SUBMISSION TO THE DEPARTMENT OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT: JUDICIAL MATTERS AMENDMENT BILL, 2010

TSHWARANANG
LEGAL ADVOCACY CENTRE
TO END VIOLENCE AGAINST WOMEN

Prepared by the Tshwaranang Legal Advocacy Centre to End Violence Against Women

c/o Lisa Vetten
PO Box 31006
Braamfontein 2017
Tel: (011) 403-4267
Fax: (011) 403-4275
lisa@tlac.org.za

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1. Introduction

Tshwaranang Legal Advocacy Centre (TLAC) is an NGO established to work towards the eradication of secondary victimization of women by the law and the criminal justice system. It undertakes various activities to achieve its objectives, including providing direct legal services to women who are survivors of gender-based violence, and conducting strategic research designed to provide better insight into the needs of women. TLAC thus has direct experience of the many difficult issues that women and girls face daily when they have been made victim of a sexual offence. We therefore thank the Department of Justice and Constitutional Development (DoJ&CD) for this opportunity to strengthen the provisions of the *Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007* (SOA) via the *Judicial Matters Amendment Bill, 2010*. Our submission focuses on resolving conflicts between the SOA and other important legislation protecting children, as well as strengthening existing sections within the SOA.

This submission has been endorsed by:

- OUT LGBT Wellbeing
- Childline
- Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN)
- Women and Men Against Child Abuse (WMACA) (with the exception of recommendation 2a).

2. Resolving conflicts between the SOA and other legislation

2.a. Sections 42 ï 53: Establishment of National Register for Sex Offenders and designation of Registrar of Register

In addition to the National Register for Sex Offenders contained in the SOA, provision for a National Child Protection Register is contained in sections 111 ï 128 of the Childrenôs Act (no. 38 of 2005). As with the National Register for Sex Offenders, the implementation and associated regulations for the National Child Protection Register are also in the process of being finalised. The chief differences between the two Registers lie in their administration, as well as the procedures they provide for, and the fact that the one also includes people with mental disabilities within its ambit. Their purpose is almost identical (preventing people who have harmed children from working with children and/or being placed in a position of authority, supervision or care of children). In fact, the National Child Protection Register (ôProtection Registerô) is broader in scope than the National Register for Sex Offenders (ôOffender Registerô) and arguably of greater protective value to children.

The Offender Register, managed by the DoJ&CD, includes only the details of those found guilty of a sexual offence against a child or person with mental disability. By contrast, the Protection Register, to be maintained by the Department of Social Development, captures the

details of those found unsuitable to work with children by a childrenôs court, any other court in any criminal or civil proceedings, or any disciplinary forum in proceedings concerning a personôs conduct towards a child. Such a finding must be made if the accused person is convicted of murder, attempted murder, rape, sexual abuse or assault with intent to do grievous bodily harm to a child.

The Offender Register requires the police, correctional services personnel, the Registrar or clerk of the court and the Department of Health to forward the details of convicted offenders to the DoJ&CD. In terms of the Protection Register, the registrar of the relevant court, the relevant administrative forum, or person who brought the application for a finding of unsuitability, are required to forward information to Social Development.

The extent to which these registers duplicate each other is of serious concern. Equally concerning is the cost of two Registers. In a presentation to the Committee for Women, Children, Youth and People with Disabilities, the police stated that the implementation of the Offender Register alone was going to cost in the region of R300 million.[1]

Recommendation:
We strongly recommend that the DoJCD liaise with the Department of Social Development to rationalize the registers, the regulations attached to them and their implementation. Failure to do so will involve all structures in both government and civil society who have any duties with regard to the management of and obligations in respect of the registers in duplicate processes.

It must be noted further that the South African Law Reform Commission (SALRC), after consultation between the committees established to develop the drafts of the Childrenôs Act and the SOA, strongly recommended that the register in respect of sexual offences against children should not be in the SOA but contained in part B of the Protection Register, as this legislation captures a broader range of persons unfit to work with children.

The amendments proposed in clauses 82 ï 84 and clause 86 of Judicial Matters Amendment Bill, 2010 therefore become redundant in terms of this recommendation.

2.b. Section 54: Obligation to report commission of sexual offence against children or persons who are mentally disabled

Section 54(1)(a) and (b) of the SOA states that any person who has knowledge that a sexual offence has been committed against a child, must report such knowledge to a police official. Failure to do so constitutes an offence and a person convicted of such an offence may be sentenced to five yearsô imprisonment. (It is also obligatory to report to the police knowledge, or a reasonable belief, or suspicion, that a sexual offence has been committed against a mentally disabled person. Failure to do so will result in the same sanctions as the failure to report a sexual offence against a child.) The provision applicable to children conflicts with provisions in the Childrenôs Amendment Act (no. 41 of 2007), as well as health policy.

