

Statement of the DGGG – Recommendations on the Care and Support of Female Minors Suspected of Having Been Subjected to Acute Sexual Violence or Rape

Stellungnahme der DGGG – Empfehlungen zur Betreuung und Versorgung von weiblichen Minderjährigen, die mutmaßlich von akuter sexualisierter Gewalt bzw. einer Vergewaltigung betroffen sind



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Key words

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ZUSAMMENFASSUNG

Ziele Die vorgelegten Empfehlungen sollen zur weiteren Verbesserung und Standardisierung der ärztlichen Versorgung von Betroffenen sexualisierter Gewalt, insbes. von einer Vergewaltigung betroffenen weiblichen Minderjährigen in Deutschland beitragen. Sie wendet sich vor allem an Frauenärztinnen und Frauenärzte in der Klinik und in der Niederlassung und ergänzt die umfangreiche Kinderschutzleitlinie der Bundesrepublik Deutschland.

Methoden Unter Einbeziehung der Ergebnisse einer umfassenden selektiven Literaturrecherche wurden von einer interdiszi-

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plinär besetzten Gruppe von Expertinnen und Experten in einem 3-stufigen Verfahren im Auftrag des Vorstands der DGKG diese Empfehlungen erarbeitet und im Konsens verabschiedet. **Zusammenfassung** Diese DGKG-Stellungnahme ist entsprechend dem Alter der Betroffenen (ca. 14 bis 17 Jahre/pubertär; 0 bis ca. 13 Jahre/präpubertär) zweigeteilt. Dies hat medizinische, strukturelle und forensische Gründe. Es werden zahlreiche Empfehlungen zum Umgang mit den mutmaßlich von akuter sexualisierter Gewalt bzw. einer Vergewaltigung betroffenen Minderjährigen, zur Erstversorgung, zu Versorgungsformen (z.B. Vertrauliche Spurensicherung), zur Anamneseerhebung, zur medizinisch-forensischen Untersuchung, zur medizinischen, psychischen und psychosozialen Versorgung sowie zur Nachbetreuung gegeben.

ABSTRACT

Objective The recommendations presented here aim to further improve and standardise the medical care of persons affected by sexual violence, particularly female minors in Ger-

many who have been raped. The recommendations are primarily addressed to gynaecologists working in hospitals or private practices and complement the detailed child protection guidelines of the Federal Republic of Germany.

Method After an extensive selective search of the literature, these recommendations were compiled by an interdisciplinary group of experts in a three-stage process at the request of the Board of the DGKG and were adopted by consensus.

Summary This DGKG Statement is divided into two parts according to the age of the affected person (about 14 to 17 years of age/pubertal; 0 to about 13 years of age/prepubertal). There are medical, structural and forensic reasons for this. The Statement provides many recommendations, ranging from how to deal with minors presumed to be victims of acute sexual violence or rape, to the initial emergency care, type of care (e.g., confidential securing of evidence), how to take the patient's history, the appropriate medical forensic examinations, and medical, psychological and psychosocial care and aftercare.

Introduction

According to the Istanbul Convention, rape (Latin: stuprum) is defined as "... non-consensual vaginal, anal or oral penetration of a sexual nature of the body of another person with any bodily part or object ..." [1].

According to a representative study published in 2005 and commissioned by the German Federal Ministry of Family Affairs, Senior Citizens, Women and Youth, 5.5% of surveyed women reported that they had been raped at least once in their life since they had turned 16, 4.3% had suffered at least one attempted rape, and between 1 and 5.4% had experienced some form of sexual assault [2]. According to a study carried out in Germany, the prevalence for adolescents was 3% [3]. The impact and extent of this differs for each affected individual; for some affected persons, it can have a lifelong negative impact on their physical and psychosocial health.

As studies in the USA have shown, between two-thirds and three-quarters of sexual assaults on young people are carried out by persons who are known to them [4].

The World Health Organisation (WHO) has emphasised the importance of the initial medical care given to victims after sexual violence. This care is both an early intervention and serves to help the affected person cope with the negative experience [5, 6]. Empathic, non-judgemental and appropriate initial care is a great support for the affected person. Medical care can have a positive impact on healing processes and on processing the experience [7, 8]. At the same time, the professionals who are most often consulted in this context are doctors [2].

This Statement aims to further improve and standardise the medical care offered to persons who have experienced sexual violence, particularly young females affected by rape in Germany.

The Statement is primarily aimed at gynaecologists working in hospitals and in private practice; it is based on a Statement by

Fryszler et al. published in spring 2022 on the care and support of female *adults* suspected of having been raped [9].

In addition, this Statement makes specific reference to the extensive 2019 Child Protection Guideline of the Federal Republic of Germany which was updated in 2022 [10].

This DGKG Statement is divided into two parts, based on the age of the affected person (about 14 to 17 years of age/pubertal; 0 to about 13 years of age/prepubertal). There are medical, structural and forensic reasons for this division.

The care and support of young females above the age of about 14 years who have suffered sexual violence, particularly if they have suffered a suspected rape, resembles the medical examinations undertaken in grown women, meaning that these duties may and should be carried out by gynaecologists (or appropriately qualified paediatricians and specialists in adolescent medicine, possibly also involving medical forensic specialists). Very often, the initial contact will occur in a paediatric emergency room, meaning that it is important to provide interdisciplinary care, depending on the local circumstances.

