is usually taken care of by the police (see Chapter 9).

However, exceptions to the consent rule apply in the same way as they do for the breach of confidentiality (see Chapter 8), or if data has previously been given to the police or prosecutor with the patient's consent.⁷ If consent is required and the patient is unconscious, the situation may be solved by the legal representative giving consent.

Other patients without legal capacity

For adults who for some other reason lack legal capacity, e.g. due to mental disability or mental illness, the same general principles as for minors should be applied. If the patient is unable to make a judgement concerning the examination and forensic medical report, these may only be carried out with the consent of the patient's legal representative.⁸

¹ *Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons — Revised ed.*, Geneva, World Health Organization/United Nations High Commissioner for Refugees, 2004

² Stegeryd Y och Ansell R. Läkares säkring av biologiska bevis efter sexualbrott utgör en viktig del i rättsprocessen. *Läkartidningen*. 2008;105(7): (in the press)

³ Slaughter L et al. Patterns of genital injury in female sexual assault victims. *Am J Obstet Gynecol*. 1997 Mar;176(3):609-16, Jones JS et al. Anogenital injuries in adolescents after consensual sexual intercourse. *Acad Emerg Med*. 2003 Dec;10(12):1378-83, Lenahan LC et al. Colposcopy in evaluation of the adult sexual assault victim. *Am J Emerg Med*. 1998 Mar;16(2):183-4.

⁴ Data from the National Laboratory of Forensic Science. January 2008.

⁵ Section 4 of the Act (2005:225) on forensic medical reports occasioned by crime

⁶ Ch. 11, Section 4 of the Parental Code

⁷ Section 5 of the Act (2005:225) on forensic medical reports occasioned by crime

⁸ Ch. 11 of the Parental Code

7. Crisis counselling and psychosocial follow-up

Psychosocial support after a sexual assault can be decisive for the victim's processing of the trauma. Patients' need for help is highly individual and varies depending on how the trauma has affected the patient and on how much time has passed since the assault. Various specialists from several different fields may be needed during the different phases following the trauma.

Sexual assault victims should be offered access to a counsellor in the acute phase. Appointments for follow-up visits and feedback should also be arranged. Many victims are too traumatised to speak at the time of the emergency visit. It is therefore important to make a connection with the patient in order to reduce the risk of a suppression of the crisis reaction. If the acute crisis is very severe, hospitalisation may be necessary.

Individual therapy with a psychologist or other therapist may be necessary later on. Resources for psychological support and processing vary in different parts of the country. Public health care must always have staff on hand who are specialised in crisis management and counselling, as well as in more in-depth therapeutic measures.

There are also many resources in the private sector, e.g. psychotherapists in private practice, clinics belonging to non-profit organisations such as RFSU (the Swedish Association for Sexuality Education) and the Swedish Red Cross, and support, counselling and protection at crime victims' and women's shelters. Knowledge about what local resources are available should exist in every health care unit that meets sex crime victims.

Kvinnofridslinjen has information about what support is available in each municipality and health care districts for women subjected to violence.

Telephone no. 020-50 50 50. Open around the clock, every day of the year (only domestic phone calls).

Important factors in psychosocial treatment

An active approach

An active approach on the part of the counsellor is usually the most helpful. It is important to convey security without over-consoling or becoming too protective. It is also important that the care provider dares ask the patient what happened

to her/him. One justification for support and counselling from a professional is precisely that the patient will be given an opportunity to air all the thoughts and emotions that the assault has brought on, without feeling that she/he is burdening her/his family or friends. If the victim is not allowed to work her/his way through the trauma properly, there is a risk that it will return later in the form of a post-traumatic stress syndrome.

Recapitulation and processing of the sequence of events

The aim of the patient's recounting of events is for her/him to understand her/his own reactions and thereby regain control. Even the sexual details may be important to recapitulate in order for the patient to access her/his emotions. If memory lapses have occurred, the processing of events may help to restore the memories. That way, the victim can understand what it is the lapses are protecting her/him from, and see her/his own actions in the assault as a survival strategy.

The personal significance of the trauma

A sexual assault may reopen old traumas and conflicts from earlier periods in the victim's life—events which now resurface and contribute to further effects. A loss, bereavement or a difficult separation may have made the victim especially vulnerable. Old reaction patterns may become linked to current ones.

Reactions and support needs of family and friends

The reactions of family and friends influence the victim's ability to recover. A partner, parents or other people close to the victim may sometimes almost assume the blame for the assault, or feel like victims themselves. The assault may also be perceived as an infidelity. Some partners become over-protective, others may distance themselves or become emotionally blocked. Family and friends may need counselling in order to be able to deal with their own emotions and be supportive of the victim.

The book "Våldtagen. En handbok i att möta utsatta kvinnor" ("Raped. A handbook for meeting survivors") and the report "Våldtäkten drabbar också de anhöriga" ("Rape also affects family members") can be ordered from RFSU on www.rfsu.se.

8. Documentation

All documentation carried out within the health care and medical services in connection with the examination of sexual assault victims may come to be requested by the judicial system as supporting evidence.¹ This always applies if the patient has consented to it, but also in the absence of the patient's consent in the case of certain serious crimes (see the section on breaching confidentiality below). All records, regardless of what category of professional has made them, are included in this material. These circumstances place high demands on the language used by the care provider in the medical records.

Health care records are primarily used to document decisions on diagnosis and treatment measures, but in judicial matters they instead constitute a basis for supporting evidence in court. Records should therefore be concise, limited to the incident in question and only concern medical observations and assessments.

The Patient Records Act (1985:562)

The health care and medical services' duty to keep records, and how such records are to be made, is regulated by the Patient Records Act.

Section 3 A patient record shall contain the information necessary for good and safe care of the patient.

Information shall be added to the record as soon as this is possible.

If the information is available, a patient record shall always include

1. Information about the patient's identity,
2. Essential information about the background to care,
3. Information about the diagnosis made and reasons for more significant measures,
4. Essential information about measures taken and planned for the future,
5. A description of the information given to the patient and of the decisions made about choices of treatment, and of the possibility for a renewed medical assessment

/.../

Section 4 Each item of information in a record kept within the health care and medical services shall be so designed as to respect the patient's integrity.

- Report concisely and specifically the patient history data on which the examination is based.
- Be objective when describing the patient's mental and physical condition. Avoid emotionally charged words.
- Avoid assessments of the adequacy of the patient's reaction to the incident.
- Be thorough and objective in the description of injuries. Make measurements and take photographs.

Photography

All injuries should be documented using colour photographs. Digital cameras are available in most emergency wards and in many other health care departments.

The patient's consent must be obtained before photography takes place. Respect the patient's integrity and remember not to undress the patient more than necessary. Use a green or blue surgical drape as a backdrop and to cover the patient, e.g. to cover the chest if the upper arm is being photographed.

All images collected as evidence may become public documents. The images become accessible to the suspect and the defence counsel and may be shown during the trial. The images may also be accessed by other persons or be shown in the media.

Begin the series of photographs with a shot of the patient's identity, the date and the time. The flash will almost always be activated indoors; avoid over-exposure of the area in question by taking the picture from farther away and using the zoom function. When photographing smaller areas, also take a wider shot to better show the area's position on the body. Indicate which side of the body the area belongs to (left or right), and place a tape measure next to injuries to show the scale.

Bruises often become more prominent after one to three days. If necessary, contact a forensic examiner and discuss a suitable time for a renewed assessment by the initial physician or, if a police report has been filed, an examination by the forensic examiner.

Confidentiality

Confidentiality in health care is stipulated by law and aims to protect the individual's integrity. For anyone working with patients, confidentiality and professional secrecy have become natural approaches to handling information about the patient. Such an approach is important if the general public is to have confidence in health care and medical services—particularly in matters that may be sensitive to the patient.

In certain situations, the confidentiality of data concerning the patient ceases to apply:

- Confidentiality is rescinded if the patient consents to having data released.
- For children under the age of 18, confidentiality is breached due to the duty to inform the social services (see below) any suspicion that the child is coming to harm.
- When certain serious crimes are suspected, confidentiality for both the victim and the suspected perpetrator may be lifted (known as breaching confidentiality, see below).

As these situations amount to a deviation from the health care worker's usual approach, it is important to explain the circumstances to the patient. By giving the patient an opportunity to give her/his permission for releasing information, she/he will be better able to maintain a sense of self-determination and of trust for the health care services.

The Secrecy Act (1980:100)

Chapter 7. Confidentiality with regard principally for the protection of an individual's personal circumstances

Section 1 c Confidentiality shall apply, unless otherwise provided in Section 2, within the health care and medical services for data about an individual's state of health or other personal circumstances, if it is not apparent that the data can be disclosed without the individual or anyone closely associated with the individual suffering harm. The same applies in other medical activities, such as medico-legal or forensic psychiatry examinations, insemination, in vitro fertilisation, determination of sex, abortion, sterilisation, castration, circumcision, measures against infectious diseases, and matters before a committee charged with pursuing patient committee activities.

/.../ Confidentiality shall apply in activities regarding taking charge of patient records within private health care and medical services for data about an individual's state of health or other personal circumstances. Notwithstanding its confidentiality, data may be released to health care and medical personnel if the data is needed for care or treatment and it is of extreme importance that the data is released

/...

Breaching of confidentiality

For certain types of serious crimes, confidentiality is lifted. This is known as breaching confidentiality. There are two main legal aspects to breaching confidentiality. One is that upon request by e.g. the prosecutor's office or the police, the health care and medical services are obliged to disclose data as long as confidentiality or the handling of patients does not constitute an obstacle to this.² The other

is that confidentiality is lifted for certain serious crimes so that the health care and medical services can disclose data to authorities investigating the crime—even without the patient’s consent.³ The breaching of confidentiality applies even without an official authority request. This makes it possible, but not obligatory, for health care staff to report a crime in situations where they learn that a patient has been subjected to a serious crime but the patient her- or himself does not want to report it to the police.

It is the person in charge—the chief medical officer, head of clinic or senior physician—who decides whether circumstances obtain for applying the rule of breaching confidentiality. For this reason, staff in the health care and medical services need to know how sex crimes are classified. These kinds of decisions are both important and complex, and they should be taken at a high level, as shown in the preparatory work on the Secrecy Act.

From the preparatory work on the Secrecy Act

The issue of who should decide on the question of disclosure of data on suspicion of crime has been resolved such that it rests upon the individual officials and not the authorities as such to decide on disclosure. It has nonetheless been regarded as in the nature of the thing that the decision as a rule be taken at “a high level” within the authority. In many cases, it may be appropriate for the individual official to consult with a superior if the data to be disclosed concerns crime and, in doubtful cases, to turn the question over to the authority for a decision. Authorities are free to regulate more closely the extent to which individual officials are able to release data to other authorities and the extent to which such decisions should rest with the administration of the authority. To the greatest possible extent, disclosure should be made in writing.⁴

If hospital staff are uncertain as to how a suspected act should be classified /.../ they can consult with the police or prosecutor by describing the circumstances without identifying those involved before deciding whether circumstances exist for breaching confidentiality or not.⁵

Children under the age of 18 are also covered by the Social Services Act. This means that all staff who come into contact with children and adolescents in the course of their normal activity, and all who work in the health care and medical services are obliged to report to the social authorities any suspicion that a child or adolescent is coming to harm.

The following table shows when secrecy may be broken in connection with sex crimes.

Table: Sex crimes and possible breaking of secrecy on suspicion of consummated crime (not attempted crime).

