REVIEW OF SEXUAL ASSAULT EXAMINATION FORMS AND MANUAL PREPARED BY THE APPOINTED HIGH COURT COMMITTEE

Background:
In 2009, a PIL was filed in the Nagpur bench of the High Court that raised concerns about the quality of medical examination and evidence collection that was being carried out in cases of sex assault in Maharashtra. The court directed the DHS, Maharashtra, to set up a committee that would formulate a standard protocol for examination of these cases, which would be implemented across the state. The proforma and guidelines so created were issued by the DHS and critiqued extensively by CEHAT.

In September 2010, CEHAT, intervened in the case, putting forth its concerns with the guidelines that had been drafted, and the fact that the component of treatment that should be provided to all survivors of sexual assault was absent from the guidelines. CEHAT has set up interventions in three municipal hospitals in Mumbai, which provide a Comprehensive health care response to sexual assault. In February 2011, the court asked the committee to study this model intervention, submit a report based on the visit and redraft the guidelines. Visits to these hospitals were conducted by the committee in March 2011 after which revised guidelines and proforma were drafted and submitted to court on 27th April 2011. The court on 8th June 2011 accepted this proforma and ordered that it be circulated to all hospitals in Maharashtra for implementation.

We at CEHAT have studied the revised proforma and manual and find it problematic in many ways. While some problematic areas such as the ‘two-finger test’ have been eliminated in the last revision, there are still several serious problems that need to be rectified as they compromise health rights of the survivor. This document looks at the implications that the problematic proforma and manual that are to be implemented in all hospitals as per the court order, have for survivors of sexual assault.

1. REVIEW OF PROFORMAS [Victim: Medical Examination, Forensic Samples and Age Estimation]

A. Issues in ‘Forensic Medical Examination Report of Alleged Victim of Sexual Assault’:

The use of the term ‘alleged victim’ questions the veracity of the survivor’s complaint. The word ‘alleged’ should therefore not be used. Instead of use of the term ‘victim’, the term ‘survivor’ should be used, as it conveys that s/he has overcome the ordeal and broken her silence. The act of reporting a sexual assault is a mark of courage. It also denotes empowerment and healing. The term ‘victim’, on the other hand takes away from the person’s agency.
I. Preliminary information and consent

(I). 10: Consent:

- This proforma does not include provision to decline consent for any part of the medical examination procedure. Section 164 (A) of the CrPC, mandates that informed consent of the survivor be sought prior to commencement of any medical examination. Consent must be sought separately for each of the following: (1) Medical examination including that of genitals, (2) collection of forensic evidence, (3) treatment and (4) provision of information to the police for purpose of investigation. Often, survivors may not want to undergo one or more of the above. In 3 of the 55 cases that CEHAT has provided intervention services for between August 2008 and January 2011 at three public hospitals in Mumbai, it has been observed that the women expressed the desire to not give consent for all three of the above. For instance, in one case the woman reported to the hospital solely for treatment and did not want to go through the ordeal of making a police case. She therefore did not want the police to be informed. In another, she was willing to undergo physical examination but refused genital examination. However, because of hospital protocols and because providers are trained to take consent for all or none, so this decision of the woman has not always been respected. This creates barriers in their accessing services. Hence, provision for partial consent needs to be made in the proforma, so that women’s decisions in such situations are respected and they are able to choose as much or as little of the services they want.

- Further, the language used in informed refusal is threatening: “In this event I shall be responsible for any problem arising in the process of crime investigation and court trial.” Rather the emphasis needs to be on communicating to the survivor the possible implications of loss of evidence and documentation and a clear statement that refusal will not have any impact on the quality of treatment provided.

- The proforma does not mention the age under which a person is considered a ‘minor’.

