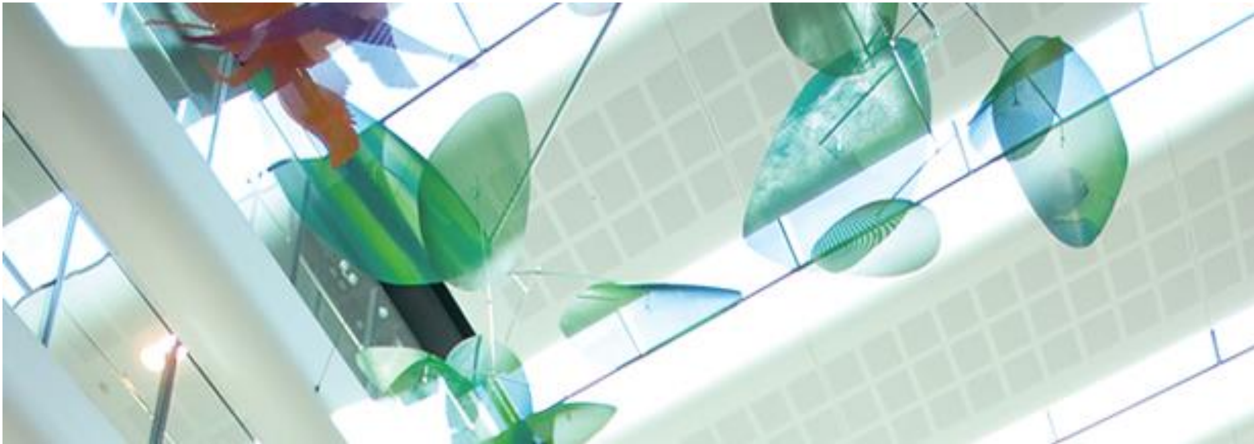
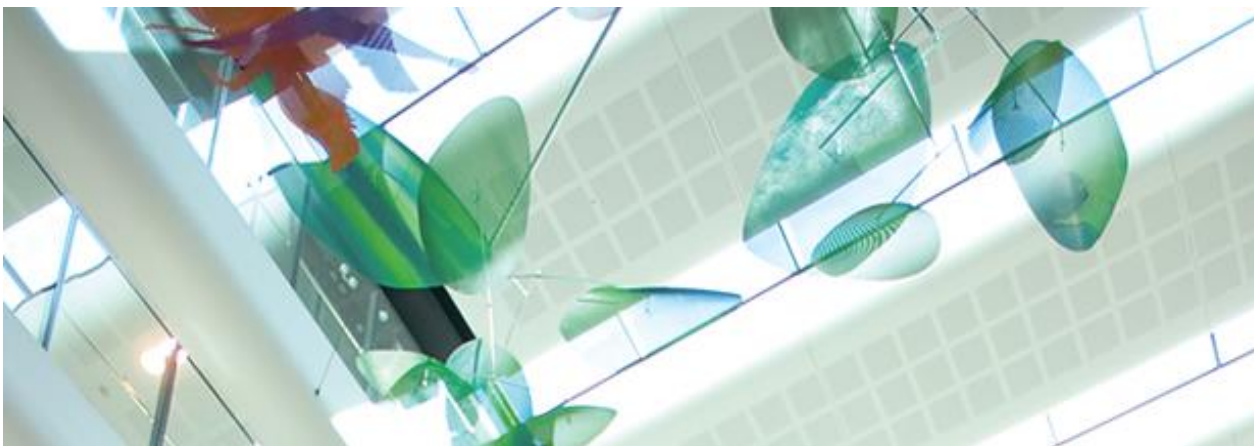


FORENSIC PAEDIATRIC MEDICINE

VFPMS MANUAL **2025**



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A Guide for Paediatric Practice in Clinical Forensic Medicine (VFPMS 2025)

1. Introduction

This manual provides information regarding the operation of the VFPMS. Trainees and new VFPMS staff might find this information useful.

The manual aims to provide staff with an orientation to the VFPMS, an explanation regarding VFPMS processes, procedures and VFPMS guidelines as well as tips for safe practice. Current staff may use the manual as a single point of reference regarding best practice and currently recommended VFPMS processes and procedures.

The manual explains the principles that underpin practice in the field of paediatric forensic medicine and aims to assist VFPMS staff to understand the policies, processes, procedures and standards of practice that are expected of professionals working within the VFPMS. The manual should be read in conjunction with the VFPMS clinical practice guidelines published on the VFPMS website and the various CPGs on the RCH website relating to injury and child abuse.

The manual serves as a single “source document” in relation to the operation of the VFPMS. It is updated annually.

1.1 Principles guiding practice

Most (but not all) of the children seen by the VFPMS are living with adults who are finding it difficult to adequately provide for their children’s health, safety, developmental and emotional needs. Some children are referred to the VFPMS because they have sustained injury as a result of accidents or they have medical findings that have been confused with findings caused by abuse. It is important that professionals do not jump to conclusions or assume that children have been abused merely because they have been referred to the VFPMS (i.e. professionals must work to avoid confirmatory bias).

Contact with the VFPMS should provide each child with a “one-stop-shop” comprehensive assessment of his/her/their health and developmental needs. This holistic “model of care” was developed in consultation with stakeholders and funding organisations when the VFPMS was established.

Each VFPMS assessment should result in broad-based recommendations aimed to alter the trajectory of the child’s life for the better.

The philosophies underpinning the operation of the VFPMS have been in existence since the service commenced operations in 2006. In summary, we strive to be all of the following when we provide care for children and their care-givers; We strive to be:

- Informed. Working with an awareness of the ecology of child abuse. We aim to provide an “eco-bio-developmental” perspective of a bio-psycho-social problem.
- Integrated (operating collaboratively in an integrated way with all other health services for children so health services are not duplicated or fragmented).
- Specialist (using knowledge and skills acquired by paediatricians who have forensic medical qualifications).

- Effective (proven to produce good outcomes — this means that there is an evidence base that supports our decision-making).
- Efficient (not wasteful of resources, including time and energy).
- Innovative (adapting to changing demands and circumstances).
- Accountable (with monitored KPIs).
- Leaders in the field. We do this by demonstrating a high standard of care and excellence in clinical practice (using CPGs and protocols to standardise good practice)
- Continuously improving. We do this by using service-user and stakeholder feedback and audits to adapt to changing demand, changing clinical problems and changing socio-political circumstances.

2. Everyone in VFPMS develops and maintains their clinical competencies

2.1 VFPMS Training Program

The training program for advanced trainees in forensic paediatric medicine and child abuse has been designed to meet the training needs set out in the framework of the Royal Australasian College of Physicians (RACP) Division of Paediatrics and Child Health Advanced Training Curricula in Community Child Health and General Medicine (Paediatrics) for training in "Child Protection". The VFPMS is accredited by the RACP to provide child protection and developmental-behavioural training for advanced trainees in paediatric medicine. We recently applied for RACP CCH accreditation to train in social paediatrics. It is envisaged that almost all VFPMS trainees will be advanced trainees in paediatric medicine currently training under the RACP in the late stages of their training. Trainees in Emergency Medicine, particularly joint trainees in paediatric medicine and Emergency Medicine, are strongly encouraged to apply for training positions with the VFPMS.

Because of some definitional peculiarities used by the RACP CCH ATC, the VFPMS was not accredited in 2024 to oversee training in social pediatrics (the RACP CCH ATC defines 'social paediatrics' to be something that occurs only in locations "outside" hospital-based clinics). We aim to rectify this anomaly in 2025.

Trainees in Clinical Forensic Medicine with the Faculty of Clinical Forensic Medicine, Royal College of Pathologists Australasia, are also encouraged to apply but (at the current time) must have independently arranged funding. Observerships (unfunded honorary positions with no clinical responsibilities) are possible for selected applicants.

2.1.1 Site accreditation has been obtained by the VFPMS for training in Clinical Forensic Medicine (Royal College of Pathologists Australasia)

Information about the training program and training requirements in Clinical Forensic Medicine are available at www.rcpa.edu.au. Trainees should understand and comply with requirements listed in the RCPA Trainees Handbook – Clinical Forensic Medicine, as well as Trainee Handbook – Administrative Requirements. The initial registration form for CFM training is available from the website under "initial registration". Note that prospective trainees must have a CFM training position (minimum of 0.3 EFT) in an accredited training site prior to application. At the completion of CFM training, doctors will be qualified to practice in the field of forensic medicine (note that Ahpra does not recognise forensic

medicine as a medical specialty). A doctor who is not a trainee of the RACP and who is interested in obtaining CFM qualifications as a RCPA CFM trainee is encouraged to discuss their plans with the Director, VFPMS and the Chief Examiner of the Faculty of CFM (currently Nicola Cunningham).

2.1.2 Maintenance of log books of clinical experience (case-based experiences)

Trainees and new consultants are encouraged to keep log-books of their child abuse cases to facilitate self-assessments, self-reflection and discussions with supervisors regarding the scope of experience. This activity might also meet some CPD requirements and will assist conversations with managers around professional development and performance (PDAP). The log books might also facilitate conversations between trainees and supervisors about skills development and the need for exposure to particular types of cases. (The log books might serve as tools to enable trainees to identify gaps in exposure to certain types of clinical presentations).

2.1.3 Certificates of Competency

The VFPMS manual aims to provide staff with information about how to acquire knowledge, skills and experience to increase expertise in this field of medicine. The VFPMS awards a Certificate of Competency to trainees who have successfully completed the training program and demonstrated the requisite knowledge, skills, attitudes and behaviours. The VFPMS evaluation of competencies is modelled on the (now outdated) UK Royal College of Paediatrics and Child Health[1] categories of desired competencies for forensic physicians and paediatricians. It also reflects the required clinical competencies described by the RCPCH in the document ‘Service specification for the clinical evaluation of children and young people who may have been abused September 2015’.[2]

The approach to supervision of clinical work undertaken during advanced training with the VFPMS is in keeping with the philosophies underpinning the use of “Entrustable Professional Activities” (EPA). If you want to read more about EPA, see the reference “Nuts and Bolts of Entrustable Professional Activities” by Olle ten Cate in the Journal of Graduate Medical Education 2013[3]. Over the course of trainees’ rotations with VFPMS, they will progressively be entrusted to make increasingly complex decisions regarding clinical care. At the commencement of the rotation, all work will be supervised either face-to-face or by telephone. This might feel “untrusting” but it is based on desire for safety and accuracy, even though it might seem insulting and overly cautious! Gradually, as trainees’ competencies in forensic medicine increase, they will be rewarded with greater autonomy. They will be trusted to independently communicate directly with Child Protection practitioners and police and will probably present evidence and their opinions at case conferences and in court. This means that at the start of rotations, trainees need to discuss each and every case and each decision with supervisors. By the end of rotations, trainees are usually capable of performing most tasks with only minimal supervision.