The specific psychological and developmental characteristics of children and adolescents must be taken into account. For this reason, the first part of this statement will focus on detailed recommendations on obtaining information and carrying out examinations. It is worth noting that because of the heterogeneous development during puberty, following a strict age limit to carry out recommendations is neither useful nor beneficial. The proposed age limits are therefore only intended as a general guide to differentiate between prepubertal and pubertal levels of development.

However, it is imperative that the paediatric gynaecological examination of prepubertal girls up to the age of about 13 years required in connection with suspected sexual abuse is carried out by an experienced specialist gynaecological or paediatric physician

with specialist knowledge of paediatric and gynaecological forensic diagnostics.

The authors of this statement expressly recommend that if this specialist knowledge is not available in the hospital or the doctor's surgery, the affected child/adolescent should be referred without delay to an appropriate centre, child protection outpatient unit, or Childhood House, where available.

It should be noted in this context that in Germany, § 176 of the German Criminal Code (*Strafgesetzbuch*, StGB) states that any sexual activity with a person under the age of 14 years is a criminal offence. Additional offence-related aspects must be present for sexual activities involving adolescents between the age of 14 and 17 years of age to be classified as a criminal offence (§ 182 StGB) [10].

This Statement wishes to specifically refer to the recommendations issued by the German Society for Forensic Medicine (*Deutsche Gesellschaft für Rechtsmedizin*) on how to carry out medical forensic examinations [11].

Method

The recommendations in this Statement were compiled between December 2021 and April 2022 at the behest of the Board of the DGGG. A selective search of the literature in the databases PubMed, Livivo and Google Scholar was carried out to search for publications published up until December 2021 which focus on the support and care of female minors or children and adolescents who have experienced acute sexual violence or rape (search terms: children, adolescents, rape, stuprum, sexual assault, sexual violence, forensic examination, psychological, psychosocial care, child protection). Relevant national and international monographs as well as guidelines, recommendations, and statements by national and international professional associations were additionally consulted. One of the most important articles was the "Recommendations for Care and Support of Female Rape Victims" by Fryszer et al., published in 2022. After considering the results of the extensive literature search, a draft text was compiled by an interdisciplinary group of experts using three-stage nominal group process; the text was discussed in detail and amended, and finally adopted using a joint formal consensus process.

Female Adolescents or Pubertal Minors (Approximate Age: 14 to 17 Years)

General recommendations on initial care

The initial care provided after sexual violence/suspected rape covers three different aspects and is an interdisciplinary matter. It includes medical-gynaecological and medical forensic examinations as well as psychosocial support.

Reporting the assault to the police is not a precondition for providing care to the affected person.

The treating physician is not legally obliged to file charges with the police – neither in their institutional role nor as private individual.

Medical and psychosocial care must be offered or recommended to the affected person, irrespective of whether police

charges are filed or not, and irrespective of the requirements for the confidential securing of evidence (*Vertrauliche Spurensicherung*, VSS).

In all cases where minors are affected, both persons having care and custody of the minor should, in principle, be involved in the medical examination, the filing of police charges (if this is done) and the (confidential) securing of evidence. If only one parent is present, the physicians can assume when carrying out routine procedures (e.g., securing evidence) – as long as they have no evidence indicating the contrary – that the parent/guardian accompanying the minor is authorised *inter se* by the other parent/guardian in the context of the familial division of labour to make decisions. If no parent/guardian is present, it is also possible to obtain parental consent by telephone in the presence of witnesses. If more extensive interventions are required (e.g., HIV prophylaxis), however, the written consent of both guardians must be obtained.

But this consent can be dispensed with if the minor is sufficiently capable of reasoning herself (usually from the age of 14 years) and provides reasons which must be respected based on her general right to privacy and her right of self-determination as to why the custodial parent/guardian should not be informed about the suspected rape itself, the medical examination, the police charges or the (confidential) securing of evidence. This applies especially in cases when the information provided by the minor appear to indicate that one or both of the custodial parents/guardians could be the perpetrator.

General principles and recommendations

- The care of minors subjected to sexual violence/a suspected rape should be provided on an interdisciplinary basis.
- Initial care should be provided in quiet, calm rooms [14, 15, 16].
- Waiting times must be kept as short as possible.
- The treating physicians and the nursing staff involved in providing care should have received training on how to provide initial care after sexual violence/a suspected rape and should be trained in trauma-sensitive physician-patient communication [5, 6, 12] and be familiar with the psychological and developmental specificities of adolescence [4, 13, 14]. Regular training should be carried out [5, 6].
- From a forensic standpoint, it would be desirable that the treating physician is a medical specialist or specialist registrar. If this is not possible, the (medical forensic) examination should be carried out by a trained gynaecologist (or an appropriately qualified paediatrician or specialist physician for adolescent medicine, possibly assisted by a medical forensic specialist). Special knowledge about the appropriate diagnostic procedures, how to ensure that the examination is carried out in an age-appropriate manner, psychological factors, how to evaluate the findings, providing post-exposure prophylaxis, legal implications, and aftercare are necessary [4, 15, 16, 17, 18, 19, 20].
- The decision about the forensic urgency of carrying out the examination is based, in the first instance, on the time which has elapsed since the incident and the resulting probability of obtaining DNA evidence – an examination should be carried

out promptly and within 72 hours in adolescents. The time window for prepubertal children is up to 24 hours after the incident.