(I). 10 (c) Photography/Videography: It is not clear how confidentiality of photographic evidence will be maintained in the hospital. There is also no established chain of custody in the hospital to ensure that the photographic evidence is not tampered with. This has serious implications as photographs that are taken during the course of examination may be misused.
(II) History of alleged sexual assault as stated by victim

- There are no probes for recording the different types of sexual assault, nor other facts that have a bearing on the examination findings and evidence obtained. Eliciting and documenting an accurate history is important to chart the nature of examination and evidence collection that follows. It is vital to record in detail what kind of penetration occurred (anal, oral, vaginal), by what (finger, penis, object), whether there is any past history of abuse, whether there was emission of semen, whether a condom or lubricant was used, whether the survivor was threatened verbally/physically, use of any weapons, or alcohol/drug intoxication. Activities such as bathing, douching, washing, and urinating may result in loss of evidence and must be recorded.\(^1\) History taking is also vital for interpreting findings (for instance, semen/spermatozoa may be absent if the survivor was menstruating at the time of assault/examination or if a condom was used; injuries may be absent if a lubricant was used or if threats were issued or the survivor was intoxicated). However, doctors are often poorly trained and are unaware of what is to be recorded. Hence, there is a high chance that they may miss probing for and documenting these vital components in the history. These must therefore be explicitly incorporated as probe questions in the form.

(III) Personal History

The items mentioned under this section are not ‘personal history’, but in fact medical history and history of the episode of sexual assault. They should be re-distributed as follows:

- (III) (a) ‘History of alcohol/other drug abuse’: This must be recorded as part of the history of sexual assault. If there is a history of intoxication during or before the assault, this invalidates consent for sexual intercourse and is therefore relevant. **History of alcohol/drug abuse is altogether irrelevant to the case and should be removed.**
- (III) (c) & (d) ‘was the patient menstruating at the time of assault’ and ‘is the patient menstruating at the time of examination’ should both be recorded under ‘history of sexual assault’ as these have a bearing on the findings.
- (III) (b), (e), (f), (g) & (h) should all be recorded as ‘medical history’.

(IV) General physical examination

- The proforma records Height, Weight, and Nutrition. This is unnecessary for sexual assault examination. It only perpetuates the stereotype that a well-built woman cannot be raped as she would be able to offer resistance. In reality, women even though physically capable of resisting may have been threatened, physically restrained, intoxicated or shocked with fear. The built of the woman, therefore is irrelevant and should not be recorded.
- BP, pulse and respiration are relevant only for treatment and should not be recorded in the medico-legal form.

1. Injuries on body:

The proforma lays undue emphasis on “signs of struggle”. This perpetuates the notion that survivors of sexual assault must demonstrate injuries. It is important to note that most sexual

assault survivors do not show obvious injuries. Literature suggests that injuries are seen only 1/3rd of cases of sexual assault. Among 55 cases of sexual assault that CEHAT has responded to in three public hospitals in Mumbai between August 2008 and January 2011, only 21 and 15 showed genital and physical injuries respectively. 15 had been threatened, and 7 were intoxicated/unconscious – these factors could affect whether women are able to resist. Additionally, lubricants had also been used in some cases which would reduce the likelihood of sustaining injuries. Given that injuries are not necessarily associated with all sexual assault cases, laying undue emphasis on them will make doctors look for injuries only. Instead, examination should be guided by the history provided and interpreted in that light.

II. Local Examination of Genital / Perineal areas

- **Per Speculum and Per Vaginal examination are not mentioned in the proforma at all.** PS/PV examination helps to visualize and document injuries more accurately. While not warranted in children, PS/PV examination needs to be done at least in case of adults reporting vaginal penetrative assault.

- The proforma places too much emphasis on recording the type of hymen, whether intact or torn, nature of tears, whether fresh or old. Recording all of this is unnecessary in most cases and perpetuates the faulty notion that the status of hymen can determine virginity or lack thereof. Research shows that an intact hymen does not rule out sexual assault, and a torn hymen does not prove previous sexual intercourse- as hymen may be torn due to other activities like cycling, horse-riding, masturbation etc. In a widely acclaimed study that attempted to diagnose, on the basis of physical examination whether a woman had previously engaged in sexual activity, the researchers found that they had mis-diagnosed ‘virgins’ in 50% of the cases. Among 20 of the 55 sexual assault cases responded to by CEHAT in three public hospitals in Mumbai who reported even completed peno-vaginal penetration, 13 had no assault related finding (such as bleeding, edema, redness or tenderness) with respect to the hymen. Hymen should therefore be treated like any other part of the genitals while documenting examination findings in cases of sexual assault. Only those findings such as fresh tears, bleeding, edema etc. that are relevant to the episode of assault are to be documented.

Specific examinations

- B] Wet mount: During interpretation of wet-mount findings, there is no mention that absence of spermatozoa does not rule out sexual intercourse because a condom may have been used during the assault or the assailant may have had a vasectomy/disease of the vas. There is also no mention of the fact that spermatozoa are found only for 72 hours and so performing this procedure after that period is not warranted.


