

# Forensic genital and anogenital examination in suspected sexual violence and cases involving minors

## Practical aspects, legal framework and interpretative limitations

Critical narrative review

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## Abstract

Genital examination following a possible sexual assault aims to identify and document relevant findings, guide healthcare and preserve evidence. It is not a stand-alone test of whether an offence occurred. This paper examines the relationship between medical findings, interpretation of mechanisms and legal assessment, distinguishing prepubertal children, adolescents and adults. It discusses consent to examination, child protection, the significance of a normal examination, limitations of hymenal interpretation, biological evidence and the wording of conclusions. Its practical recommendations seek to prevent two opposite errors: unjustifiably excluding abuse when injuries are absent and attributing abuse on the basis of nonspecific findings.

**Keywords:** forensic medicine; sexual violence; minor; anogenital examination; consent; hymen; biological evidence; differential diagnosis.

## 1. Aim and method

This paper is a selective narrative synthesis of official and professional sources: Romanian legislation, WHO documents, CDC recommendations, the Canadian Paediatric Society position statement and the US national sexual assault medical forensic examination protocol. It is not a systematic review, meta-analysis or validated institutional protocol. No formal risk-of-bias assessment was performed and the literature search is not claimed to be exhaustive.

The Romanian framework was supplemented by consulting the relevant provisions of the Code of Criminal Procedure (Articles 189-190), Law No. 46/2003 and the forensic procedural rules approved by Order No. 1,134/C/255/2000, including the 2023 amendments. Legal rules are distinguished from clinical recommendations and proposed practical interpretations. Verification concerns the cited provisions and is not an exhaustive analysis of case law or all special situations involving legal representation. English renderings of Romanian legal concepts in this paper are explanatory translations; the Romanian statutory text governs.

## 2. Three levels that must be distinguished

A rigorous analysis distinguishes **what is observed, what medical significance it may have, and what legal conclusion follows from the evidence as a whole**. A documented injury does not automatically identify its perpetrator, and compatibility with a mechanism does not establish that mechanism uniquely.

The person's account, the records consulted and the examiner's findings must be separately traceable in the report. Wording such as "the person reports" must not turn into the examiner's own finding through editorial choices. Conversely, the absence of an injury does not justify describing the account as untrue.

This distinction is the methodological principle proposed in this review: expert evidence assists the investigation by defining precisely what it can and cannot demonstrate.

### **3. Legal framework in Romania**

The Criminal Code distinguishes rape and sexual assault, including specific offences against minors under Articles 218<sup>1</sup> and 219<sup>1</sup>. For certain acts committed by an adult against a minor under 16, coercion is not an element of the basic offence. Distinct rules apply to acts between minors and to certain situations involving persons aged 16-18. Close-in-age exceptions have a limited scope; they are not a general permission and do not remove the relevance of coercion. The date of the act and successive legislative changes matter. Legal classification belongs to the judicial authorities. [1]

Consent to examination, capacity to consent to medical care and the legal significance of sexual conduct must therefore be distinguished. They are not interchangeable.

Articles 89(3) and 96 of Law No. 272/2004 establish reporting obligations when child abuse is suspected. Reporting must not depend on finding a genital injury. Child protection and criminal proof have different thresholds and purposes. When an accompanying person may be involved, the child's representation and safety must be clarified with the competent authorities. [2]

### **4. Consent, communication and prevention of retraumatisation**

In a voluntary examination, consent is an ongoing process: the person should understand the proposed components, how images and samples will be used, and the possibility of stopping a component. Agreement to a consultation must not be treated as implicit agreement to every sample collection or photograph. The US protocol recommends accessible communication and individual assessment of capacity; these clinical principles do not replace Romanian law. [3]

For children, understanding and cooperation appropriate to development should be sought alongside the required legal basis. In voluntary clinical assessment, a nonurgent examination of a frightened child should be deferred or adapted to obtain cooperation; this recommendation does not describe the separate legal regime for an examination ordered without consent. Any refusal should be recorded neutrally, without treating it as evidence for or against abuse. [4]

WHO supports care centred on safety, respect, autonomy and reducing distress. Practical measures include explaining each stage, avoiding leading questions and limiting repeated accounts. Medical history-taking must not become an investigative interview. [5]