All VFPMS supervisors have undergone training to be “approved supervisors”, i.e. supervisors are required by the college(s) to have successfully undertaken a supervisors’ training program and to be

[1] Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse, produced by The Royal College of Paediatrics and Child Health and The Association of Forensic Physicians, September 2004.
[2] Service specification for the clinical evaluation of children and young people who may have been abused September 2015. Royal College of Paediatrics and Child Health 2015.
[3] Olle ten Cate, Nuts and Bolts of Entrustable Professional Activities, J. Grad Med Educ. 2013 Mar; 5(1): 157-158

certified as approved supervisors of trainees. The VFPMS is only able to appoint SMS who have successfully completed supervisor training to college supervisory roles. Neither college (RACP and RCPA) currently recognises a supervisors' training program run by any other college. At this time, most VFPMS senior medical staff have completed the required 3 modules to be accredited RACP supervisors. Anne Smith and Jo Tully have completed the RCPA supervisors training program and are accredited supervisors of Clinical Forensic Medicine (Faculty CFM RCPA) trainees. All VFPMS senior medical staff oversee trainees' day-to-day VFPMS work but only college-accredited supervisors can "sign off" college paperwork with regards to trainees' rotations with the VFPMS.

The following tables set out the core competencies and case-specific competencies (skills) that are seen as highly desirable for practitioners working in the field of paediatric forensic medicine. The table also sets out how these skills might be assessed by supervisors.

Table 3 sets out the skills that are likely to evolve during trainees' rotations with the VFPMS and during the first few years of employment as senior medical staff.

TABLE 1 - CORE COMPETENCIES

	Core skills	Evaluation
1	Ability to communicate comfortably with children and carers about injury, sexuality, all forms of child abuse and sensitive child protection matters	Demonstrated during clinical supervision, observed by supervisor
2	Apply knowledge of child's development, social and emotional needs to clinical situation	Demonstrated to supervisor's satisfaction
3	Apply knowledge of consent and confidentiality as these relate to children	Pre reading completed, Discussion with supervisor to test knowledge
4	Ability to conduct a comprehensive general examination of children and young people	Observation by clinical supervisor
5	Ability to conduct a comprehensive genital examination using video or DVD colposcopy Competency in genital examination techniques	Peer review of genital examination findings Demonstrated use of labial separation, labial traction, left lat anal and prone knee-chest
6	Apply knowledge of genital anatomy (normal, variants and injuries) to evaluation of examination findings	Discussion at peer review sessions, clinical supervision
7	Apply knowledge of physical injuries (accidental and abusive) to clinical evaluations	Demonstrated to supervisor All medical reports reviewed
8	High standard of documentation of history and examination findings	Demonstrated All reports reviewed
9	Evaluation of history, examination findings and investigations with INTERPRETATION of these factors to formulate an opinion as to the likelihood that child abuse has occurred	Review of medical reports supervision
10	Produce detailed medical reports in 3 domains Physical injury Sexual abuse Neglect / at risk	Review of medical reports
11	Verbal presentation of case and opinion about likely cause of injury	Peer review Supervision Multidisciplinary team
12	Conduct literature review relevant to clinical problem	Demonstrate to supervisor – at least one
13	Collate information from multiple sources to provide recommendations for child's holistic care	Demonstrated by recommendations in reports
14	Contribute effectively as member of multidisciplinary team	Case conference
15	Presentation of evidence using sound reasoning and flawless logic!	Court

TABLE 2 - CASE SPECIFIC COMPETENCIES

	Case Specific Skills	Evaluation
1	Order appropriate investigations for evaluation of physical injuries	Reports reviewed
2	Order appropriate investigations for sexually transmitted infections	Supervision / reports
3	Collect forensic samples, maintaining chain of evidence and high standard of documentation	Supervision / reports
4	Prescribe post-coital contraception and STI prophylaxis as required	Supervision / reports
5	Refer as required to other medical / health specialists	Supervision / reports
6	Notify child protection when appropriate, demonstrate knowledge of regional networks and apply judgement in decision making	Supervision / reports Case conference
7	Present evidence to Victoria Police	Case conference Supervision / reports

TABLE 3 - EVOLVING EXPERTISE

	Evolving Expertise	Evaluation
1	Understanding and use of sound logic and reasoning Knowledge of fallacies of logic	Complete ppt Demonstrate in reports
2	Opinion formulation using forensic principles	Complete ppt demonstrate
3	Presentation of evidence in written and verbal reports and in court	demonstrate
4	Provision of expert opinion referenced by critical evaluation and understanding of literature	Demonstrated in at least 1 report
5	Understanding of systems and socio-political context in which medicine is practiced.	Discussion with mentor or supervisor
6.	Awareness of public health / epidemiology of child protection with demonstrated willingness to intervene to promote change (improvement)	Discussion with mentor or supervisor

3. Orientation and induction to VFPMS clinics

Trainees and new medical staff are invited to sit in with a VFPMS consultant for at least one sexual abuse assessment and to have a VFPMS consultant sit in with the trainee when the trainee performs their first sexual abuse assessment. It is for this reason that trainees will not be rostered to participate in the after-hours roster for the first month of their rotation.

We invite trainees to “shadow” the VFPMS consultants working after hours prior to commencing their own after-hours shifts and we may also roster a consultant on after hours with trainees (as a buddy) for their first shifts. (Warning: because we see fewer cases of recent sexual assault than we used to, it is possible that trainees might not have seen many recent sexual abuse cases when the time comes to commence “on call”).

For cases seen after the induction period, trainees should conduct the assessment on their own and discuss each assessment with a senior consultant. As the demand for our medical services varies and we have no control over the types of presenting problems that greet us each day, we cannot guarantee when sexual abuse cases will occur. We anticipate but cannot guarantee that trainees will be exposed to at least one sexual assault evaluation in working hours or during a period of shadowing consultants prior to being on-call, so if the first on-call shift is approaching and trainees have not yet seen a sexual assault assessment then they might need to consider making themselves available to “shadow” additional consultants (if possible). They will be paid for **recall** time at the usual hourly rate. Trainees should watch the videos about conducting examinations and collecting samples and learn all about the process from the PowerPoint presentation about using the Forensic Medical Examination Kits (FMEKs). It is up to trainees to ensure that they take up opportunities to observe sexual abuse assessments as soon as possible after the commencement of this rotation.

All VFPMS trainees and senior medical staff must ensure that they are familiar with the use of the equipment (colposcopes at RCH and MCH, as well as Victorian Forensic Medical Examination Kits (FMEKs) and Contamination Reduction Kits (CRKs) prior to their first on-call period.

The VFPMS will provide time and opportunities for education and training, noting that each VFPMS doctor is responsible for achieving and maintaining their clinical competencies.

The VFPMS managers assume that trainees will be able to conduct an assessment of a physically injured child (with VFPMS SMS supervision) from their first day.

The VFPMS provides time to compete mandated training at RCH and MCH.

3.1 What do VFPMS doctors do?

The key work of the VFPMS is to provide assessments of children when child abuse is suspected, to provide opinions about the likelihood that child abuse has occurred (demonstrating reasoning and the basis for these opinions) and to make recommendations for intervention, **aiming to improve the quality of children’s lives**.

Many doctors consider the “one child at a time” approach to medical practice to be deeply rewarding. This approach does not preclude a co-existing public health approach to working with populations of

abused and vulnerable children. Most, if not all, of us work in both these ways during our professional lives.

The format of the assessment of the individual child follows the usual “history / examination / investigations / opinion / medical report” sequential process, although there are a few additional tasks that might be required when children present with problems such as child sexual abuse. Follow up regarding further testing for STIs and referral for ongoing management of HIV prevention are two examples.

VFPMS doctors provide consultations and advice via face-to-face conversations, email, telephone calls and videocalls/Telehealth. We also provide non-face-to-face assessments via case file reviews, secondary consultations including forensic opinions in relation to the causes and timing of children’s injuries, and advice for medical professionals about appearing in court. Some senior medical staff have studied forensic toxicology and can interpret toxicology results (with some limitations). Some of us trained (perhaps briefly) in medical and mental health subspecialties that intersect with paediatric forensic medicine, such as child and adolescent psychiatry, adolescent medicine, developmental medicine, trauma medicine, dermatology and gynaecology, to name a few subspecialty areas of interest. We encourage consultations within the VFPMS team prior to a child’s referral to subspecialists external to the VFPMS.

VFPMS provides education and training about child abuse, forensic paediatric medicine and information about appropriate responses to suspected child abuse. Teaching and training is a core function of the VFPMS. Education is provided to medical and other health professionals, students, police and Child Protection practitioners, in addition to maternal and child health nurses, child-care workers and family-support professionals working in non-government organisations. Everyone in the VFPMS is encouraged to contribute to the VFPMS education program.

3.2 What do VFPMS nurses do?

The Nurse Unit Manager at RCH and the Clinical Nurse Coordinators at MCH perform a key role in being the point of first contact for professionals who wish to use the VFPMS. The nurses triage incoming requests for VFPMS services, liaise with referring agencies and counselling services and coordinate service delivery within the VFPMS. **The VFPMS nurses manage the operation of the VFPMS clinics at RCH and MCH** and they coordinate the VFPMS service response regarding inpatients. The nurses are responsible for the day-to-day operation of these clinics, including the allocation of patients to be seen and case-work to be completed. Although the nurses assist with accessing results of tests and arranging patient follow-up, it must be remembered that **responsibility for interpretation of tests, follow up and ongoing medical care rests with allocated VFPMS doctors**. Treating doctors are responsible for the quality of their patients’ care and for ensuring appropriate ongoing medical follow up and liaison with Child Protection and police.

The VFPMS Nurse Unit Manager at RCH and Clinical Nurse Coordinators at MCH are responsible for scheduling of clinic appointments. Nurses provide education and training, advice and assistance for clinical practice and they have a key role in policy development, improvements in clinical practice and in quality assurance.

The Nurse Unit Manager has responsibility for clinical activity-related data collation and reporting. All nurses are responsible for monitoring and ordering of supplies and for nursing staff training and supervision.

