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The role of the state in addressing sexual violence: Assessing policing service delivery challenges faced by victims of sexual offences

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Introduction

The focus of this policy paper will be to look at the role of the state in addressing sexual violence in public and private spaces. Specifically, the focus will be on the policy provisions in terms of service delivery to sexual offences victims in terms of policing and health services and how these services are currently being provided. The paper begins by discussing the prevalence of violence against women globally and in South Africa. It then examines the South African state's response to gender-based violence and the gendered nature of the state's response to addressing violence against women. The paper further examines the response of the criminal justice system, and assesses the service delivery challenges faced by victims of sexual offences at the hands of the police and broader criminal justice system, and the intersection of this with healthcare provision. The paper concludes by making recommendations on how to address these challenges.

Violence against women as a global epidemic

Violence against women is a global phenomenon and is typically not treated as a policy priority by states across the world. Intimate partner violence and sexual violence against women are a significant public health problem and a violation of women's human rights. Recent global prevalence figures indicate that 35 per cent of women worldwide have experienced either intimate partner violence or sexual violence in their lifetime.[1] The World Health Organization (WHO) estimates that as many as 30 per cent of women in a relationship have experienced some form of physical or sexual violence by a partner.[2] The effects of gender-based violence are widespread and include physical, mental, emotional, psychological, sexual and reproductive health issues. It also increases vulnerability to HIV and in the long term impacts upon the quality and duration of lifespan. High levels of violence against women tend to be endemic in most societies, although there are variations in public attitudes and the investment of resources in addressing it.

Statistics on gender-based violence in South Africa

South Africa has one of the highest rates of gender-based violence reported to the police in the world. In the period from 2007 to 2013 there were approximately 1 016 588 contact crimes against women.[3] This is estimated to be only a fraction of the total number of cases given the stigmatisation and fear of secondary victimisation associated with reporting rape. In 2013/14, 62 649 sexual offences were reported to the police. In 2011/12, there were 87 191 incidents of assault against women and 57 345 assaults with the intent to cause grievous bodily harm.[4] The 2013/14 statistics in this regard do not differentiate by gender – they report only on the total number of assault cases. The number of interim protection orders for domestic violence applied for increased by 18 per cent from 208 747 in 2011/12 to 246 609 in 2012/13. The number of interim protection orders granted increased by 34 per cent while the number of warrants of arrest issued on protection orders increased by 40 per cent in the same time period.[5] Abrahams et al. (2012) found that intimate femicide has become the leading cause of female homicide in South Africa, with 56 per cent of all female homicides committed by an intimate partner.

South Africa's response to addressing gender-based violence

As part of its response to addressing gender-based violence, South Africa has sought to put in place a comprehensive legislative and policy framework to combat gender-based violence. This includes:

- The Domestic Violence Act (Act No. 116, 1998);
- The Criminal Law Sexual Offences and Related Matters Amendment Act (Act No. 32, 2007);
- Firearms Control Act (Act No. 60, 2000);
- National Policy Guidelines on Victim Empowerment;
- National Instructions on Domestic Violence;
- National Policy Framework on the Management of Sexual Offences;
- National Instructions on Sexual Offences; and
- National Directives and Instruction on Conducting a Forensic Examination on Survivors of Sexual Offences in terms of the Criminal Law Sexual Offences and Related Matters Amendment Act (Act No. 32, 2007).

In addition, the National Council on Gender Based Violence (NCGBV) was launched in December 2012 and was tasked with developing a national plan on gender-based violence. Since inception, the NCGBV has been unable to come up with a national plan and its future is in abeyance as violence against women seems to have shifted off the state's agenda of priorities after the 2014 elections.[6] Notwithstanding a relatively comprehensive policy and legislative framework, levels of violence against women remain alarming high. This can be attributed to a number of attendant reasons such as the inability adequately to resource and budget for gender-based violence and to translate policy frameworks into realistic and achievable plans, and the lack of political will to implement such plans. In 2014, KPMG reported that conservatively speaking, gender-based violence costs South Africa between R28.4 billion and R42.4 billion per year, an estimated 0.9–1.3 per cent of the GDP annually.[7]

Understanding sexual violence

While the state has largely failed to address violence against women in both public and private spaces, and while intimate partner violence and violence in the home is what creates the social context within which violence in public spaces takes place, the focus of this policy brief will be to look at the role of the state in addressing sexual violence. While the focus is on sexual violence, violence against women is seen as existing in a continuum. It is the everyday acts of violence, the gendered power dynamics within intimate relationships, the catcalls and acts of harassment directed at women on the streets that create the gendered social order within which more brutal manifestations of violence can take place.

Much of the state's approach to addressing such violence has been one of protectionism – namely, to keep women safe. This approach is underscored by the fact that women should be cautious in

engaging with public spaces – that they should not be in certain places at certain times. Narratives of danger are used to invoke a sense of fear of being in public spaces and to get women to re-negotiate their navigation of such spaces. Narratives of danger are internalised by most women who consequently limit their movement in public spaces in an attempt to be safe. An inherent part of the narratives of danger is that sexual violence happens to 'bad' women who risk being in public spaces at certain times, while 'good' women who adhere to the unspoken rules of protectionism will be safe. In reality, rape and sexual violence have confounded this myth. Most acts of gender-based violence are known to take place within the home and by perpetrators known to the victim. Even women who adhere to all the rules have been victims of sexual violence. This form of protectionism is a form of violence in its own right. Phadke argues that it reflects a concern with women's sexual virtue and sexual safety rather than actual safety. As such, it serves to hide the real agenda, which is controlling women's sexuality. Approaches that seek to limit women's occupation of public spaces result in the worst possible outcome for women in that they further control women's sexuality and their right to freedom of movement. Instead, the focus should be on claiming these public spaces; in a sense, women should viscerally write their cities with their bodies.[8] Rather than focusing on safety and limited movement in public spaces, women should instead place their claim in the discourse of rights rather than protectionism as an integral part of urban living. The more strategic, long-term strategy is for women to enhance claims to public space and to engage with risk and pleasure while accepting that violence is something that must be negotiated in the process of doing so.[9] The disproportionate focus on the dangers to women in public spaces ignores the reality that more women face violence in private spaces.

'Rape myths', a series of misplaced beliefs that hold that the victim is somehow at fault for being raped, lie at the root of poor prosecution and conviction of rape. This can take various forms. They include the view that it is impossible to rape a resisting woman, that some forms of forced sex are not really rape and that a woman who says 'no' can actually mean 'yes'. Rape myths stem from deeply embedded views about the role of women and women's sexuality in relation to that of men in a society. One of the more common rape myths is rooted within the notion that women somehow 'ask' for rape. This is tied to gendered notions of men's sexual needs and women's seductiveness. Women who are overtly sexualised in any way and who dress in a particular way are therefore seen to be 'deserving' of being raped. Similarly, women who consume drugs or alcohol are viewed as being responsible when they are raped, yet men who are under the influence of drugs or alcohol are rendered less responsible. In the same way, the problematic notion of the 'corrective rape' of lesbian women is viewed through the lens of not being an act of violence, but rather an attempt to make amends of sorts, to rectify something that is wrong. Stemming from this is the myth that not all forms of coerced sex constitute rape. Women who are seen to lead men on and then 'change their minds' are seen as being delinquent, as being irresponsible 'teasers'. Opting out of sex is therefore not an option for women.

Bourke (2007) argues that for a long time, the view was held that to be proved guilty of rape, a man had to believe that a woman was not consenting. A case in the United Kingdom in 1968 argued that to be guilty of rape, a man must have believed that his victim was not consenting. If he genuinely believed that his victim was consenting to sexual intercourse, then he lacked the requisite *mens rea* to rape.[10] One other popular rape myth is that women lie about being raped to settle scores as part of ulterior agendas. Researchers have at times sought to establish the extent to which this is a phenomenon.[11] However, these studies have been fraught with contestation. In reality, it is not possible statistically to calculate the number of such cases. In contrast with inflated guesses, examinations of rape cases actually reveal low levels of deception. Some investigations have shown that the percentage of false accusations in rape cases probably does not exceed 2–3 per cent.[12] Most victims would not put themselves through the associated trauma of lodging a false case and contending with secondary victimisation within a largely insensitive criminal justice system. It is important to note that just because the police describe a rape charge as unfounded does not necessarily mean that it is false. Contrary to the notion that men are at risk of being falsely accused of rape, it is more common for rapists to get away with their actions. One survey of 1 007 women in 11 UK cities found that a startling 91 per cent failed to report their rape.[13]

Sexual violence and the criminal justice system

A study on protecting victims of sexual offences done by Rape Crisis and the Women's Legal Centre[14] identified five key problem areas in the criminal justice system that curtail a victim's ability to seek justice. Firstly, most victims do not have access to information from the time of reporting a sexual offence to the time that that the matter is heard in court. Secondly, victims generally do not have access to case-specific information. For example, they have little or no idea whether the police investigation is going well or not, whether more information is required from them etc. Thirdly, the lack of psychosocial support is a significant deterrent in terms of pursuing a sexual offence case. Where adequate psychosocial support is not being provided, the process can become very overwhelming and the inclination to drop a case can be significant. Fourthly, the lack of coordination between the different service delivery line departments such as the Department of Social Development, South African Police Service (SAPS), the Department of Health and the Department of Justice and Constitutional Development exacerbates ineffective service delivery and the consequent frustration experienced by the victim. Lastly, the fact that there is no real complaint mechanism for when things go wrong skews the power relations against the victim. When service delivery is poor or inadequate, victims generally are at a loss in terms of knowing what to do in this regard.