#### **4.1. Medical care and refusal of an intervention**

Article 13 of Law No. 46/2003 recognises refusal or discontinuation of a medical intervention, with an explanation of the consequences and written acknowledgement of responsibility for that decision. Articles 14-15 address emergency intervention when the patient cannot express their wishes and, respectively, circumstances in which a legal representative's consent is unnecessary in an emergency. These provisions do not create a general permission to disregard a capable adult's refusal. When a representative's agreement is required, the patient participates according to their understanding; a representative's refusal of an intervention considered to be in the patient's interests is subject to the specialist medical arbitration mechanism under Article 17. This does not replace judicial authorisation to obtain evidence. [12]

## 4.2. Physical examination in criminal proceedings

Article 189 of the Romanian Code of Criminal Procedure regulates forensic medical examination and permits assessment from records when physical examination is impossible or unnecessary. Article 190 covers external and internal examination and biological sampling. The criminal investigation authority must first request written consent. For persons without legal capacity to act, consent is requested from the legal representative; persons with restricted legal capacity give written consent in the presence of their legal guardians. [13]

Where the required consent is absent, examination may be ordered by the judge of rights and liberties on a reasoned application from the prosecutor under Article 190(2)-(4). Exceptionally, in the evidentiary urgency described in paragraph (5), the criminal investigation authority may order examination by a formal order. The documents are forwarded immediately to the judge for validation; failure to satisfy the conditions in paragraph (2) results in exclusion of the evidence. This provision does not prescribe a 24-hour deadline. [13]

**Practical interpretation:** a referral letter, the existence of a complaint or a family request does not replace the legal basis required for examination without consent. Urgent preservation of evidence and urgent treatment have distinct justifications. Evidentiary authorisation must not be read as unlimited permission for any manoeuvre, sedation or coercion.

## 4.3. Minors: representation, attendance and protection

Article 14(2) of the forensic procedural rules provides for examination of a minor in the presence of a parent or legal representative or, in their absence, an adult family member of the same sex as the minor. This is a rule about attendance: an accompanying person does not automatically acquire authority to consent on the person's behalf. Article 16 regulates who may request a forensic medical certificate; requesting an examination and consenting to it are not the same act. [14]

Article 190(7) permits a parent to attend the internal examination of a child under 14 at the parent's request. Internal examination and sampling are reserved for the healthcare personnel specified by the provision, with respect for privacy and human dignity; the professional competence required for the procedure remains necessary. Paragraph (9) requires a procedural record of the activities and samples. [13]

If the accompanying person is suspected of involvement or there is a conflict of interests, representation and protection must be clarified with the judicial authority and child protection authority. As a practical recommendation, record who is present, the relevant capacity, explanations, consent or refusal, the procedural order and the components actually performed. Refusal is not, in itself, evidence that abuse did or did not occur. [2,4]

## 4.4. Samples, photographs and confidentiality

Article 18 of Law No. 46/2003 concerns biological material for diagnosis and treatment; evidentiary sampling follows the criminal procedural regime. Article 20 regulates photography, including medical exceptions, while Articles 21-23 concern confidentiality and lawful disclosure. Consent to examination does not amount to consent to publication or research. [12]

The forensic rules require protection of information (Article 5), compliance with professional ethics (Article 6) and communication to judicial authorities of indications of offences prosecuted ex officio (Article 8(b)). Article 22 requires a written judicial request specifying objectives and materials; these requirements do not displace the procedure in Article 190. [14]

## 5. Urgency: care and evidence have complementary priorities

Initial assessment should identify haemorrhage, severe pain, suspected internal injury and urgent safety needs. Genital examination forms part of the overall assessment; it does not replace examination of other relevant regions. [3,4]

For exposures carrying an HIV risk, the 2025 CDC recommendations advise starting post-exposure prophylaxis as soon as possible, ideally within 24 hours and no later than 72 hours, when indicated. The recommended duration is 28 days. The decision and regimen belong to the competent clinician after assessment of exposure and individual patient factors. [6]

Pregnancy risk should be assessed in people with reproductive potential. Emergency contraception is time-dependent; WHO describes options usable within five days, with greater effectiveness when given earlier. Method selection is individualised; not every option is suitable following sexual assault, particularly where infection risk is present. [7]

**Passing a therapeutic time window does not make forensic examination useless.** The windows for prophylaxis, sampling and morphological assessment must not be confused.