Crime	Definition	Sentencing scale	Breach of confidentiality?
Rape	Coercive sexual intercourse or other comparable sexual acts by assault or other violence or threat, or improper exploitation of the victim's state of helplessness.	Normal crime: 2–6 years in prison Aggravated crime: 4–10 years in prison	Yes Yes
Rape of a child	To have sexual intercourse or carry out other sexual acts comparable with sexual intercourse with a child under 15 years of age. Or similar act with a child who has turned 15 but not 18 and who is a descendant of the perpetrator, or for whose care and supervision the perpetrator is responsible by decision of a government authority.	Normal crime: 2–6 years in prison Aggravated crime: 4–10 years in prison	Yes Yes
Sexual coercion	To induce a person to carry out or endure a sexual act by the use of unlawful coercion.	Normal crime: A maximum of 2 years in prison Aggravated crime: 6 months–6 years in prison	No* No*
Sexual exploitation of a person in a position of dependence	To induce a person to carry out or endure a sexual act by serious abuse of that person's position of dependence on the perpetrator.	Normal crime: A maximum of 2 years in prison Aggravated crime:	No* No*
Sexual exploitation of a child	If the crime of rape of a child is considered less serious.	A maximum of 4 years in prison	Yes
Sexual abuse of a child	To carry out a sexual act other than sexual exploitation or rape against a child under 15 years of age, or against a child who has turned 15 but not 18 and who is a descendant of the perpetrator, or for whose care and supervision the perpetrator is responsible by decision of a government authority.	Normal crime: A maximum of 2 years in prison Aggravated crime: 6 months–6 years in prison	Yes Yes
Sexual intercourse with a descendant	To have sexual intercourse with one's own child or grandchild.	A maximum of 2 years in prison	No*
Sexual intercourse with a sibling	To have sexual intercourse with one's full sibling.	A maximum of 1 year in prison	No*
Sexual molestation	Sexually to touch a child under 15 years of age or to induce the child to carry out or participate in an act with sexual implications. To expose oneself indecently to someone or to molest someone by means of words or deeds likely to violate that person's sexual integrity.	Fines or a maximum of 2 years in prison	No*
Exploitation of a child for sexual posing	To promote or exploit the undertaking of or participation in sexual posing by a child under 15 years of age. Or similar act against a child who has turned 15 but not 18, if the posing is likely to harm the child's health or development.	Normal crime: Fines or a maximum of 2 years in prison Aggravated crime: 6 months–6 years in prison	Yes Yes
Purchase of a sexual act from a child	To induce a child who has not turned 18 years of age to carry out or endure a sexual act against payment.	Fines or a maximum of 2 years in prison	Yes
Purchase of a sexual service	To obtain casual sexual relations against payment.	Fines or a maximum of 6 months in prison	No
Procuring	To promote or improperly financially exploit another person's engagement in casual sexual relations against payment.	Normal crime: A maximum of 4 years in prison Aggravated crime: 2–8 years in prison	No Yes

* If the victim is under 18 years of age, confidentiality is lifted in relation to both the police and the social services irrespective of the sentencing scale.

Under the Secrecy Act, confidentiality is broken in relation to the prosecutor and the police on suspicion of a crime against a child as specified in Chapters 3, 4 and 6 of the Swedish Penal Code, and on suspicion of a breach of the Act (1982:316) Prohibiting the Circumcision of Women.⁶ In other words, confidentiality is in principle lifted in relation to both the social services and the police for all sex crimes against children.

Responsibility for deciding to breach confidentiality should lie with the chief medical officer, head of clinic, or senior physician level. A less experienced doctor should not have to make such a decision on her/his own. Consult with colleagues!

¹ Supreme Court decision, see NJA 2005 p. 76

² Ch. 15, Section 5 of the Secrecy Act 1980:100

³ Ch. 14, Section 2, paragraphs 5 and 6 of Secrecy Act 1980:100

⁴ Bill 1983/84:142 *Changes to the Secrecy Act (1980:100) etc.*, p. 41

⁵ Bill 2005/06:161 *Secrecy issues—protected addresses etc.*, p. 103

⁶ Ch. 14, Section 2, paragraph 6 of the Secrecy Act 1980:100

9. Forensic medical reports

Forensic medical reports are written medical opinions which are only issued following a request by the police or a prosecutor, in connection with a criminal investigation or a trial. The same rules apply for medical doctors and dentists.¹ The request must be in writing and must state the specific questions that the forensic medical report is to address.

The act on forensic medical reports which came into force on 1 January 2006 stipulates that the issuing of forensic medical reports is limited to a small number of medical specialities. Forensic medical reports should principally be written by forensic examiners from one of the country's six departments of forensic medicine, or by a doctor contracted by the National Board of Forensic Medicine, and who has undergone special training for this purpose.

Exceptions have been made for certain situations which require either specialist competence or emergency measures:

- Sex crimes—a gynaecological examination for evidence collection is required immediately.
- Crimes against children—paediatric specialisation is desirable. However, in the view of the National Board of Forensic Medicine it is often suitable that an examination of a child is carried out by a doctor from the National Board of Forensic Medicine together with a paediatric specialist.
- Emergency situations in which care measures are required immediately and in which these measures make a later examination impossible or difficult, e.g. in cases where an injury has been examined and then sutured.
- Other specialist knowledge is required, e.g. a dentist or an eye specialist.
- If no doctor from the National Board of Forensic Medicine and no doctor contracted by the Board is available and an examination/forensic medical report cannot be delayed.²

Act (2005:225) on forensic medical reports occasioned by crime

Section 2 A forensic medical report shall be obtained from a doctor at a department of forensic medicine within the National Board of Forensic Medicine, or from a doctor who is under contract with the National Board to issue such certificates, if injuries, illness or other circumstances that the certificate is to refer to are deemed to have some possible significance for a criminal investigation

1. which can be expected to result in a sanction other than fines,

or

2. pursuant to Section 31 of the Act (1964:167) with special provisions regarding young violators of the law, and the crime could have been expected to result in a sanction other than fines.

If there are special circumstances, however, a forensic medical report as referred to in the first paragraph may also be obtained from another doctor of sufficient competence.

From the preparatory work³: "The provision of the second paragraph means that it shall be possible to obtain a forensic medical report from other doctors than those referred to in the first paragraph, if there are special circumstances. Such circumstances may e.g. obtain in situations where care measures need to be applied immediately. If a person seeks care in an emergency ward following a crime, it may be suitable for the doctor who examines and treats the patient also to issue a forensic medical report. For example, a knife wound may need to be examined immediately regarding its direction and depth, after which it is sutured. Another example is if someone has been subjected to a sex crime. In such cases, an examination may need to be carried out straight away in order to collect evidence. Specially qualified doctors will be limited in number, which means that they cannot be available at all times of the day and night for such examinations. In such cases, the doctor who receives the patient can issue a forensic medical report.

A prerequisite for this, however, is that the doctor possesses the competence required for the task. A gynaecological examination, for example, should be done by a gynaecologist."

Writing a forensic medical report

In cases of rape and other forms of sexual assault, great importance is attached to the contents of the forensic medical report. It follows that it is very important that the forensic medical report is written in a professional manner and based on a well-conducted examination with full documentation.

The forensic medical report should preferably refer to information from the judicial system regarding the sequence of events, e.g. an interrogation report from

the crime victim, and should not be based on notes from the medical record. State where the information has come from, as it is important for the court to know what background knowledge the doctor issuing the forensic medical report had when making her/his assessment.

Obligation to inform

When a medical examination is held as a basis for a forensic medical report, the examining doctor is obliged to inform the patient about what a forensic medical report is and in what circumstances consent is required.⁴ This information must be provided before the examination and should, if possible, be provided both orally and in writing. An information sheet written by the National Board of Forensic Medicine in consultation with the National Police Board, the Office of the Public Prosecutor and the National Board of Health and Welfare is available for download from the National Board of Forensic Medicine. The fact that the information has been given to the patient must be recorded on the forensic medical report.⁵

http://www.rmv.se/pdf/rattsintyg/infoblad-om-rattsintyg_070115.pdf

Consent

A medical examination of a crime victim for the purpose of issuing a forensic medical report always requires the individual's consent.⁶ Consent must also be obtained before the forensic medical report is issued, which is normally done by the police. Exceptions to the consent requirement for issuing a forensic medical report (but not for a medical examination) occur in the case of breaching confidentiality as described earlier. The decision on whether the requirements for breaching confidentiality have been fulfilled must be made by a senior official in the health care and medical services as described on page 51.

Quality assurance

The health care and medical services are responsible for forensic medical reports issued by publicly employed doctors. Forensic medical reports should be written or reviewed by doctors with sound clinical experience. If less experienced doctors write forensic medical reports under the supervision of more experienced colleagues, the need for training can be satisfied while the quality of the certificate to be presented to the judicial system is guaranteed at the same time.

Expediuousness

A forensic medical report must be issued as soon as possible.⁷ If the suspect has been detained or if the victim or the suspect is under 18 years of age, action must be expeditious. Routines for dealing with forensic medical reports should be in place at every clinic, and the examining doctor or a superior should take personal responsibility for ensuring that the certificate is written immediately.

Act (2005:225) on forensic medical reports occasioned by crime

Section 5 ... A forensic medical report regarding a plaintiff may be issued without consent

1. if a crime is suspected which carries a punishment of no less than one year in prison, or an attempted crime which carries a punishment of no less than two years in prison.

2. if an attempted crime is suspected which carries a punishment of no less one year in prison, if the act included the attempt to transmit such dangerous diseases as referred to in Chapter 1, Section 3 of the Communicable Diseases Act (2004:168).

3. if a crime under Chapter 3, 4 or 6 of the Swedish Penal Code is suspected, or a crime as referred to in the Act (1982:316) Prohibiting the Circumcision of Women is suspected, and the victim of the crime has not turned 18 years of age.

or

4. if data for which secrecy applies under Chapter 7, Section 1 c of the Secrecy Act (1980:100) or for which professional secrecy applies under Chapter 2, Section 8 of the Act (1998:531) on professional activities in the health care and medical services field, has been disclosed to police authorities or prosecutors' offices following consent by the plaintiff. (A forensic medical report may be issued on the basis of data which has previously been disclosed with the patient's consent, even if the patient has subsequently withdrawn consent. Authors' note.)

Template for forensic medical reports: see the Guide to Care Following Sexual Assault, page 92.

¹Section 1 of the Act (2005:225) on forensic medical reports occasioned by crime

²*Att skriva rättsintyg*. Stockholm, Utbildningsmaterial från Rättsmedicinalverket, 2005

³Bill 2004/05:64 *New directions for the issuing of forensic medical reports*, pp. 59-60

⁴Section 6 of the Act (2005:225) on forensic medical reports occasioned by crime

⁵*Rättsmedicinalverkets riktlinjer vid utfärdande av rättsintyg*, Nr 2006-08

⁶Section 4 of the Act (2005:225) on forensic medical reports occasioned by crime

⁷Section 9 of the Act (2005:225) on forensic medical reports occasioned by crime

10. How the judicial system works

A person who has been subjected to a sex crime is not just a patient but also a plaintiff in the judicial system. If the victim reports the crime to the police, an investigation begins which may lead to an indictment, a trial and a sentence. In the course of this process, the victim will meet a number of actors, each with their own separate area of responsibility.

In many respects, the victim of a crime must be active her- or himself in order to protect her/his rights. Moreover, the process differs in many ways from the criminal investigations and trials we are used to seeing in films and television series. The plaintiff therefore needs a great deal of support and help from the professional actors involved, throughout the entire judicial process. By receiving correct information about what happens after a crime is reported, the victim will not only be motivated to report the crime but will also regain some control over her/his life. It is from this perspective that it becomes important for staff in the health care and medical services to possess knowledge about the judicial system.

www.brottsofferportalen.se
www.brottsrummet.se

The judicial chain

The judicial system includes all the agencies and authorities that are responsible for upholding the rule of law and security and equality before the law. Among them are the courts, the police, the Swedish Prosecution Authority, the Swedish National Economic Crimes Bureau and the Swedish Prison and Probation Service.

Within the judicial system, the term “judicial chain” is often used to describe the chronology of a criminal case, from the initial reporting of a crime until a perpetrator has served her/his sentence. The rest of this section describes how a case progresses through the judicial chain.

The judicial chain can be summarised in the following way:

- A crime is reported to the police.
- During the preliminary investigation, possible suspects are investigated and evidence collected.
- Once the preliminary investigation has been completed, the prosecutor decides whether or not to indict a suspect.
- If an indictment is made, the district court calls a hearing, or what is usually called a trial.

- Once the hearing is over, the district court delivers its judgement in the case. Appeals against the court's judgement may be made to a court of appeal and to the Supreme Court.

It hadn't been her idea to go back to her place after the last beer. But he was just so charming and they'd had such a lot of fun during the evening. When she said goodbye to Camilla they both giggled and promised to speak the following day. On the way up in the lift they were all over each other. He really was too cute. They'd hardly got in through the door before they started taking their clothes off and moving on into the bedroom. When she lay down on the bed her head started spinning and she felt nauseous. Perhaps it wasn't such a good idea after all—she was too drunk and she didn't really know him.

– No, I don't want to. I'm too drunk!

– Ah, come on, you can't back down now. Aren't we having a nice time?

– No, I mean it. I don't want to!

In a flash he became a different person. He held her arms fast as a tore her knickers off.

From report to indictment

The report

In sex crimes cases it is important that the crime is reported to the police as soon as possible after it has happened. If evidence can be collected promptly in a medical examination and a crime scene investigation, the possibilities of resolving the crime increase.

When a crime is reported, the police are obliged to inform the victim of her/his rights, e.g. the right to legal counsel and to a support person, the possibilities for claiming damages, and the possibilities for a visiting ban.¹

It was Camilla who said they should phone the police. As for herself, she felt like she'd rather just forget any of it had happened. Two uniformed policemen came to her flat. They said it was important to report the incident and that she should go to the hospital for an examination. In order for the prosecutor to be able to prove the crime, it was important to collect all the available evidence. The police also told her that she could have her own lawyer, or legal counsel, who would help her during the proceedings. She would like that very much, she said to the police before they gave her a lift to the hospital.