3 Of the remaining, three survivors reported after over a month and so presence or absence of injuries in these cases would be irrelevant. Additionally, one case had not been examined and hence data on injuries is not available.

C] UV light (to be carried out only when the infrastructure is available): WHO guidelines state that “use of Wood’s lamps to detect semen on areas of skin is no longer recommended clinical practice. Wood’s lamps do not fluoresce semen as well as previously thought, and more reliable methods of detecting semen (e.g. swabs) should therefore be used.” Further, Wood’s lamps are known to also fluoresce other body fluids, vegetable fluids and washing detergents. Therefore they are likely to show false positive results.

I. **Provisional opinion regarding sexual assault**

- The provisional opinion is focused on whether there is any ‘evidence of injuries’ and ‘evidence of spermatozoa’, without any role for history and examination to explain why certain findings were seen or not seen. The proforma just asks to provide ‘ultra-brief’ justification for age of injury or supporting remarks. Such an opinion is grossly insufficient as injuries and positive wet smear may not be seen in most cases of sexual assault owing to several factors. Limiting the opinion to this may lead to a false impression that there has been no sexual assault. Instead, the opinion should be able to comment on whether there is any evidence of a penetrative or non-penetrative sexual assault and provide *reasons for the same*.

There needs to be scope to provide reasoning for why evidence may be absent as recorded in history - due to use of condom/ lubricant, if the survivor was menstruating, has presented 72 hours after the incident, has washed/bathed; and so forth. Likewise, injuries may not be seen in cases where the survivor was intoxicated, verbal or physical threats were used or if she reported soon after the assault and deep bruises had not yet developed.

- Further, an ‘IMPORTANT NOTE’ in the proforma states “An opinion about sexual assault can be given on the basis of findings of relevant injuries and positive results of FSL reports. Hence it is advised to keep the opinion pending till FSL reports.” Going by this guideline, any survivor with no injuries will have an opinion that is “awaited FSL reports” and the entire purpose of history and examination findings would be lost.

B. **Issues in Final Opinion form:**

- Point IX) 1) The field asks for ‘evidence of recent, forceful vaginal/anal sexual intercourse’. These are two discrete findings and should be broken up into ‘evidence of recent intercourse’ and ‘evidence of signs of use of force’, as one may be present without the other. Evidence of recent intercourse may be present without any injuries.

C. **Issues in Victim FSL Samples form:**

- The requisition form asks for DNA profiling of all samples. It must be kept in mind that currently FSL does not have the resources to conduct DNA tests for all cases. Whether such a requirement is practically feasible and relevant needs to be reviewed.

- Point 23: Sample of scalp and pubic hair to be collected either by plucking or cutting: Plucking of hair is extremely inhuman and should not be allowed.

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• Point 24: Control swab of skin to interpret the evidence swab is irrelevant. Presence of semen as a positive finding is important and control swab is unnecessary.
• Point 4, 5, 21 & 22: Bulbs/vials have been suggested for collection of body fluids. However, vaccutainers should be used instead as they are less likely to be tampered with and less likely to spill.

D. Issues in Age Estimation form:

• The proforma asks for consent for photography in age estimation. The need for this is unclear, as age is to be estimated using radiographs, dental and physical examination.

• Further, it is stated that the report may be used for “clinical audit, research and academic purposes”. This is inconsistent with the goal of medico-legal examination in sexual assault and should be eliminated from the form. To expect a survivor to consent to this when it has no relevance to either her treatment or to her legal case is unjustifiable.

• There is no mention of who must provide final opinion regarding age, on the proforma. In most facilities, the dental, physical and radiological ages would be estimated by different doctors. It must therefore be clarified that the final opinion regarding age needs to be provided by the examining doctor after calculating mean of ages obtained from all three methods.

• Pulse, BP is included in the age estimation form. This has no bearing on age whatsoever and should be removed.

E. Body Charts: There are no body charts accompanying the proforma. Examination findings such as injuries or other marks are best documented on body charts, which make the depiction much easier and accurate. These should therefore be added.