Nurses at both sites are responsible for coordinating the scheduling of appointments across both sites (as an integrated multi-site service) and assisting in a practical way with the delivery of clinical services. Nurses are members of the VFPMS Management Committee.

3.3 What is the VFPMS Management Committee?

The Management Committee (Medical Director, Deputy Director, a co-opted senior medical staff member, and two Nurses) meets monthly to review and manage the overall operation of the VFPMS. The senior Administration Officer is the minute-taker for these meetings.

Minutes of these meetings are distributed to the clinical team.

3.4 What do our social work partners do? (Gatehouse, SECASA and hospital social workers)

Medical social workers working within hospitals in Victoria are familiar with the needs of patients interacting with the health system. Social workers are trained to recognise children's vulnerability to a range of harms and to intervene to better protect and support vulnerable children and their carers.

Social workers provide advice, risk assessment, and education regarding family violence (according to the MARAM framework and CISS and FVISS information-sharing obligations), which is an important role for social workers within all Victorian hospitals.

Some of their work involves psychosocial assessments relating to injured children which is performed in collaboration with the clinical work of VFPMS medical and nursing staff. Social work assessments focus on the child's psychosocial circumstances and interaction with the Child Protection system.

The VFPMS assessments of physical injuries, assessments of risk of harm and assessments of symptoms and signs that might or might not be caused by abuse can occur concurrently with social workers, preceding, or subsequent to a social work assessment of a child's psychosocial situation. (Note that Child Protection usually performs this task for children who are outpatients and Child Protection practitioners typically have access to far more information than hospital-based social workers.) Concurrent assessments with hospital-based social workers rather than Child Protection practitioners are more likely to occur for children who are inpatients, have recently sustained injuries or who present to Emergency Departments (EDs) after hours. Hospital social workers provide support for parents and carers while helping them navigate the system.

A VFPMS doctor may choose to conduct a joint interview/assessment with a hospital-based social worker or counsellor. Some doctors prefer to provide medical consultations prior to social workers and/or counsellors assessments. Doctors may choose to perform joint interviews with Child Protection practitioners or police. Because the doctor–patient relationship should be safeguarded (and patients expect a relationship of confidence and privacy with their doctor), the presence of additional people during the consultation should only occur with the patient's consent and at the discretion of the doctor.

Assessments of sexual abuse allegations must occur as joint work with sexual assault counsellors from the Centres Against Sexual Assault (CASAs). (**Note that observers, previously called "chaperones", must always be present during children's genital examinations by VFPMS staff. These observers can be CASA staff**).

The CASA counselling teams comprise professionals who trained as social workers or psychologists, with a few exceptions. The two sexual assault counselling programs provided by Centres Against Sexual Assault at RCH and MCH are 1) victim support services for the child and family members, known as Sexual Assault Support Services (SASS), and 2) sexually abusive behaviours treatment (SABT) for children who are behaving in a manner that places others at risk of harm from sexual assault.

Some of the CASA counselors have family therapy training and/or training in specific counselling techniques and interventions. Many CASA counsellors use sand-tray therapy and some use art therapy. All are supervised according to guidelines established by their disciplines and managers. All these groups of professionals provide teaching and liaison work.

Sexual assault counselling services do not usually provide direct access to psychiatrists, although Gatehouse employs a psychiatrist (but only for secondary consultations) one session per week. None of the CASAs are governed according to the frameworks set up for Victorian Mental Health Services. Instead, the CASAs are managed by Sexual Assault Services Victoria, a Victorian government organisation funded by DFFH. The CASAs operate independently to mental health services in Victoria but many of their staff work collaboratively with individuals and agencies providing mental health care in relation to individual children (and young adults — CASAs other than Gatehouse provide services for adults). Some CASAs operate as departments within health services (e.g. Gatehouse and SECASA) while others operate as independent organisations with CEOs and Boards of Management, albeit with at least partial DFFH funding. Many CASAs provide services within Multidisciplinary Centres (MDCs) in Victoria — co-located with Victoria Police and Child Protection practitioners. MDCs are currently located at Dandenong, Mildura, Geelong (Barwon), Bendigo (Loddon), Morwell, Seaford (Bayside Peninsula) and Werribee/Wyndham.

Much of the counsellors' work with children involves therapy for abused children and their families (this includes counselling work with parents, carers and siblings). These services are Sexual Assault Support Services (SASS). The counsellors may provide individual therapy, group therapy, family therapy or a combination of these.

The Sexually Abusive Behaviours Treatment program (SABT) was originally designed for children aged 10 to 14 years but eligibility for services has been expanded to other age groups. CASAs are one of the key service providers for this program (Gatehouse and SECASA demonstrate leadership in this field). Children do not need to be on a Therapeutic Treatment Order to be eligible for a SABT service. Note that services other than CASAs are also funded to provide SABT programs.

SECASA does not usually provide individual services to children aged less than 5 years.

Some CASAs also provide counselling services to adult victims of physical assault, particularly in the context of intimate partner violence. Counselling for victims of physical abuse is also provided at The Orange Door and other counselling services for victims of family violence (see below).

You are encouraged to consider referral of younger traumatised and emotionally distressed children to CAMHS or other local mental health services for young children.

Many counselling programs and mental health services across Victoria are currently funded to provide services to victims of family violence. Note that the RCH Mental Health Service treats child victims of family violence aged less than 11 years and Orygen is the lead agency for treatment of older children

and adolescents. Orange Door also provides services to victims of family violence (https://www.orangedoor.vic.gov.au/).

A wide range of additional organisations in Victoria provide services to people affected by family violence. The following websites provide useful information or you might seek advice from the social workers at RCH and MCH.

- Domestic Violence Resource Center Victoria — https://www.dvrcv.org.au/support-services/victorian-services.
- Safe Steps Family Violence Response Centre — https://www.safesteps.org.au/.
- Family violence services for women at Better Health Channel — https://www.betterhealth.vic.gov.au/health/HealthyLiving/family-violence-services-for-women.
- 1800 Respect: National Sexual Assault, Family and Domestic Violence Counselling Service — https://www.1800respect.org.au/ or 1800 737 732 (telephone).
- Relationships Australia — https://www.relationships.org.au/what-we-do/services/family-violence-prevention.
- Victorian government (links to The Orange Door locations) — https://www.vic.gov.au/family-violence-support.

Use your clinical experience and the advice of senior VFPMS staff/colleagues to refer children to the **most suitable service to meet the child's needs**. Please consider the mental health needs of infants and young children. Be particularly mindful of the need to refer young physically abused children to Infant Mental Health teams.

You may also consider the broad range of mental health services to meet the carers' needs, particularly when carers are not the child's biological parents. The health and mental health needs of grandparents and other kinship carers may warrant particular attention.

You can also refer children to specialist mental health services such as gender dysphoria clinics and eating disorder clinics. Your clinical judgement about the child's symptoms and their family situation should guide you to make a referral to the service **best suited** to meet the child's particular needs and/or their carers' needs.

3.5 What do the Fellows in forensic medicine do?

The VFPMS Fellows are 1) students/scholars and 2) service providers. The Fellows' role is twofold; firstly to perform medical evaluations of children in whom child abuse is suspected (a clinical service component), and secondly to increase their own personal knowledge and skills in relation to child abuse (and thus, increase their own clinical competencies) in order to provide a great service to children throughout the remainder of their professional careers. The training aspect is important but so too is the service provision component of the role. Knowledge, skills, attitudes and behaviours learned during VFPMS rotations are therefore likely to benefit many others with whom trainees come into contact throughout their long and successful careers.

Day-to-day clinical work is overseen by VFPMS consultants who are working in the same VFPMS clinic. All SMS and nursing staff are expected to assist, guide and teach all VFPMS trainees.

Fellows have an allocated college-approved supervisor/supervisor of advanced training (or two) who may be in addition to their allocated VFPMS clinical-work supervisor with whom they should have a

weekly one hour 1:1 clinical supervision session. The college-approved supervisors bear the overall responsibility for trainees' progress throughout their VFPMS rotation.

Trainees should work closely with their VFPMS clinical-work supervisor. NB: One hour of clinical supervision should occur each and every week unless something exceptional intervenes and takes priority.

The trainees' college-approved supervisors will meet with trainees at least quarterly in order to "sign off" paperwork and complete RACP (and/or RCPA) evaluations and assessments. VFPMS clinical-work supervisors who are not college-approved supervisors will be asked for their evaluations and for advice regarding formative assessments when forms are submitted to the college(s).

All supervisors are expected to contribute to trainees' work-based assessments such as miniCeXs and case-based discussions and to complete forms for the college(s) according to college requirements.

VFPMS consultants working 2 days or more per week (4 sessions/week) with the VFPMS are expected to undertake supervisor training with RACP so they are eligible for a clinical supervisor role within the VFPMS.

3.6 What must trainees do to develop clinical skills?

Clinical work will occupy a significant percentage of trainees' time with VFPMS. Time must be set aside (and protected) for clinical supervision. Time for personal study will fit around the demand for clinical services.

The trainee/Fellow functions as part of a multidisciplinary team, liaising with counselors, police, protective services and others. Cases for clinical assessment will be allocated by the VFPMS nurses who will ensure (as much as is practicable) that the workload is manageable and equitable.

The trainee conducts face-to-face consultations that are child abuse assessments of children referred to the VFPMS because of suspected child abuse or neglect. At all times, the trainee is expected to consult with his/her supervisor about cases and issues of concern.

Trainees will write a medicolegal report for every child seen. Note that consultants (not trainees) carry primary responsibility for signing off on reports in relation to inpatients who have intracranial injuries that might have been caused by abusive head trauma. Towards the end of rotations, trainees may draft reports of assessments undertaken under consultants' supervision and with significant input from consultants in relation to these cases (particularly in forming the forensic opinion regarding cause, timing and consequences of injury). Consultants take ultimate responsibility for these forensic opinions and this must be clearly stated in the VFPMS reports. Consultants should either co-sign jointly written reports for highly complex cases or it should be declared within the report that the consultant has supervised the trainee's assessment and opinion formulation.

Cases of suspected abusive head trauma and case file reviews, in relation to suspected factitious illness, will usually be allocated to SMS rather than trainees at the start of their rotations, but trainees near the end of their rotations and trainees interested in careers in this field may be allocated more complex and challenging cases.