Preliminary investigation

A preliminary investigation must be initiated if there is reason to believe that a crime has been committed.²

www.polisen.se

The expression “reason to believe” means that not much is required in order for a preliminary investigation to be initiated. The decision to do so must be made by the police or the prosecutor.³ The police is in charge of the preliminary investigation in cases without a known offender and in cases where the crime is of what is known as a simple nature. The prosecutor is in charge of the preliminary investigation in other cases.

Among sex crimes, only sexual molestation in the form of indecent exposure and purchase of a sexual service are normally regarded as crimes of a simple nature.⁴ For all other sex crimes with a known offender, a prosecutor is in charge of the preliminary investigation. When this is the case, the prosecutor instructs the police as to what measures are to be taken. The police reports back to the prosecutor as the case proceeds.

www.aklagare.se

On the day after the examination, a policeman phoned and told her that he was an investigator and that he wanted to interview her. He wondered if she could come to the police station at one o'clock. He had checked with her legal counsel, who was available at that time. She said that was fine but wondered if Camilla could come along too. That was fine, he said, but perhaps Camilla could wait outside during the interview.

The preliminary investigation has two main aims.⁵ The first is to investigate who might be suspected of the crime and if there is sufficient evidence to indict a particular suspect. The second is to prepare the case so that the evidence can be presented at a trial.

An objectivity principle applies during the preliminary investigation. This means that not only circumstances and evidence that go against the suspect must be recorded and collected, but also circumstances and evidence that favour the suspect.⁶ The preliminary investigation must be carried out expeditiously.⁷

In sex crime cases there are usually no direct witnesses, and it is the plaintiff's word against the suspect's word. It is unusual for the suspect to confess to a crime.⁸ In such circumstances, evidence other than the information provided by the victim, known as supporting evidence, has great significance. Such supporting evidence might be a forensic medical report or an interview with the doctor who examined the victim. Supporting evidence most often plays a decisive role in the assessment of the credibility of the victim's and the suspect's stories.

The plaintiff

A person who has been subjected to a crime is known as the plaintiff.⁹ If the victim is a minor, and the crime is against her or his person, the minor is represented

by her/his guardian. If the plaintiff has died, the survivors have a limited right to taking over the plaintiff's cause.

Plaintiff under the age of 18

If the plaintiff is under 18 years old, the preliminary investigation must be conducted with particular expeditiousness if the crime was against the plaintiff's life, health, liberty or peace. This applies for all sex crimes. The preliminary investigation must be completed and a decision made about indictment as soon as possible, and no later than three months after someone has been justifiably suspected of the crime.¹⁰

Protection of the plaintiff

A prosecutor may decide on a visiting ban if there is a risk that a person will commit a crime against, persecute or in any other way seriously harass another person.¹¹ Such a decision is made following a request from the persecuted person. There are also possibilities for imposing an extended visiting ban with respect to a shared home.

www.skatteverket.se

Sometimes the situation is so serious that a so-called security package may be considered. This means that the threatened person has access to a mobile telephone, an assault alarm and telephone answering service in order to be able to get help from the police quickly. Security packages are offered by the local police authority following special consideration.

The National Tax Board can decide to protect the personal data of a threatened person. In the first instance, the person may be given a secrecy tag in the population registry database.¹² This tag is meant to serve as a warning, so that any release of data about the person is preceded by careful scrutiny. Another way of protecting personal data in the population registry is by means of a retained registration.¹³ This means that a person who moves is allowed to remain registered at the old address for up to three years. If the threats are particularly serious, a person can be provided with another identity, which is known as fictitious personal data.¹⁴ Decisions in these matters are made by the Stockholm City Court after an application with the National Police Board.

Special representative for children

Under normal circumstances, a minor is represented by her/his guardian or guardians in legal matters. But when the child has been subjected to a crime, there are some situations in which the guardian/s are not suitable representatives. This applies in situations where a guardian may be suspected of the crime, but also when there is a risk that the guardian, due to her/his relationship to the suspect, will not protect the child's rights.

If such a situation occurs for one of two guardians who are not married or cohabiting, the other guardian is named sole representative of the child. In other cases, a special representative must be appointed.¹⁵ This may be a lawyer or someone else whose knowledge, experience and personal characteristics make them particularly suited to the task. The special representative is to protect the child's rights during the preliminary investigation and at a possible trial.

The prosecutor applies to the court for the appointment of a special representative. The special representative is paid for by the state and carries no cost for the child.

Legal counsel

When a preliminary investigation into a sex crime has been initiated, a special legal counsel for the plaintiff must be appointed, unless it is apparent that the plaintiff does not need such counsel.¹⁶ The legal counsel, who is a lawyer, must protect the plaintiff's rights in the case and provide support and help. The legal counsel is also to help the plaintiff with damage claims if this is not being done by the prosecutor.

The court appoints the legal counsel, normally after the prosecutor has relayed the plaintiff's request for counsel. The legal counsel is paid for by the state and carries no cost for the plaintiff.

The legal counsel was there during the whole police interview. After the interview they went to the law firm. The legal counsel then explained to her how a preliminary investigation and a trial work. There were so many unfamiliar words that it made her head spin.

"Don't worry," the lawyer said, "I'll be with you throughout the whole process."

"But I can't afford to pay for a lawyer," she said in desperation.

"And you won't have to," the lawyer said. "It's all on the state, so it won't cost you a thing."

Support person

A plaintiff may take a support person along to interviews during the preliminary investigation or to the trial.¹⁷ Unlike a legal counsel, the support person may not intervene in judicial matters during interviews or the trial, e.g. by asking the plaintiff or the suspect questions. A support person's role is only to offer personal support to the plaintiff, and it is the plaintiff who decides if a support person should come along. A support person does not have to fulfil any requirements for special qualifications, other than being "suitable". A support person is not paid by the state for her/his participation.

In the evening, when they were having coffee, Camilla promised to come along to the trial if there was going to be one.

"But aren't you working?"

"Never mind, I'll take a day off, that's all right. Then I'll be there with you all day and we can have lunch together."

Apprehension, arrest and remand in custody

During a preliminary investigation there are some situations in which coercive measures may be used, e.g. in order to be able to collect evidence. There is a distinction between coercive measures against individuals and coercive measures against property.

Coercive measures against individuals include apprehension, arrest and remand in custody.

Apprehension

The police has the principal right to apprehend persons suspected of crimes.¹⁸

In the case of some crimes, the general public may apprehend a person they see committing a crime or have just seen committing a crime. If a suspect has been apprehended by someone other than the police, the suspect should promptly be turned over to the police.¹⁹

Arrest

If the police has apprehended a suspect, they contact a prosecutor who has to decide whether the suspect should continue to be deprived of liberty or not. The prosecutor does this by deciding if the suspect is to be placed under arrest.²⁰ If there are grounds for remanding the suspect in custody, the suspect may be placed under arrest pending the court's determination of the remand issue.

Remand in custody

If the prosecutor has placed a suspect under arrest, and the suspect is not subsequently released by the prosecutor, a court reviews the decision in a remand hearing. A person who is suspected on probable grounds of a crime that carries a sentence of no less than one year in prison may be remanded in custody if, in view of the nature of the offence, the suspect's circumstances, or any other factor, there is a risk that the person will

1. Flee or otherwise evade legal proceedings or punishment,
2. Remove evidence or in some other way impede the investigation, or
3. Continue her/his criminal activity.

If the crime in question is serious and carries a minimum sentence of two years in prison, as in the case of rape, the suspect must be remanded in custody unless it is apparent that no reason for it exists.²¹ If the court decides that a suspect is to be remanded in custody, it must also specify a period of time within which the prosecutor must make an indictment, usually one to two weeks.

Restrictions

If it may be suspected that the person remanded in custody will try to remove evidence or otherwise impede the investigation, his contacts with the outside world may be curtailed, e.g. with respect to visits, letters and telephone conversations. These are known as restrictions.

Expeditiousness requirement

A preliminary investigation must be conducted expeditiously.²² This applies in particular to cases in which the suspect has been apprehended, arrested or remanded in custody, or if the suspect or the plaintiff is a minor.

The expeditiousness requirement in a preliminary investigation can be compared to a situation in which a patient has to be moved to another hospital for intensive care. It is then important to make the final note in the record very quickly so that the patient will receive correct and adequate care. If the suspect has been remanded in custody, the investigation must be conducted expeditiously and such things as forensic medical reports be written quickly, as there are deadlines to meet.

The policeman rang and wondered if she could come for another interview. He told her that they had been able to apprehend the guy based on her information. He had been arrested and remanded in custody on suspicion of rape. The investigation now needed to be speeded up since the court had remanded him for two weeks.

"Could you come at ten o'clock today?"

"Only if my legal counsel can be there too," she said. "By the way, what happens if the guy who raped me phones me?"

"He can't. He's been put under restrictions, so he can't phone or write to anyone without the prosecutor's permission," the policeman replied.

Record of the preliminary investigation

During the preliminary investigation a record must be kept of matters of importance to the investigation.²³ This includes the police report, interviews with various

people, forensic medical reports and photographs. This record of the preliminary investigation constitutes the court's and the parties' working material during the trial.

The supervisor of the preliminary investigation decides what should be included in the record. In the course of the investigation, information will be collected which will not be part of the record but will be saved as secondary material. The deciding factor for whether something is included in the record or among the secondary material is its significance for the case. But it is not just information that can be said to have a direct significance for the case which is included in the record; information that the suspect and his defence counsel may be expected to regard as significant is also included. In principle, the suspect has the right to peruse all the secondary material. However, the secondary material is not presented to the court during the trial.

Discontinuance of a preliminary investigation

The supervisor of the preliminary investigation must continuously review whether the investigation is to carry on or be discontinued. Reasons for discontinuing a preliminary investigation may be that the offender cannot be identified, that there is insufficient evidence for an indictment, or that the reported act is not a crime.

A discontinued preliminary investigation may be resumed if new facts appear. If the victim of a crime is dissatisfied with the fact that a preliminary investigation has been discontinued, a reconsideration may be requested. A senior prosecutor will then go through the case and ensure that the decision was correct. There are no deadlines for requesting a reconsideration, but ultimately the term of limitation for the crime can constitute a deadline.

Secrecy applies in principle to discontinued preliminary investigations.²⁴ However, the decision itself and its justification are public. A plaintiff has the right to receive, on request, a copy of the decision to discontinue a preliminary investigation.

Notification

When a preliminary investigation has advanced so far that someone is reasonably suspected of committing the crime, this person must, in the course of questioning, be notified of the suspicion. The suspect and her/his defence counsel are entitled to continuous information about developments in the investigation, as long as this does not harm the investigation. The suspect and her/his defence counsel must then be given the opportunity to present their comments on the investigation. An indictment may not be made before this has been done.²⁵ This notification of the investigation's material before indictment is usually referred to as the final notification or the 23:18 notification.

The legal counsel rang her to ask her how she was and if she could come to the office the following day. The record of the preliminary investigation had arrived and they needed to discuss what damages they were going to claim.

"I have no idea about things like that", she said.

"Don't worry," said the lawyer "I do!"

Indictment decision

When the preliminary investigation has been completed, the prosecutor must consider whether to make an indictment or not. For Swedish prosecutors, a principle of obligatory indictment applies. This means that prosecutors are obliged to indict for crimes falling within the domain of public prosecution, if there is no rule to the contrary.²⁶ All sex crimes fall within the domain of public prosecution.

In order for the prosecutor to be obliged to indict, "sufficient grounds" must be present, for which the case is re-examined in two respects:

1. The prosecutor must first determine whether the act in question constitutes a crime.
2. The prosecutor must then review the strength of the existing evidence that the suspect committed the act. The evidence must be sufficiently strong for the prosecutor to expect, on objective grounds, a conviction²⁷.

A prosecutor who wants to bring an indictment must file a written application for a summons with the district court, after which the district court will issue a summons against the defendant, i.e. the person suspected of the crime.²⁸

The evidence requirements in order for an indictment to be brought can vary for different situations. If, for instance, a person who has reported a rape has no physical injuries and the suspect admits that sexual intercourse took place but that it was voluntary, sperm finds are not of any great significance. If the prosecutor cannot prove that sexual intercourse was coercive, the preliminary investigation may be discontinued.

"I'd like to meet my prosecutor," she said to the legal counsel.

"I'm the one representing you, not the prosecutor. But I'll phone the prosecutor's office and see if a meeting can be arranged," the legal counsel said.

Main hearing and judgement

Criminal cases are heard at the following public courts: district courts, courts of appeal and the Supreme Court.

When an indictment has been brought and the court has issued a summons against the defendant, the court will call a main hearing. That is the legal term for a trial.

Oral, immediate, concentrated

Three important principles apply at the main hearing:

- *The oral principle* means that the hearing must be oral in principle and that the parties may submit or read out written statements only if the court finds that it would facilitate the understanding of a statement or otherwise be advantageous to the proceedings²⁹.
- *The immediacy principle* means that only that which has emerged during the main hearing may form the basis of the judgement³⁰.
- *The concentration principle* means that the main hearing must be conducted without unnecessary interruptions and, as far as possible, on one single occasion³¹.