- If there is a language barrier, a professional translator should be called in to obtain the medical history as well as for the examination and counselling. If only limited verbal communication is possible, it is always recommended, particularly with regard to a possible police investigation, to record how and in which language all verbal communications were carried out and the quality of the verbal communications.
- If the affected child or adolescent prefers to be cared for by female or male staff, their preference should be taken into account where possible [5, 11, 21, 22] (cf. § 81 of the German Criminal Procedure Code [*Strafprozessordnung*, StPO]). The examination should always be carried out in the presence of a female third party (medical staff) [11], unless the child or adolescent explicitly states that she should not be present.
- In the event of a medical emergency (serious injuries, panic attacks, dissociation, intoxication, etc.), treatment of the medical emergency must take priority [7, 23].

Recommendations on dealing with the affected minor

In principle, the first step should consist of offering the minor the opportunity to talk without her parents/guardians being present, unless the minor expressly states at that point that she wishes her custodial parent(s) to be present. From then on, the custodial parents should always be included unless the minor expressly requests that they should not be involved. If necessary, separate conversations should be held with the minor and her custodial parents.

It should be noted that when an incident of sexual violence/suspected rape occurs, the custodial parents may often also be traumatised, especially if they themselves have previously experienced sexual violence in their own lives.

If the custodial parents are not able to adequately and appropriately support their child in this situation, other familial support should additionally be made available, if necessary, with the help of the youth welfare service.

For the situation in which minors receive medical care after sexual violence without involving the parents, we refer to a statement from the German Institute for Youth Welfare and Family Law e.V. (DIJuF) [24].

- An offer should be made to the affected minor that someone else can accompany her to support her during her care (see also § 81 of the German Criminal Procedure Code [StPO]). This accompanying person should then be informed that s/he may be required to act as a witness in the event of a legal trial [22, 23].
- No police employees must be present during the physical and/or gynaecological examination.
- All steps of the investigation should be explained to the affected minor in such a way that she can understand them and investigations must be carried out in the context of informed consent [5, 8, 11, 25].

- The option of filing charges with the police should be explained to the affected person once and without urging her to file charges.
- The affected person must be informed that the examination is voluntary, that she can ask questions at any time, and that she can stop or interrupt the examination at any time.
- Any (partial) rejection of the examination, any interruptions to the examination and any premature termination of the examination should be recorded. The medical examination and the collection of evidence/securing of evidence can increase the feeling of shame and loss of control.
- No pressure should be exerted on the minor to have an examination or receive treatment, and the affected person should have the greatest possible control of the investigation process.
- The physician should use active listening techniques (validate, confirm the narrative of the affected person, keep an eye on her stress levels, have a calming effect, focus on the “here and now”, activate resources, emphasise the process of healing) and should provide a sense of calm and security. The physician should refrain from any forms of criticism [5, 7, 8, 26], especially because negative social reactions can promote the development of a post-traumatic stress disorder (PTSD) [12, 26, 27, 28, 29, 30].
- The affected minor should be treated objectively and empathically, and it should be conveyed to her that she is believed and that she bears no blame for what has happened [12, 23, 26, 31]. The affected minor should feel safe and feel that she can trust the medical staff caring for her [32].
- If evidence is lacking, it is important to inform the minor that this does not mean that the suspected rape did not happen.

Information about forms of care and support (police charges, confidential securing of evidence, medical care only)

Care after sexual violence/a suspected rape can consist only of medical and psychosocial care if that is what the affected minor wants. Nevertheless, in every case the information must be entered into a medical record, because even if no further evidence is secured, the records can serve as a relevant source for potential investigative procedures, if necessary, if the medical facility is released from its duty of confidentiality. However, the affected minor should be carefully informed about the use any secured evidence in the form of photographs and DNA samples could have in a possible trial later on and also with regard to claims for victim compensation.

Confidential securing of evidence

If she does not want to file police charges, the affected minor will be offered the option of so-called confidential securing of evidence (*Vertrauliche Spurensicherung*, VSS) and it should be explained to her what this entails. VSS consists of securing evidence independently of whether any charges are filed with the police or not. This will provide affected persons with medical records of their injuries which can be used in court and will allow evidence to be secured without immediately filing charges.

This approach offers affected minors the opportunity to recover physically and mentally, obtain support, and then consider filing charges together with her parents.

Irrespective of how long the secured evidence is stored, if charges are filed at a later date, it will be possible to refer to the secured materials and analyse them. The affected minor should be informed how long such materials/evidence will be stored and must confirm this with her signature. The respective storage duration can vary, depending on where the minor is treated [33, 34, 35].

Irrespective of whether evidence is secured and how long the material evidence is stored, at present it is possible to file charges for up to 20 years after the offence was perpetrated. In criminal law, the period of limitation generally only starts on the date the last offence was carried out. However, special arrangements are in place for sexual offences. In such cases, the statute of limitations only begins when the victim has completed her 30th year. But these periods of limitation only provide orientation: the respective public prosecutor's office or criminal court makes the legally binding decision about the duration of the statute of limitations. In claims for damages under civil law for wilful violation of the right to sexual self-determination and intentional injury to life, limb, health and liberty, the law provides a period of limitation of 30 years (see: <https://www.hilfe-portal-missbrauch.de/wissenswertes/recht>).

For the confidential securing of evidence, obtaining a verbatim record of the initial questioning by a doctor is particularly important, as the police does not do any questioning. The information obtained during the initial questioning must always be recorded and should never include leading questions.