3.7 The start of my VFPMS rotation: What happens regarding day-to-day oversight of clinical work?

As a general rule, during their first week with the VFPMS, trainees should sit in with consultants (for at least one consultation) and observe medical evaluations for suspected physical as well as sexual abuse. The trainee should then conduct his/her own assessment whilst the consultant observes the process. The trainee should then be able to conduct the assessments using the consultant for advice and technical assistance, particularly for the first few genital examinations using the colposcope. **All recordings of genital examinations and all images of injuries should be reviewed and discussed with trainees' clinical supervisors or SMS in clinic at the time of the consultation.** If possible, the SMS who is working alongside the Fellow in clinic should promptly see the physical injuries and genital examination findings face-to-face, however this is not always possible. Both the cause(s) and timing of injuries should be discussed for each case as routine practice, as well as case management and interagency communications.

All trainees have been rostered for times when consultants are routinely in clinics. However, there are times when consultants are not on site because they are in court, attending case conferences, on holidays or unwell. When a SMS is not in clinic to provide face-to-face advice, then trainees are expected to telephone the Director or Deputy Director (or delegate) to discuss patients.

The Director and Deputy Director want to know about any problems, particularly if Fellows are finding work challenging or distressing and if assistance with clinical work is not readily available. We also need to urgently know if there are any problems related to the frequency, quality and safety of clinical supervision, for whatever reason.

4. VFPMS guide to clinical practice: Duties and responsibilities

The following section provides an explanation of VFPMS processes and procedures.

The VFPMS website provides information about VFPMS tools and templates, referral processes and recommended procedures to follow when investigating suspected child abuse.

The Director and Deputy Director act as Clinical Leads in relation to VFPMS work undertaken at RCH and MCH.

The VFPMS Clinical Practice Guidelines offer advice regarding recommended investigations for the various presentations that generate concern regarding child physical abuse, sexual abuse and neglect. These guidelines have been developed in line with advice offered by international organisations such as the American Academy of Pediatrics (USA), the Royal College of Paediatrics and Child Health (UK) and the Canadian Paediatric Society. The guidelines are also informed by review of current literature covering a wide range of topics related to the child abuse field, noting that knowledge in this field is changing rapidly.

4.1 Working from home and the use of video-links

As a result of COVID-19 restrictions, changes occurred within hospitals and VFPMS to maintain patient and workforce safety while maintaining a service to the community and stakeholders. Working from home requirements and privileges varied according to Department of Health and hospitals' advice and the need for staff to work on site to meet the needs of the VFPMS. These days most staff work on site

but occasional working-from-home days are permitted. It is the responsibility of staff to ensure that they meet hospital requirements and approval to work from home from time to time, as the needs of the department allow. (NB: The required hospital paperwork must have been completed and approval to WFH obtained — there are security and OH&S issues at stake).

Meetings (departmental meetings, SCAN meetings and Discharge planning meetings) are generally held via video-conference (virtually), because it saves travel time and easily connects staff at both clinics (RCH and MCH) and across the broader service system.

Telehealth consultations remain possible but are infrequently used within VFPMS for a variety of reasons. Parts of the consultation (rather than the entire consultation) may be conducted via telephone or videolink. For example, information gathering may occur via a telephone call then the examination occurs in person. Examination of injured children should occur at a face-to-face consultation (a thorough search for occult injury cannot be reliably conducted in any other way). Infants and young children should always be examined top to toe and their orifices should be inspected. A focused examination (i.e. not the entire body) may be reasonable in older children under some circumstances.

Limitations exist to forensic opinions based on images. These limitations must be acknowledged whenever forensic opinions are communicated to others (orally or in writing).

- See template for written VFPMS reports based on images.
- Emailed brief forensic opinions based on images should include the following disclaimer or similar words:

"This opinion is provided in good faith to assist with urgent decision-making around case management. It is based on limited information provided by the caller and viewing of images sent as email attachments.

These images have been viewed on a computer monitor and may have been enlarged for close inspection.

Significant limitations apply to the interpretation of injury based on images. These limitations reduce the confidence with which forensic opinions can be provided and likely increase the diagnostic error rate when compared to real-life examinations.

This opinion has not been subjected to the usual VFPMS peer-review process".

4.2 On call — recall

4.2.1 Information about the after-hours telephone call service located at VIFM, Southbank

The after-hours call service operator is off site, located at the Victorian Institute of Forensic Medicine (VIFM). Confusion can occasionally arise in relation to the VFPMS after-hours roster, so feel free to contact the Director if/when difficulties arise.

Telephone advice is provided by VFPMS to:

- Victoria Police,
- Health professionals, and
- Child Protection practitioners.

The VFPMS is not funded to provide telephone advice and consultations directly to members of the public.

The routing of telephone calls made to the 1300 661 142 number is an automated service managed by Telstra. In working hours, calls are diverted to the RCH Nurse Unit Manager's office (9345 4299). On occasion, in-hours' calls can be diverted to other numbers such as the Nurse's office at MCH or to a mobile number.

The after-hours VIFM call service currently receives and responds to after-hours calls for coronial and forensic services including the VFPMS. The VFPMS 1300 661142 telephone number is answered by VIFM after 5:30pm and prior to 9:00am on weekdays, and for 24 hours on weekends and public holidays. Between 8:30am and 9:00am on weekdays, the calls are received by reception staff at VIFM Department of Clinical Forensic Medicine, rather than the after-hours coronial services reception staff, but the process for contacting VFPMS staff regarding referrals should be unaffected. The VIFM operator will receive incoming calls, collect basic information about the referral and then telephone the on-call VFPMS doctor, who must maintain availability during the on-call period. This means that mobile telephones are charged, switched on, and the doctor is able to respond to a call within minutes. Messages will be left on voicemail when doctors cannot immediately be contacted. Doctors must promptly respond to telephone calls. When the call service operators are unable to contact first-on-call doctors, then VFPMS second-on-call doctors are contacted by telephone (usually after 20 minutes or so have elapsed from the time of the initial attempt to contact the first-on-call doctor).

Calls received after hours are commonly received in relation to requests for an urgent after-hours face-to-face consultation but may relate to information about more general in-hours VFPMS services, advice regarding injury interpretation, procedural guidelines, appointments for in-hours services or follow-up regarding particular patients.

4.2.2 Principles underpinning our after-hours work

The aim of the VFPMS 24/7 telephone advice service is to promptly solve problems, minimise angst and increase diagnostic accuracy. The principles and attitudes that underpin our work should also guide our attitudes and behaviour after hours. We aim to be helpful. We go the extra mile. We work hard. We collaborate. We demonstrate integrity. As good team players, we are mindful of everybody's roles and responsibilities, and we always work as respectful partners with other professionals. We advocate for the safety, wellbeing and health of children and adolescents whom we treat and we will not be pressured into compromising the quality of their medical care.

Our work practices are ethical.

4.2.3 Guidance for decision-making around the VFPMS after-hours response

INPATIENTS — When do inpatients need to be seen after hours?

VFPMS doctors make decisions about whether to attend RCH or MCH after hours to provide VFPMS assessments of physically or sexually abused children based on the child's best interests and need for medical care, forensic sample collection and safety. The VFPMS doctors arrange out-of-hours consultations on a case-by-case basis, mindful of the child's circumstances and need for a forensic medical evaluation, competing priorities, availability resources, and stakeholder needs.

Under exceptional circumstances, VFPMS doctors will provide out-of-hours examinations overnight when a ‘next day’ service is not able to be scheduled or the case details are unusual and extenuating.

In general, inpatients that meet criteria for an after-hours VFPMS face-to-face examination should be seen within 24 hours of referral.

Referral received after 5pm:

- Inpatients referred to VFPMS after 5pm on any day of the week, including weekends, will typically be seen the following day. Under exceptional circumstances, seriously physically injured children admitted to PICU or NICU might be seen overnight.

Rationale: Children admitted with non-life-threatening injuries can safely be seen the following day. Deferring the assessment means that more staff and resources are available to support the VFPMS consultation (e.g. social work, VFPMS nursing staff, better room lighting), reduced financial cost to VFPMS (reducing on-call recall payments), and minimising Out of Hours attendances for VFPMS doctors where possible (to reduce exhaustion and burnout).

Acute (urgent) SEXUAL ASSAULT ASSESSMENTS:

Note: The designated timeframes for forensic specimen collection apply.

Recommended timeframes for forensic specimen collection from child and adolescent victims of sexual assault guide decision-making about timing of VFPMS consultations.

VFPMS doctors will provide an out-of-hours response to recently sexually assaulted children when forensic specimen collection is required (within recommended timeframe) and:

1. Referrals are received prior to 9pm.
2. Referrals received after 9pm but before midnight AND sexual assault occurred within the previous 12 hours. When allegations are limited to recent oral penetration (no other body site penetrated) AND children have not eaten or drunk, then recommendations will likely be made for Police to collect mouth swills and wipe perioral regions using dampened gauze from Early Evidence Kits (EEKs).
3. Under exceptional circumstances; for example, in relation to a strong suspicion of a recent Drug-Facilitated Sexual Assault (DFSA).

When referrals are received after midnight, recently sexually assaulted children will be offered an appointment in VFPMS Clinic the following day (this includes weekends and public holidays). Under exceptional circumstances, an examination and forensic sample collection might be provided overnight following discussion with senior staff from VFPMS and the referring agency.

Other factors to consider when making decisions in relation to referrals received after 9pm:

- Delaying the assessment will push the forensic medical examination significantly out of maximum time frame for forensic specimen collection.

- Referrals received after about 3am: The exam can usually reasonably be deferred until the following day, even if the child has not washed. If the allegation is of very recent oral penetration and the child/young person has not eaten or drunk, advise a mouth swill (EEK) and early review by VFPMS rostered day team.

- Referrals for a child/young person who is currently in the RCH/MCH Emergency Department: There should be a low threshold for attending to conduct a forensic exam in preference to the patient being discharged home and returning in the morning.

- Referrals received after 3am on Friday and Saturday on-call shifts (i.e. Sat and Sun mornings): A degree of flexibility in relation to attending for referrals for recent sexual assault examinations received after 3am may be required for doctors on call on Friday or Saturday nights, depending on the projected workload of the doctor on call the following day.

- Allegations of DFSA: These cases may require an overnight response if sample collection is time-critical.

Prioritisation of 'next day' sexual assault consultations:

Sexual assault assessments that were deferred to the following day will be prioritised over inpatient consultations and existing scheduled outpatient appointments.

4.2.4 Expectations of first-on-call Trainees and SMS

When on call, trainees receive incoming telephone calls for the VFPMS (24/7 telephone number 1300 661 142) from the VIFM after-hours service as the "first on call" while rostered on with a consultant. The SMS who is also on call for VFPMS will act as the trainee's supervisor, as well as being "second on call" for advice and consultation across the VFPMS network. Typically, the VFPMS Director or Deputy Director are also "first on call" with trainees but other SMS can also fulfil this role from time to time.