The first two principles imply, among other things, that statements made during police questioning cannot be a basis for the court's judgement. Instead, the person questioned must come to the trial and once again describe what happened or what she/he saw.

Public

A hearing in a court of law is public in principle, i.e. the general public is allowed to be present at it.³²

The court may, however, decide to hold the hearing behind closed doors on grounds of secrecy. That means that only the court and the parties may be present.

It is common to hold hearings behind closed doors in sex crime cases, among others. The plaintiff or the defendant may request that the hearing be held behind closed doors, or the court may consider the issue without a request.

www.dom.se

Witness support

Most of the country's district and appeals courts have witness support schemes with volunteers who offer witnesses and crime victims support and practical information in connection with a trial. The aim is to create a greater sense of security for the plaintiff and witnesses in connection with hearings in criminal cases. However, the witness support person must never discuss the particulars of the case with the plaintiff and witnesses. Witness support persons have been trained in reception issues and in the judicial process.³³

When they arrived at the courthouse a woman approached them and said that she was a witness support person. When they told her why they were there, the woman showed them to a special waiting room for crime victims. The legal counsel was already there.

– Hi, shall we get some coffee while we wait?

The course of the main hearing

Main hearings follow a set course stipulated by law.³⁴ Witnesses may not be present at the trial before they are heard, so after their attendance has been checked, they have to return to the waiting room. The plaintiff sits next to the prosecutor throughout the hearing. If a legal counsel has been appointed, she/he is also seated next to the plaintiff.

The prosecutor had requested that Camilla be heard as a witness. She was only allowed into the courtroom to show that she was there. Then she had to leave.

“Let’s go and sit in the plaintiff’s room for the time being,” said the witness support person.

After attendance has been checked, the prosecutor and defence counsel present their cases and introduce their respective actions, followed by the presentation of evidence. Just about anything may be used as evidence under the principles of free submission of evidence and free evaluation of evidence.³⁵ A large part of the presentation of evidence is made up of questioning different people, but evidence can also be written, as in the case of forensic medical reports. The plaintiff and the defendant are questioned first, and then witnesses, experts, and so on are heard. To be heard at a trial is often perceived as stressful. Questions from both the defence counsel and the prosecutor can seem mistrustful. However, insulting the person being heard is not permitted, and it is the president of the court who is responsible for maintaining order in the courtroom. When the presentation of evidence is complete, the parties make a concluding statement each, known as a plea.

Monitoring

If a witness is afraid of someone, e.g. the defendant, or for some other reason finds it particularly difficult to speak when a certain person is present, the court may decide that the person causing the fear will not be allowed to be present during the questioning. This possibility exists for both witnesses and plaintiffs. However, the defendant always has a right to hear what is being said in the courtroom. The situation is solved by placing the defendant in a room next to the courtroom, in which she/he can hear what is being said through a loudspeaker. This is known as monitoring. If a plaintiff or a witness wants monitoring, they can bring this up with the prosecutor or the court.

At first she didn't want the one who had done it to sit and look at her during her hearing. The prosecutor said that he could be placed next door to listen to what was being said in the courtroom.

"But," said the prosecutor, "I think you can handle it without moving him in there. You can always change your mind during the questioning, if it becomes too much to bear, or else we'll just take a break. Just let the legal counsel know."

Both the prosecutor's and the defence counsel's questions during the hearing were stressful. It was a good thing that the legal counsel had told her how these things could be. Afterwards both the prosecutor and the legal counsel said that she'd done well. It didn't matter that she'd started crying.

Experts

During the trial, experts may also be heard as part of the presentation of evidence.³⁶ The difference between a witness and an expert is that the task of a witness is to describe the observations she/he has made, while an expert's task is to help the court with expert knowledge which requires special experience or training.

If it is the court which has appointed the expert, the person is called a court expert. Health care secrecy does not apply when a court expert describes something, orally or in writing, to a court or to an authority conducting a preliminary investigation in a criminal case.³⁷

If it is the prosecutor or the defendant who has brought in the expert, the person is simply called an expert. The provisions of the Secrecy Act (on health care secrecy among other things) apply when an expert is heard, as well as legal privilege (which prohibits questions about information with which the heard person has been entrusted in the execution of her/his profession).³⁸ However, secrecy and legal privilege may be overridden if the case concerns certain serious crimes for which breaking of secrecy applies, e.g. rape (see Chapter 8, page 51).³⁹

The crime of rape carries a minimum sentence of two years in prison. That means that health care secrecy is overridden and that the examining doctor, for instance, may be heard on the matter with or without the plaintiff's consent.

The doctor who had examined her on the night it happened was questioned at the trial. She described what injuries she had had and what samples they'd taken. The prosecutor had to ask her several times to avoid using medical terms in Latin and instead describe it so that anyone who wasn't a doctor would understand.

Forensic medical report

A forensic medical report is another type of evidence, described in detail in Chapter 9, concerning the plaintiff. A forensic medical report concerning a suspect in a criminal case may be issued without consent

1. In connection with a body examination in accordance with Chapter 28 of the Swedish Code of Judicial Procedure, or
2. If some examination other than a body examination has taken place and a serious crime is suspected which is of a certain nature (see Chapter 8, page 51).

The prosecutor's burden of proof

In criminal cases, the burden of proof lies with the prosecutor.⁴⁰ This means that it is the prosecutor's task to prove all criminal elements, e.g. the use of violence and sexual acts, as well as any absence of factors which could lead to freedom from liability for the defendant, e.g. self-defence or limitation. The defendant is under no obligation to prove that she or he is innocent.

It was as if he was a completely different person at the trial, sitting there in expensive clothes and talking about that night. She was so angry when he blandly lied and said that she really had wanted to have sex.

"Take it easy," said the legal counsel, "he doesn't have to tell the truth. He doesn't actually have to tell anyone anything."

Judgement

When the hearing is over, the court must hold discussions to reach a judgement.⁴¹ These discussions are known as deliberations. After the deliberations, the president of the court briefly announces the contents of the judgement (delivers the judgement) and explains how anyone who is not happy with the judgement can appeal against it. Sometimes the judgement is not delivered at the trial, but only at a later time. In that case, the president of the court will say when the judgement is to be announced. On that day, the parties can go to the courthouse and read the judgement, or telephone the court to hear about it. A copy of the judgement is always sent to the parties by post.

When the trial was over, the judge told them to go outside and wait for a while. She went with Camilla, the legal counsel and the prosecutor to the special waiting room. After three-quarters of an hour, they were called back to the courtroom. Now the court was ready to announce the judgement.

Appeal

If a party is dissatisfied with the district court's judgement, it can appeal against the judgement in a court of appeal.⁴² In certain cases, leave to appeal is required in order for the court of appeal to try the case. If so, this will be specified in the judgement.⁴³ A common ground for an appellate court to grant leave to appeal is if there is reason to believe that it would arrive at a different conclusion than the district court.⁴⁴ A hearing in a court of appeal follows largely the same pattern as a hearing in a district court.

Appeals are common in sex crime cases. A study showed that about 66 per cent of indictment counts were appealed against. One explanation for this might be that a large share of the defendants had denied the act. In the same study, about 88 per cent of defendants indicted for rape denied committing a crime.⁴⁵

In practice, the first court of appeal becomes the final court of appeal for most cases. The Supreme Court may try appeals against the judgement of a court of appeal, but this usually requires leave to appeal. A leave to appeal is granted if the Supreme Court's judgement or ruling may serve as guidance for similar cases, which is known as a precedent.⁴⁶ Therefore, a claim that the court of appeal has misjudged the case is not usually sufficient grounds for leave to appeal.

When the deadline for appeals has passed without either party appealing against the judgement (or if an appeal has been made but leave to appeal has not been granted), the judgement enters into final force. This means that the judgement applies and that appeals cannot be made against it.⁴⁷

Damages

In principle, at the request of the plaintiff, the prosecutor is obliged to prepare and present the plaintiff's claim for damages as well, in connection with the indictment.⁴⁸ A legal counsel may help the plaintiff to present a claim for damages if the prosecutor does not.

If the court has ruled that the perpetrator must pay damages to the victim of the crime, the victim needs to pursue the matter actively, as such damages are not paid automatically. Sometimes the convicted person contacts the victim to make good, but if that does not happen the victim must pursue the matter.

This is done by filling out a form that the Enforcement Authority will send to the plaintiff. The Enforcement Authority will then help ensure that the damages are paid, if the convicted person has assets to pay with.

If the convicted person lacks assets, the victim will receive a report from the Enforcement Authority about this. Help from the Enforcement Authority involves no cost for the victim.

If the victim has not received the damage payments, or only a part of them, from the Enforcement Authority, the victim should file a claim with her/his insurance company. Home and accident insurance policies will often cover damage due to crime. Additionally, many people are insured through their employer or union, and these policies may also include such cover.

If the convicted person lacks assets and the victim cannot get compensation through any insurance policy, the victim may be able to get compensation from the Crime Victim Compensation and Support Authority. This is a government authority whose tasks include the payment of what is known as criminal injuries compensation when a crime victim has not received compensation in any other way.⁴⁹

www.brottsoffermyndigheten.se

The victim may have a right to insurance payments or criminal injuries compensation even if the offender is not convicted of a crime. This applies if the offender is unknown but other circumstances show that the victim has been subjected to a crime.

Correctional treatment

Sanctions for crimes include fines and prison, as well as conditional sentences, probation and committal for special care.⁵⁰ No sanction is imposed for crimes committed by a person before she/he has reached 15 years of age.⁵¹

www.kriminalvarden.se

The Prison and Probation Service is responsible for implementing prison and probation sentences and for activities at remand prisons. Probation refers to the supervision of conditionally released persons and of those committed for special care. Supervisors may be either a probation officer or a layman supervisor, i.e. a person who is not employed by the Prison and Probation Service.

Prison sentences vary in length from two weeks to lifetime imprisonment.⁵² When a prisoner has served two thirds of a fixed-term sentence, but not less than one month, she/he is conditionally released in most cases.⁵³ Conditional release comes with an initial probationary period⁵⁴ during which the released person must lead an orderly life.⁵⁵ If the conditionally released person does not comply with the conditions for her/his release, the conditionally granted liberty may be forfeited, which means that the person must continue to serve her/his prison sentence.⁵⁶

If the prisoner has served a sentence for a crime against a person's life, health, liberty or peace (e.g. sex crimes), the plaintiff has the right, on request, to be informed if the prisoner is granted leave or released.⁵⁷