Sexual offences statistics

Given that the focus of this policy brief is on sexual violence, sexual offences statistics over the course of the past few years are considered to paint a picture of reporting in this regard. It is important to note that the police do not distinguish between different types of sexual offences. There are over 50 different categories of sexual offences crimes that fall within this broad use of the term, which is a significant problem. The table below reflects sexual cases reported over the period 2007/08 – 2013/14:

Table 1: Sexual offences cases from 2007/08 – 2013/14[15]

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Reported sexual offences	63 818	70 514	68 332	66 196	64 514	66 387	62 649
% women 18 and older	49%	42.7%	52.8%	54%	48.5%	-	-
Criminal prosecutions	4 365	5 300	No reporting on stats	No reporting on stats	6 913	No reporting on stats	No reporting on stats
Convictions	2 887	3 535	-	-	4 501		
Conviction rate	66%	66.7%			65%		

The statistics indicate a slight drop in the number of reported cases of sexual offences, from 66 387 in 2012/13 to 62 649 in 2013/14. Over the course of the past few years, the trend has begun to drop, then increase again and then drop again at different points in time. In 2004/05, for example, there were 69 117 reported cases. By 2007/08, this had dropped to 63 818. In 2008/09, it increased again to 70 514, dropped to 64 514 in 2011/12 and then increased to 66 387 in 2012/13. The pattern that emerges is not one of a steady decline because of a coherent, targeted strategy to eradicate sexual offences, but rather a rise and drop at different points in time. It is, however, important to point out that an increase in reporting does not necessarily mean that there is an increase in sexual offences: it could also mean that more victims have been encouraged to report. Equally concerning is the fact a small fraction of the total number of reported cases eventually go to court. In 2007/08, 6.8 per cent of the total number of sexual offences went to court. Of the total number of cases reported to the police, 4.5 per cent resulted in convictions. This improved marginally in 2008/09, when 7.5 per cent of the total cases reported went to court and 5 per cent of the total cases reported resulted in convictions. For the next two years, there was no reporting on the related statistics. In 2011/12, there was a marginal improvement with 10.7 per cent of the total number of reported cases going to court and 6.97 per cent of the total cases reported resulted in convictions. The subliminal message is abundantly clear – a rapist has to be extremely unlucky to get convicted.

In South Africa, the process of establishing whether to prosecute a perpetrator of sexual offences usually starts when the police present a docket to the prosecutor. In terms of the National Prosecuting Authority's Prosecution Policy, the decision on whether to institute criminal proceedings against an accused person is informed by the extent to which there is sufficient and admissible evidence to provide a reasonable prospect of successful prosecution.[16] This policy brief, however, explores how evidence in rape cases can be difficult to collate, possibly adding to a situation where very few sexual offences end up going to court. One civil society activist noted that the performance of the NPA is assessed on the number of cases that it wins. This then also plays a role in the decision to not take certain cases to court.[17] The assessment of whether or not to proceed with prosecution can be a difficult one to make and requires careful probing and investigation to elicit information that can assist in securing a conviction. For this reason, the role of SAPS in assisting with this is critical. Effective cooperation with the police from the outset is essential to the efficacy of the prosecution process.[18] If the police do not exercise due diligence in investigating sexual offences cases, then this negatively impacts upon the rights of victims to justice.

Research methods

In trying to understand low conviction rates and the experiences of sexual offences victims in engaging with the criminal justice system (specifically with police and health-related services), interviews were conducted with the following role players:[19]

- Police Station;
- FCS Unit;
- Sexual Offences Prosecutor at Mitchells Plain Court;
- Sexual Offences Prosecutor at Wynberg Court;
- National Prosecuting Authority;
- Clinical forensic doctors who conduct medical examinations of sexual offences victims (interviews conducted with three doctors);
- Thuthuzela Care Centre (TCC) at Karl Bremer;
- Thuthuzela Care Centre (TCC) at GF Jooste Hospital;
- DNA Project;
- Rape Crisis; and
- Women's Legal Centre.

These interviews brought forward some of the key attendant problems in both securing convictions in sexual offences cases and in providing a victim-friendly service to sexual offences victims. The policy brief seeks to trace what happens to sexual offences victims from the time they report a case to the time the case goes to court. In particular, it tracks what is meant to happen in terms of the related policy and legislative framework and what transpires in practice. Discrepancies are discussed with a view to making recommendations for addressing these issues. It should be noted that a limited number of interviews were conducted for the purposes of this paper. Its findings should therefore be read in conjunction with other work in this regard.[20]

Service delivery to victims of sexual offences

The role of the police

Several studies have highlighted a number of problems with how the police deal with sexual violence.[21] The police are accustomed to working in innately violent contexts and have set ideas on what constitutes violence or force. Being accustomed to violent crime, they are often desensitised when dealing with more subtle forms of violence. The police have been known to be less susceptible to psychological aggression and less attuned to subtle intimidation. Many hold inherently violent attitudes towards sexuality and are deeply mistrustful and unsympathetic towards sexual offences victims.[22] If the victim is incoherent, inconsistent or fits any of the rape myths, then the police are often unwilling to take the case further.

Showering before reporting a rape, delays in reporting or not appearing totally coherent are some of the known factors that contribute towards the police encouraging victims to withdraw charges.[23]

In the South African context, the police's ability to deal effectively with sexual offences must be located within the broader context of low public confidence in the police. In 2013, the police disclosed that an internal audit had revealed that 1 448 serving police officers were convicted criminals, guilty of serious crimes such as murder, rape, assault, corruption, theft, robbery and drug trafficking.[24] The audit had been conducted in 2009 and is somewhat outdated. At the time, SAPS indicated that it would take well over a year to review all these cases as a fitness board would need to hear representations from those involved.[25] In 2013/14, the Independent Police Investigative Directorate (IPID) received a total of 4 585 criminal cases against police officials.[26] The lack of public confidence in the police was also a finding in an international study. Transparency International's Global Corruption Barometer ranked South Africa amongst 36 countries in which the police were seen as the most corrupt institution.[27] In terms of this, an estimated 53 per cent of respondents admitted to having paid a bribe to the police. This paints a relatively bleak picture of the context within which sexual offences victims have to engage with the police. This lack of public confidence resulted, in one instance, in a Commission of Inquiry being established in Khayelitsha to investigate the breakdown of trust between the community and the police.

Sexual offences victims are generally severely traumatised and need to be treated with sensitivity and empathy. Often, the police are the victim's first point of contact with the criminal justice system. The experience of the interaction with the police will set the tone for the rest of the engagement with the system. As a direct result of the trauma, a victim may be incoherent and unable to remember specifics relating to the offence. The police have a critical role to play in keeping the victim contained, which impacts on the ability to put together a good statement. All reports of sexual offences have to be taken seriously, regardless of when the offence was committed. The police may not turn away a victim on the grounds that the sexual offence was committed a long time ago or that it took place in the station area of another police station. When a victim reports a sexual offence, this invariably entails a reliving of the event and is likely to elicit secondary trauma. In instances where a victim is too traumatised to make a clear statement, the police are supposed to open a docket and make provision for the statement to be taken at a later point. Once the statement has been taken and a docket opened, the case must be registered on the Crime Administration System (CAS).[28] All details regarding the offence must be recorded as well as any details regarding possible witnesses. The police must ensure that the victim is given both the case number and the details of the investigating officer. They must also ensure that the victim understands the process that will be followed from the time of reporting. After the initial statement has been taken, the investigating officer should take a more in-depth statement within a 24- to 36-hour period. The statement must be taken where there is privacy and the victim must be given the option of having someone available to provide support.