All incoming calls received by the trainee must be discussed with the senior doctor on call as soon as possible (within minutes) after the incoming telephone call. Trainees will obtain information from the caller, consider a possible management plan, telephone the senior to discuss this plan (modifying the plan if necessary) and then telephone (return call to) the original caller. All incoming calls will therefore be promptly handled by both the trainee and the senior doctor. This guided telephone consultation process aims to build trainees' skills in managing complex situations involving police and Child Protection practitioners.

The trainees must complete their log of telephone calls and send the information sheets as soon as possible to the VFPMS Admin officer. Trainees will need this information to claim payments for their time spent receiving and responding to telephone calls. This is part of the expectations of Doctors-in-Training as set out in the industrial award.

In some instances, the senior doctor on call may "take over" a case and deal directly with the caller. This is most likely to occur when situations arise requiring complex case management of children residing in regional Victoria.

4.2.5 Senior medical staff on-call WFH claims

Senior medical staff should invoice the VFPMS for time spent working from home after hours and while on call (this includes responding to incoming telephone calls and email communications managed as part of their on-call duties). This time will be totalled per pay period and paid at WFH rates.

4.3 Documentation of consultations regarding inpatients

All VFPMS staff must document information about the referral and all advice provided. This applies to all enquiries and consultations in hours and after hours. In relation to advice provided when on call, documentation may be provided in the form of an email to VFPMS managers as soon as possible at the end of on-call shifts (usually as close as possible to 9am). The same approach to promptly documenting calls and handing over to and informing managers should be taken to advice provided by VFPMS staff to calls received during working hours. It is also important that on-call VFPMS staff to know about current inpatients.

The following template might be useful for documentation and handover purposes following a period of on call (a modified ISBAR format):

Date and time of call	
Author's name	
Patient Name & DOB **UR/MRN**	
Referrer	
Situation & Advice	Age, gender Concerns Plan
ALERT	Urgent action required and by whom

VFPMS staff must document consultations regarding inpatients in patients' medical records to communicate with treating health care professionals. A conversation with the treating medical/surgical team is strongly recommended — some might say "expected" (preferably with the bed-card consultant rather than junior residents/registrars). This should occur at the time of the consultation.

The VFPMS doctor who provides the consultation remains responsible for ongoing communication with other professionals and family members, decision-making and recommendations around forensic investigations, attendance at case conferences (or delegating other VFPMS doctors to convey information and opinions on their behalf) and writing the VFPMS report. Only under exceptional circumstances (for example, annual leave and illness) are cases to be handed on to other doctors for

ongoing care and follow up. The expectation within the service is that doctors remain responsible for "their cases" in an ongoing way.

Attendance at case conferences must be documented; however, VFPMS staff do not need to independently document attendance at SCAN meetings and discharge planning meetings if case conferences are documented by others, the attendance list is included, and minutes are included in the child's electronic medical record (EMR). A single record of a meeting is ideal (multiple records are discouraged because they can lead to confusion and inconsistencies). Ideally the VFPMS representative should check that the minutes accurately document the forensic opinion before the minutes are uploaded to the child's EMR. At MCH, the SCAN meeting minutes will be emailed to the (involved) VFPMS doctor by the (involved) social worker for editing, prior to uploading to the child's EMR.

Information regarding on-call communications and in-hours communications with outside agencies will be stored on the VFPMS log (of advice provided to referrers). The email containing information about calls should be sent to the administration officer, all 3 VFPMS Nurses, the Director and the Deputy Director. This might seem excessive but it "is as it is" to enable all senior managers to maintain oversight of clinical operations in the simplest, easiest way possible, over time.

For RCH and MCH inpatients, a note must be written in the child's medical record whenever VFPMS staff provide a consultation, review an inpatient or attend a case-based multidisciplinary meeting.

4.3.1 The "care team" approach

When VFPMS doctors function as part of a "care team" managing patients, the VFPMS doctor responsible for the case must ensure that communication between members of the care team occurs regularly, and that the primary VFPMS doctor communicates with VFPMS colleagues and the bed-card team. The VFPMS doctors must ensure that others can contact them regarding decisions around investigations and multiagency case management. Good communication is essential. This professional responsibility is required for safe patient care. While VFPMS works as a care team and everyone on site helps with patient care as part of the team, it is only when VFPMS doctors are on leave for more than 2 working days (for VFPMS) or are in court for more than 2 sequential days that inpatient care can be handed over.

4.4 Handover: Principles and processes (ISBAR)

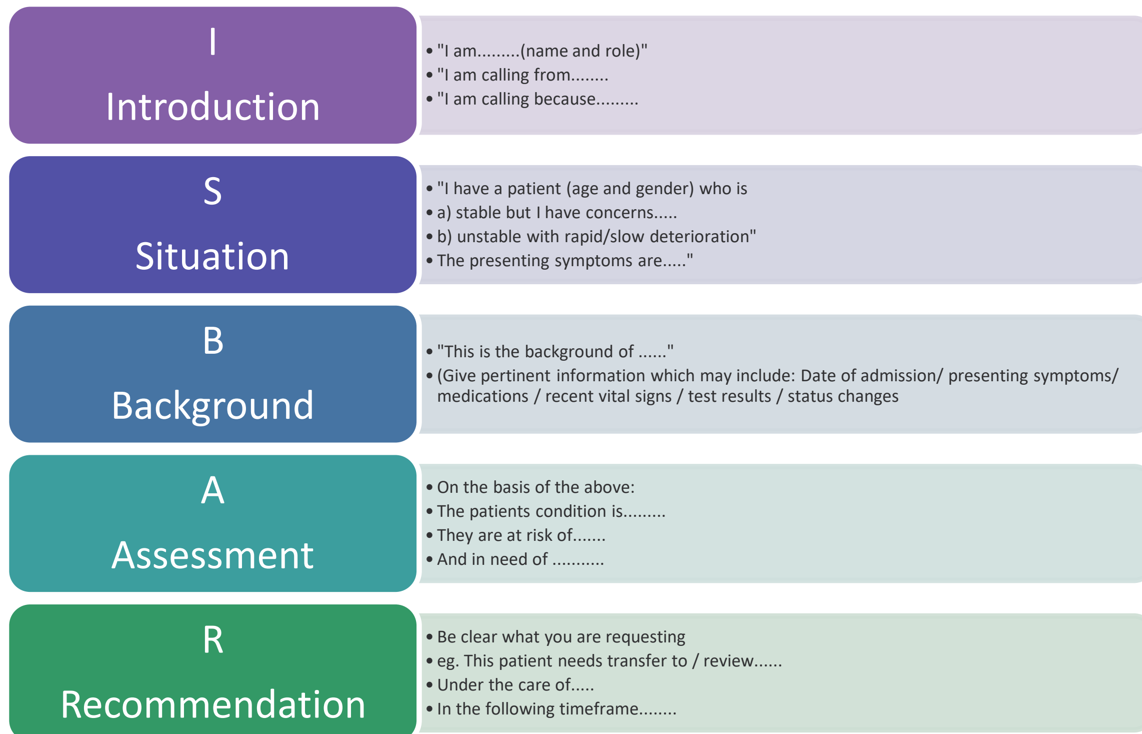
If there is a need to hand over a case, this must occur (as per standard hospital handover procedures) via direct communication with the doctor (preferably by telephone) as soon as possible at the end of the shift. It is extremely important, and a requirement of all staff, that timely and high-quality handover occurs as a routine process within the VFPMS, just as it does for all other departments within RCH and MCH. Timely and effective handover is a required standard of good professional practice.

ISBAR (Identify, Situation, Background, Assessment and Recommendation) should be familiar to everyone.

Include the following information in your documentation (emails) and telephone calls:

- Date and time of call.
- Caller — name, organisation (region) and contact phone number.

- Patient — name and DOB .
- +/- Patient's parent or guardian name and contact details (phone number).
- CASE INFORMATION.
- Your advice or action taken.
- Recommended action(s) that any other VFPMS staff will now need to undertake (administrative work, patient follow-up including communication with other professionals and family members, organising appointments or investigations, review of results, etc.).



It is recommended that for cases involving inpatients (particularly at hospitals other than RCH and MCH), the referring doctor is included as a recipient of the email documenting the call so that he/she has a written copy of the VFPMS advice provided.

A handover email should be sent to the VFPMS on-call doctors rostered for the weekend regarding MCH or RCH inpatients that are expected to remain in hospital over the weekend, in case the VFPMS doctors are called for advice about forensic management or other issues that arise. This may also be necessary during the week if contact between the inpatient team and VFPMS is anticipated overnight.

As a general principle across the VFPMS statewide network, VFPMS staff should ensure that their advice is documented in patients' medical records, noting that the method used to document this advice may vary between sites. It is hoped that this additional effort to document advice provided by VFPMS will reduce the risk of miscommunication (and prevent error resulting from miscommunication/s).

4.5 Referrals to specialists, ordering investigations

Children should be referred to paediatric subspecialists for their opinion in the same way and at the same thresholds as referrals to specialists occur for children assessed by paediatricians working in general medical clinics or in the community. Trainees are encouraged not to refer to medical specialists unless the need for referral has been discussed with a VFPMS consultant. Initially advice may be sought from other VFPMS SMS who have experience in diagnosing conditions that can be confused with abuse/assault and who are well informed about paediatric haematological, dermatological and gynaecological conditions, and uncommon conditions involving other subspecialist areas of practice.

Because VFPMS SMS are required to know a great deal about conditions that might be confused with abuse (for example, coagulation disturbances, fractures, internal injuries and accidental trauma, as well as methods used to determine the cause and timing of injury), their advice should be sought prior to referral to other subspecialist consultants. In other words, first ask VFPMS consultants (many of us are more expert in “thinking about” differential diagnoses/considering conditions across a broad range of “internal medicine” that can be confused with injury than some of the subspecialists).

The medical evaluation of children with whom the VFPMS has contact should be thorough and comprehensive. In addition, there is often a therapeutic component to our engagement with children and their carers. VFPMS staff are supported and encouraged to intervene to improve children’s safety, health, growth, development, relationships, behaviour and social engagement.

VFPMS staff are encouraged to perform developmental assessments using RACP recommended age-appropriate developmental assessment tools, to telephone staff at schools and kindergartens (with parental permission) and to communicate with others involved in children’s lives, particularly Child Protection practitioners. Some children will require consultations on more than one date for a comprehensive evaluation to be undertaken.