F. Treatment Summary: No part of the proforma records the nature of treatment that was provided to the survivor at all. Treatment for the effects of sexual assault is the most crucial role of the health care provider. Among 55 cases of sexual assault that CEHAT responded to at three public hospitals in Mumbai, 25 had injuries requiring treatment, 8 had burning micturition, 10 had bleeding from the vagina, 1 had bleeding from the rectum, 7 had pain in the abdomen, 4 had pain in the genital region related, 2 had pain while walking, 2 developed pregnancy as a result of assault, and 2 had pain as a result of physical injuries.

Unfortunately, treatment is often not provided at several health facilities whose focus rests on medico-legal examination and evidence collection. Among the 55 cases received by us at the three public hospitals, 3 had undergone medico-legal examination at other health facilities but had not received any treatment. They reported with symptoms like burning micturition and abdominal pain, to one of the three hospitals where a comprehensive response to sexual assault is being implemented, in need of treatment. To ensure that survivors receive treatment at health facilities, it is crucial that this be made a part of the proforma. The WHO prescribes that survivors be assessed and treated for injuries, pregnancy, Sexually Transmitted Illnesses, and psychological trauma. This includes
conducting urine pregnancy tests, microbiological investigations for assessment of STIs, blood investigations for Hepatitis B and HIV. In case a pregnancy is detected, abortion needs to be provided. Further, counseling to address psychological trauma caused due to the assault is to be provided. All of these need to be included in the proforma.

II. REVIEW OF THE MANUAL FOR VICTIM

Introduction:
- **Language used is archaic:** For instance, use of the term “unnatural sexual offences” should be replaced by describing the nature of the offence (forced anal intercourse). Also, the meaning of “the manual is aimed at insuring natural justice to be delivered to the deserving party” is unclear. The objective of the manual thus appears misdirected. Rather the manual should aim to equip healthcare providers with necessary guidelines for executing their medical and forensic roles with respect to sexual assault effectively.

Scope:
- **Provision of treatment to survivors of sexual assault does not feature in the scope of the manual at all.** This is an integral part of the role of health facilities and must be included. This is a glaring gap in the manual and proforma as it is violates the right to treatment of survivors of sexual assault.
- There is a suggestion that “in hospitals where services of specialists from Forensic Medicine and Gynecology are available, this examination can be jointly conducted by them.” The following needs to be considered:
  - The role of each department in such situations is unclear, which is likely to cause confusion. For instance, when will the forensic department be called in, would they be available round-the-clock, who will sign the final report etc. None of these are explicitly stated.
  - Specifying who, within a health facility should conduct the examination, may be beyond the scope of a manual that is meant to serve as a guide for an examining physician. This should, instead, be addressed in the ‘Standard Operating Procedures’ of the health facility.

Regarding facilities where examination may be carried out,
- **The manual states that since PHCs are not equipped with requisite facilities, examination should be conducted in hospitals and a circular to this effect should be issued.** The notion that hospitals are well-equipped to conduct examinations, collect evidence and provide treatment to survivors of sexual assault is false. A multi-facility survey conducted by CEHAT found that even secondary and tertiary care hospitals are not equipped to provide optimal services. The State-run secondary hospital for instance, did not have any provision for providing medical treatment to survivors.⁷ This means that in general, the infrastructure needs to be improved in all facilities. Stipulating that PHCs should not conduct examinations raises concerns because cases of sexual assault are a medico-legal emergency and there should be no delay in conducting examinations as it would result in loss of evidence. Mandating that it be conducted only in a hospital can create several barriers. Even as per the law, any Registered Medical Practitioner (RMP) can

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conduct the examination (164(A) CrPC). In areas where a PHC is the closest facility, the examination must be conducted there itself.

- **What is meant by an ‘authorized hospital’ or one with ‘adequate infrastructure’ has not been specified.** This would lead to ambiguity about which hospitals can conduct examinations, resulting in survivors being turned away. The parameters for this therefore need to be specified.

**Information regarding different acts of sexual assault:** This information is stated without any references. Neither the IPC definitions of the various acts, nor the WHO definition of sexual assault has been used. The different types of sexual assault need to be defined in the manual, along with correct citations.

- **Every offence is described with an undue emphasis on the nature of injuries that will be seen with that offence.** This fails to educate the health care provider about the spectrum of acts that fall into the realm of sexual assault and reinforces the notion that any sexual assault leaves signs of injury.