Care after filing police charges

Should police charges be filed, a minor who is sufficiently capable of reasoning herself and/or her primary carers must be informed that she is obliged to release the treating physicians from their obligation of medical confidentiality with regard to the findings documented in the context of the offence and the secured evidence and must permit them to make these available to the police and the judiciary [25].

If someone has already been commissioned as authorised expert, then the investigation is no longer subject to medical confidentiality. Any findings and the contents of talks must be disclosed; the person being examined must be informed about this in advance.

In every case when a request is made to surrender documents, when dealing with minors the doctor requires a release from confidentiality signed by a minor capable of reasoning for herself and/or her primary carers before information can be passed on to the investigating authorities.

The German Society for Forensic Medicine recommends that an interdisciplinary examination is carried out by gynaecological and medical forensic staff [11]. A departure from this approach is permissible, depending on where the minor is receiving care, the duties and responsibilities, the human and structural resources, and the injury patterns of the affected person. But the quality

standards for the documenting of relevant findings and securing of evidence must be complied with [11, 36].

Interdisciplinary child protection groups have been set up in many hospitals for children's and adolescent medicine which, in addition to paediatric care, also provide forensic expertise and resources to care for children and adolescents who have experienced violence, quite often in co-operation with the respective gynaecological department or hospital (DGKiM 2020; <https://dgkim.de/kinderschutzgruppen>).

If a medical forensic examination is carried out, it is recommended that specially developed forensic evidence kits are used [5, 11, 36, 37]. The kit should include both templates for taking the medical history as well as materials for the medical forensic investigation and instructions on how to carry out the investigation correctly and systematically and how to secure the evidence [11]; collating materials in consultation with the local competent police authority/forensics has proven to be useful.

Case history

- The minor's case history must include both a general gynaecological history and the history relevant for the offence.
- The questions asked while taking the case history must not be leading questions (where possible, question should be open and consist of "W" questions: What? How? Where? When?) and should be recorded verbatim.
- Both the medical history and the history about the progression of events which led to the offence will point the way for the clinical and medical forensic investigation and the securing of evidence, the medical care (e.g., assessing the risk of sexually transmitted diseases and of becoming pregnant) and other necessary measures to support the affected person [23, 38].
- Asking about the details of the progression of events and the event itself should be limited to what is necessary for the investigation, the minor's care and the securing of evidence to limit the stress for the affected person [11].
- The case history should include the following points:
 - The circumstances of the assault including the date, time, place, number of persons involved/persons in the room at the time, including specifically asking whether any of the persons involved in the assault or present during the assault took photographs (e.g., with a cell phone), the use of any weapons, physical violence, anything used to tie her up, other items, and other types of violence or threats, descriptions of other forms of violence used on her throat (strangling or similar) and any associated soiling of herself with urine or faeces, changes in perception, difficulty swallowing, sore throat, hoarseness and foreign body or globus sensation (it is imperative that the subject is directly asked about subjective changes in perception in connection with an attack on her throat to ensure the answers can be used forensically);
 - Information about possible memory gaps or any suspicion of intoxication.
 - Information about oral, vaginal or anorectal contact or penetration, whether or not ejaculation occurred and/or whether the perpetrator used a condom;

- Information about any bleeding by the attacker or the affected subject; this could be relevant for assessing the risk of hepatitis or HIV transmission, it can also be forensically important when assessing the severity of injury;
- Information about consensual sexual activities before or after the assault, including details about any site of contact (oral, genital, anorectal) and the use of condoms;
- Information about whether the affected person has wiped herself down, or showered or bathed since the assault and whether she has changed her clothes, has eaten, used toothpaste or mouthwash, has used a douche or had an enema, has changed or removed a tampon, a sanitary pad or a barrier contraceptive;
- Any current complaints/pain of the affected person must be recorded.

Recommendations for medical forensic examinations

A medical forensic examination can also be carried out after charges have been filed with the police or as part of the confidential securing of evidence. The medical forensic examination includes a description of the affected person's mental state, a detailed physical examination including documentation of all injuries, a gynaecological examination and the securing of evidence.

Attention must be paid to the following points when a medical forensic examination is carried out:

- A declaration of consent by the affected person is the prerequisite for carrying out a medical forensic examination [11].
- If the affected person is not capable of giving her consent, for example, in the event of intoxication, the medical forensic examination may only be carried out when her capacity to consent has returned; alternatively, the consent of a caregiver (e.g., in cases of psychiatric disorders) or a court order (for example, in the case of a patient who is in a coma) must be given. Whether the parental wish that an examination be carried out in such cases should be decisive is a moral dilemma, as the wishes of the adolescent who is potentially capable of giving her consent are unknown. At least when dealing with younger children, it can be assumed that the custodial carers are acting in the best interests of the child. When dealing with adolescents, it is better to wait until the capacity to consent has returned [4].
- Affected persons should be encouraged – if they plan to do so – to undergo the forensic physical examination as quickly as possible after the assault [23].
- Medical care should be provided preferably as soon as possible following the medical forensic examination.
- If the affected person rejects the examination at that moment but a medical forensic examination is still planned, she should be informed that until the examination is carried out, she should avoid bathing/showering/changing her clothes; she should keep any condoms, if used; she should avoid eating, drinking, or smoking if the assault included oral penetration; she should leave the tampon or similar which is currently being used in place in the vagina (it should only be removed after the external genitals have been swabbed); urine from the first/next urination should be collected in a clean sealable container.