Investigations and referrals to evaluate, monitor, intervene and safeguard children’s health, growth, developmental, behaviour, emotional and psychological wellbeing should be considered. The quality of children’s relationships (particularly with caregivers) and each child’s self-concept are also very important considerations. Effort may be required to advocate for especially vulnerable children and to prevent “systems abuse” including “systems neglect”. Particular care is often required to obtain information about and to fully assess children on Care by Secretary Orders and children living in residential care placements. Extra efforts may be required to ensure that children’s safety and wellbeing is monitored in an ongoing and effective way, whereby interventions occur as needed and suboptimal management plans change. This may require VFPMS staff to arrange or facilitate medical appointments with general practitioners, audiologists, local paediatricians, dentists, and others. Consideration should also be given to specific advice regarding when (for example, within a set timeframe) these recommendations should be actioned.

- E.g. *I recommend that X is assessed by a dentist as a matter of urgency (within the next month) so that dental restorations can commence as soon as possible. Children 0–12 years are eligible for public dental care in Victoria, as are young people aged 13–17 years who hold a health care or pensioner concession card, or who are dependants of concession card holders, and all children and young people in out-of-home care provided by the Department of Families, Fairness and Housing (DFFH), up to 18 years of age (including kinship and foster care). Children and young people have priority access. The Australian Government’s Child Dental*

Benefits Scheme provides up to $1,095 in dental benefits over 2 years for children aged from 0 to 17 years in families that are eligible for Medicare; and receive an eligible Australian government payment.

5. Sexual abuse: Roles and responsibilities

In Victoria, VFPMS has sole responsibility for provision of forensic medical services to under-18-year-olds who allege, or whom someone suspects, has been sexually abused. This means that VFPMS is the service that collects forensic samples using the FMEK.

All medicolegal reports regarding sexual abuse of under-18-year-olds should be written using the VFPMS report format, including when children are examined in regional Victoria.

5.1 Urgent VFPMS services regarding sexual assault

An urgent VFPMS service will be provided in relation to sexual abuse when one or more of following criteria are met, and medical care is best provided by VFPMS either as a sole care provider or in collaboration with others. Criteria for an urgent face-to-face consultation include:

- Urgent medical care is required (e.g. the child is experiencing genital pain or bleeding that requires urgent medical examination and possible treatment).
- Urgent (i.e. time-critical) collection of forensic samples is required (e.g. FMEK sample collection is required).
- Police or Child Protection require urgent medical examination in order for police or Child Protection practitioners to make time-critical decisions regarding protective intervention for this child or his/her siblings, and the matter cannot be resolved by a conversation or via other means.
- Crisis intervention requires medical examination as a matter of priority (medical examination cannot reasonably be delayed).

Note that plans should be made for dispensing of postcoital contraception and prophylactic antibiotics according to circumstances, and that dispensing of these medications should not be delayed. Consideration should be given to the patient urgently accessing medications from the nearest source.

VFPMS provides <u>medical triage</u> regarding concerns about sexual abuse of under-18-year-olds. This means that VFPMS collects sufficient information from the caller about the caller's concerns regarding the nature and timing of possible sexual abuse, in order to make decisions about:

- Whether a face-to-face consultation with VFPMS might be required, and if so:
  - The best location,
  - The best time, and
  - The best health professional to conduct the assessment.
- When no VFPMS face-to-face consultation is required, then decisions are made and (when required) planning occurs for counselling, mental health care, medical care and engagement with Child Protection and police.

When children have symptoms and signs that might be associated with sexual assault, medical triage by VFPMS (for the purposes listed above) should occur prior to engagement with sexual assault counsellors for optimal health care to be arranged at the best location, best time and with appropriately skilled medical professionals.

When children are seen face-to-face for urgent evaluations of sexual assault by VFPMS, these evaluations should always occur as joint responses with counsellors (Gatehouse and SECASA when examinations occur in Melbourne).

If/when forensic nurses use FMEKs to collect samples, then joint assessments by a nurse and paediatrician team (+ counselor–advocate) should be considered.

5.1.1 Allegations of sexual assault

When children allege recent sexual assault, joint responses by VFPMS and counsellors should always occur. This means that sexual assault counsellors must be promptly informed by telephone about under-18-year-olds who might require urgent counselling (possibly because of recent "disclosures"), even when VFPMS deems that individual case details indicate that urgent VFPMS evaluations are not required.

When children require urgent face-to-face evaluations for suspected sexual assault, both VFPMS and counsellors should attend.

The presence of individuals other than the doctor and patient in the consultation room during "history taking" is at the discretion of the doctor and consent of the patient.

A chaperone (third party/"observer") should be present whenever a genital examination is undertaken.

Note: Only essential persons enter DNA-cleaned rooms. A log must be maintained of all persons entering DNA-cleaned rooms.

VFPMS provides holistic health responses inclusive of a forensic component (which is forensic sample collection and provision of evidence for the legal system). VFPMS services are offered regardless of children's or their guardians' willingness to involve police (although the decision about police involvement might affect the time and location of service delivery). In other words, a referral to VFPMS in relation to suspected sexual assault should not be rejected on the basis of the child's or caregiver's decision not to involve police. Under such circumstances, a VFPMS service should be offered to meet the child's health needs and to prepare a medicolegal report that might be used in the legal system should the decision be made at a later date to involve police. Note also that there should be a sensible reason for the VFPMS to become involved (VFPMS does not need to provide face-to-face consultations for cases of "historical sexual assault" [more than 3 days to one week previously] or when the child's situation does not require use of a FMEK), particularly when alternative health care is available and may be more appropriate for a range of reasons. Consideration should be given to the appropriate use of local health care providers when children have health care needs post sexual assault but they do not require the use of a FMEK. This decision is best made by VFPMS clinical staff (doctors and nurses) and may require consideration of a range of complex factors.

Sometimes, when forensic samples do not need to be collected after hours, VFPMS face-to-face evaluations can be delivered during working hours on the next business day. The collection of forensic samples is part of the service we provide but is only a component; the other components of the service are documentation of history and examination findings with reports written for future legal action, general health care including preventive health care (e.g. prescription of Azithromycin to prevent STI), discussion of sexual health, contraception, mental health and other concerns, discussion of safety issues and consideration as to whether contact should be made with Child Protection.

5.2 Non-urgent VFPMS services regarding possible sexual assault

When no allegation of sexual assault has been made but children have symptoms and signs that might be associated with sexual abuse, but alternatively might be caused by conditions other than sexual abuse (that is, there exists a differential diagnosis that includes but is not limited to sexual abuse), then careful medical evaluation is required. **Accurate diagnosis is extremely important**. An open mind regarding all possible diagnoses must be maintained during the evaluation process. Professionals working in this field must be aware of and take steps to minimise confirmatory bias in relation to suspected sexual abuse. They must also be well informed about the evidence base that forms the foundation for a diagnosis of child sexual abuse. Child sexual abuse ought not be over-diagnosed on the basis of non-specific symptoms and signs!

In these situations, it is not appropriate for a sexual assault counsellor to be engaged until there exists a “reasonable probability” or, at the very least, a strong suspicion that the child might have suffered sexual abuse. It is not appropriate for VFPMS staff to refer children for sexual abuse counselling when, in the absence of other concerns, the children have conditions such as accidental fall-astride injuries, urinary tract infections, dermatitis in the genital area, vulvovaginitis, labial adhesions, normal behaviour and medical conditions confused with abuse.

All VFPMS doctors should be well informed about the range of behaviours that might be termed “sexualised”, and the evidence base that exists around differentiating the range of behaviours seen in children who have experienced sexual abuse from behaviours seen in children who have not experienced sexual abuse. Sexual abuse should not be “diagnosed” on the basis of spurious concerns and non-specific behaviours.

Urgent reporting to Child Protection should occur if further comprehensive <u>protective</u> evaluation is required because of the child’s psychosocial situation.

Note that the forensic medical approach (being objective, impartial, unbiased and open-minded) is not in sync with the approach used within counselor–advocate services, which is to accept without question their client’s statements around their sexual victimisation. Both philosophical approaches have their place. It is important that VFPMS staff are not pressured by others to “downplay” the need for impartiality, open-mindedness and objectivity when joint assessments are undertaken. The legal system is intolerant of bias affecting medical evaluations of alleged and suspected sexual assault, particularly when it seems that confirmatory bias and contextual bias might be involved.

Other non-urgent sexual abuse assessments:

From time to time, appointments might be offered to children regarding “historical sexual abuse”. This is on a case-by-case basis.