[1]Parliamentary Monitoring Group. *Violence against children & women, forced marriages (ukuthwala), femicide, child murders, implementation of Domestic Violence Act, Child Justice & Sexual Offences Acts: Department of Police & Childline briefings.* Minutes for the Portfolio Committee on Women, Children and People with Disabilities, 26 August 2009 http://www.pmg.org.za/node/17942

Section 110 (1) of the 2007 Childrenôs Amendment Act reads as follows: ñAny teacher, medical practitioner, psychologist, dentist, registered nurse, physiotherapist, speech therapist, occupational therapist, traditional health practitioner, legal practitioner, social worker, social service professional, minister of religion, religious leader, member of staff at a partial care facility, shelter, drop-in centre or child and youth care centre, labour inspector or police official who on personal observation concludes that a child has been sexually abused, deliberately neglected or abused in a manner causing physical injury must report that conclusion to the provincial department of social development, a designated child protection organisation, police official or clerk of the childrenôs court.ò

Where the SOA imposes a legal obligation on everybody to report child sexual abuse, the Childrenôs Amendment Act restricts this obligation to particular categories of people. In addition, in terms of the SOA, persons must have knowledge of a sexual offence and must report this knowledge to the police. By contrast, the 2007 Childrenôs Amendment Act relies on the designated officials drawing a conclusion that sexual abuse has occurred based on their personal observation of the child. Such conclusions can be reported to a broader range of bodies than the police alone. Such officials are also required to substantiate their conclusions or belief.

These mandatory reporting provisions also conflict with the provision of healthcare to children, particularly adolescents.

Section 13 of the 2005 Childrenôs Act contains the following provisions: ñEvery child has a right to access to information on health promotion and the prevention and treatment of ill-health and disease, sexuality and reproduction; confidentiality regarding his/her health status and the health status of a parent, caregiver or family member, except when maintaining such confidentiality is not in the best interests of the child.ò Section 134 deals with childrenôs access to contraceptives and states ñany child (from age 12) who obtains condoms, contraceptives or contraceptive advice in terms of this Act is entitled to confidentiality in this respect subject to section 105ò (which subsequently became section 110, following the 2007 Childrenôs Amendment Act).

However, in terms of the SOA, a child between the ages of 12 ï 16 may not consent to sexual penetration. This implies that any child between these ages seeking information about contraceptives, HIV or pregnancy, for example, must be considered sexually abused and reported to the police by the healthcare worker.

It is in the best interests of children having consensual sex to be protected from teenage pregnancy, HIV and other STIs and to have access to termination of pregnancy services. It is also important that health facilities provide a health service, rather than becoming a surveillance arm of the law. Their assumption of such a surveillance role may well deter adolescents from using health services ï a highly undesirable policy outcome.

Finally, the Older Persons Act (no. 13 of 2006) contains section 26(1) which obliges any person who suspects that an older person has been abused, or suffers from an abuse-related injury, to notify the Director-General of Social Development or a police official, of this suspicion. Notably, section 30(3)(b) of this Act includes sexual abuse within the ambit of its definition of acts of abuse towards older persons.

Recommendation:
We propose that section 54(1) of the SOA be expunged and replaced with the following amendment:

Obligation to report commission of sexual offences against <u>certain categories of persons.</u>

54(1). <u>There is a legal duty to report sexual offences against children and older persons. In relation to children this Act upholds the provisions set out in 110 of the Childrenôs Amendment Act 41 of 2007), read in conjunction with sections 13 and 134 of the Childrenôs Act 38 of 2005.</u>
<u>(2). In relation to older persons, section 26(1) and section 30(3)(b) of the Older Persons Act 13 of 2006 also apply in terms of this Act.</u>
<u>(3). Any teacher, medical practitioner, psychologist, dentist, registered nurse, physiotherapist, speech therapist, occupational therapist, traditional health practitioner, legal practitioner, social worker, social service professional, minister of religion, religious leader, member of staff at a care facility, or police official who on personal observation concludes that a person with a mental disability has been sexually abused, must report that conclusion to the provincial department of social development or a police official.</u>

The insertion of this amendment will also require the Department of Health to revise 18(j) of Directive 4 contained in Government Gazette no. 31957 of 6 March 2009.