The medical forensic examination must comply with the following requirements:

- The entire examination and securing of evidence must be carried out using a standardised examination protocol or documentation form. The use of kits to secure evidence which include protocols with appropriate examination forms is highly recommended.
- When securing the evidence, it is important to follow certain procedures and ensure that the chain of evidence has no gaps. Evidence which has been secured must be stored for later use and documented in such a way that they can be handed to the appropriate police officer if charges are filed [8, 39].
- Evidence such as clothing, pantyliners, tampons, condoms, etc. should be secured in separate paper bags or in special evidence collection bags. If no police charges are filed, these bags can initially be stored appropriately by the hospital or, if this has been agreed upon, by the competent medical forensic institute.
- To ensure that the evidence can be accepted as evidence in later legal proceedings, the evidence must not be handed over to the person being investigated; this also applies to all other collected forms of evidence and samples.
- The entire body must be examined very carefully, but it is important to ensure that any undressing is only partial. The examination should start with a general physical examination and the securing of evidence and only then progress to an anogenital examination.
- When carrying out the physical and the anogenital examinations, all injuries must be recorded, including their size, shape, colour, and the depth of the injury (if applicable); the precise location should additionally be documented photographically and the site of injury should also be drawn on a diagram of the body [8, 11, 36]; the colour of any haematoma should also always be expressed in words (caution: colour may be distorted if the photographic documentation is made under artificial light). The lack of injuries (so-called negative findings), apparently minor injuries (so-called trifling injuries) and any refusal by the affected person to allow certain areas to be examined must be recorded. If an attack on the affected person's throat has been reported, it is imperative to note the presence of petechiae in the face (particularly in the area of the eyes, the visible part of the conjunctiva, the oral mucosa, the retroauricular region) and to document their presence or absence.
- The established format used to classify and assess these somatic findings is the Adam's classification [10, 14, 16, 17].
- Photographs of injuries outside the anogenital area are a useful addition to the documentation drawn on the body diagram and the description of the findings. It is important to be very sensitive when using the medium of photography; a firm consent to photographs being taken as part of the examination must be obtained. If photographic documentation is done, this must be noted in the report. A portrait shot of the affected person should be taken for later use in assigning the documentation. Close-up photographs should be conclusive and telling; the photographs should include a scale (a general picture and a close-up with a scale; photographs of the injury and the scale must be taken vertically; ABFO L-shaped scale No. 2 should be

preferably used) and a colour scale should be used; the photographs and colour scale should be protected and appended to the documentation [11]. Photographs of the anogenital area are often experienced by the affected person as particularly humiliating [11]; for this reason, no general overview photographs should be taken of the anogenital area. Conclusive close-up photographs, preferably colposcopic images, should be taken; these images should be protected and appended to the documentation [21]. Colposcopies are the standard professional approach for collecting and documenting genital findings and are therefore required in accordance with the AWMF child protection guideline [10, 14].

- Digital photographs should not be deleted (not even photos that are apparently blurred). This is to safeguard the persons carrying out the examination.
- Where possible, the securing of samples on the body should be carried out in parallel to the examination to spare the affected person from having to repeatedly undergo the same investigative steps [40].
- The extent of evidence to be secured depends on the characteristics of the offence (for example, the type of penetration, the extent and severity of the violence and the time that has passed since the offence was committed).
- Depending on the information provided in the case history, the following swabs should be taken [10, 11, 36]:
 - Swabs used as evidence must be taken “from the outside to the inside” to prevent trace evidence being spread elsewhere.
 - *In cases of vaginal penetration:* swabs to be taken from the external genitals, vulvar vestibule. (A speculum examination is not routinely required, but if it is carried out, it will allow more targeted swabs to be taken from the posterior and anterior vaginal vaults and the cervical canal. Whether a speculum examination is carried out must be discussed in detail with the affected person and it must only be carried out with her express consent to avoid retraumatising her.) Finally, swabs must be taken from the perineum/perianal area.
 - *In cases of anal penetration:* swabs to be taken from the perineum/perianal area, rectum.
 - *In cases of oral penetration:* swabs to be taken from the mouth. (In this case it is particularly important to rub the swab in the cheek pouches and lip folds, if possible.)
- It is recommended to be very cautious when suggesting a speculum examination in cases when no vaginal intercourse has occurred prior to the described incident. In such cases, a deep vaginal swab may be carried out “blindly”.
- Swabs should be taken of any traces of blood, saliva and sperm which may still be there, and swabs should be taken from any injuries and from under the fingernails of the affected person using moistened swabs; all sites where swabs were taken must be carefully recorded.
- Care must always be taken to ensure that sample tubes are labelled correctly.