Given that counselling is a critical step in helping the victim to process and manage the experience of violence, the police are obliged to keep an updated list of local organisations that are able to provide counselling and other support services. The police must explain the importance of undergoing a medical examination as soon as is practically possible.[29] The victim must consent to being medically examined and the consequences of opting not to be examined must be clarified. It must be clarified that the purpose of the examination is not only to secure evidence, but also to test for sexually transmitted diseases, pregnancy and generally to ensure physical well-being.

If the victim came into contact with blood, semen or vaginal fluid of the perpetrator, then there is a chance of HIV infection. In this case, the victim must be given a notice of available services. The police must ensure that the victim understands the importance of obtaining PEP without delay, within a 72-hour period from the time of the sexual offence. The police also have to explain that during the course of the medical examination, samples will be taken for forensic evidence. The victim's clothes and underwear may be required for this. The victim may not wash until after the medical examination. While it is easier to secure forensic evidence within a 72-hour period after the sexual assault and if the victim has not washed, all victims, regardless of this, must be taken for medical examination. In instances where the victim has already washed, the police should advise that this does not happen

again until after the medical examination. In order to facilitate the collection of forensic evidence, the police have to explain that in the event of needing to use the bathroom, all toilet paper and sanitary material must be retained. This needs to be dried and placed in an envelope or brown paper packet and sent to a forensic laboratory. No liquid should be consumed until after the medical examination. This applies only if the victim has not already had something to drink or rinsed her mouth. The police have to explain that if an oral sexual act had occurred, that rinsing the mouth could result in the destroying of critical evidence. As soon, as is practically possible, an oral swab must be taken from the mouth. A buccal swab can be taken by a police member of the same gender as the victim and with the informed consent of the victim. In practice, however, buccal swabs are taken primarily by healthcare practitioners. Given the fact that the victim is unable to wash, drink liquid and has to hand over toilet paper and sanitary material, it is critical that the police move as quickly as possible to take down her[30] statement. The sense of physical discomfort from the time of reporting until after the examination can enhance the sense of trauma.

In terms of the National Instructions for Police on Sexual Offences, the police must also enquire from the victim if she/he had sexual intercourse fewer than 72 hours before the sexual offence took place. If this is the case, then samples must be obtained from the partner(s) concerned. All samples must be clearly marked and forwarded to a forensic laboratory within seven days. The police must escort the victim to a trained healthcare practitioner for the purpose of the medical examination. A member of the police of the same gender as the victim may be present but only if this has been requested. If the victim of the sexual offence is a child, then the police must explain the medical examination to the parents or guardian and obtain their consent for the medical examination. The parents or guardian must be told that they may accompany the child during the medical examination. If it is not possible timeously to gain the consent of the parents, if the parents refuse consent or if the parents are a suspect in the sexual offence, then the police must make an application to a magistrate for consent to examine the child medically.

As the regards the possibility of HIV infection, the police need to ensure that the victim is told that she/he may apply for an order at the magistrate's court to force the perpetrator to undergo an HIV test. This cost is borne by the State. The decision to test the perpetrator does not have to be taken immediately – it can be taken up to 90 days from the time that the sexual offence took place. An investigating officer can also decide, without the victim, to apply for the HIV testing of a perpetrator. If an alleged perpetrator refuses to have blood samples taken, then an application for a warrant of arrest may be made to ensure compulsory testing. Once the records of the test results have been received, a copy of the result together with a notice on confidentiality and how to deal with the test results must be handed to the victim (if the victim made the application for the results) and the perpetrator. If the application was not made by the victim but by the investigating officer, then the results and notice are given to the perpetrator.

Sexual offences cases are notoriously difficult to prove. Often, perpetrators will argue that the sex was consensual. As a result, the case ends up being about the narrative of the perpetrator against that of the victim. For this reason, special care must be taken to ensure the validity of the evidence collected. It is critical that a police member handling evidence is suitably trained and has experience in this regard. In order to avoid the contamination of evidence, members of the police investigating sexual offences must avoid coming into physical contact with both the victim and perpetrator before they have been medically examined or changed clothes after the sexual offence was committed. In this instance, different members of the police should be used to interview the victim and arrest or interview the perpetrator. To avoid contamination of evidence, the victim and perpetrator may not be escorted in the same police vehicle. Similarly, in packaging the clothes of the victim and perpetrator for forensic examination, each set of clothes must be packaged separately and by different members of the police. Different tables and work surfaces must be used for the packaging of both sets of clothes. A body sample is supposed to be taken from the crime scene investigator in order to exclude this profile in the event of the contamination of samples. In terms of the Criminal Law Forensic Procedures Amendment Act, the DNA profile of the investigating officer who attends or processes a crime scene must be added to an Elimination Index in the DNA database. In order to ensure the chain of evidence[31] in the

handling of evidence, a member of the police must ensure that all the necessary paperwork is filled in before moving evidence (e.g. when transporting kits with body samples for forensic analysis).

Alleged perpetrators have to be medically examined so as to examine their bodies for traces of evidence. The police have a duty to ensure that once the suspect has been located, that he is taken to a healthcare professional. Body samples (including a control sample) have to be taken. The police must ensure that all visible injuries on the suspect are recorded and that a J88 is completed by the healthcare professional. The samples must then be sent for forensic analysis within 30 days.

The police have an important role to play in giving the victim some insight into what will happen at court. This is critical as the experience of going to court is likely to be intimidating and consequently to cause anxiety. If the victim is well prepared, this impacts positively on the quality of testimony presented. In preparing the victim, it is important to explain court postponements and how this might impact on the victim, and to encourage the victim to persevere notwithstanding the frustration that a postponement might cause. The investigating officer is also expected to take an impact statement from the victim. This speaks to how the sexual offence has impacted on the victim's life. The impact statement can also be supported by impact statements from other relevant role-players, such as social workers, psychiatrists and psychologists. The investigating officer must also explain that the victim has the option of giving evidence in camera. In order to prepare the victim for court adequately, the investigating officer should take the victim to court before the case is heard. A pre-trial consultation should be arranged between the prosecutor, the investigating officer, the victim and any witnesses. Witnesses must, however, be kept separate from each other and from the victim. This meeting, which often does not happen in practice, is critical to preparing for a case properly and for allaying any fears and concerns that the victim might have. Mostly, it gives the victim an opportunity to visualise the environment and to meet the prosecutor. Close to or on the day of the trial, the victim must be given a copy of the statement to be reminded of its contents.

Reflections on the role of the police

Family, Violence and Child Protection Units

The feedback from the research interviews highlighted both the areas in which the police are fulfilling their role in providing an effective service to victims of sexual offences as well as the areas where they are not. The Family, Violence and Child Protection Units (FCS units) are mandated with police crimes relating to family violence, children and sexual violence. The FCS units were established in 1995. By 2006, there were 66 FCS units nationally, with an average of 22 police members attached to each FCS. These were located in police stations and for this reason, the services that were provided were not the same across the country. In 2006, following restructuring in the police, a political decision was taken to disband the FCS units. In 2011, following significant public outcry, the FCS units were reintroduced on the basis of the fact that they played a critical role in developing targeted expertise in family violence. By May 2014, SAPS reported that it had 176 FCS units servicing 1 135 police stations, countrywide.[32] The provincial breakdown is depicted in the table below:

Table 2: Number of FCS units by province[33]

Province	No. of FCS units
Free State	18
Gauteng	22
KwaZulu-Natal	25
Limpopo	16
Mpumalanga	15
Northern Cape	16
North West	12
Western Cape	25
Eastern Cape	27
Total	176

Within the context of high levels of violence against women and children, the number of FCS units is clearly not adequate. The FCS units nationally employ a total number of 2 529 SAPS members.[34] This comprises both detectives responsible for the investigation of cases and social workers specialising in forensic work. The generic training offered to SAPS members at the FCS units includes training in domestic violence, resolving crime, and a sexual offences programme. Specialised courses offered include a detective learning programme and a forensic social work programme. In practice, sexual offences are dealt with by the FCS units, domestic violence is generally dealt with by police stations. The interviews with an FCS unit raised the issue of resource constraints within which the unit has to operate. Budgets are tight and the FCS unit has to operate within a constrained fiscal environment.[35] This highlights the fact that the units should be adequately resourced so as to enable effective service delivery. The FCS unit interviewed, for example, had no email facilities at the time of the interview. This is a basic functioning tool that could enable detectives and staff to communicate more effectively and in so doing, contribute towards providing better services. Work done by the Women's Legal Centre in interacting with the FCS units brings to the fore the fact that FCS units are challenged by high a staff turnover. This is in part due to the fact that the units are under-resourced, that some of the investigators employed by the units do not necessarily want to be located within them and that investigators working only on sexual offences and family violence matters face significant levels of secondary trauma.[36]