- **Each offence mentioned is mechanically associated with the type of injury it would cause.** For instance, while describing ‘sexual intercourse’, the manual mentions that ‘due to the natural difference in the size of the male and female genital organs and element of resistance and force used, there will be characteristic injuries in the vulva, hymen and vagina’. This is absolutely unscientific and is not borne out by any data. On the contrary, data shows that only 1/3rd of cases of sexual assault sustain injuries. Further, correlating and essentializing the type of injuries that will be seen in each type of assault is also unscientific.

- **There is also an assumption that physical force will be used, and there will be resistance which will cause injuries.** No effort is made to explain why injuries may be absent, such as if there was use of physical or verbal threats, or restraint, or drug or alcohol intoxication or if there was a delay in reporting. Data from 55 cases of sexual assault responded to by CEHAT show that 15 had been threatened, and another 7 were intoxicated at the time of the assault.

**Consequences of sexual assault:**

- **There is no mention that treatment needs to be provided for the listed health consequences of sexual assault.** This again takes away from the emphasis of the role of the health care provider in providing treatment.

- **Use of the term ‘criminal’ abortion in ‘physical health consequences’.** Seeking unsafe abortion is an act of desperation, and labeling it ‘criminal’ puts the onus of the ‘offence’ on the woman herself. Instead, it should be listed as ‘unsafe abortion’.

**Duties of health care providers**

- **Informing the police about the case is mentioned as a ‘duty’ of the health care provider.** However, as per section 39 of the CrPC, a HCP is not bound to inform law enforcement authorities about a case of sexual assault. In keeping with the process of seeking informed consent, it would be a violation to inform the police if this is against the wishes of the survivor. This issue has been raised several times before the committee (during a meeting
where interveners and petitioners were called as well as the committee’s visits to the three hospitals where the model response for sexual assault is being implemented), however no comment has been made on this. This needs to be opined upon conclusively.

**Guidelines**

**Section II: History**

- The manual asks the doctor to record the following in history:
  - **“Whether the woman cried or resisted and in which manner.”** This is irrelevant as the survivor may have been too scared, threatened or intoxicated, to resist the assault. In such cases, the doctor may end up writing that the woman did not cry or make any effort to resist the assault which will lead to a wrong interpretation.
  - **“Relative position of the victim and accused during assault.”** This has no relevance at all. Sexual assault can occur with the victim and assailant in any position. Any sexual contact against the will of the person is defined as sexual assault.
  - **“Intoxication, voluntary or forceful.”** This has no relevance at all. Irrespective of whether intoxication was caused by voluntary or forceful consumption of alcohol, consent would be rendered invalid under Section 376 IPC. Hence, doctors should only write whether there was history of intoxication or not.
  - **“Is there history of last consensual sexual intercourse, if yes when”** The rationale for seeking this history is not explained and if recorded indiscriminately could result in needless probing of past sexual history. This information should be recorded only if there has been any consensual intercourse within the past week, because detection of that sperm or semen has to be ruled out. If not, there is no need to record this.

**Section IV: General Physical Examination**

- **Height, Weight, Nutrition:** This is unnecessary for sexual assault examination. It only perpetuates the stereotype that a well-built woman cannot be raped as she would be able to offer resistance. In reality, women even though physically capable of resisting may have been threatened, physically restrained, intoxicated or shocked with fear. The built of the woman, therefore is irrelevant and should not be recorded. Sexual assault is most often planned and so there is little scope for resistance from survivors.

- **Emotional and Mental status – No guidelines have been provided on how one is expected to comment on emotional and mental status.** As a result, doctors may end up writing ‘appears composed’, without understanding why that is so, which could be counterproductive. Instead, the doctor must describe the mood of the survivor using terms like shock, scared, numbed etc. It must further be stressed that all survivors would not show obvious emotional reactions and writing that the patient is ‘indifferent’ or “controlled” could be used against her. It is also irrelevant if there is no provision of counselling being made.

**Section VI: Local examination of genitals**

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8 Correspondence with Archana Patil, DHS. Dated 7th December 2010. Meeting held on 5th December 2011.
• Point (e) It is mentioned that the examination of the hymen can give ‘valuable information’ related to peno-vaginal sexual intercourse and should therefore be commented upon in great detail. This is inaccurate and should be removed from the manual. The problems with relying on the hymen to assess whether sexual intercourse occurred or not have been discussed in detail in the previous section.