<u>2.c. Section 11: Engaging sexual services of persons 18 years or older</u>

This section makes it an offence for a person to engage the services of another adult for financial reward, favour or compensation. Its inclusion within the SOA pre-empts both the current process of legislative reform around adult commercial sex work being undertaken by the SALRC, as well as parliamentary and public participation in the finalisation of this legislation. By contrast, part 6 of the SOA (sections 70 ï 71), ñTransitional provisions relating to trafficking in persons for sexual purposesò, is deliberately noted as transitional pending the adoption of comprehensive legislation in this regard. The SOA thus treats two concurrent law reform processes inconsistently, making the provision in relation to sex work final while treating the provisions on trafficking as transitional.

Recommendation:
We recommend that section 11 be expunged in its entirety.

3. Other revisions to the SOA

<u>3a. Acts of consensual sexual violation with certain children (statutory sexual assault)</u>

This provision allows for the prosecution of those who, with consent, kiss and touch children between 12 and 15 years old in a sexual manner. This touching excludes penetration of the anus and female genitalia. Because such touching and kissing carries no possibility of pregnancy or the transmission of any sexually transmitted infection and is consensual, it is difficult to see its harm and the consequent need for prosecution. While some of this sexual behaviour may be cause for concern when it occurs between an adult and child, it should not

be applied to instances where both parties are children. Arguably, when children are prosecuted, it wastes criminal justice system resources and has also contributed to the trivialisation of the SOA, now known as the ôKissing Actô in some circles.

Recommendation:
We recommend that section 16 be amended in the following manner:

Acts of consensual sexual violation <u>between adults and</u> certain children (statutory sexual assault)
16.(1). <u>An adult</u> person (ñAò) who commits an act of sexual violation with a child (ñBò) is, despite the consent of B to the commission of such an act, guilty of the offence of having committed an act of consensual sexual violation with a child.

Sections 16 (2)(a) and (b) would therefore fall away.

Or:

Section 16 could be deleted in its entirety and such acts dealt with instead in terms of the provisions around sexual assault contained in section 5. Read with section 1(3) ï and 1(3)(b) in particular ï the adultôs age would be treated as an abuse of their power or authority, thus vitiating the childôs consent.

<u>3b. Execution of order and issuing of warrant of arrest</u>

Part 4 of the SOA deals with the execution of orders for compulsory HIV tests and the management of the results of the HIV test. In terms of Section 33(e)(i) of the Act, once the accused has been tested for HIV, the investigating officer must hand the survivor a sealed envelope containing Form 8 as well as the results of the accusedôs HIV test. Many survivors, still deeply traumatised by the sexual assault (the application for testing and the test itself must take place within 90 days of the assault), will therefore be left to fend for themselves and try to locate the ñexpert assistance" referred to in the regulations, either by contacting the investigating officer or by perusing the telephone directory. Clearly such a scenario will not be conducive to the victimôs peace of mind, nor will she be empowered to make decisions about treatment and protecting her intimate partners.

Victims who elect to obtain the HIV test results of the alleged perpetrator must be treated within the same ethical and legal framework as anyone else who elects to undergo an HIV test to ascertain their own HIV status. For some victims, the HIV test result of the alleged perpetrator will be an indirect indication of their own HIV status, and for all victims, the trauma of waiting for the HIV test result and the consequences of the result, whatever it may be, are the same as those for an individual undergoing VCT.

Government and all leading medical organizations agree that HIV testing must include voluntary, informed consent and pre- and post-test counselling. The national Department of Health in its National Policy on HIV Testing recognises that:

> *"Testing for HIV infection presents serious medical, legal, ethical, economic and psychological implications in the health care setting. Because HIV infection is a life-*

threatening condition, reasonable persons and health care workers will attach significance to the outcome of an HIV test, especially a positive diagnosis"

The policy establishes that HIV testing may only be conducted with informed consent, accompanied by pre- and post-test counselling (except in extremely limited circumstances). For this reason, the Department of Health has invested substantial resources in VCT services.

Both the Heath Professions Council of South Africa (HPCSA), a statutory body regulating the medical profession and the South African Medical Association (SAMA) have issued ethical guidelines for the medical profession on how to conduct HIV testing of patients. The HPCSA Guidelines on the Management of Patients with HIV and AIDS states that: "HIV testing should only take place with the voluntary, informed consent of the individual.ò The guidelines also state that the patient must be given information about the test and the ñpsychosocial impact of a positive test resultò in a language that ñis easily understood by the patient.ò The guidelines are at pains to stress that the patient should clearly understand the information provided and that ñthe principle of informed consent entails that the health care worker accepts that if a patient were HIV-positive, appropriate counselling will follow.ò

The SAMA guidelines have similar principles.