The FCS unit interviewed employs 11 investigators, two of whom are women. It covers a station area of an estimated 1.2 million people. The unit is located away from the police station, which seems to have had a positive impact on service delivery.[37] The fact that the team exists as a separate unit facilitates the development of specialist expertise in dealing with sexual offences. When a victim reports a sexual offence at the police station, a SAPS officer from the police station will start taking the initial statement while they wait for a member of the FCS unit to arrive. The FCS unit does not give the victim the option of having a man or a woman take down the statement, given that it employs only two women. However, if the victim specifically requests a woman police officer, then this is catered for. Someone from the FCS unit will then escort the victim to the TCC and this time is used to start building a relationship with the victim. If the victim chooses to report to a private doctor, then this is allowed, but the FCS notes that this significantly complicates the process.[38] This is because the likelihood of the chain of evidence being compromised is greatly increased. If the process at the TCC takes less than an hour, then the FCS unit staff member will stay with the victim. If, however, it takes longer than this, then the victim will be left at the TCC. There is much overtime work entailed in dealing with sexual offences cases. Investigators are, however, reluctant to claim this, as the process is a tedious one that involves much red tape. TCCs usually create two case files. The first is a hospital folder, which contains clinical information, which is strictly confidential unless requested by a court if the matter goes to trial. The second file contains a copy of the victim's statement, a copy of the front page of the police docket, the SAPS 308 consent form and a copy of the front page of the hospital folder, which shows the folder number. This ensures that if the SAPS docket is lost that the information can be reconstructed. A clinical forensic doctor noted that because of this, there had never been an instance, in his experience, of a docket not being located.[39]

The experience of Rape Crisis is dealing with FCS units is that the detectives within the units are working hard under very difficult circumstances. [40] Most are severely traumatised because of working on sexual offences cases and many opt to not go for debriefing. Rape Crisis noted that there are pockets of excellence within the police and that where the police work closely with TCCs, this seemed to have a positive impact on the processing of sexual offences cases. A serious challenge facing the police is a high workload and the fact that they are unable to cope with the demands placed on them.[41]

Collation of data

One of the significant problems on the part of the police has always been the collation of data on sexual offences. While it is estimated that most sexual offences go unreported, given the associated trauma and stigmatisation entailed, it is critical that SAPS improves upon its ability to collate information on the reported cases reliably. There are many different types of sexual offences, such as rape; compelled rape; indecent exposure; incest; sexual exploitation of children; sexual grooming of children; compelled witnessing of a sexual offence; bestiality etc. SAPS, however does not distinguish between different categories of sexual offences. Without disaggregated data in this regard, it is not

possible to examine trends in terms of the categories of sexual offences. In addition, SAPS statistics do not factor in women who are killed as a result of a sexual offence. Such cases are collated only as murder cases. It is therefore necessary to look at the statistics in the context of other statistics such as femicide, domestic violence, assault and assault with the intention of doing grievous bodily harm to elicit a more holistic picture of the extent of violence against women.

Recording of sexual offences cases

There have been significant challenges in documenting sexual offences cases. One such challenge has been the fact that the quality of statements taken from sexual offences victims is generally very poor.[42] In addition, the police have shown poor discretion in deciding which type of charge to lay against perpetrators,[43] refusing to allow victims to lay charges, not allowing victims to lay charges in private and making victims repeat their statements to many different officers, and not allowing women to make supplementary statements as is provided for by the National Instructions on Sexual Offences.[44] A clinical forensic doctor who has experience of working in California noted that the system there entailed the clinical forensic doctor and the police sitting in a designated area in the hospital with the victim to take down the statement. The police official conducts the interview while the doctor takes notes. This avoids a situation where a victim ends up having to tell her story several times.[45] The Thuthuzela Service Care Model advocates that victims should not give statements at the charge office of a police station. Instead, the statement should be taken once the victim has received initial counselling, has been medically treated and had a chance to shower and change clothes. When this is the case, the quality of the statements taken are far superior to those taken when the victim has not had access to basic services. This practices happens in some instances, but is not always the case.[46]

Processing of sexual offences cases

The processing and investigation of sexual offences cases must be located within the broader context of the police's overall detection rate for serious crimes, which was at 38.1 per cent in 2013/14.[47] The goal over the course of the Medium Term Strategic Framework[48] is to improve this and increase it to 41 per cent in 2017/18. As can be seen from this, the overall detection rate of serious crimes is poor and requires significant improvement. The processing of sexual offences cases is often inconsistent and riddled with problems. This ultimately impacts negatively upon the preparation of a case for court. As has already been mentioned, in 2011/12 10.7 per cent of the total number of reported sexual offences cases went to court.

The NPA will not take a case to court if there is not a reasonable chance of securing a conviction. The investigation done by the police plays a critical role in determining whether or not a case goes to court. Research has attested to the fact that the police take a long time to arrest a perpetrator from the time of the reporting of a sexual offence, that the quality of detective work has generally been poor and that the police are largely inaccessible to victims of sexual offences.[49] Victims mostly do not have access to information pertaining to their case, the progress made with the investigation and generally have no control over the police's collation of evidence in this regard.[50]

The police have also not delivered on their mandate in terms of preparing victims for court. Poor communication with victims contributes to a situation in which victims are mostly unprepared for going to court.[51] Court preparation is also done by Court Preparation Officers, but not all courts have them. The NPA reports that there is a high demand for court preparation services and that there has been a considerable increase in requests from prosecutors for the creation of additional court preparation posts. Since 2001, 140 Court Preparation Officers have been appointed nationally. Court preparation services are only provided at 140 courts across the country. Given that there are 476 district courts and 567 regional courts, this does not begin to cover the demand for such services.[52]

The interview with an FCS unit revealed that less than a third of an investigator's time is spent communicating with the victim. Most of the investigator's time is spent in liaising with the courts.[53] The Women's Legal Centre noted that often, court preparation happens on the day of the trial.[54] This is something that needs to shift as ongoing liaison with the victim has the potential to impact on the case positively. The chances of securing a conviction are greatly enhanced with adequate court preparation.

The police have also been known not to follow the policy provisions in terms of explaining the process from the time of reporting a sexual offence to the time that it goes to court. A study done by Rape Crisis and the Women's Legal Centre found that just over a third of sexual offences victims who participated in the study had the procedure for lodging a sexual offences complaint explained to them.[55]

Collection of evidence

Research has shown that the police have been inefficient and negligible in collating evidence in sexual offences cases. Often, there are delays in taking statements from victims; at times, no statements are taken from witnesses, the contact details for victims and witnesses are not recorded and the police do not facilitate the victim's access to a forensic examination.[56] The police have also been known not to process kits expeditiously and not to follow up with forensic laboratories regarding the analysis of the kits. Often, the kits 'sit in closets, don't go anywhere and at times, they get lost'.[57] When kits are processed, the chain of evidence is at times compromised.[58] This can happen if the related paperwork is not signed and filled in each time that the kit is moved. In such instances, the evidence is considered to have been contaminated and cannot be used.

There have also been claims that the police often do not investigate the scene of the crime. In sexual offences cases, both the body of the victim and the location where the sexual offence took place are regarded as crime scenes. In practice, the victim's body is tested for evidence, but the crime scene is mostly not investigated.[59] When the crime scene is investigated, this is at times poorly done as the first respondents on the crime scene are often not trained and have been known inadvertently to interfere with the scene of crime.[60] A case manager at a TCC recounted a story of a woman who was raped. The perpetrator removed her panties and threw them behind the stove. Despite the victim telling this to the police, they were not retrieved for DNA testing.[61]

An interview with an NPA official revealed that the NPA had in the past been fighting an ongoing battle with the police with regards to the police sending off kits for analysis. The NPA official interviewed noted that the practice was to only do buccal swabs or a blood test on the perpetrator if sperm had been detected. However, the police were meant to do this regardless of whether or not sperm had been detected. In one instance, a warrant for arrest was issued 17 years earlier, but the police had failed to act on this.[62] The promulgation of the Criminal Law (Forensic Procedures) Amendment Act (Act No. 37, 2013) addresses this problem to some extent as it now prioritises the analysis of crime scene samples,[63] if there is a suspect. All samples received at forensic laboratories must be sampled and the resultant profiles loaded onto the National Forensic DNA Database (henceforth 'the DNA database'). The Act further recognises the value of loading crime scene profiles onto the DNA database in instances where there is no suspect. This allows the police potentially to link cases that may be seemingly unrelated. In instances where the perpetrator is known to the victim, it is technically easier to locate the perpetrator, although in practice, there are significant problems in this regard. Where the perpetrator is unknown to the victim, an estimated two out of every 100 men are found.[64] If the perpetrator is not identified, the case is then closed as undetected. For this reason, it is critical that the police collate evidence, based on the statement of the victim, in an expeditious and responsible manner.