- ¹ Sections 13a and 14 of the Ordinance on preliminary investigations (1947:948)
- ² Ch. 23, Section 1, first paragraph of the Code of Judicial Procedure
- ³ Ch. 23, Section 3, first paragraph of the Code of Judicial Procedure
- ⁴ Annex to 2005:9
- ⁵ Ch. 23, Section 2 of the Code of Judicial Procedure
- ⁶ Ch. 23, Section 4, first paragraph of the Code of Judicial Procedure
- ⁷ Ch. 23, Section 4, second paragraph of the Code of Judicial Procedure
- ⁸ Åklagarmyndigheten Utvecklingscentrum Göteborg *RättsPM 2007:13* sid. 28
- ⁹ Ch. 20, Section 8, fourth paragraph of the Code of Judicial Procedure
- ¹⁰ Section 2a of the Ordinance on preliminary investigations (1947:948)
- ¹¹ See the Act (1988:688) on visiting bans
- ¹² Cf Ch. 7, Section 15 of the Secrecy Act (1980:100)
- ¹³ Section 16 of the Population Registration Act (1991:481)
- ¹⁴ See the Act (1991:483) on fictitious personal data
- ¹⁵ See the Act(1999:997) on special representatives for children
- ¹⁶ Section 1 of the Act (1988:609) on legal counsel
- ¹⁷ See Ch. 20, Section 15, first paragraph and Ch. 23, Section 10, third paragraph of the Code of Judicial Procedure
- ¹⁸ Ch. 24, Section 7, first paragraph of the Code of Judicial Procedure
- ¹⁹ Ch. 24, Section 7, second paragraph of the Code of Judicial Procedure
- ²⁰ Ch. 24, Section 8, second paragraph of the Code of Judicial Procedure
- ²¹ Ch. 24, Section 1 of the Code of Judicial Procedure
- ²² Ch. 23, Section 4, second paragraph of the Code of Judicial Procedure
- ²³ Ch. 23, Section 21, first paragraph of the Code of Judicial Procedure
- ²⁴ Ch. 5, Section 1 of the Secrecy Act (1980:100)
- ²⁵ Ch. 23, Section 18, first paragraph of the Code of Judicial Procedure
- ²⁶ Only a few crimes fall outside of the domain of public prosecution—in principle only crimes of libel. See also Ch. 20, Section 6 of the Code of Judicial Procedure
- ²⁷ Fitger m.fl. *Kommentar till rättegångsbalken* p. 20:11 ff.
- ²⁸ Ch. 45, Section 1 of the Code of Judicial Procedure
- ²⁹ Ch. 46, Section 5 of the Code of Judicial Procedure
- ³⁰ Ch. 30, Section 2 of the Code of Judicial Procedure
- ³¹ Ch. 46, Section 11 of the Code of Judicial Procedure
- ³² Ch. 5, Section 1, first paragraph of the Code of Judicial Procedure
- ³³ Brottsoffermyndigheten *Vittnesstöd Slutredovisning av regeringsuppdrag Ju 2001-4716/KRIM*
- ³⁴ See Ch. 46 of the Code of Judicial Procedure
- ³⁵ Ch. 35, Section 1 of the Code of Judicial Procedure
- ³⁶ Fitger m.fl. *Kommentar till rättegångsbalken* p. 40:3 ff.
- ³⁷ Ch. 14, Section 2, second paragraph of the Secrecy Act (1980:100)
- ³⁸ Ch. 36, Section 5 of the Code of Judicial Procedure
- ³⁹ Ch. 14, Section 2, fifth and sixth paragraphs of the Secrecy Act (1980:100)
- ⁴⁰ Ekelöf *Rättegång IV* 5:e upplagan p. 121 ff.
- ⁴¹ See Ch. 30, Section 7 of the Code of Judicial Procedure
- ⁴² Ch. 51, Section 1 of the Code of Judicial Procedure
- ⁴³ Ch. 49, Section 15 of the Code of Judicial Procedure
- ⁴⁴ Ch. 49, Section 14 of the Code of Judicial Procedure
- ⁴⁵ Åklagarmyndigheten Utvecklingscentrum Göteborg *RättsPM 2007:13* sid. 26
- ⁴⁶ Ch. 54, Section 10 of the Code of Judicial Procedure
- ⁴⁷ However, see Extraordinary Remedies, Ch. 58 of the Code of Judicial Procedure, about e.g. relief
- ⁴⁸ Ch. 22, Section 2 of the Code of Judicial Procedure
- ⁴⁹ See the Criminal Injuries Compensation Act (1978:413)
- ⁵⁰ Ch. 1, Section 3 of the Penal Code
- ⁵¹ Ch. 1, Section 6 of the Penal Code
- ⁵² Ch. 26, Section 1 of the Penal Code
- ⁵³ Ch. 26, Section 6 of the Penal Code
- ⁵⁴ Ch. 26, Section 10 of the Penal Code
- ⁵⁵ Ch. 26, Section 14 of the Penal Code
- ⁵⁶ Ch. 26, Section 19 and Ch. 34 of the Penal Code
- ⁵⁷ Section 35 of the Act (1974:203) on Correctional Treatment in Institutions

11. Conclusion

Sexual assault occurs at all times of the day and night, in all parts of the country. The victim may seek medical care either directly following a sexual assault or some time—occasionally a very long time—afterwards. Regardless of when care is sought, staff in the health care and medical services must possess the competence to receive and care for the patient in a professional manner.

This *Handbook—National Action Programme for the Health Care and Medical Services' Reception and Care of Victims of Sexual Assault*, including the *Guide to Care Following Sexual Assault* is the first stage in improving the health care and medical services' reception and care of sex crime victims. They describe the procedure for adults, both women and men. The conditions have hereby been created for asking the patient the question about exposure to sexual assault and for guaranteeing consistent and legally acceptable routines for taking samples and carrying out documentation in emergency situations. Further, the health care and medical services' role in the judicial process has been clarified.

The second stage involves the crucial work of implementing the programme. Sweden is a relatively small country, which means that the chances that these routines will be introduced are favourable. If correct initial measures are applied by the health care and medical services, there is the prospect of achieving more in the criminal investigation of sex crimes. As the work of implementation begins, a few points need to be highlighted in particular.

Routines in health care and medical services for asking the question

The aim of the handbook is to improve the health care and medical services' reception and care of sex crime victims. A basic premise for achieving this is that staff within the health care and medical services identify the victims. It is not until then that she or he can begin to describe events. In the handbook, the issue has been approached from the perspective of the crime victim, with the conclusion that all patients should be asked about experiences of sexual assault and violence. The inclusion of experiences of violence in the question is justified by the fact that these two circumstances, sexual assault and violence, often occur together. It is urgent for clear routines to be established within the entire health care organisation so that this may be realised.

New guide in the Sexual Assault Evidence Collection Kit

Many sex crime victims seek care regardless of whether they have reported the incident to the police or not. The opportunity for collecting evidence during this health care visit must be taken, and evidence must be collected as thoroughly as possible. For this reason, a dialogue has been initiated with the National Laboratory of Forensic Science about including the *Guide to Care Following Sexual Assault* with the *Sexual Assault Evidence Collection Kit*. By recommending the health care services to use the evidence collection kit in all examinations after a sexual assault, whether a police report has been made or not, there is some guarantee that health care and medical services staff ask the right questions and take the right samples in the right way. This means that conditions have been improved for providing the judicial system with as complete and expedient a basis for decisions as possible.

Review of the routines at other authorities

With the handbook and the guide, the health care and medical services have assumed their responsibility for the correct handling of samples and tests until they are handed over to the police. During the work on the handbook and guide it has emerged that other authorities within the judicial system also have reason to review their procedures for testing following sex crimes.

Samples collected as evidence

It is of the utmost importance from a legal rights perspective that all staff who handle samples collected as evidence have clear and unambiguous routines to follow. Within the police authorities, the handling of samples collected as evidence varies, and there are no guidelines or suggested procedures. Just as the health care and medical services are now reviewing their handling of samples collected as evidence, so should the police authorities.

It is not unusual for a victim of a sex crime to seek care but put off reporting the incident to the police, which means that samples collected as evidence end up being stored temporarily with the health care and medical services for purposes to do with the judicial process. The responsibility issues surrounding the handling of samples collected as evidence should be clarified as soon as possible.

Medical samples

Knowledge about what medical samples are taken during an examination of a patient who has been subjected to a sex crime varies within the judicial system, with the consequence that test result reports are not requested. Since test results of medical samples are of value for the continued judicial process, communication channels between the health care and medical services and the judicial

system should be developed. The responsibility for this is shared equally by the health care and medical services and the judicial system.

The health care and medical services' role in the continued judicial process

During the work on the handbook and the guide it has emerged very clearly that the health care and medical services must be included as an actor in the judicial chain. In sex crime investigations, health care staff often apply the important initial measures, and forensic medical reports are very important for the continued investigation, including for the possibility of making an indictment. Finally, if the case comes to court, the participation of health care staff in their capacity as experts constitutes important evidence.

In order to raise competence within the health care and medical services and to be able to meet the demands that these tasks imply, recommended routines for documentation and taking samples during the examination of sex crime victims are included in the handbook, and the judicial process is described.

Other authorities' responsibility for improving quality

Regarding forensic medical reports and experts there are also reasons for other authorities in the judicial system to develop their competence and routines in the same way that the health care and medical services are now doing.

Forensic medical reports

Uniform routines for taking samples and for documentation during examinations following sex crimes ensure that conditions exist for issuing forensic medical reports of high quality. There is every reason to emphasise that the responsibility for assuring the quality of certificates written by publicly employed doctors lies with the health care and medical services. By asking the right questions to the health care and medical services, quality can be raised even further. This aspect of quality improvement efforts is significant, and can only be implemented within the police and prosecution authorities. Collaboration between the health care and medical services and the judicial system is one way of achieving results in this respect.

Experts

In view of the fact that supporting evidence is of great importance in sex crime cases, it is remarkable that the judicial system does not make full use of the competence that exists within the health care and medical services. The judicial system has been focused to a great extent on forensic examiners, thereby missing other specialities, such as gynaecology, which can be valuable in assessing injuries. The responsibility for raising competence in this area lies with the judicial system.

Implementation of the action programme

The handbook offers concrete recommendations for routines in the health care and medical services' encounter with sex crime victims. Such national recommendations have not existed earlier, with the consequence that sex crime victims have not received the same professional reception and care all over the country. The aim of the handbook, besides good reception and care, is to improve patients' chances of legal redress in a possible judicial process. Concrete recommendations in the handbook include:

- All doctors whose activities may include the examination of sex crime victims must be able to conduct a full examination with evidence collection.
- The Sexual Assault Evidence Collection Kit should be used in all examinations of sex crime victims.
- Full evidence collection within ten days of the assault.
- Uniform routines for infection screening.
- Samples collected as evidence should be kept for two years in cases where a police report has not been made at the time of the examination.

In view of the significance of the handbook and the guide for the professional reception and care of patients, the implementation of this programme is highly important. This work will begin during 2008 and will include the following measures:

- All staff within the health care and medical services who may come into contact with sex crime victims will be given access to the handbook and the Guide to Care Following Sexual Assault.
- Staff at the country's emergency wards and women's clinics will be offered a day of training in the reception and care of sex crime victims.
- All basic training of doctors, nurses and assistant nurses should include a module on the reception and care of sex crime victims.

The Crime Victim Compensation and Support Authority's reception project

The Crime Victim Compensation and Support Authority has been commissioned by the government to prepare and undertake a training programme for staff within the police, prosecution and court authorities.¹ This commission is to be completed and reported on no later than 1 October 2009.

During the work in the Crime Victim Compensation and Support Authority's reference group on the government commission, it was agreed that the handbook and guide which have now been produced would be used in the Crime Victim Compensation and Support Authority's reception project. This means that some staff within the police, prosecution and court authorities will be introduced to it.

Quality register

The number of examinations following sexual assault varies in different parts of the country, and a national quality register for such examinations could contribute to a levelling of quality. It would show the national spread and any local deviations, as well as create a statistics basis for scientific and strategic studies. It is urgent that such a register is set up, and the responsibility for it should lie with the National Centre for Knowledge on Men's Violence Against Women.

¹Ju2007/4690/KRIM and Ju2005/9839/KRIM

CONTENT

Instructions for examination and collection of samples	1
Patient data	2
Anamnesis.....	3–5
Examination with collection of samples.....	6
Common	6
Female genitals.....	7
Male genitals	8
Body pictograms	9–11
Template for forensic medical reports.....	12–13

PRIORITY PROCEDURE

*To bear in mind
when meeting
the patient*

Security	Make sure the patient is not left alone. Arrange a room so that the patient does not have to sit in the waiting room.
Control	Remember that it is the patient who decides if an examination is to be done, and the extent of any examination, not the police or health care staff.
Privacy	Meet with the patient in private, without family or friends, to the greatest extent possible.
Information	Describe calmly but briefly what is going to be done. Use an interpreter if necessary; do not let family or friends interpret for the patient.
Evidence collection	Do not offer food, drink or washing facilities until the examiner has decided what samples need to be collected as evidence. Evidence is collected regardless of whether a police report has been made.
Allow the patient to recount events	Be prepared to support with specific questions.
Child victims	A paediatrician must be in charge of the procedure. This is important for the follow-up.
Children at home	Are there children in the patient's home who could come to harm? Contact the social services if you have any questions.
The patient's need for protection	Carry out a risk analysis and consider the need for hospitalisation or a shelter.
Follow-up	Make sure that a follow-up appointment is made and that the patient receives contact information for psychosocial support.
Forensic medical report	Follow the instructions in the guide for a complete medical documentation. Give the patient written and oral information about forensic medical reports. Obtain the patient's consent for the examination. Obtain the patient's consent for a forensic medical report.

Only include the forensic evidence list with the evidence samples!

INSTRUCTIONS FOR EXAMINATION AND COLLECTION OF SAMPLES

THE ASSISTANT'S TASKS

1. Prepare collection of samples:

(Blood and urine samples may be taken before or after the examination. Note here which samples have been taken)

- | | |
|---------------|--|
| Blood samples | <input type="checkbox"/> EDTA tube (purple stopper) for DNA, 1* |
| | <input type="checkbox"/> NaF tubes (grey stopper) for drugs analysis, 2* |
| | <input type="checkbox"/> S-HIV, hepatitis, syphilis** |
| | <input type="checkbox"/> Serum ethanol tube (red stopper)** |
| Urine samples | <input type="checkbox"/> Sterile 10 ml tubes, 2* |
| | <input type="checkbox"/> Urine test strips (dip sticks)** |
| | <input type="checkbox"/> U-hCG** |
| | <input type="checkbox"/> U-chlamydia (male patients only)** |
- Samples taken by (Sign.) _____
Date _____ Time _____
- | | |
|------------------------|---|
| Samples as evidence | <input checked="" type="checkbox"/> Cotton swabs in sterile packs* |
| | <input checked="" type="checkbox"/> Pointed swabs for fingers/nails* |
| | <input checked="" type="checkbox"/> NaCl solution, a few drops to dampen swabs* |
| | <input checked="" type="checkbox"/> Adhesive films* |
| | <input checked="" type="checkbox"/> Bags for collected underpants* |
| Other clinical samples | <input checked="" type="checkbox"/> Swabs for wet smears, in sterile packs |
| | <input checked="" type="checkbox"/> NaCl solution for wet smears |
| | <input checked="" type="checkbox"/> Microscope slides |
| | <input checked="" type="checkbox"/> Samples for chlamydia and gonorrhoea** |

* materials included in the Sexual Assault Evidence Collection Kit

** clinical samples to be analysed locally

2. Prepare possible photography:

- Photograph the patient's identity data and the date of the examination.
- Prepare tape measure + sheet to use as backdrop.