- A cheek swab sample may be taken from the affected person for potential DNA analysis [11]. Alternatively, the DNA of the affected person can also be obtained using blood samples (EDTA tube).
- Blood and urine samples are required to obtain evidence of the consumption or administration of alcohol, drugs, or medications [11]. Testing for the consumption or administration of alcohol, drugs, or medications must be selective, i.e., in suspicious cases (e.g., amnesia relating to the incident, manifest symptoms, affected person voices her suspicions, etc.), [35]. In such cases, the following must be kept in mind:
 - In sex offences where there is a suspicion that the affected person was not conscious or only partly conscious due to the effect of alcohol, drugs or medication, alcohol is the most commonly detected substance [41, 42, 43, 44, 45]. The detection of ethanol during the clinical lab workup does meet the requirements for forensic blood alcohol determination but can offer some guidance.
 - The perpetrator can have used any number of different substances such as benzodiazepines, γ -butyrolactone (which is metabolised to gamma-hydroxybutyric acid, GHB) and GHB itself, ketamine, anticholinergics, antihistamines and muscle relaxants [43].
 - Depending on the circumstances, the substances may only be detectable for a short period of time after the offence was committed, for example GHB is detectable for 6–8 hours in blood and around 12 hours in urine [43]. That is why samples (blood and urine) should be taken as quickly as possible (preferably even before the start of the actual securing of evidence). If a longer time has elapsed since the offence was committed, hair analysis may be considered under certain circumstances [46].

Recommendations for medical care

If the affected person only wants a medical examination and care but no (confidential) securing of evidence, the option of securing evidence and what that would entail should nevertheless be explained to her. If the affected person still explicitly rejects securing any evidence, then her stated wish must be absolutely accepted and recorded.

A documentation form should be used even in cases who only receive medical care; the form will carefully lead the examiners through the entire examination procedure and can serve as “evidence” in possible criminal proceeding at a later date.

General recommendations

- Physical injuries must be appropriately recognised, documented and cared for; other medical specialties may be involved in the care, if necessary.
- The person's tetanus vaccination status should be ascertained and the affected person should be vaccinated, if necessary.
- A medical examination should always be done if the throat was attacked (choking/throttling). An additional CT or MRI scan is only necessary in exceptional cases and should only be carried out if medically indicated.

- Affected persons of reproductive age should be offered the opportunity to have a pregnancy test (urine test).
- Affected persons of reproductive age should be offered emergency contraception if necessary (ulipristal acetate, levonorgestrel, in exceptional cases a copper IUD) [6].

Sexually transmitted diseases

(More details are available from the AWMF guideline “Sexually Transmitted Infections – Counselling, Diagnosis and Therapy”, Chapter 4.3.2. Diagnosis of sexually transmitted infections in cases of sexual abuse [47].)

If a child or adolescent is subjected to a physical and sexual attack, they must be examined for the following sexually transmitted pathogens: *Chlamydia trachomatis*, *Neisseria gonorrhoeae* and *Trichomonas vaginalis*, using nucleic acid amplification testing (NAAT/PCR) in urine; if necessary, carry out anal swabs for *Chlamydia trachomatis*, *Neisseria gonorrhoeae* [46] as well as potentially for HIV, hepatitis B and C in serum and for syphilis, if necessary; swabs to obtain evidence must, of course, always be taken before collecting swab samples for microbiological testing.

Swabbing for *Chlamydia trachomatis*, *Neisseria gonorrhoeae* and *Trichomonas vaginalis* may be carried out in cases with pre-existing vaginal discharge. Follow-up examinations must be carried out in accordance with the currently established recommendations on infection control. The currently established recommendations on infection control should also be followed when considering whether providing post-exposition prophylaxis is indicated or not. Every positive lab result must be confirmed by the respective pathogen-specific test [10, 47].

The person's hepatitis-B vaccination status should be ascertained and she should be vaccinated, if necessary.

HIV post-exposition prophylaxis should be considered.

Recommendations on psychological and psychosocial care

(See also the AWMF guideline “Diagnosis and Treatment of Acute Consequences of Psychological Traumatization” [48].) During the course of care and treatment the psychopathology of the affected person should be recorded as soon as possible, at the latest after four weeks, unless she is suffering from acute stress reaction. If this is the case, it should be diagnosed shortly after the offence occurred and is of vital importance for the prognosis of post-traumatic stress disorder (PTSD).

For minors, the diagnostic workup after 4 weeks also includes an assessment of the options to receive support from her custodial parents and the support available in the area where she is living as this will also have an impact on the prognosis of PTSD. In addition, documenting the subsequent psychological damage is also important as this will have a significant impact on the sentence given to the perpetrator.

To ensure that reliable psychosocial care will continue to be available to the affected person, the recommended first-line approach is to contact specialised counselling services and outpatient trauma care services in accordance with Germany's Crime Victims Compensation Act (*Opferentschädigungsgesetz*, OEG) or,

depending on the indication, to contact other outpatient and inpatient psychotherapeutic/psychiatric treatment facilities. Legal counselling services/victim protection counselling services also offer low-threshold legal support and can work towards ensuring that psychosocial care will be available throughout the process.

General recommendations with regard to the psychological and psychosocial care of affected persons are:

At the start of the process, the affected person should be offered the option of talking with professionals by herself; later on, it is important to include her custodial guardians. The minor should be assured that all talks are confidential unless she or someone else is at real and present risk. In this case, the minor will be informed that this matter must be talked about with her custodial guardians. In principle, it is important to arrange with the minor which information may be passed on to her custodial guardians.