Establishment of a DNA Database

Section 15(g) of the Criminal Law Forensic Procedures Amendment Act makes provision for the establishment of the DNA database. This was a groundbreaking development as a criminal investigative tool. The DNA database allows for the DNA profiling of arrestees and convicted criminals, including offences convicted before the promulgation of the Act. The DNA database will serve to create a record of the DNA profiles of all crime scene evidence submitted to the forensic laboratories for analysis as well as convicted criminals, arrestees and other persons of interest to an investigation and will enable comparative forensic DNA searching across all indices. The Act provides for the creation of a crime scene index,[65] an arrestee index,[66] a convicted offender index,[67] an investigative index,[68] an elimination index,[69] and a missing persons and unidentified human remains index.[70]

In instances where the sexual offence was committed by a perpetrator unknown to the victim, and DNA is found, it is possible to trace the perpetrator through the database. Tracing unknown victims

usually takes a considerable period of time.[71] The DNA database has the potential to address this in future if a perpetrator already has a profile on the database. At the time of writing, there were an estimated 320 000 profiles on the database and it is hoped that approximately three to four million profiles will be added over the course of the next five years.[72]

One key challenge pertaining to taking buccal swabs is that the police are still being trained in how to do this. The interview with the DNA Project revealed that 6 000 detectives have already been trained and it is envisaged that a further 25 000 will be trained by the end of March 2016.[73] Because of this, the police are still using clinical forensic doctors to take buccal swabs.[74]

The role of the healthcare practitioner[75]

Before the medical examination, sexual offences victims will ideally receive counselling first so as to assist with emotional containment and to prepare them for the medical examination. The examination is an invasive procedure and can exacerbate the sense of trauma if the victim is not adequately prepared for it. Usually counselling is provided at the TCC by counsellors either employed by the Department of Social Development[76] or provided directly by NGOs. From a cost perspective, it is important to note that the cost of counselling services is mostly borne by the NGO sector.[77] In most instances, no counselling is provided on site. Victims are provided with the contact details of off-site NGOS that provide counselling services. In such instances, it has been noted that when no counselling is offered on site, sexual offences victims are not likely to come back for follow-up medical visits. Once the victim has been counselled, a nurse will usually prepare the victim for the medical examination. The medical examination is two hours in duration. The procedure is a thorough one and entails both the actual examination and the filling in of the related paperwork. The purpose of the medical examination is to:[78]

- Meet the immediate needs of the victim with crisis intervention and support services;
- Provide an effective, sensitive approach to victims of sexual offences; and
- Assist the police in conducting an investigation of the crime by documenting and preserving evidence for the prosecuting of the alleged sexual offender.

When the victim is taken to the healthcare practitioner, the police deliver the Sexual Assault Evidence Collection Kits (hereafter 'the kits') to the healthcare practitioner for the collection of forensic evidence. However, this is only done if the case is an acute one. The FCS unit in Mitchells Plain clarified that acute sexual offences are those that had been committed within three days from the period of reporting. The kits consist of specially designed swabs and plastic bags for collecting and storing evidence such as hair, saliva, clothing fibres, blood, semen and body fluid that may assist in identifying a perpetrator in a criminal trial. While forensic evidence is taken for sexual offences committed within the past three days, it is technically possible to detect DNA for up to ten days after the sexual offence.[79] If, for example, the victim had not washed or douched, then it might still be possible to detect DNA. The discretion for taking DNA samples resides with the healthcare practitioner. Kits are kept by the police and not the healthcare practitioners, as this is part of the process of securing the chain of evidence.

The healthcare examination begins with a recording of the relevant medical history and medication of the victim so as to record information about physical well-being. The details of the offence must then be described in full. In many instances, the victim will not fully convey the details of the offence as it is not a sworn statement. When this information is inconsistent with the formal legal statement given to the police, it can be used in court to discredit the victim.[80] A clinical forensic doctor interviewed noted that it is usually very hard to get the victim to be focused. Given the trauma they have experienced, most victims find it difficult to relay what happened to them coherently. One doctor noted that in his experience of treating sexual offences victims over a course of 15 years, it always took more than two hours to treat the victim and get her to relay what had happened to her.[81] If the healthcare practitioner is male, then a female nurse must be present (if the victim is female) and must present a running commentary of everything that is done so that the victim understands every part of the process and consents to each part of the examination. Informed consent to the examination is critical and the required form (SAPS 308) must be completed prior to the examination.

After relaying how the sexual offence took place, the healthcare practitioner will record things such as the victim's general body build, mental health and emotional status. Body build, including weight and height, is sometimes used (problematically so) to argue whether or not a victim could defend herself. Clinical evidence of drugs or alcohol and the condition of the victim's clothing is also noted. This is followed by taking down the clinical history of information relevant to the sexual offence. This includes age of menarche, number of pregnancies, number of deliveries, contraception history, date and time of last intercourse with consent, number of consensual partners in the last seven days and whether or not the victim has bathed, showered or urinated since the offence. In the case of women victims, a gynaecological examination is conducted and for men, the genitalia are examined. An anal examination is done for both sexes to look for things like abrasions, swelling, fissures and discharge. The healthcare practitioner records all the samples taken for forensic evidence purposes. The following samples should be collected:[82]

- Oral specimen;
- Clothing collection;
- Evidence on victim's body;
- Fingernails;
- Saliva on skin;
- Semen or other stains on body;
- Head hair;
- Public area specimen;
- Ano-rectal specimen;
- Genital specimen; and
- Reference blood sample.

The medical examination must offer treatment of all physical injuries, treatment of STIs and other infectious diseases, and AIDS prevention, and must also offer a pregnancy risk evaluation. The healthcare professional must adequately complete the required documentation, including the J88 form, and must draw conclusions about the sexual offence based on the examination and the narrative of events as told by the victim. It is critical that the components of the different kits not be swapped, that each item in the kit is barcoded and that the evidence is securely packaged. It is imperative that the healthcare practitioner takes care to avoid cross contamination of biological substances (including his/her own). In the case of sexual offences against adults who are not elderly, there is no statutory obligation on the part of the healthcare practitioner to report a sexual offence.[83] As regards sexual offences against minors, the healthcare practitioner must report the case given that legally, children under the age of 16 years cannot consent to sexual intercourse.[84] If an adult victim decides to report to the police, then the kit is transferred by the police to a forensic laboratory. If the victim decides not to report, then the kit must be securely stored for a minimum period of six weeks. Ideally, the information should be handed over to the police immediately after the examination. The dispatching of the forensic medical samples may only be done by the police. The final collation of evidence will include not only the biological samples, but also a record of physical injuries, the psychological status of the victim, photographs and diagrams as required.

Post Exposure Prophylaxis (PEP) must be provided to all HIV-negative patients who present within 72 hours of a sexual offence if the victim came into contact with the blood, semen or vaginal fluid of the alleged offender. If the victim gives consent, the healthcare practitioner has to take a blood sample for a rapid HIV test. This may be done at the initial examination or after three days if the victim so chooses. If the first test is positive, then this must be confirmed with a second rapid test and must be followed up with a laboratory enzyme-linked immuno assay (ELISA) test to detect antibodies in the body. Counselling on the use of ARVs, their side-effects and the importance of follow-up testing must be given to the victim. A three-day starter pack of PEP must be offered to victims who prefer not to test immediately as well as those who are not ready to receive results immediately. While PEP is given to victims who choose not to undergo an HIV test, it must be explained that if the victim is already HIV-positive, then PEP may complicate their ARV treatment in future. The rest of the treatment is usually given once the HIV status of the victim has been confirmed as negative. In the case of victims

who are unable to return for the one-week assessment,[85] a 28-day treatment supply must be provided. In cases where the sexual offence took place more than 72 hours earlier, it must be explained to the victim that there is no evidence that PEP will have an impact if taken more than 72 hours after exposure. The victim must be made to understand that there is a possible risk of HIV infection and general counselling must be provided. Victims who test HIV positive must be referred for long-term HIV and AIDS care. While on PEP and until the three-month visit showing that the victim is HIV negative, the victim must be advised to use condoms with all sexual partners. Condoms should be provided by the healthcare practitioner. Emergency contraceptives, together with an antiemetic, should be provided to all girls and women of reproductive age who present within five days of the sexual offence.