3. Prepare examination:

- Set up for a gynecological examination with a speculum and depressor.
(IMPORTANT! Lubricate with water only)
- Set up for a rectal examination with a proctoscope.
(IMPORTANT! Lubricate with water only)

4. Label and package all samples as they are collected.

5. Tick off collected samples in the checklist included with the Examination and Samples template.

6. Assemble samples

- Clinical samples are sent for immediate lab analysis.
- Samples of evidence are stored in a dry, locked location until requested by the police.
- Blood and urine samples for the police are stored in a locked refrigerator until requested by the police.

THE EXAMINER'S TASKS

1. A full collection of samples as evidence according to the Guide is recommended. An extended evidence collection may be done based on the patient's account (areas of contact). Foreign material found on the body is collected with lengths of sticky tape.
2. Record finds in the checklist. Make drawings on the pictograms and/or take photographs.
3. Fill out and sign the delivery note for Sexual Assault Evidence Collection Kit.

NAME	CIVIC REGISTRATION NUMBER
------	---------------------------

Medical record document

PATIENT DATA

PATIENT

Civic registration number ____ - ____ - ____ - ____ Name _____

Address _____

Telephone no. _____

Confirmed ID Yes Driving Licence ID card Passport Other _____
 No

ARRIVAL

Arrival time _____ Emergency Appointment

Accompanied by _____

Relationship and tel. no. _____

ESCORTED BY POLICE

Policeman's name _____

Police report filed Yes No Date 20 ____ - ____ - ____

Circumstances described in an oral or written police report Yes No

EXAMINER

Date of examination 20 ____ - ____ - ____ Time of examination _____

Examining doctor _____

Assisted by nurse/assistant nurse _____

Examination conducted in collaboration with Medico-legal specialist
 Paediatrician
 Other specialist

Name _____

NAME

CIVIC REGISTRATION NUMBER

Medical record document

ANAMNESIS

PREVIOUS/CURRENT ILLNESSES

Previously healthy. No current illnesses.

GYNECOLOGICAL ANAMNESIS

Date of last menstruation 20 ___ - ___ - ___

Contraceptives

Yes Type _____
 No

Sexual debut

Yes No

Previous childbirth

Yes No

Pregnancy in course

Yes No

Previous gyn. examination

Yes No

Previously subjected to rape/assault

Yes No

Most recent voluntary sexual intercourse, date 20 ___ - ___ - ___ Time _____

ALLERGY

No allergy

MEDICATION

No medication

THE ASSUALT

Let the patient freely recount the sequence of events, but be prepared to support with specific questions. The data to be listed on pages 4–5 below can usually be picked up during the course of the account. Answers to these questions are important because they affect the emphasis of the examination and the collection of samples and evidence.

NAME	CIVIC REGISTRATION NUMBER
------	---------------------------

Medical record document

Date/time of the assault 20 ____ - ____ - ____ Time _____

Location where the assault took place

- In the perpetrator's home In the victim's home In the shared home
 Outdoors Other location Doesn't know

Relationship with perpetrator/s:

- Unknown Superficially acquainted/Met the same evening Friend/Close acquaintance
 Current partner/Co-habitee/Spouse Previous partner/Co-habitee/Spouse Family member/Relative
 Doesn't know

Number of perpetrators

- One perpetrator More than one perpetrator Doesn't know

The perpetrator/s used violence

- Yes No Doesn't know

The perpetrator/s used weapons or blunt instruments

- Yes No Doesn't know

How and against what parts of the body:

What kind: _____

The patient has used alcohol or drugs

- Yes No Doesn't know
 Voluntarily Involuntarily

Which: _____

There are other circumstances that may have put the patient in a state of helplessness (illness, sleep, functional disability)

- Yes No Doesn't know

Which: _____

Type of sexual acts

- | | Yes | Attempted | No | Doesn't know |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Oral intercourse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vaginal intercourse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anal intercourse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Did the perpetrator ejaculate? Yes where? _____ No Doesn't know

Was a condom used?

- Yes No Doesn't know

Penetration using fingers or objects?

- Yes Attempted No Doesn't know

Licking, kissing, or bites to the body?

- Yes No Doesn't know

Where: _____

Touching of genitals or other parts of the body

- Yes No Doesn't know

Where: _____

NAME	CIVIC REGISTRATION NUMBER
------	---------------------------

Medical record document

AFTER THE ASSAULT

The patient has

- Had a shower or a bath Yes No
- Urinated Yes No
- Defecated Yes No
- Used/changed tampon or pad Yes No
- Vomited Yes No
- Eaten or drunk something Yes No
- Brushed teeth Yes No
- Changed underpants Yes No
- Changed clothes Yes No

FOLLOW-UP

Emergency contraceptive

- Yes No

Antibiotics Prophylaxis

- Yes which? _____ No

Wants to receive test results

- By letter By telephone

Appointment with a counsellor

- Yes when? _____ No

Wants to be telephoned by a counsellor

- Yes No

Information about forensic medical report given

- Yes No

DIAGNOSES

- Examination and observation after alleged rape Z04.4
- Sexual assault by spouse/partner T74.2,Y07.0
- Sexual assault by acquaintance/friend T74.2,Y07.2
- Sexual assault by other specified person T74.2,Y07.8
- Sexual assault by unspecified person T74.2,Y07.9
- Gynaecological examination Z01.4
- Injuries to the vagina, vulva S31.4
- Anal fissure, unspecified K60.2
- Contusion on outer genitals S30.2
- Acute stress reaction F43.0
- Nausea, vomiting R11.0
- Restlessness, agitation R45.1
- State of emotional shock R45.7
- Physical abuse by spouse/partner T74.1,Y07.0
- Abuse by parent T74.1,Y07.1
- Abuse by acquaintance/friend T74.1,Y07.2
- Abuse by other specified person T74.1,Y07.8
- Psychological abuse by spouse/partner T74.3,Y07.0

NAME	CIVIC REGISTRATION NUMBER
------	---------------------------

Medical record document

COMMON ♀/♂

EXAMINATION

SAMPLES

If not a full examination, give reason:

GENERAL CONDITION

- Alcohol or drug intoxication? Has consciousness been affected?
- Signs of extensive bodily injury? Signs of acute crisis reaction?
- Consultation with another specialist? (state which)

	Health care samples
	Samples for evidence

Height _____ cm	Weight _____ kg	Blood pressure _____	Pulse rate _____ /min	Body temp _____ °C
-----------------	-----------------	----------------------	-----------------------	--------------------

If any injuries:
Describe colour, shape and size. Fill out the body pictograms. Photograph as necessary.

HEAD AND NECK

- Wound
- Skin discolouration (*Bruises*)
- Abrasions (*Grazes, scratch marks*)
- Swelling
- Hair clumps/bald spots
- Motion pain
- Pain to palpation
- Other _____



SAMPLES

- Damp swab from area of contact (state location):

EAR INJURIES

- Outer ear, R/L
- Eardrums, R/L

EYE INJURIES

- Conjunctival haemorrhaging, R/L

MOUTH AND THROAT

- Wound
- Dental damage
- Other _____
- Swelling
- Mucosal haemorrhaging



SAMPLES

- Oral cavity, 2 dry swabs (rub against teeth, gums, on as well as under tongue)
- Lips/around mouth, 2 damp swabs
- Chlamydia, throat Gonorrhoea, throat



CHEST, BACK, ABDOMEN

- Wound
- Skin discolouration
- Abrasions
- Other _____
- Motion pain
- Pain to palpation
- Swelling



SAMPLES

- Damp swab from area of contact (state location):

ARMS AND HANDS

- Wound
- Skin discolouration
- Abrasions
- Other _____
- Motion pain
- Pain to palpation
- Swelling



SAMPLES

- Finger wash/nail scrapings with damp pointed swab
- Damp swab from area of contact (state location):

BUTTOCKS, LEGS, FEET

- Wound
- Skin discolouration
- Abrasions
- Other _____
- Motion pain
- Pain to palpation
- Swelling



SAMPLES

- Damp swab from area of contact (state location):

NAME

CIVIC REGISTRATION NUMBER

Medical record document

WOMAN ♀**GENITALIA****Outer genitalia:** Outer genitalia: pubic hair, labia majora and minora, urethral meatus, introitus and perineum

- | | |
|--|--|
| <input type="checkbox"/> Wound | <input type="checkbox"/> Pain to palpation |
| <input type="checkbox"/> Skin discolouration | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Abrasions | |
| <input type="checkbox"/> Other _____ | |

**SAMPLES**

- Introitus/perineum, 2 damp swabs
 Damp swab from area of contact (state location): _____



- Gonorrhoea, urethral meatus

Inner genitalia: hymen, vagina, posterior fornix, portio, cervix (IMPORTANT! Lubricate with water only)

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Wound | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Mucosal haemorrhaging | <input type="checkbox"/> Other _____ |

**SAMPLES**

- Cervix, 2 dry swabs
 Posterior fornix 2 dry swabs
 Wet smear
 Sperms established
 not established

Bimanual palpation: Cervix, uterus, ovaries/oviducts

- | | |
|--|---|
| <input type="checkbox"/> Tenderness when palpation | <input type="checkbox"/> Abnormal findings at palpation |
| <input type="checkbox"/> Other _____ | |

**IMPORTANT!** Always collect chlamydia before gonorrhoea

- Chlamydia, cervix + posterior fornix (on same swab)
 Gonorrhoea, cervix

ANAL AREA

- | | |
|--|--|
| <input type="checkbox"/> Scarring | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Wound | <input type="checkbox"/> Pain to palpation |
| <input type="checkbox"/> Skin discolouration | <input type="checkbox"/> Sphincter injury |
| <input type="checkbox"/> Abrasions | <input type="checkbox"/> Other _____ |

**SAMPLES**

- Rectal orifice, 1 dry + 1 damp swab
 Damp swab from area of contact (state location): _____

Proctoscopy (IMPORTANT! Lubricate with water only)

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Wound | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Mucosal haemorrhaging | <input type="checkbox"/> Other _____ |



- Further up the rectum, 2 dry swabs

IMPORTANT! Always collect chlamydia before gonorrhoea

- Chlamydia, rectum
 Gonorrhoea, rectum

NAME

CIVIC REGISTRATION NUMBER

Medical record document

MAN ♂

GENITALIA

Outer genitalia: pubic hair, penis shaft, foreskin, frenulum, glans, urethral meatus, scrotum

- Wound
- Skin discolouration
- Abrasions
- Other _____

- Pain to palpation
- Swelling



SAMPLES

- Glans, 1 damp swab
- Under foreskin, 1 damp swab
- Penis shaft, 2 damp swabs
- Damp swab from area of contact (state location): _____

IMPORTANT! Always collect chlamydia before gonorrhoea



- Chlamydia, urine sample
- Gonorrhoea, urethral meatus

ANAL AREA

- Scarring
- Wound
- Skin discolouration
- Abrasions
- Swelling
- Pain to palpation
- Sphincter injury
- Other _____



SAMPLES

- Rectal orifice, 1 dry + 1 damp swab
- Damp swab from area of contact (state location): _____

Proctoscopy (IMPORTANT! Lubricate with water only)

- Wound
- Mucosal haemorrhaging
- Swelling
- Other _____



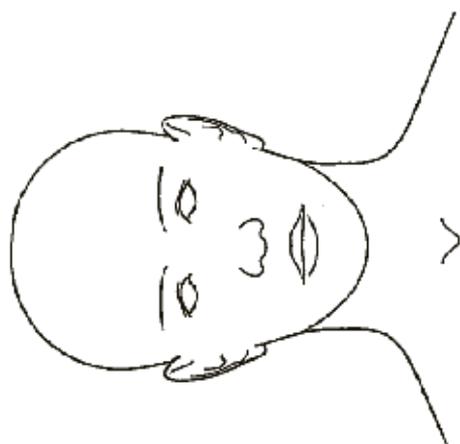
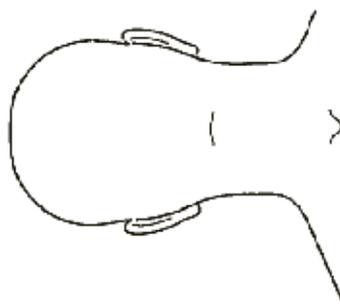
- Further up the rectum, 2 dry swabs