## 6. Examination adapted to development

Table 1 is a practical synthesis, not an instruction for examination by untrained persons.

| Group                                  | Examination approach                                                                                     | Main limitation                                                                               |
|----------------------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| Prepubertal child                      | Assessment by personnel with paediatric experience; gentle inspection and descriptive documentation      | Speculum examination is not routine; suspected internal injury requires specialist assessment |
| Adolescent                             | Adaptation to development, symptoms and reported contact; assessment of reproductive and infection risks | Pubertal development does not establish legal capacity to consent                             |
| Adult                                  | Individualised examination, with justification of internal components and sampling                       | The appearance of injuries does not independently establish consent                           |
| Person with communication difficulties | Communication adjustments and assessment of capacity in the particular situation                         | A disability diagnosis does not automatically mean inability to decide                        |

In children, digital rectal examination and anoscopy are not recommended as routine methods to identify abuse. Authorised photographic documentation may enable expert review and reduce repeated examination. [4] In every age group, documentation should identify regions not examined and the reasons, not merely positive findings.

## 7. What does a normal examination mean?

Paediatric literature indicates that most children examined for suspected sexual abuse have no identifiable genital or anal injuries, particularly when examination is delayed. Contact may cause no injury, and some injuries heal without persistent signs. [8]

This does not mean that every normal examination confirms abuse. The result has a narrower meaning: at the time of examination, using the methods employed, the injuries sought were not identified. The finding must be integrated with the time interval, type of contact and other evidence.

A normal examination is synonymous neither with “no contact occurred” nor with “the contact was consensual”. Assigning exclusionary value requires a specific justification, not a standard phrase.

## 8. The hymen and differential diagnosis

WHO states that “virginity” is not a medical diagnosis and that examination of the hymen cannot establish a history of vaginal intercourse. Examination for trauma has a different purpose from a “virginity test”. Anatomical description should not become a social or moral label. [9]

In Romania, Order No. 1,434/687/C/2023 removed the reference to virginity from Article 15(a), concerning certificates requested by interested persons. The term remains in Article 26(a), concerning examinations requested by judicial authorities. It is therefore inaccurate to claim that it was removed from all the rules. Persistence of the legal terminology does not scientifically validate a “virginity test”; the expert's response must explain the medical limits of the question posed. [9,14,15]

**Table 2. Cautious interpretation of findings**

| Finding                           | Justified interpretation                                | Conclusion to avoid                         |
|-----------------------------------|---------------------------------------------------------|---------------------------------------------|
| Examination without injuries      | No injuries identified at the current examination       | “Assault is excluded”                       |
| Nonspecific erythema or fissure   | Requires differential diagnosis and context             | “Proves penetration”                        |
| Acute traumatic injury            | Supports trauma; the mechanism requires reasoning       | “Automatically identifies the perpetrator”  |
| Hymenal appearance without injury | Limited morphological description                       | “Proves virginity”                          |
| Positive microbiological result   | Requires confirmation and assessment of transmission    | “Automatically proves the reported episode” |
| Negative biological sample        | Target material was not detected in the sample analysed | “Excludes any sexual contact”               |

Inflammatory and dermatological changes and some anatomical variants may be mistaken for trauma. In uncertain cases, review by an experienced examiner is preferable to a categorical conclusion. [4,8] The table is an interpretative synthesis, not a comprehensive diagnostic classification.

## 9. Microbiology, biological evidence and traceability

In children, the value of an infection as an indicator of abuse depends on the organism, age and possible routes of transmission. CDC emphasises both the significance of certain infections for suspicion of abuse and exceptions involving perinatal or nonsexual transmission. Positive tests with forensic implications require appropriate confirmation; an isolated result must not be overinterpreted. [10]

In a sexually active adolescent or adult, an infection detected after the event may have been present beforehand. The date of diagnosis is not automatically the date of infection. Care includes individualised testing, prophylaxis where indicated, vaccination and follow-up. Adult recommendations do not transfer automatically to prepubertal children. [11]

Forensic sampling should be coordinated with the laboratory. Origin, timing, labelling, sealing, storage and transfers must be documented. Chain of custody is not a formality: it enables assessment of the integrity of evidence. Suspected drug-facilitated assault requires a specific toxicology strategy and timely sampling. [3]

As a principle of evidential reasoning, identifying a biological source and reconstructing the circumstances of deposition are different questions. Interpretation must remain within the limitations of the laboratory method and documented context.

## 10. Proposed report structure

For clarity and auditability, the following editorial structure is proposed:

1. Basis of the request, questions posed and documents received.
2. Identification, examination date and time, accompanying persons and communication conditions.
3. Consent or the procedural basis for each component; where consent is absent, identification of the order authorising examination and its limits.
4. Reported information, with identification of its source.
5. General and anogenital findings, described separately.
6. Investigations, samples, photographs and traceability.
7. Differential diagnosis, temporal correlation and limitations.
8. Conclusions addressing the objectives and available results.