Urine is collected for a pregnancy test from women who are of childbearing age. The product of conception from a sexual offence should also be collected either at birth or after an abortion. This is done using the Human Tissue Collection Kit. Over and above the verbal explanation, victims should be given clear written instructions about taking medication. The victim should also be given information about ongoing counselling support such as access to NGO support services, rape crisis centres, shelters and safe houses, and termination of pregnancy services. A clinical follow-up visit should be scheduled for after one week, six weeks and three months. These are used to provide the results of the HIV test, results of ARV for HIV-negative victims, assessment of the general state of health and emotional and psychological well-being, as well as completion of medication.

Until such time as the trial takes place, access to the information collected in the J88 is confidential and is accessible to the investigating officer and the Department of Justice and Constitutional Development. Defence lawyers may have access to the information after having obtained a court order from the magistrate or prosecution.

Reflections on the role of the healthcare practitioner

Is the collection of DNA a problem or not?
There have been no clear findings on the extent to which forensics is a factor in securing convictions. This is an area of research that requires further study. The interview with the DNA Project[86] revealed that forensics is an important criminal intelligence tool and that there are instances where the collection of DNA has been problematic and has indeed been a factor in not securing convictions. In its work, the DNA Project has found instances of clinical forensics healthcare practitioners not collecting the evidence properly and this leading to the contamination of evidence.[87] The DNA Project partly attributes this to the fact that there is often no proper training put in place for clinical forensic healthcare practitioners. While the extent to which forensics is an issue is not entirely clear, it is important to note that of 64 514 sexual offences reported in 2011/12, only 6 913 went to court and of these 4 501 resulted in convictions. The question then becomes, why are 57 601 cases falling through the cracks? In an interview with the National Prosecuting Authority (NPA), the respondent noted that 'If we feel that a case won't win, we won't proceed. If there is no corroborating evidence, then it becomes a case of his word against her word'.[88] This clearly suggests that if there is no evidence, then the case is not likely to even make it to court, a strong imperative for ensuring that forensic evidence, where it can be extracted, to be done so properly and in a way that can corroborate a case. The criterion for instituting a prosecution is that the case is a 'prima facie case' and not one with a 'probability of securing a conviction'. The NPA should prosecute if they have a prima facie case and not one that has a high chance of probability of securing a conviction.

It is important to note that South Africa is not the only country to experience problems with securing DNA evidence to prosecute sexual offenders. In the USA, a 2011 report[89] showed that there were serious problems in several states in analysing forensic material in sexual offences cases. One such issue was the backlog and delay in DNA analysis, which resulted in additional victimisation of the victims involved. The report indicated that 18 per cent of all unsolved sexual offences between 2002 and 2007 were as a result of forensic evidence still being in police custody and not been submitted to a laboratory for analysis. The report further found that 43 per cent of law enforcement agencies did not have a computerised system for tracking forensic evidence, either in their inventory or after it was sent to a laboratory for analysis. Further, on average, an estimated 50 to 60 per cent of kits tested positive

for biological matter that did not belong to the victim. At one point, 17 000 untested rape kits were found in New York and were eventually eliminated.[90] Victims are often not updated as to the status of the analysis of their kits and are not kept abreast of the exact reasons for backlogs and delays.

Problems with Sexual Assault Evidence Collection Kits

At the time of the interview with the TCC in Manenberg, there had been no kits for adults for a period of about 12 months. This was addressed by using kits intended for children. While it is possible to collect forensic evidence in this way, it is not ideal. An interview with DNA Project[91] pointed out that because the physiology of a child is different to that of an adult, the swab sizes for the collection of evidence would be smaller. Three clinical forensic doctors attested to the problems with the change in developing several kits for the collection of evidence. In the past, one rape kit was used to collate the samples for forensic evidence. However, to cut costs, this was replaced with seven different rape kits. The cost of the initial kit was an estimated R280.00.[92] When a kit is opened and not used, it has to be discarded. The rationale for introducing seven rape kits was essentially a cost-cutting measure as healthcare practitioners do not always use everything in the kit. The idea was to create separate kits so that only those that are needed are opened as opposed to wasting some of the material that is not required. The problem that has since emerged is that in most instances when a victim is about to be medically examined, the police will bring the first kit only. Doctors interviewed expressed the view that if 'they were lucky', they might get three kits. Very rarely, however, are all seven kits delivered. The doctors are then only able to take samples in terms of what they have been provided with. This is problematic in the sense that it potentially limits the evidence of what can be sent for forensic testing. In one instance, a doctor recounted a story of a victim who had died after being raped. In this instance, only the first rape kit had been sent for samples. By the time that this had emerged, it was too late to take additional samples as the body of the victim had already been autopsied and washed.

However, the interview with the DNA Project[93] pointed out an important reason for using several different kits. In the past, a problem had been experienced with the cross contamination of evidence and the incorrect usage of different parts of the kit on the part of the healthcare practitioner – for example, using the nail pick for scraping debris from beneath the nails for an ano-rectal specimen. The separation of the kits into different sub-components is a useful way of addressing this problem, but only if all the different kits are made available to the healthcare practitioner. Given the contestation on this issue, it clearly emerges as one that needs to be further discussed and addressed by all the role-players.

Securing evidence that can lead to conviction

As has already been mentioned, most reported sexual offences cases do not result in convictions. Based on the research interviews conducted, the following six key issues emerge in relation to evidence:

1. Difficulties in securing DNA evidence

In reality, most sexual offences cases are reported long after the period within which it is possible to extract DNA. In instances where a sexual offence is reported a while after it had taken place and the victim has washed, it becomes very difficult to secure forensic evidence. A clinical forensic doctor interview recounted a story of a woman who had been raped but was afraid to tell her husband.[94] Seven days after being raped, she told her husband and went to report the case. By this time, she had washed several times and it was not possible to find DNA evidence. It can also be very difficult to extract forensic evidence if the perpetrator did not ejaculate in or on the victim's body. Even if semen is located, there are situations where 'there is not enough' for forensic analysis.[95] The clothing of the victim is also an important potential source of securing DNA evidence. In many instances, however, the police do not send the clothing away for forensic analysis. In a recent, publicised rape case in Grabouw, the family of a fourteen-year old girl complained that the police did not investigate the scene of the crime where torn clothes and a wire used to tie up the girl were left at the scene. The police did not send the clothing of the victim for analysis.[96]

2. Contamination of the DNA evidence

Healthcare professionals have a responsibility to defend the rights of victims through the effective collection, documentation and preservation of forensic evidence.[97] At times, evidence is compromised

by poor completion of the J88,[98] by not following the proper process for securely passing evidence from one custodian to another[99] and by cross-contamination of biological substances.[100]

3. Delays in securing results of forensic analysis

South Africa has four forensic laboratories nationally. These are located in Cape Town, Pretoria, Durban and Port Elizabeth. Of these, only two do forensic analysis, while the other two focus on preparatory work. In 2012, the forensic laboratories have an estimated 6 930 staff.[101] Data from 2011/12 shows that of the total cases received by the biology units of the laboratories, more than 50 per cent were related to rape and murder cases.[102]

In terms of the Criminal Law Forensic Procedures Amendment Act (Act No. 37 of 2013),[103] body samples and crime scene samples must be analysed and loaded on to the National Forensic DNA Database within 30 days of being received unless there is a compelling reason why this timeframe cannot be adhered to. It is too soon to tell whether the Act has made a significant difference, but in the past, most cases were held up by lengthy periods of time. An interview with the NPA[104] noted that the preliminary results are meant to take about a week and a final result should be procured within about 30 days. In practice, however, the NPA official indicated that it takes about four months to get results back and in some instances, up to nine months. The NPA official noted that the NPA constantly has to question the forensics laboratory about when results will be available and showed several email exchanges between the NPA and police, repeatedly requesting that forensic analysis is expedited. The impact of the Act in terms of addressing this situation will need to be monitored to assess the extent to which the time delays are addressed in practice.

SAPS has made a concerted effort over the course of the last few years to reduce the backlog of cases held up in forensic laboratories. SAPS data in this regard for 2010/11 shows that 77 per cent of evidence is generally processed in a 28-day period (this against a target of 92 per cent). This follows significant improvement where backlogs in forensic analysis cases lodged at laboratories were reduced by 30 per cent in 2011/12. This was followed by a reduction of 60 per cent in terms of a decline in backlogs from 2009/10.[105] From this data, it becomes evident that the forensic laboratories were clearly performing very poorly in terms of timeously analysing forensic evidence prior to 2009.