The approach that should be followed is:

- Establish a relationship; ask about concerns and needs [5, 8, 26].
- Determine whether suicidal ideation or self-harming behaviour is present [7, 32] and, in this context, consider whether inpatient admission may be necessary.
- Support short-term relief and support: Who can provide support in her area? Which counselling services can she be referred to?
- Determine whether the affected person (urgently) requires protection and identify the options to protect her, particularly in cases of sexual partner violence and sexual violence in her immediate or extended area [25]. The affected person should be released into a safe environment, ideally accompanied by a person of trust. If necessary, youth welfare services will need to initiate protective measures. To determine whether the affected minor is at risk of harm, it may be necessary to transfer her to child protection services/a special child protection halfway house, a child protection outpatient department or so-called Childhood House (*Childhood-Haus*).
- The Federal Child Protection Act of Germany (§ 4 Act on Cooperation and Information in Child Protection Matters (*Gesetz zur Kooperation und Information im Kinderschutz*, KKG), <https://www.gesetze-im-internet.de/kkg/BjNR297510011.html>, <https://www.bmfsfj.de/bmfsfj/themen/kinder-und-jugend/kinder-und-jugendschutz/bundeskinderschutzgesetz/das-bundeskinderschutzgesetz-86268>) allows additional information beyond what is usually conveyed to be passed on to Youth Protection Services even without the consent of the custodial guardians, if there are serious indications that a child is at acute risk. The authority to pass on information to Youth Protection Services is conditional on two assessment or deliberation processes: one the one hand, an assessment about whether “serious indications” are present. As this is a loose legal term, there is no definitive catalogue on what constitutes a serious indication; indications must be evaluated individually. If the assessment comes to the conclusion that there are “serious indications” that the child is acutely at risk of harm, the situation must be discussed with the custodial guardians and they must be encouraged to make use of the help available. If the risk cannot be averted using own resources, the relative merit of maintaining medical confidentiality will have to be weighed up

against the need to break medical confidentiality and prevent the expected harm; this weighing up must be documented. §4KKG explicitly provides the option of receiving pseudonymised counselling from an appropriately experienced professional from the youth welfare service to aid this deliberation process and elucidate the resulting possible courses of action and the need for action. This provides persons who are obliged by their profession to maintain confidentiality with a legal claim against the public authority which funds the youth welfare service. In Germany, there is no obligation to report the matter to child protective services or the police.

- The medical child protection hotline can be called 24/7 using the number 0800/1 921 000. Callers are advised by doctors who have a specialist background in three of the following specialities – paediatrics, child and adolescent psychiatry, child and adolescent psychotherapy and forensic medicine – and have received additional training as an experienced specialist.
- The affected person may be informed for psychoeducational reasons about the possibility that she may experience psychological reactions such as distressing memories of the incident, so-called flashbacks, overwhelming emotions and phases of emotional numbness, dissociation as well as increased agitation and sleep disturbances, so that she is able to classify them as understandable reactions [8, 26]. A gentle and cautious approach should be used during the first contact and the minor should be informed that she should attend follow-up examinations and contact specialised advisory services where additional help will be provided if required. A trauma outpatient department should be contacted if symptoms still persist four weeks after the incident.
- It is important to recognise risk factors which are associated with a high probability of developing long-term psychological symptoms (e.g., the suspect is a current or former intimate partner, pre-existing mental illness, traumatic events such as psychological, physical or sexual experience of violence in the past) [26]. Affected persons who have such prior negative experiences – and possibly their custodial guardians – require more intensive psychoeducational information about the risks and options for support.
- Raise and utilise resources: the support from her social environment should be discussed together with the affected person and possibly her custodial guardians.
- Information about possible psychosocial and/or psychotherapeutic support should be provided if requested [5, 7, 8, 25, 40]. The affected person should be informed that according to the German Victim Compensation Act (*Opferentschädigungsgesetz*, OEG) she has the right to receive such offers of support. (The rights of victims who have suffered acts of violence to claim social compensation and immediate assistance were revised in December 2019 and are outlined in the German Social Security Statute Book [SGB] vol. XIV. Although the Act will only become law on January 1 st, 2024, some parts of it already entered into force on January 1 st, 2021. Since that date, victims of an act of violence have the legal right to psychotherapeutic interventions in a trauma outpatient unit, with adults entitled to receive up to 15 sessions and children and adolescents to receive up to 18 sessions (Art. 1 §§ 31, 34 SGB XIV).

- Affected persons must be provided with information about specialised advisory centres, OEG trauma outpatient departments and other drop-in centres – for example, where they can receive legal advice [5, 7, 8, 49].
- Affected persons should receive information in writing, as concentration levels and memory function are often diminished in acute situations [8, 21, 37, 39].
- Prescribing benzodiazepines should be avoided where possible, as they do not prevent post-traumatic disorders but instead promote the chronification of such disorders [48].

Recommendations on follow-up care

To continue providing care to affected persons after the acute intervention, it would be best to agree on follow-up appointments at specific intervals or refer them on to appropriate facilities (non-hospital-based gynaecologist, paediatrician/specialist for adolescent medicine, GP, outpatient infection department, health departments) [7, 8, 37, 39].

Subsequent physical and psychological symptoms must be recognised and the affected person should be referred for further support where necessary. The standard should be that the affected person is given an appointment in an OEG trauma outpatient unit four weeks after the incident to allow incipient PTSD or any other post-traumatic disorder to be diagnosed and treated at an early stage. This is very important as minors in particular and also their guardians often need support to organise appointments.

The importance of appointments to monitor her progress should be explained [39] and the affected person should be supported to attend appointments [32].