IMPORTANT! Always collect chlamydia before gonorrhoea

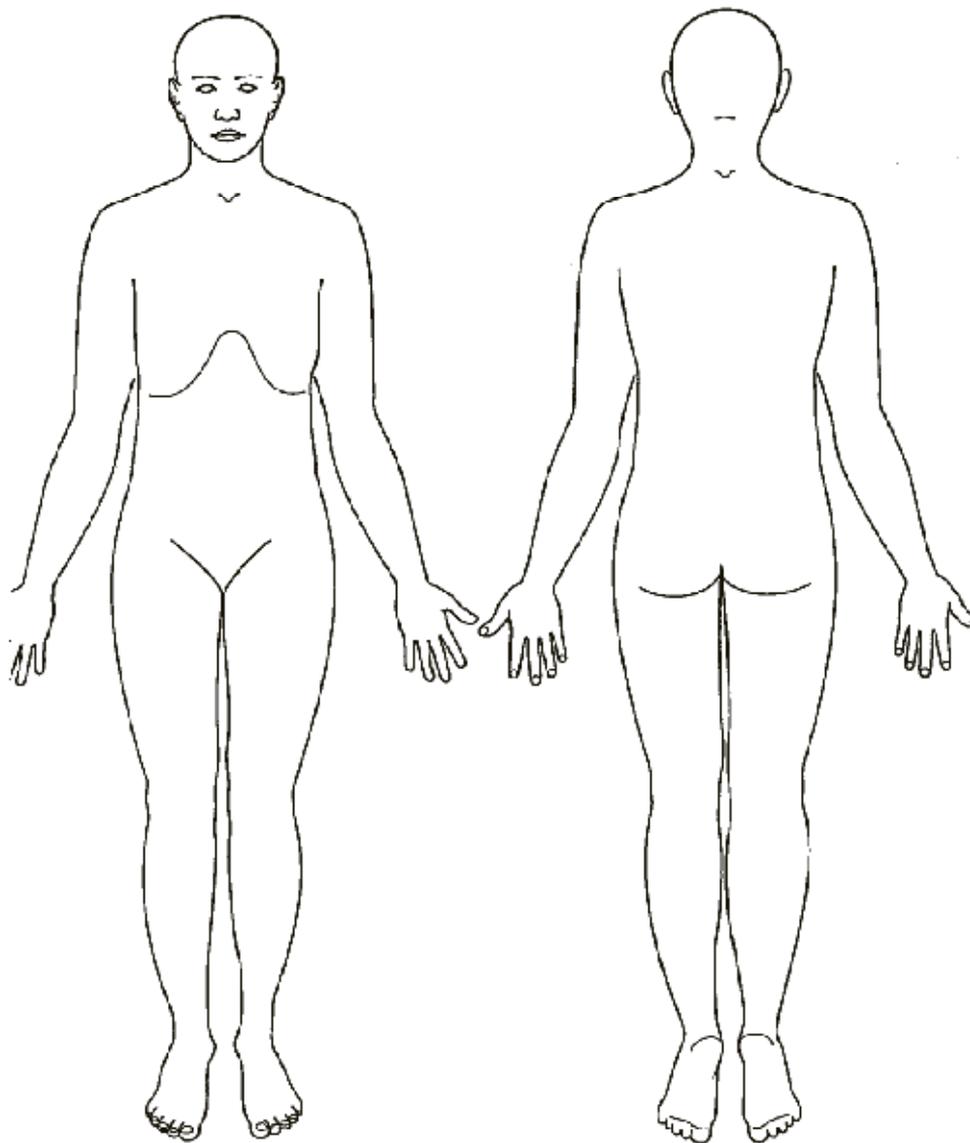


- Chlamydia, rectum
- Gonorrhoea, rectum

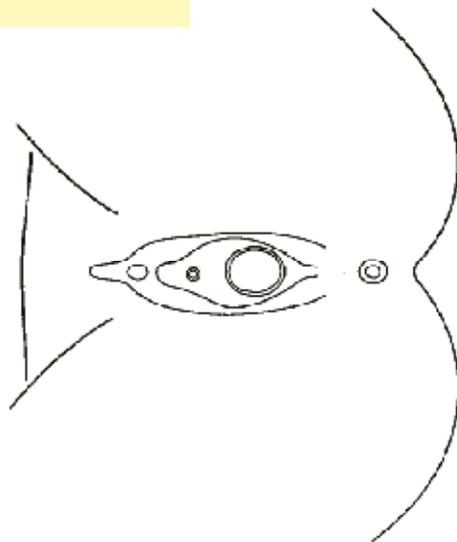
Patient's name:
Date:
Examiner's name:



Patient's name:
Date:
Examiner's name:



Patient's name:
Date:
Examiner's name:



SIMPLE TEMPLATE FOR A FORENSIC MEDICAL REPORT

FORENSIC MEDICAL REPORT

Today's date

DATA

On (date), an examination of (NN) was conducted at the request of (e.g. police authority). The examination was carried out by the undersigned at (location) in the presence of (e.g. nurse's name). The patient's identity was confirmed by means of an *ID card/a driving licence/personal knowledge*.

BACKGROUND

At the time of the examination a police report *had/had not* been made, dated (date) and written by (name) at police district. The examinee consents to an *examination/a limited examination*. The incident is described in the *police report/interrogation report*.

Consent to issue a medical certificate has (choose one of the following)

- *Been given to the doctor by the examinee*
- *Been given to the police/prosecutor (according to the police/prosecutor)*
- *Is not required, as a crime with a minimum sentence of 2 years imprisonment is suspected*
- *Is not required, as a crime against a minor as specified in Chapter 3, 4 or 6 of the Penal Code is suspected*

Information *has been provided by the examiner/by someone else/has not been provided* in accordance with Section 6 of the Act (2005:225) on medical certificates and the Personal Data Act (1998:204).

PATIENT HISTORY

Adequate information about any illnesses or medication.

In sexual assault and rape cases, information is also provided about contraceptives and most recent voluntary sexual intercourse.

EXAMINATION

During the examination, which covered *the entire body and visible orifices/incomplete body examination (specify limitation)*, the following was noted:

1. *Normal/heavy/slim body constitution (weight and height) General condition (note intoxication, signs of acute crisis reaction etc.)*
2. *(Systematic examination region by region, describe all changes: Size, shape, consistency and exact location. Pain? Tenderness? Signs of injury?)*
3. *(State if drawings were made or photographs taken.)*

GENITAL EXAMINATION

Woman

On outer inspection, normal conditions in vulva. Vaginal mucosa appear without irritation; normal discharge. Cervix appears normal. The uterus, palpated, is of normal size, mobile and without tenderness. No tenderness when palpating across oviducts and ovaries.

Or

State any deviating conditions on examination of the genitals.

Man

Normal conditions on outer inspection and palpation of the outer genitals.

Or

State any deviating conditions on examination of the genitals.

cont. **SIMPLE TEMPLATE FOR A FORENSIC MEDICAL REPORT**

SAMPLES

*Samples and evidence collection according to the Guide. / Limited samples and evidence collection due to _____ .
Infection samples normal/positive. / No test results.*

(State test results for S-Ethanol, presence/no presence of sperm, other samples of value for the medical certificate. Also specify any further examinations done and their results).

ASSESSMENT

Based on the findings specified above I hereby issue the following assessment:

- that NN showed signs of *_(type of violence)_* violence against *_(part/s of the body)_* (summary description)
- that the lesions *can/cannot* have arisen at the stated time
- that the findings *show/strongly suggest/possibly suggest/do not suggest/do not allow for the conclusion* that the lesions arose according to the stated sequence of events
- that the lesions were *slight/neither slight nor life-threatening/life-threatening (the spontaneous healing process is decisive; only these three degrees can be used from a judicial point of view)*
- that the lesions *can/cannot* be expected to cause lasting physical harm/*it is still too early to say anything about lasting physical harm*
- that the lesions *can/cannot* be expected to cause psychological harm/*it is still too early to say anything about psychological harm*

Or

- that NN showed no signs of violence
- that the absence of lesions does not contradict the stated sequence of events (if that is the case).

Which is hereby certified

Name, title

Place of work, address, telephone no.



REGERINGEN

Regeringsbeslut 41

2007-02-22

Ju2007/2177/KRIM

Justitiedepartementet

Nationellt kunskapscentrum för frågor
om mäns våld mot kvinnor vid Uppsala
universitet
Box 256
751 05 UPPSALA

Ett nationellt program för omhändertagande av offer för våldtäkt och andra sexualbrott

Regeringens beslut

Nationellt kunskapscentrum för frågor om mäns våld mot kvinnor vid Uppsala universitet skall utarbeta ett nationellt program för hälso- och sjukvården avseende omhändertagande av offer för sexualbrott.

Uppdraget skall genomföras inom ramen för kunskapscentrumets tilldelade anslagsmedel.

Uppdraget skall redovisas senast den 15 februari 2008.

Bakgrund

Ett sexuellt övergrepp är en djupt kränkande handling och för brottsoffret kan det innebära en stor påfrestning att genomgå läkarundersökningar, polisförhör och rättegång. Det är därför av största betydelse att brottsoffret får ett bra och professionellt bemötande.

Många sexualbrottsoffer söker sig till hälso- och sjukvården för att få sina skador omhändertagna och behandlade, men väljer att sedan inte anmäla övergreppet till polisen. När sexualbrottsoffer i dag söker vård och stöd inom hälso- och sjukvården ser det bemötande och den vård de får vid landets sjukvårdsinrättningar olika ut, beroende på var de bor. Detta kan ha betydelse för såväl det medicinska omhändertagandet som delrättsliga beslut som senare skall fattas i det enskilda fallet. Det är viktigt både för brottsoffret och rättsprocessen att bemötandet i sjukvården sker med kunskap om vad den vårdsökande kan ha varit utsatt för samt att rutiner avseende provtagning och dokumentation fungerar på ett bra och rättssäkert sätt.

Postadress 103 33 Stockholm	Telefonväxel 08-405 10 00	E-post: registrator@justicia.ministry.se
Besöksadress Rindögatan 1	Telefax 08-12 07 34	Fax 08 12 07 34

Hälso- och sjukvårdens bemötande av offer för sexualbrott kan ha betydelse för brottsoffrets möjligheter att bearbeta händelsen. Bemötandet inom vården kan också påverka brottsoffrets benägenhet att anmäla brottet.

Det är också angeläget att de brottsoffer som kommer i kontakt med socialtjänsten bemöts professionellt och att alla berörda aktörer samverkar på ett effektivt sätt för att det enskilda brottsoffret skall få ett fullgott stöd och omhändertagande.

År 2004 beslutade Justitiedepartementet att utse en utredare bl.a. för att föreslå åtgärder som syftar till att öka benägenheten att anmäla sexuella övergrepp. Utredaren redovisade sitt uppdrag i promemorian Anmälan och utredning av sexualbrott. I promemorian föreslås bl.a. att Nationellt kunskapscentrum för frågor om mäns våld mot kvinnor bör ges i uppdrag att ta fram ett nationellt program för omhändertagande vid våldtäkt och andra sexualbrott, vilket tidigare har föreslagits av utredningen om ombildning av Rikskvinnocentrum (SOU 2004:117).

Närmare om uppdragets innehåll

Nationellt kunskapscentrum för frågor om mäns våld mot kvinnor skall utarbeta ett nationellt program för hälso- och sjukvården avseende omhändertagande av offer för sexualbrott. En grundläggande förutsättning vid omhändertagandet är att det finns kunskap om att personen kan ha utsatts för brott. I det nationella programmet bör ingå åtgärder för att öka uppmärksamheten avseende frågan om den vårdsökande kan ha utsatts för brott. Programmet bör också omfatta medicinsk och psykosocial behandling, dokumentation, rättsintyg, kvalitetssäkring och samverkan mellan berörda myndigheter och instanser. Särskild vikt skall läggas vid rutiner kring provtagning och den medicinska undersökningen av sexualbrottsoffer liksom vid samverkan med rättsväsendets myndigheter. Det är vidare angeläget att man i programmet förtydligar hälso- och sjukvårdens roll i förhållande till rättsväsendets myndigheter och rättskedjan.

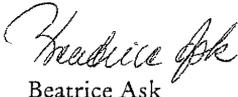
Syftet med uppdraget är att förbättra omhändertagandet av sexualbrottsoffer inom hälso- och sjukvården. Ett annat syfte är att utarbeta rutiner för hur provtagning och dokumentation skall genomföras för att rättsväsendets beslutsunderlag skall bli så fullständigt och ändamålsenligt som möjligt.

Det är viktigt att det hos personal inom vården finns kunskap om hur man bör ställa frågor till patienter som kan ha utsatts för sexuell våld. Det nationella programmet bör omfatta rekommendationer för hur dessa frågor skall ställas och hur svaren skall hanteras.

Uppdraget ligger väl i linje med Nationellt kunskapscentrum för frågor om mäns våld mot kvinnors verksamhet. Nationellt kunskapscentrum för frågor om mäns våld mot kvinnor kan verka för implementering av programmet inom hälso- och sjukvården inom ramen för sin ordinarie verksamhet.