4. Looking at evidence holistically

A dilemma in many sexual offences cases is that much emphasis is placed on securing evidence. At times, this is at the expense of the testimony of the victim. It is critical that the victim's account of what transpired becomes the primary focus and that this is what informs service delivery. This is important as even in instances where DNA evidence is detected, cases are not always cut and dried as there is always the chance that the perpetrator will claim that the sex was consensual. For this reason, it is important to document all other related evidence. The victim's statement is the primary focus and is examined in conjunction with her physical and emotional state.

5. Challenges involving children

All the doctors interviewed noted that children constitute about a third of the sexual offences cases that they treat. In most cases, the perpetrator is someone known to them. In cases involving children, the consensual sex argument cannot be used and the presence of DNA is therefore more likely to result in a conviction. The complication here is that the medical examination is particularly traumatic and invasive for children. Children can be anaesthetised for the examination if this is preferred by the parents/guardians. An additional challenge is the fact that most children do not report within a 72-hour period. Most report long after the occurrence of the sexual offence. This is largely because they are not likely to report on someone in their home, family or extended family.

Research has shown that definitive medical evidence is mostly not forthcoming in the overwhelming majority of sexual offences cases involving children.[106] It is possible for children to be sexually abused and leave no discernible physical trace due to the rapid healing of injuries on children. Research has further shown that sperm, semen and blood on a child's body are unlikely to be identified after a 24-hour period.[107] In a study of 36 pregnant adolescents who presented for sexual abuse evaluations,

it was found that penetration during sexual intercourse with a child does not necessarily result in visible tissue damage and that acute injuries had often healed completely by the time of the examination.[108] Definitive medical findings will only present in a minority of all sexual abuses cases against children. The child's testimony should therefore be the deciding factor in determining the nature of the abuse experienced.

Of concern is that fact that the DNA Project noted that it appears as if the highest attrition rate is in sexual offences cases against children. In the majority of cases against children, the child kits are not yielding positive DNA results even when there are other signs of physical injury.[109] This is an area that needs to be focused on as a matter of priority.

Two clinical forensic doctors noted that there also seems to be an increase in the number of children who are perpetrators of sexual offences. This too is an issue that needs to be addressed.

6. Infrastructure at clinical forensic units

In the Western Cape, there are clinical forensic units at Victoria Hospital, Karl Bremer Hospital, Khayelitsha Hospital, Helderberg Hospital, GF Jooste Hospital and Mitchells Plain Hospital. Clinical forensic units are generally structurally separated from emergency services. At times, however, the clinical forensic unit is located in the emergency unit of a hospital. This is the case, for example, at the clinical forensics unit at the recently built Mitchells Plain Hospital. Ideally, it is better to locate the clinical forensic units away from emergency services such as in the case of the unit at Karl Bremer Hospital. The rationale for this is that sexual offences victims are usually severely traumatised when reporting for a medical examination. The experience of having to pass through an emergency unit at a hospital can potentially exacerbate this sense of trauma. The interview with Rape Crisis revealed that sexual offences victims have complained that the staff at the trauma units have exacerbated the experience of trauma by being dismissive, aggressive and disrespectful. Often, this is a direct result of their difficult working circumstances where they have to deal with patients who are abusive and violent, and work in conditions where the trauma units are overcrowed and incapacitated.[110]

Clinical forensic units are meant to be operational on a 24-hour basis. This is imperative as many sexual offences cases take place at night. Some clinical forensic units are open on a 24-hour basis, but others, such as the one at Mitchells Plain Hospital, close at 4 p.m. Given that it is best to report a sexual offence case within a 72-hour period, a closed clinical forensic unit would serve as a disincentive to reporting if the victim had to wait until morning to come back.

The clinical forensics doctors interviewed all attested to a general concern in relation to access to resources and infrastructure. For example, the NPA is supposed to provide clothes to sexual offences victims. This is because the clothes worn by the victim may need to be submitted for forensic analysis. Yet, in practice, NGOs take on this role. It is important that after the medical examination the victim is allowed to take a shower and put on clean clothes. The infrastructure and ambience for this must be conducive to making the victim feel comfortable and relatively at ease. Clinical forensic doctors noted challenges in this regard. In one instance, a clinical forensic doctor noted that malfunctioning toilets that were out of order for an extended period of time was an issue of concern, particularly because it had health-related implications.[111] One doctor mentioned that it would be nice, after the examination, to have facilities for the victims to make a cup of tea. Another doctor noted that attempts were being made to elicit sponsorship to buy a camera for the purposes of taking photographs of wounds so that these could be used in court.[112] This is something that is critical and should be provided for without having to resort to sponsorship.

An additional issue of concern was that staff at clinical forensic units were described as being 'skeletal'.[113] Usually, there is one doctor, one nursing assistant and, in some instances, a counsellor providing services through an NGO. The perception is that most doctors do not want to specialise in forensics as it is a difficult, stressful environment within which to work.[114] Because of this, there are very few specialist forensic doctors. In South Africa, the highest qualification that a doctor can attain in this field is a higher diploma in clinical forensic medicine. In other countries, it is possible to study forensics

at a doctorate or masters level.[115] Given the lack of specialists in this field, it is often difficult to find a locum to assist when doctors go on leave or are off duty at night. One doctor noted that it was a significant source of frustration and a big challenge to get doctors, even general practitioners, to stand in.[116] General practitioners are reluctant to assist as they are not inclined to want to spend long periods of time giving testimony in court. Added to this challenge was the fact that general practitioners were not specialists in forensics and that this was not ideal in terms of their expertise in extracting forensic evidence.[117]

There is also a significant challenge with regards to professional nursing assistants who are able to assist in the clinical forensic units. An assistant nurse has to be present during the course of the medical examination of a sexual offences victim. There is usually not a problem with the provision of this service. However, there is a problem with acquiring the services of professional nurses. This is because the diploma in clinical nursing forensics has not been recognised by the South African Nursing Council. This has been a considerable disincentive in getting nurses to specialise in forensic nursing.

Attachment of clinical forensic units to Thuthuzela Care Centres

Some clinical forensic units are not attached to a TCC. At the time of the research interview in July 2014, the clinical forensic unit at Victoria Hospital was not attached to a TCC. This was a significant shortcoming as the hospital services a catchment area of 23 police stations including Wynberg, Muizenberg and Milnerton. This has since been addressed and a TCC has been established with funding from the NGO sector. However, because the NPA has not invested funding in this TCC, it is currently operating without a case manager. This is not ideal as case managers play a significant role in coordinating sexual offences cases. Where a clinical forensic unit is not attached to a TCC, sexual offences victims are provided with a list of NGOs and are referred for counselling after the medical examination. Ideally, some counselling should happen before the examination to prepare the victim. It is estimated that when the TCC is not on site, about ten per cent of victims end up going for counselling.[118] Given that psycho-social support is critical to the ongoing health and well-being of sexual offences patients, it is critical that there is easy access to counselling in the form of a one-stop centre. Failure to provide this can result in secondary trauma. A clinical forensic doctor interviewed pointed out that when there was no counselling offered on site, this was also a significant disincentive for patients to come back for their follow-up medical examinations.[119] Sexual offences victims are meant to return for a follow-up examination after a week, at which point they are given more mediation. In instances where the doctor suspects that a patient is not likely to return, she/he might take the decision to provide the patient with medication for a month.[120] The following table depicts a breakdown of TCCs and Khuseleka One Stop Centres by province: [121]

Table No 3: Number of TCCs and Khuseleka One Stop Centres by Province

Province	No. of TCCs	No. of police stations using the TCC	No. of Khuseleka One Stop Centres	No. of police stations using Khuseleka One Stop Centres
Eastern Cape	8	53	3	23
Free State	4	36	0	0
Gauteng	7	90	0	0
KwaZulu-Natal	8	63	0	0
Limpopo	6	35	1	97
Mpumalanga	5	29	0	0
Northern Cape	4	25	0	0
North West	5	31	2	13
Western Cape	5	57	0	0

As can be seen from the table above, the number of TCCs is not adequate. In total, there are 52 TCCs servicing 419 police stations. In Gauteng, for example, there are seven TCCs servicing 90 police stations. However, the far bigger crisis is the lack of adequate service provision in rural areas.