5.3 Presentations to Emergency Departments regarding sexual assault

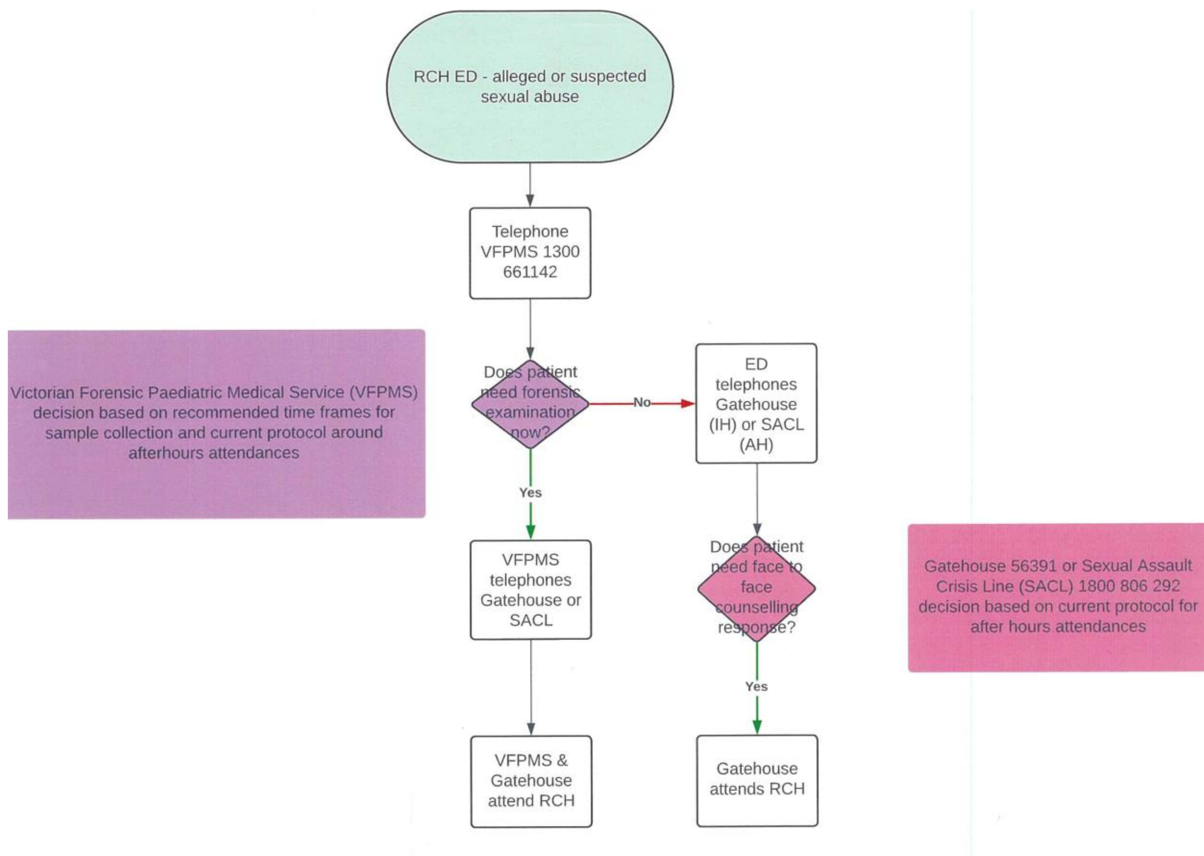
Children present to hospital Emergency Departments (Eds) because of a broad range of conditions, concerns, injuries, symptoms and signs. Amongst this group of children, there exists a very broad range of situations and conditions that raise concerns about possible sexual assault/abuse. Situations and conditions that generate thoughts about possible sexual abuse range from clear statements (allegations) of sexual assault to vague and nonspecific thoughts about sexual abuse that might be sensible or, alternatively, might be ill-founded, based on misinformation or unreasonable suspicions. Children attending triage desks in EDs thus have “pre-test probabilities” of a diagnosis of sexual abuse that range from a high likelihood (>95% probability) to an extremely low probability that sexual abuse has occurred.

There is no algorithm or formula that reliably predicts the probability of a diagnosis of sexual abuse based on presenting symptoms and signs. An unbiased, objective, impartial evaluation is required in all circumstances, including when allegations of sexual assault have been made. A small but significant proportion of allegations of sexual assault are not based on fact.

When sexual abuse is considered in the context of a number of differential diagnoses (that is, sexual abuse might or might not be the reason for the child’s symptoms or signs), then VFPMS will consult with ED staff about possible examination and investigation. Attendance by VFPMS for urgent face-to-face assessment is possible, but not the only management option. Sometimes VFPMS consultants might have sufficient expertise to exclude the diagnosis of sexual abuse with a reasonable degree of certainty based only on information obtained over the telephone, and under such circumstances will recommend medical management in the absence of VFPMS face-to-face consultation and/or follow up. For example, a toddler who has labial adhesions has a low probability that these adhesions were the result of sexual abuse.

It is not appropriate for ED staff to refuse to provide a medical service to patients based only on their concerns about sexual abuse and/or their reluctance to become involved in legal matters or child protection activities (including possible report writing or testifying in court).

When clear statements about alleged sexual assault exist, both VFPMS and counsellors should respond to a request from ED staff. VFPMS should perform medical triage to determine the requirement for an urgent face-to-face forensic evaluation or an in-hours consultation. Counsellors should be promptly informed in order to respond as they deem appropriate. They should be informed about the timing and location of the forensic medical service. On some occasions (for example, because of psychological distress caused by a recent disclosure), urgent counselling may be provided when a VFPMS medical consultation has been arranged for later in the week or has been deemed unwarranted.



Note: After hours, the call should be made to the Sexual Assault Crisis Line (SACL) on 1800 806 292. SACL staff are (or should be) aware that paediatricians use a different process for initiating a coordinated response to a victim of sexual assault (i.e. SOCIT and paediatricians organise the multiagency response) to the process used when adult victims require a FMEK to be used (when SACL initiate and organise the multiagency response).

In some situations, ED staff will attend to the child's urgent medical needs prior to the attendance of VFPMS.

This ED assessment and treatment might include:

- Resuscitation.
- Examination/treatment of serious physical injury (assault or accident).
- Examination for signs of head injury, monitoring and treatment.
- Examination and monitoring for signs of airways compromise if strangulation is suspected.
- Treatment of effects of drugs/alcohol, including hypoglycaemia.
- Prevention of complications of injury.
- Stabilisation and treatment of pre-existing medical conditions (e.g. diabetes).
- Monitoring of vital signs while effects of drugs and/or alcohol wear off.

Note: It is absolutely contraindicated for children who allege recent sexual assault and who have not yet undergone an assessment of their medical needs to wait in an out-of-the-way area of an ED unsupervised by ED staff or supervised by individuals who lack medical training (this includes social

workers and CASA staff). If, after initial assessment by ED staff, counsellors assume sole responsibility for monitoring the physical wellbeing of children who allege recent sexual assault, then this decision should be made in conjunction with senior ED staff who are aware of the risks posed.

Patients who are or who might become aggressive, and thus pose a risk to staff, ought not be managed in out-of-the-way areas in EDs. Such patients might not be suitable for an after-hours evaluation because of safety risks.

Particular care should be taken when patients and/or their carers might be drug-affected, withdrawing from drugs, be mentally unwell or have a medical condition (such as head injury) that might result in a sudden collapse or deterioration. Such patients ought to be monitored under close surveillance in ED.

5.4 Assessments for sexual assaults of children in regional Victoria

VFPMS-style consultations in regional Victoria may be organised by police who contact service providers directly or may be arranged in consultation with the VFPMS Nurses or consultants. Services in regional Victoria are in a constant state of flux and the Nurses and consultants are likely to know of the current situation in each region with regards to accessing medical care in relation to a possible sexual assault. Plans are in place for establishment of a Victorian network of forensically trained nurses capable of collecting forensic swabs from adult victims of sexual assaults (and possibly older teenagers), but this is still a work in progress.

Currently children from the Geelong/Barwon region and Traralgon (West Gippsland) region who have recently been sexually assaulted and who urgently need samples collected when a local service provider is unavailable must travel to Melbourne for VFPMS consultations. Goulburn Valley Hospital (Shepparton) is in a similar situation. Other major Victorian regional hospitals usually provide a service to victims of child sexual assault, but the default position is to transfer a child to Melbourne for a forensic service when a local service cannot be obtained. Almost all child victims of physical assaults and neglect are able to receive a VFPMS-style forensic assessment in regional Victoria reasonably close to where they live.

In general, we aim to have the child seen at the closest site where a high standard of forensic medical care can be provided. The quality of care should not be unreasonably compromised nor should anyone accept an inadequate medical service, or a dangerous or risky option merely because it best suits professionals. **The goal should be for the child to access to an acceptably high standard of care as close to home as possible.**

Regional services (large publicly funded health services that employ paediatricians and child health professionals) are responsible for the medical care provided to children when child abuse and neglect is suspected. These health services employ the paediatricians and other doctors and nurses who provide health care. VFPMS provides these doctors and nurses with advice, tools to use when evaluating children in relation to suspected abuse, professional support, and assistance for report writing and court appearances. Memoranda of Understanding (MoU) were initially used to document agreements between the RCH and the major paediatric health services at Bendigo, Ballarat, Geelong, Shepparton, Albury–Wodonga and Traralgon. These MoU lapsed as the operation of the VFPMS network became “business as usual”.

VFPMS is responsible for the advice offered to callers regarding the adequacy of a forensic service in regional Victoria and in recommending the use of local/available expertise. At times, the combined

services of a paediatrician (who obtains the history, performs the physical examination and produces the medical report) and a forensic nurse examiner (who collects swabs for forensic analysis and produces a brief report) may be utilised. **If in doubt, a child may need to travel to Melbourne in order to obtain forensic paediatric medical expertise.**

When the doctor or nurse who is on call for a regional Victorian health service refuses (for whatever reason) to provide a child with a forensic medical service, local options (e.g. doctors in neighbouring regions) may be considered under exceptional circumstances, but this relies on the availability and goodwill of the doctors in neighbouring regions to accept the “out of our Health region” referral. This option should not be considered lightly because of the negative impact on regional services and the overall operation of the VFPMS network in the long term. Travel to Melbourne with all the negative consequences on the regional police workforce, the child and their family members might be a better overall option.

5.5 Assessment of suicide risk

Some children and adolescents who present following a recent sexual assault have physical signs of recently self-inflicted injury, or voice concerns around self harm and/or suicidal ideation. When children are deemed to be at risk of serious self-inflicted harm (i.e. children express suicidal ideation and suicidal behaviours, excluding isolated non-suicidal self-injury), then the hospital-based mental health service should be asked to assess the children, or a CATT assessment might be urgently required. Enquiries should be made regarding suicidal ideation and suicide plans. When concerns arise, then children should be referred for an urgent mental health and safety assessment; children should not be discharged from VFPMS when serious concerns exist about current risk of suicide or self harm. Referrals should immediately occur to the crisis mental health team, and this should be documented.

- Urgent mental health assessments may occur while the child is in the ED. This may require the child’s care to be “transferred” from VFPMS to the ED for this to occur.
- Referral to outpatient CAMHS or alternative should be arranged prior to children leaving the hospital. The planned time, date, location and (if known) name of service provider should be recorded in the child’s medical record.
- If children are deemed by the mental health care team to require an inpatient admission because of serious mental illness associated with significant risks to health and safety, then the responsibility for arranging admission rests with the mental health clinicians and ED staff.
- If children are deemed to be safe for discharge from ED, then the mental health team (in collaboration with ED staff) is responsible for arranging ongoing mental health care.
- When an urgent after-hours mental health assessment is needed for a child’s parent/caregiver, arrangements should be made in collaboration with Child Protection.

6. Physical abuse: Roles and responsibilities

6.1 The integrated mainstream paediatric healthcare system

Most doctors and many nurses possess the knowledge and skills to assess injuries and wounds to determine appropriate treatment. Some of these professionals have also been trained to assess wounds and injuries in order to determine their cause and timing. It is these medically trained professionals who work in the broader health system who have the capacity to provide (at least a component of) forensic evaluations of children's injuries and reports/testimony in court. These professionals might include doctors working in EDs, some general practitioners, most paediatricians, most forensic physicians, some specialists and some forensically trained nurses.

The VFPMS works in an integrated way with other medically trained professionals to provide a forensic medical service to physically assaulted/abused children. This is a shared skill and duty.