This is a proposal for organising information, not a mandatory national form. Pending results must be identified as such; conclusions must not be written as though genetic or toxicological analysis has already been completed.

## 11. Examples of conclusion wording

The following are drafting suggestions requiring adaptation to the individual case:

**No injuries identified:** “No traumatic anogenital injuries were identified at the current examination. This finding does not, by itself, exclude the reported sexual contact or assault. Interpretation is limited by the interval before examination and the nature of the contact described.”

**Nonspecific change:** “The described change is not specific to a sexual mechanism. Establishing its aetiology requires correlation with clinical data and exclusion of relevant alternative causes.”

**Traumatic injury:** “The findings document a traumatic injury in the region described. Assessment of compatibility with the reported mechanism is presented in the discussion; the injury alone does not establish the legal circumstances of its occurrence.”

**Incomplete voluntary examination:** “Assessment was limited to the components accepted and performed. The absence of information about unexamined regions cannot be interpreted as absence of injury.”

## 12. Discussion and conclusions

The principal risk is an unjustified transition from observation to certainty. A report may be descriptively precise while remaining limited in causal attribution. Recognising that limitation is a condition of its evidentiary value.

For Romanian practice, the proposed direction is standardised documentation, interdisciplinary consultation and access to expert review, alongside local clarification of consent, reporting and evidence-transfer pathways. International models offer professional guidance; they do not replace national rules.

A high-quality examination should provide care and verifiable findings while keeping conclusions proportionate to the evidence. Neither a normal examination nor a nonspecific change alone justifies a determination that an offence did or did not occur. In cases involving minors, child protection must not wait for morphological certainty.

## References

Romanian statutory titles are retained in their original language. The links below identify the same sources as the Romanian edition.

1. Romania. Codul penal, Legea nr. 286/2009, forma consolidată accesată la 21.09.2026, art. 218-219<sup>1</sup>. [Romanian legislation portal](#).
2. Romania. Legea nr. 272/2004 privind protecția și promovarea drepturilor copilului, republicată și actualizată; art. 89 și 96. [Romanian legislation portal](#).
3. U.S. Department of Justice, Office on Violence Against Women. A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents. Third Edition. September 2024. Ediția este confirmată pe coperta PDF, deși metadatele web pot indica ediția a doua. [Protocol integral](#).
4. Canadian Paediatric Society. The medical evaluation of pre-pubertal children with suspected sexual abuse. [Poziție profesională](#).
5. World Health Organization. Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. 2017. ISBN 9789241550147. [Pagina oficială](#).
6. CDC. Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV - CDC Recommendations, United States, 2025. MMWR 2025;74(RR-1). [Recomandări](#).
7. World Health Organization. Emergency contraception. [Fișă informativă](#).
8. Adams JA, Farst KJ, Kellogg ND. Interpretation of Medical Findings in Suspected Child Sexual Abuse: An Update for 2018. J Pediatr Adolesc Gynecol. 2018;31(3):225-231. doi:10.1016/j.jpag.2017.12.011. Există erratum publicat în 2018. [PubMed - rezumat consultat](#).
9. WHO, UN Human Rights, UN Women. United Nations agencies call for ban on virginity testing. 17.10.2018. [Declarație oficială](#).
10. CDC. Sexual Assault or Abuse of Children. STI Treatment Guidelines, 2021. [Ghid pediatric](#).
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12. Romania. Legea nr. 46/2003 a drepturilor pacientului, art. 13-23, forma oficială consultată la 21.09.2026. [Romanian legislation portal](#).
13. Romania. Codul de procedură penală, Legea nr. 135/2010, art. 189-190; forma consolidată afișată la 13.06.2026, consultată la 21.09.2026. [Romanian legislation portal](#).
14. Romania. Normele procedurale din 25 mai 2000 privind efectuarea expertizelor, a constatărilor și a altor lucrări medico-legale, aprobate prin Ordinul nr. 1.134/C/255/2000; art. 5-6, 8, 14-16, 22 și 26; forma consolidată afișată la 24.12.2024, consultată la 21.09.2026. [Romanian legislation portal](#).
15. Romania. Ordinul nr. 1.434/687/C/2023 pentru modificarea și completarea Normelor procedurale medico-legale, Monitorul Oficial nr. 370 din 2 mai 2023; art. I pct. 5-6. [Romanian legislation portal](#).

**Editorial note:** The Romanian procedural section was reviewed on 21 September 2026. Practical recommendations are a synthesis for professional appraisal, not a validated institutional protocol. No individual case data or images are included.