Section VII: Specific examinations
• Point B] Toluidine blue dye tests: There is no clear guideline on when, in the course of examination, this test needs to be performed. The test if not done properly can have serious implications. For instance, because the test is known to show false positive results because breach of the epithelium could be caused due to use of the speculum as well, it is recommended that it should be done before PS examination. But it should be done after collection of vaginal samples as spraying of the dye and washing away the excess can cause loss of evidence. This needs to be clarified.

Section VIII: Collection of Samples of Forensic Evidence Material
• There is no guideline in the manual for which samples need to be collected in what situations. This would result in doctors collecting samples indiscriminately, without taking into account factors that influence the nature of samples to be collected such as the nature of assault. For instance, if there is no history of forceful oral sex, and oral swab need not be collected. Further, genital evidence is not likely to be found after 96 hours and should therefore not be collected if a survivor reports after this period. Spermatozoa can be identified only for 72 hours and so swabs for spermatozoa need not be taken after this time has lapsed.
• No mention of Chain of Custody at all: The manual mentions that evidence must be taken away by the police immediately after evidence collection. However, in instances when the police is not available to collect the evidence, the evidence needs to be kept in the custody of assigned persons in the health facility. The details of all handing over from one ‘custodian’ to the other must be logged and continuity must be maintained. This is not mentioned anywhere.

Section IX: Framing of Provisional Opinion
Discussed in proforma.

Section X: Framing of Final opinion
• No reasoning is offered for the basis of formulating the final opinion. For instance, in one situation the manual says “If FSL reports and wet smear are negative for presence of spermatozoa and there are no physical and genital injuries then the opinion would be “there are no signs suggestive of vaginal/anal intercourse”. There are several problems in this:
  ○ Presence or absence of semen based on FSL reports is not accounted for at all, and the emphasis is only on spermatozoa.
  ○ Spermatozoa could be absent because 72 hours may have lapsed after the assault or if the assailant may have had a vasectomy or diseases of the vas deferens. Therefore absence of spermatozoa does not rule out sexual intercourse – this needs to be stated by the doctor in the final opinion.
Absence of genital/physical injuries does not rule out sexual assault. There should be scope to provide explanation for why certain evidences or signs were not observed – such as if too much time had lapsed, if a condom was used, if physical or verbal threats were used, if deep seated injuries were not taken into account etc. Just saying that no signs of recent forceful sexual intercourse were seen makes the opinion very biased.

Section XII:
- The manual provides no detailed guidelines on treatment for injuries, STI assessment and prophylaxis, pregnancy assessment and prophylaxis or counseling, as prescribed by the WHO. Sexual assault has various health implications and treatment for these needs to be provided. Doctors are often unaware of the various components of treatment that are to be provided and hence they might miss out on some, if not explicitly stated. There should therefore be specific guidelines on the above.

Section XIV: Age estimation:
- There are no specific guidelines on when age estimation is to be done. This will result in age estimation being done for all survivors irrespective of their age. Age estimation needs to be carried out only among those survivors whose age is at the ‘borderline’ (10-20 years) and can be disputed. It is unnecessary to conduct this examination among adults or small children with documentary proof of age.
- Exact guidelines on determining age on the basis of secondary sexual characters (Tanner staging), and other physical characteristics such as height, weight and chest circumference are not provided in the manual.
- With reference to determining dental age, the manual asks that an Orthopentogram (OPG) be used to confirm findings of observations. This is unnecessary as age can be estimated with the eruption pattern. The facility for taking extra-oral x-rays like OPG may not be available at a lot of centers, so this should not be made essential.
- With reference to determining dental age, the manual provides guidelines for age determination in the elderly. However, age determination is not required in this age group because it has no legal implications whatsoever.

Section XIII: Dos and Donts
- Point 3 states: “Authenticity of information should be ensured. Don’t get emotionally influenced by allegations.” This may indicate that doctors should view victim suspiciously or should verify through repeated questioning. It is not the doctor’s role to ensure ‘authenticity of information’. This notion that a doctor should constantly beware of ‘false allegations’ is rooted in medical education. Forensic textbooks have an entire section on ‘false charges’ which, as pointed out in one critique are offensive, entirely baseless and contrary to all available evidence.9

There is no mention that copies of documentation and the medical examination report must be given to the survivor. This is a right of the survivor and must be provided without fail.

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