In addition to providing a survivor with the necessary psycho-social support to deal with a potentially chronic, incurable illness, pre-test counselling also plays a vital role in ensuring that survivors have access to adequate, accurate and accessible information concerning the risks of HIV transmission during sexual assault, the nature and reliability of the HIV test that will be used to test the alleged perpetrator, and the impact of the so-called window period on the test result. If the perpetratorôs test result is negative and women are not properly counselled about the window period and the need to complete the course of PEP, they may elect to discontinue PEP. Without access to this information, in a language they understand, it is doubtful that survivors will be in a position to make informed decisions about whether to apply for the compulsory testing of the alleged offender and may also have unrealistic expectations about the nature of the test results.

Post-test counselling is crucial to ensuring that survivors understand that the test result is not conclusive of their own HIV status and to encourage them to undergo an HIV test, should they wish to be sure of their own HIV status. Where a perpetratorôs test result is negative, there is a particular risk that women who already have HIV (but do not know this), will fail to test themselves and to access medical care and support timeously. Post-test counselling also offers an opportunity to educate and inform women about strategies to remain negative and prevent future HIV infection. In the context of an extraordinarily high prevalence of HIV infection, no opportunities to prevent HIV infection can afford to be missed.

The procedure envisaged by the Act falls short of the stateôs current ethical and legal obligations towards any person who undergoes an HIV test and, that far from providing a victim with peace of mind, the provisions on compulsory testing may in fact serve to re-victimise victims. Consequences for women who are illiterate and cannot read the proposed notices and those who for geographical and socio-economic reasons will not have easy access to resources to assist them, will be particularly severe.

Recommendation:
We recommend that the Department of Healthôs Directive 3, 17(g) contained in Government Gazette no 31957 of 6 March 2009 be elevated to the status of law by its insertion into 33(e)(i) in the following manner:

33(e). the investigating officer must ï

(i) in the case of an order contemplated in section 31 (3), hand over to the victim or to the interested person, as the case may be, and to the alleged offender the sealed record of the test results and a notice containing prescribed information on the confidentiality of and how to deal with the HIV test results, and if necessary explain the contents of the notice. The investigating officer must ensure that the victim or interested person has been counselled before handing over the sealed record of the HIV results.

3c The National Policy Framework (NPF)

The NPF is a major strength of the Act, adopting a strategic and dynamic approach to addressing sexual offences, as well as a mechanism for monitoring the Actôs implementation. What is of concern, is the Actôs silence on the role of civil society organisations working in the area of sexual violence both in contributing to the NPFôs development, as well as monitoring its implementation.

The value of bringing NGOs into these processes derives from the wealth of experience and expertise they have developed in working with sexual offence victims/survivors. In addition, unlike government departments, many NGOs provide a continuum of services including psycho-social support, health-care and support throughout the criminal justice process and thus have a broader perspective on the needs and experiences of rape survivors. Finally, the monitoring function performed by NGOs is critical to holding departments and agencies accountable for their implementation of policy and law.

Recommendation:
We recommend the insertion of the following clause in section 62(2):

62(2). The Minister must ï

(a) consult with non-governmental organisations and other relevant bodies providing services to victims of sexual offences and their families in developing the national policy framework.

3d Comprehensive treatment and care of rape survivors

The SOA only weakly provides for a comprehensive approach to the management, treatment and care of rape victim/survivorsô physical and mental health needs. This is a particularly glaring omission in light of section 2 of the SOA which states ñ*The objects of this Act are to afford complainants of sexual offences the maximum and least traumatising protection that the law can provide.*ò

Recommendation:
We recommend that this be addressed via an amendment to section 66 of the SOA, which currently only obliges the SAPS, the NDPP and the Department of Health to develop training

courses around sexual offences, as well as directives around the procedures to be followed when dealing with such cases. A new provision 4 must be created obliging the Director General of Social Development to publish in the *Gazette* directives which, at a minimum, should spell out in detail the full nature and extent of psycho-social support required by victims and their families at various stages in the process of healing from a trauma like rape; who is to render these services, as well as how they are to be funded; and the provision of services to courts, such as intermediary services and expert reports. In addition, the Director General of Social Development must also develop training courses.