Rape Crisis is of the view that this could be addressed with mobile units that provide all the services offered by TCCs. The mobile unit could serve a predetermined geographic area and could be dispatched on a needs basis.[122] TCCs are meant to operate on a 24-hour basis given that most sexual offences cases tend to take place at night and mostly over weekends. There also appear to be more cases in winter and in December at the TCCs visited.[123] There are six Khuseleka One Stop Centres that are operational in only three provinces. The rationale for the existence of a TCC and Khuseleka model is not entirely clear. The TCCs are an initiative of the NPA and the Khuseleka One Stop Centres are an initiative of the Department of Social Development. This an example of different departments pursuing different initiatives as opposed to joining forces to support one model of best practice. The Women's Legal Centre pointed out that the TCC model has been recognised as one that works and that it would be best to pursue this model and desist from rolling out competing models that fall under a different set of strategies. The fact that there are so few TCCs and that the model relies so heavily on donor funding is a cause for concern and is indicative of the lack of priority attached to gender-based violence by the state.[124]

Recommendations

FCS units

There is an urgent need to ensure that the FCS units are adequately resourced and capacitated and that there are enough FCS units in each province. This includes basic infrastructure to enable them to provide services effectively, but also should include a monitoring mechanism for ensuring that training provided to investigators is targeted and effective. The low morale in the FCS units needs to be investigated with a view to developing a plan in this regard. A plan should also be put in place to ensure that more women are employed as investigators in FCS units. Clear goals should be developed in this regard.

Collation of statistics

The police need, as a matter of urgency, to start recording different types of sexual offences reported on the CAS system. The prevailing uncertainty as to how to categorise different types of crimes involving violence against women must be resolved. A mechanism must be put in place for monitoring the capturing this information and for addressing problems in this regard. Ideally, statistics could be released within shorter timeframes, as opposed to on an annual basis. In order to understand the trends and patterns properly, the police should map sexual offences geographically and this data should be updated on a continuous basis. Since 2013, SAPS has not reported on crime statistics for murder, assault with the intention to cause grievous bodily harm or common assault by gender. This is a problem as violence against women must be looked at in the context of these statistics.

Processing of sexual offences cases

There is a need for more structured and regular monitoring of the implementation of the National Instructions on Sexual Offences in terms of service provision to sexual offences victims. Attention needs to be paid to addressing the poor quality of statements taken, treating victims with empathy and professionalism and adequate court preparation on the part of the police. Monitoring is required of police collection of evidence specifically as it relates to investigating the scene of the crime, committed follow-up with victims, location and interviewing of witnesses, and preservation of the chain of biological evidence. In addition, there is a need to monitor and ensure that there are no backlogs in processing forensic evidence and that this happens within the requisite 30 days. The training of the police in taking buccal swabs must be monitored and this function should be taken over from the healthcare practitioners. The issues pertaining to whether or not there should be one or seven crime kits should be resolved as a matter of urgency. If the current option of seven kits is deemed to be more cost effective and more effective in preventing the contamination of evidence, then there must be a process for ensuring that healthcare practitioners are provided with all the kits that they need. The process of rolling out the DNA database must be monitored as well as the effective implementation of the Criminal Law (Forensic Procedures) Amendment Act.

Tracking of cases through the criminal justice system

There is a need to track sexual offences cases in the criminal justice system. There is no system in place that is able to track a single case in the police, health and court systems. There is a need for a centralised system in this regard with each case having a single tracking number that applies to all the different service providers. This should be available on a computerised system that links health, police and court services and provides updated information on where a case is at a given point in time. So, for example, if DNA evidence has been sent to a forensic laboratory, then this is duly recorded on the system with the date of the expected return of results.[125]

Budgeting

Budgeting for all service provision, infrastructure and operational costs should be ring-fenced within the overall SAPS vote for police-related services and within the vote of the Department of Health for health-related service provision. Without transparent budgeting, it is impossible to track what is being spent to give effect to policy and legislation aimed at addressing violence against women.

Improving accountability in the police

There is a need to ensure the proper functioning of the structures mandated with both internal and external accountability in the police, namely the Civilian Secretariat, the Independent Police Investigative Directorate and the National Inspectorate. Citizen complaint mechanisms must be strengthened and there must be a clear, targeted strategy for communicating complaint mechanisms to sexual offences victims. In addition, there needs to be greater public awareness of the rights of victims and the minimum standards that can be expected in terms of service delivery must be enforced. There must be a zero-tolerance approach to police officers who are perpetrators of domestic violence and sexual offences: police officials guilty of such violence should not continue to serve in SAPS.

Training

Training of both SAPS officials and healthcare practitioners must be effective and targeted. Appropriate resources must be made available for training and the budget in this regard must be ring-fenced. There must be strict minimum standards for training and the efficacy of training programmes must be externally monitored and evaluated. The issue involving the non-recognition of the qualifications of forensic nurses must be resolved as a matter of urgency. Doctors who want to study further in forensic healthcare must be encouraged and options for further studying in this regard need to be explored.

Infrastructure at clinical forensic units

Clinical forensic units should not be located in emergency units as this exacerbates the experience of trauma. They should be operational on a 24-hour basis and must be equipped with counselling services at all times. The importance of good quality psycho-social support is imperative to the emotional and physical well-being of victims and in reducing the potential long-term health costs to the state if not properly addressed. From a human rights perspective, the non-provision of adequate psycho-social support is a human rights violation. Clinical forensic units must be adequately resourced so that they create a soothing, nurturing ambience and must be fully equipped to deal with the mental, physical and practical needs of the victim. When clinical forensic doctors are away on leave, plans must be put in place to ensure that medical examinations are only conducted by those with specialist training in forensics.

Thuthuzela Care Centres

All clinical forensic units should be attached to a Thuthuzela Care Centre (TCC). The TCC model has been proven to work well in terms of concentrating all service provision in one place. There is a need to reduce the reliance on NGOs to fund this model through donor funding and the need for a more substantial investment on the part of government. The government should channel resources into this initiative and not create counter-initiatives such as the Khuseleka One Stop Centres. Different line departments need to cooperate to support and strengthen the TCC model.

Sexual offences courts

Research in 2014 showed that the Department of Justice and Constitutional Development had not adequately budgeted for the roll-out of the sexual offences courts.[126] This situation has not changed and must be addressed as a matter of priority.

Cases involving children

Sexual offences cases involving children are particularly challenging in that definitive medical evidence is not forthcoming in the overwhelming majority of cases involving children. There is a need to examine cases involving children within this context.

Endnotes

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28 All crimes are meant to be registered on the Crime Administration System for record keeping.
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30 While it is acknowledged that men too can be victims of a sexual offence, in practice it is mostly women who are victims. For this reason this terminology is used. It does not preclude the fact that men too can be victims.
31 The chain of evidence entails a secure process of passing evidence directly from one custodian to another. The transfer of forensic medical evidence from one official to another should be recorded by the signature or statement of the recipient. Failure to obtain acknowledgement may result in the rejection of the evidence.
32 SAPS presentation to PC on Police (20 May 2015).
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59 Interview with the Women's Legal Centre (28 May 2015).

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62 Interview with NPA official (1 October 2014).

63 Section 15(h) provides for the establishment of a Crime Scene Index. This contains the relevant forensic DNA profiles derived by means of forensic DNA analysis. This may include samples from the body of the victim or suspect.

64 Interview with FCS unit (4 October 2013).

65 Contains samples that are found and collected at the crime scene.

66 Contains forensic DNA profile of arrestee.

67 Contains forensic DNA profile of person convicted of an offence.

68 Contains forensic DNA profile from a person who has given informed consent.

69 Contains forensic DNA profiles, for example, of police officials investigating the crime, person involved in the servicing of equipment in forensic DNA analysis, any person who enters a laboratory or handles the crime scene samples.

70 Contains forensic DNA profiles of bodily or crime scene sample of missing or unidentifiable persons and bodily or crime scene sample taken from unidentified human remains.

71 Interview with FCS unit (4 October 2013).

72 Interview with the DNA Project (June 2015).

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117 Interview with clinical forensic doctor (24 July 2014).

118 Interview with clinical forensic doctor (24 July 2014).

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121 Khuseleka One Stop Centres are an initiative of the Department of Social Development, through its Victim Empowerment Programme. Similar to the TCCs, they are meant to be a one-stop service centre for women and children who are victims of violence. They are meant to provide trauma counselling, psycho-social support, healthcare, police services, legal assistance and shelter services.

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ABOUT APCOF

The African Policing and Civilian Oversight Forum (APCOF) is a network of African policing practitioners from state and non-state institutions. It is active in promoting police reform through strengthening civilian oversight over the police in Africa. APCOF believes that strong and effective civilian oversight assists in restoring public confidence in the police; promotes a culture of human rights, integrity and transparency within the police; and strengthens working relationships between the police and the community.

APCOF achieves its goals through undertaking research and providing technical support and capacity building to state and non-state actors including civil society organisations, the police and new and emerging oversight bodies in Africa.

APCOF was established in 2004, and its Secretariat is based in Cape Town, South Africa.

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