Socialstyrelsen har huvudansvaret för normeringsarbetet inom hälso- och sjukvården, exempelvis genom framtagandet av föreskrifter och allmänna råd. Vid uppdragets genomförande skall därför Nationellt kunskapscentrum för frågor om mäns våld mot kvinnor ha ett tidigt och kontinuerligt samråd med Socialstyrelsen. Vid genomförandet skall även samråd ske med Brottsoffermyndigheten, Rikspolisstyrelsen, Rättsmedicinalverket, Sveriges Kommuner och Landsting, Åklagarmyndigheten och Domstolsverket.

På regeringens vägnar



Beatrice Ask



Arne Fors

Kopia till:

Fi/BA
IJ/JÅM
Ju/DOM
Ju/PO
Ju/Å
S/HS
S/ST
SB
U/UH
Brottsoffermyndigheten
Domstolsverket
Rikspolisstyrelsen
Rättsmedicinalverket
Socialstyrelsen
Sveriges Kommuner och Landsting
Uppsala universitet
Åklagarmyndigheten

A national programme for the reception and care of victims of rape and other sex crimes

The Government's decision

The National Centre for Knowledge on Men's Violence Against Women at Uppsala University shall draw up a national programme for the health care and medical services regarding the reception and care of sex crimes victims.

The commission shall be carried out within the framework of the appropriations allocated to the Centre.

The commission shall be presented no later than 15 February 2008.

Background

A sexual assault is a deeply serious violation of a person's integrity, and for the victim it can be a considerable further ordeal to go through medical examinations, police interviews and a trial. It is therefore of the utmost importance that the victim is treated in a good and professional manner.

Many sex crimes victims seek health care and medical services to have their injuries seen to and treated, but subsequently choose not to report the assault to the police. When sex crimes victims today seek care and support within the health care and medical services, the reception and care they get at the country's health care institutions varies depending on where they live. This can have an effect, in the individual case, on both the medical care offered and the judicial decision which needs to be made later. It is important for both the victim and the judicial process that the reception in health care is carried out with knowledge about what the person seeking care may have been subjected to and that routines for taking medical samples and for documentation function in a good and legally correct way.

The health care and medical services reception of sex crimes victims can be significant for the victim's possibilities of processing the event. The reception into care can also affect the victim's inclination to report the crime.

It is also important that those crime victims who come in to contact with the social services are treated in a professional manner and that all involved actors collaborate in an efficient way to ensure that the individual crime victim receives excellent support and care.

In 2004, the Ministry of Justice decided to appoint an inquiry to propose, among other things, measures aimed at increasing the tendency to report sexual assault. The inquiry presented its findings in a memorandum entitled "Reporting and investigation of sex crimes". Among its proposals were that the National Centre for Knowledge on Men's Violence Against Women be commissioned to draw up a national programme for reception and care following rape and other sex crimes, which had previously been proposed by the inquiry into the reorganisation of Rikskvinnocentrum (SOU 2004:117).

About the contents of the commission

The National Centre for Knowledge on Men's Violence Against Women shall draw up a national programme for the health care and medical services regarding the reception and care of sex crimes victims. A basic premise of such reception and care is that knowledge exists about the possibility that the person has been subjected to a crime. The national programme should include measures for highlighting the issue that the person seeking care may be the victim of a crime. The programme should also cover medical and psychosocial treatment, documentation, forensic medical reports, quality assurance, and collaboration between all affected authorities and institutions. Particular importance should be attached to routines for collecting the medical examination of and collection of samples from sex crimes victims, as well as to collaboration with the authorities of the judicial system. It is furthermore urgent that the programme clarify the role of the health care and medical services in relation to the authorities of the judicial system and to the judicial chain.

The aim of the commission is to improve the reception and care of sex crimes victims in the health care and medical services. A further aim is to develop routines for taking samples and for documentation that will provide the judicial system with a basis for decisions that is as complete and expedient as possible.

It is important that health care staff possess knowledge about how questions should be put to patients who may have been subjected to sexual violence. The national programme should include recommendations for how these questions should be asked and how the responses should be handled.

The commission is well within the remit of the National Centre for Knowledge on Men's Violence Against Women, and the Centre can work on implementing the programme in the health care and medical services within the framework of its normal activities.

The National Board of Health and Welfare has the main responsibility for normative initiatives in the health care and medical services, e.g. through the issuing of regulations and general guidelines. In carrying out its commission, the National Centre for Knowledge on Men's Violence Against Women should therefore establish an early and continuing consultation with the National Board of Health and Welfare. Work on the commission shall also include consultation with the Crime Victim Compensation and Support Authority, the National Police Board, the National Board of Forensic Medicine, the Swedish Association of Local Authorities and Regions, the Prosecution Authority and the National Courts Administration.

On behalf of the Government

Beatrice Ask
Arne Fors

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U/UH

The Crime Victim Compensation and Support Authority

The National Courts Administration

The National Police Board

The National Board of Forensic Medicine

The National Board of Health and Welfare

The Swedish Association of Local Authorities and Regions

Uppsala University

The Prosecution Authority

Index

A

Abdomen 39
Acts:
Health and Medical Services
 Act 30
 Act on forensic medical reports 56
 On sex crimes 11
 Patient Records Act 49
 Secrecy Act 51
 Social Services Act 45, 52
Acute/severe crisis reaction 22, 39
Alcohol 16, 34, 35
 samples for 38
Anal area 16, 42
Anamnesis 34, 44
Antibiotics prophylactics 43
Anti-retrovirals 43
Anxiety 22
Appeal 72
Apprehension 64
Arms 39
Arrest 64
Availability 31

B

Back 39
Breaking of secrecy 52
 table 53
Burden of proof 71
Buttocks 40

C

Chest 39
Children 9, 16
 examination of 44
 secrecy invoked for 52
Chlamydia
 samples for 38
 treatment of 43

Closed doors 68
Coercive measures 64
Collaboration 33
Collection of evidence
 time factors 34
Colposcopy 36
Communication between
 actors 33
Competence 30
Concentration principle 68
Conclusion 75
Consent 50, 57
Contraceptives 35
Correctional treatment 73
Court expert 70
Court of appeal 68
Crime Victim Compensation
 and Support Authority
 73, 78
Criminal injuries
 compensation 73
Crisis counselling 47–48
Crisis reaction 22, 39

D

Damages 60, 72
Defendant 67
Depression 22
Digital camera 32, 50
District court 68
DNA
 samples for 38
Documentation 32, 49–54
Drugs 16, 34, 35
 samples for 38
Duty to notify 44, 52

E

Emergency contraceptives 35
Emergency foster home 45
Enforcement Authority 72

Entry into force 72
Equipment 31, 36
Ethanol
 samples for 38
Evidence 60–61, 67–68
Examination 36–46
 of unconscious patient 45
Expediency requirement
 forensic medical reports 57
 preliminary investigation 65
Expert 70, 77
Extremities
 lower 40
 upper 39

F

Family and friends 48
Fear 22
Feet 40
Fines 53, 56, 73
Follow-up
 psychosocial 47
Forensic medical reports
 55–58, 69
 obligation to inform 57
 suspect 71
 unconscious patient 45
Forensic medical reports
 Act 56
Forensic examiner 44, 50, 55
Functional disability 14
 mental 46

G

Gang rape 12
General condition 39
Genitalia
 female 40
 male 41
Gluteal area 40

- Gonorrhoea
 - samples for 38
 - treatment of 43
- Guardian 44
- Gynaecologist 44, 56

- H**
- Hands 39
- Hate crimes 23
- Head 39
- Health and medical
 - availability 31
 - organisation 31
 - services 30–33
- Health and Medical Services Act 30
- Hepatitis 35
 - samples for 38
 - vaccination 43
- Hidden number 13, 23–25
- HIV 35
 - samples for 38
- HIV/hepatitis 43
- Home insurance policies 73
- Homosexuals 15
 - reactions 23
- Honour concepts 23

- I**
- Images 50
- Immediacy principle 68
- Immunoglobulin 43
- Implementation 75, 78
- Incest 15
- Incidence 13
- Indictment 13, 60, 67
- Infections, sexually transmitted 35, 43
- Infection specialists 43
- Interpreter 35

- J**
- Judgement 68
- Judicial chain 59, 77
- Judicial system 59–74

- L**
- Labia 40
- Legal capacity, patient without 45
- Legal counsel 63

- Legal privilege 70
- Legal representative 45
- Legs 40

- M**
- Main hearing 68
- Medical care 34
- Men 15
 - reactions 22
- Mental illness
 - legal representative 46
- Monitoring 69
- Mouth 39

- N**
- National Tax Board 62
- Neck 39
- Non-profit-making organisations 24, 47
- Notification 66

- O**
- Objectivity of documentation 50
- Obligation to inform 60
 - forensic medical reports 57
- Oral principle 68
- Organisation 31

- P**
- Parents 44, 48
- Partner
 - reactions of 48
- Patient Records Act 49
- Patient's safety 32
- Patients 19–25
 - needs 19
 - rights 19
 - without legal capacity 45
- Paediatrician 44
- Penis 41
- Perpetrator 15, 16
- Photographs 32
- Photography 50
- Plaintiff 61
 - under the age of eighteen 62
- Police 42, 54, 57
- Police report 12–15, 27, 36, 60

- Post-traumatic stress syndrome (PTSD) 22
- Powerlessness, feelings of 22
- Precedent 72
- Pregnancy
 - samples for 35, 38
- Preliminary investigation 61
 - discontinuance of 66
 - record of 65
 - supervisor of 61
- Prevalence 12
- Prison 73
- Proctoscopy 42
- Prophylactics 35, 43
- Prosecutors 61
- Protective measures
 - for plaintiff 62
 - for young people 44
- Psychiatry 24
- Psychiatrists specialising in children and young people 44
- Psychologist 47
- Psychosocial reception and care 47–48

- Q**
- Quality assurance 32
 - of forensic medical reports 57
- Quality register 79
- Questions about vulnerability 26–29
 - conditions 27
 - who should be asked 26

- R**
- Rape 10
- Reactions
 - acute 22
 - long term 22
 - of family and friends 48
 - victim's 21
 - personal 21
- Records 32
 - notes 49
- Records Act, see Patient Records Act
- Rectum 42
- Remand in custody 64

- Reporting
 - to the police 12–15, 27, 36, 60
 - to the social services 44–45
- Retained registration 62
- Risk factors
 - perpetrator 15
 - victim, see Vulnerability factors
- S**
- Safety 32
- Samples collected as evidence 38–42, 76
- Samples
 - handling of 42
 - medical 42, 76
 - forensic 42
- STI 38
- Sanctions 73
- Secondary material 66
- Secrecy 50
- Secrecy Act 51
- Security package 62
- Sentencing 73
- Sentencing scale 53
- Sex crimes legislation 11
- Sex crimes
 - definitions 53
- Sexual acts
 - definition 10
- Sexual assault 10–18
 - definitions 10, 53
 - statistics 12
- Sexual Assault Evidence Collection Kit 32, 36, 76
- Sexual intercourse
 - definition 10
- Shock 22, 34
- Social emergency services 44
- Social services 45
 - duty to report to 52
- Social Services Act 45, 53
- Special representative for children 62
- State of helplessness 10, 35
- Statistics 12
- STI, see Infections, sexually transmitted
- Support person 60, 63
- Supporting evidence 61
- Supreme Court 68
- Surgeon 44, 55
- Suspect
 - examination for forensic medical reports 71
- Swedish National Laboratory of Forensic Science 34
- Syphilis
 - treatment of 43
 - samples for 39
- T**
- Therapist 47
- Throat 39
- Time factors 34
- Treatment
 - medical 43
 - psychosocial 48–49
- Trial 68
- Trunk 39
- U**
- Unconscious patient 45
- Urine
 - samples 38
- V**
- Vagina 41
- Venereologist 43
- Violence in close relationships
 - asking about exposure to 26
 - sexual assault as part of 15
- Virgin 23
- Visiting ban 62
- Vulnerability factors 16
- Vulva 40
- W**
- WHO 19, 35
- Witness 69
- Witness support 69
- World Health Organisation 19, 35
- Y**
- Young people
 - alcohol and drugs 45
 - attitudes 23
 - examination of 44
- Youth centres 24

This handbook has been developed by the National Centre for Knowledge on Men's Violence Against Women (NCK) and is primarily intended for use by healthcare and medical services personnel that care for victims of sexual assault. The Ministry of Justice commissioned NCK to compile this handbook. Victims of sexual assault come into contact with various government authorities during the legal process. However, they turn to medical services in order to receive medical and psychosocial care. Thus, healthcare and medical services become an important link in the overall legal chain of events. The establishment of uniform routines can improve patients' chances of success in the legal process. The "Guide to Care Following Sexual Assault", an appendix to this book, is therefore an important tool to assist healthcare and medical services personnel in tending to both the medical and evidentiary needs of victims of sexual assault in a professional manner.

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