These appointments should cover the following aspects:

- Testing for sexually transmitted diseases (recommended in the AWMF guideline “Sexually Transmitted Infections – Counselling, Diagnosis and Therapy” [47]).
- Completing a course of vaccinations (recommended in the AWMF guideline “Sexually Transmitted Infections – Counselling, Diagnosis and Therapy” [47]) with initiation of therapy where required.
- Enquiries and assessment of the affected person’s acute psychological condition to ensure that she is referred to the relevant specialist advisory service or OEG trauma outpatient unit or starts trauma-focussed psychotherapy where necessary.
- Recording of pre-, peri- and post-traumatic risk factors and evaluation whether the affected person is at risk of self-harming or harming others by appropriately qualified paediatricians or child psychiatrists or staff working in child protection outpatient departments.

The aim should be a transfer to a so-called Childhood House as that is a place where the first priority is the child’s welfare, it has a child-friendly atmosphere, and everyone involved in her care will come to her there. If the minor is at a Childhood House, in addition to coordinating medical and psychological/psychotherapeutic care and cooperating with the youth welfare service, police and judicial interrogations can also be coordinated from there. Videoing

statements made by the affected person means that the minor may not have to repeat her testimony personally in court.

Suspected Sexual Abuse of Prepubertal Girls (Approximate Age: 0 to < 14 Years)

Special aspects of psychosocial care

The majority of sexual abuse cases of prepubertal girls are carried out by a person or persons in the victim's immediate social circle; they are rarely committed by someone unknown to the victim.

The initial inquiry into the presumptive offence must not include leading questions and it requires special expertise; it should be carried out as soon as possible after the (suspected) offence was committed. It should be noted in this context that the affected children are often torn by conflicting loyalties and/or may have been told to keep the assault secret.

The proper assessment of psychological symptoms requires a lot of experience and should be carried out by child psychotherapists or doctors specialising in paediatric and adolescent psychiatry. Diagnosing complex developmental trauma disorders is particularly difficult. The level of traumatisation is often underestimated in children. During the first contact with the child, paediatricians and paediatric gynaecologists have the advantage that their other paediatric care will have given them a lot of experience of specific age-related and developmental characteristics; moreover, they are also experienced in carrying examinations and communicating with patients in an age-appropriate manner. The aim should be to provide interdisciplinary care.

Questions about who has custody of the child can be particularly problematic, as girls suspected of having been subjected to sexual abuse are sometimes brought in for examination by a doctor in the context of separation and divorce-related conflicts.

Because of the importance of child protection aspects, involving the Youth Welfare Office, referral to a regional child protection outpatient department or to one of the Childhood Houses in Germany, if one is located nearby, or referral to another appropriate and established care facility is recommended. The necessary further measures (medical care, youth welfare service, police, judiciary) can be initiated and coordinated there.

The paediatric gynaecological examination should be carried out by a gynaecologist experienced in child protection issues with special expertise in paediatric gynaecological forensic diagnostics or by appropriately qualified paediatricians or specialists for forensic medicine. As findings and their interpretation in this age group differ significantly from those in adolescents because of the hormone-related and dynamic developmental changes to the anogenital area, a specific knowledge of the appropriate diagnostic workup, of how to carry out the examination in an age-appropriate manner, of psychological factors, of how to assess the findings, and the legal implications and aftercare are particularly necessary. The examination should be documented using colposcopy photos, ideally recorded on video, and evaluated using Adam's criteria so that the findings can be peer-reviewed if necessary [10].

Investigative methods and interpretation of findings

See Chapter 4.4.7 "Diagnostic workup if there is a suspicion of sexual abuse" in the long version of the Child Protection Guideline (pp. 291–295) as well as recommendations nos. 112–127 (pp. 52–56), the table on the "Chronology of potential examinations for children and adolescents suspected of having been sexually abused" (p. 56) and the recommendations on "Interpretation of medical findings when abuse is suspected" (pp. 57–59) in the short version of the guideline. Evidence-based recommendations for action are provided there [10].

Detailed information on taking the patient's history and the examination procedure, the recording and interpretation of findings, sexually transmitted infections and differential diagnoses are also available from relevant up-to-date handbooks [14, 19, 20].

Appendix: Facilities providing assistance and support

- Federally coordinated specialist advisory services
- Childhood Houses (outpatient centres for children and adolescents who have been victims and/or witnesses of sexual and physical violence) <https://www.childhood-haus.de>
- DGKiM: German Society for Child Protection in Medicine (all child protection groups in Germany at a glance) <https://www.dgkim.de>
- The "Sexual Abuse" helpline is open Mondays, Wednesdays and Fridays from 9 a.m. to 2 p.m. and Tuesdays and Thursdays from 3 p.m. to 8 p.m. The number for all of Germany is 0800/2 255 530; calling the helpline is free of charge and calls are anonymous. www.save-me-online.de is the online advisory service of the helpline for adolescents.
- iGObSIS (intelligent system for the conservation of evidence from victims of violence and information system) is a web-based documentation system and information portal which assists with documenting injuries, securing evidence, and psychosocial referrals and includes training modules: <https://gobsis.de/>
- The number of the medical child protection hotline is 0800/1 921 000 (lines are open 24/7). Target groups: trained healthcare professionals, child and youth services, family courts <https://www.kinderschutzhotline.de>
- OEG trauma outpatient units for children and adolescents
- Homepage of the help portal for sexual abuse (<https://www.hilfe-portal-missbrauch.de>)
- Independent commissioner for issues relating to the sexual abuse of children (UBSKM), <https://www.beauftragter-missbrauch.de>

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Conflict of Interest

The authors declare that they have no conflict of interest.

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