After hours, VFPMS provides a 24/7 telephone advice service in relation to suspected physical assault/abuse.

Most children seen in EDs will be adequately managed by ED staff in relation to the evaluation of their injuries. This includes medical investigation and photographs. A follow-up appointment (for an in-hours VFPMS clinic) may be arranged for a small number of children who require a comprehensive, holistic VFPMS-style assessment after their attendance at ED. On most occasions, an additional VFPMS consultation will not be required.

6.2 Photographs

Photographs of injuries should be taken when there is a forensic component to the medical evaluation and treatment. This means that photographs should be taken whenever assault/abuse might have caused injury and also when injury might have been caused by parental/caregiver neglect.

- At RCH, there is a photographer on call 24/7. Authorisation from VFPMS is required for ED to call in the after-hours photographer.
- At MCH, there is a photographer on call during business hours, and a camera (Canon SLR) and iPad in the MCH VFPMS clinic. MCH ED doctors are almost certain to refuse to take photographs of injured children. VFPMS doctors are encouraged to photograph the physical injuries seen on children seen after hours and in circumstances when the MCH photographer is not available.
- Photographic equipment (cameras) and doctors' willingness to take photographs varies from site to site across Victoria. Encourage doctors to take photographs if facilities, equipment, and the capacity to take and safely store photographs exist.
- At RCH, photographs can be taken with smartphones and downloaded to the child's EPIC medical file using the Haiku app. The use of Haiku is the only method permitted at RCH with regards to taking photographs of patients using personal phones or tablets. In other hospitals, the guidelines, method and safety of storage of photographs in children's files may be problematic, and note that these things vary from site to site.
- Images of children's genitals should never be taken using a personal phone or tablet.

- Telehealth consultations involving viewing of genital examination findings or genital images should occur only via secure communication pathways suitable for Telehealth consultations.

7. What to do when things do not go as planned

7.1 What to do when others are unhappy with the VFPMS response

The Director, Deputy Director, and other senior VFPMS consultants provide 24/7 on-call advice for occasions when there are service difficulties and/or complaints. Any perception of a problem or pending complaint should result in the VFPMS senior/second-on-call being immediately notified. Under exceptional circumstances, the VFPMS second-on-call consultant has discretion to decide to provide an after-hours consultation when it is not entirely clear that VFPMS criteria for doing so have been met. This might be based on the need to maintain effective working relationships with stakeholders and other reasons such as dealing with an uncommon clinical situation. Consideration should always be given to providing a face-to-face VFPMS after-hours consultation when criteria have been met, and may be given to providing a face-to-face consultation when the caller's request is accompanied by implacable angst and/or anger, the caller's thinking cannot be changed and an alternative management plan cannot be developed.

Note that disputes between Victoria Police and VFPMS regarding the perceived need for an urgent face-to-face consultation in relation to a sexual assault should be escalated then adjudicated by the duty officer of the Victoria Police Sex Crimes Squad, after involvement of the VFPMS second-on-call.

7.2 Complaints and how to handle them

The VFPMS Director must be informed of all complaints about the VFPMS, no matter how trivial. RCH line managers must be informed by the VFPMS Director of complaints regarding the VFPMS (all complaints regarding the statewide service), and consideration given to entry of the case particulars and action taken onto VHIMS/Riskman. It is appropriate for VHIMS to be used to address matters related to the statewide operation of the VFPMS, not restricted to only RCH patients. All complaints regarding the VFPMS must be discussed at the next Huddle, at VFPMS Management meetings and, if required, escalated to the RCH Executive Director, Division of Medicine (as the appropriate line manager), to address root causes and prevent a recurrence (if possible).

Complaints in relation to service provision regarding the multiagency response to victims of sexual assault are tabled and fully discussed at quarterly VicPol-VIFM-VFPMS liaison meetings and the VFPMS-Child Protection quarterly meetings. Complaints may also be discussed at NWCALM and SECALM (regional multiagency child abuse liaison meetings).

8. Safe standards

8.1 VFPMS consultants oversee VFPMS Fellows' work

Children admitted to hospital should be seen face-to-face by VFPMS within 24 hours of referral, preferably as soon as possible. A child who is medically unstable and/or who has a serious head injury should be seen promptly (within hours). Note that children requiring intensive care might deteriorate extremely rapidly, particularly when hypoxic ischaemic brain injury has occurred.

VFPMS consultants maintain case responsibility (from a VFPMS viewpoint) and are responsible for formulating the forensic opinions (or overseeing the formulation of forensic opinions). Handover of inpatient cases should only occur under exceptional circumstances. It is important for good patient care that both a VFPMS care-team approach is used and excellent communication occurs within the VFPMS care-team, particularly with the case-responsible VFPMS consultant and whenever the child's condition changes. While the VFPMS Nurses provide liaison and facilitate communication between professionals involved in the case, information in relation to the forensic opinion should be provided by the case-responsible VFPMS consultant whenever possible.

Face-to-face consultations for inpatients should be provided in collaboration with social workers.

In hours, it is usually sensible for the VFPMS Nurse to schedule the consultation on the ward and for her to remain actively involved in the child's case during admission. This may include but is not limited to attending the SCAN meeting. She and the allocated VFPMS doctor should maintain daily contact with Gen Med (or alternative unit/treating team's) medical staff to ensure a daily two-way exchange of information. The child and their family should be visited regularly (for example, daily on weekdays) by VFPMS staff, at least during the initial stages of the child's admission.

The VFPMS doctors should discuss forensic interpretation of results with the child's parents / carers, the treating medical team (ideally with the "bed-card consultant" rather than junior medical staff) and with police and Child Protection.

Information obtained by the VFPMS should also be clearly documented in the child's EMR.

At the Royal Children's Hospital:

Note that RCH VFPMS outpatient consultations are behind "break the glass", and VFPMS entries will not be visible to those viewing only "inpatient notes". This "quirk" of EPIC at RCH creates a risk that information documented by the VFPMS in children's medical records will not be sighted by non-VFPMS staff who also need to know. Extra care will need to be taken to ensure that treating medical and surgical teams are aware of VFPMS entries into patient records at RCH. Telephone communication is encouraged ahead of the use of secure chat.

Note that emails can become part of a child's medical record.

Emails can also be subpoenaed.

At Monash Children's Hospital:

Outpatient consultations are not documented on the EMR at MCH because there is currently no functionality within CERNER to allow this. The use of secure chat, email and telephone communication is encouraged.

9. VFPMS report writing

9.1 Expectations of report writing

A medical report will be prepared for each child seen.

The only exceptions to this “rule” are when a preliminary physical examination (inspection of a finding) is required in order to appropriately triage a case. An example of this might be a quick inspection of an area of erythema to determine on purely clinical grounds that it is typical of cellulitis and not a scald, or inspection of an area of skin discolouration that has the typical appearance of dermal melanocytosis (a Mongolian Blue Spot). Such cases can then be “triaged out” and a formal VFPMS consultation does not need to occur. A note should be made in the child’s EMR when this occurs.

All VFPMS patient contacts and secondary consultations must be adequately documented in the child’s medical record and a conversation must occur between the VFPMS doctor and the referring doctor. When the VFPMS does not provide a face-to-face consultation following a doctor’s referral to the VFPMS, then 1:1 communication should occur so that the referring doctor understands the VFPMS doctor’s decision-making.

A report should be written for all “triaged-in” cases, including cases that have findings that are deemed to be caused by accidental trauma and medical conditions that may be confused with abuse (such reports can be brief, however the medical opinion must be clearly stated, evidence-based, and the rationale for the opinion justified. The quality of these reports should be similar to medical reports written in relation to children who have injuries deemed to have been caused by child abuse, while brevity is highly desirable and greatly valued).

All medical reports are subject to quality assurance activities. Trainees are expected to conduct an **appropriate review of the literature about each case** to ensure that information provided in the report, and the knowledge base that underpins the opinion, is current.

Trainees are expected to read (and use) the document titled ‘Tips for writing medical reports’ available on the VFPMS website, and to use the VFPMS proformas, diagrams and guidelines. The proformas and templates for report writing have been developed to provide a reliably high standard of paediatric forensic medical work across the state. The VFPMS proformas were updated for use on the 1st of January 2020. They are based on proforma from a range of services and organisations, including but not limited to the Faculty of Forensic and Legal Medicine, Royal College of Physicians (UK).

The standard VFPMS template for report writing was originally developed in collaboration with magistrates and judges of the Children’s Court of Victoria and legal counsel at RCH and MCH. Report templates have been updated and modified to better meet the needs of regional service providers, stakeholders and courts.

9.2 Peer review of VFPMS reports

A small team of senior forensic paediatricians who possess qualifications in forensic medicine, and who have demonstrated proficiency in report writing and in peer reviewing reports, and who are employed across several days with the VFPMS will review VFPMS medical reports before these reports are sent to police or Child Protection practitioners. This report review process aims to benefit the child, the author of the report, the VFPMS and the broader service system. Suggestions from a “peer reviewer” are offered in relation to editorial corrections (typos and minor grammatical errors),

potential improvements in the quality of the report, and advice is offered in relation to the formulation of reasonable and defensible forensic opinions. Peer reviewers try, to the best of their ability, to detect problems related to report quality and to offer suggestions (as friendly, well-intentioned colleagues) so that VFPMS medicolegal reports are the best they can be and the children receive the best service possible from the VFPMS. This means that the report review process encompasses the following:

- Quality assurance (Has the report included all relevant headings and sections and there are no gaps? Has the report addressed all relevant forensic matters?)
- Editorial review (suggestions for spelling, grammar, sentence structure and formatting).
- Technical review (suggestions for consideration of additional forensic matters, reconsideration of the opinion and suggestions regarding use of references). This is the most important aspect of peer review because it focuses on the reasonableness of the opinion, given the information contained within the body of the report. The reviewer must ask, "Is the opinion defensible on the basis of forensic knowledge and principles?".

The structure, completeness, overall quality of the report, validity and "reasonableness" of the forensic opinion are thus all given due consideration. The peer reviewer merely offers suggestions and comments that the author rejects or accepts as they choose. Ultimately the author is entirely responsible for their report.

Note: The signed and dated VFPMS report is the final iteration and the only "version" (to date) of that report. While the report is undergoing development, it is "a work in progress". Various iterations of incomplete reports are not considered to be "versions" — this iterative report development process includes the peer review process and subsequent editing, if any, by the author. Document names used by the VFPMS have been designed to ensure consistency across sites and staff, so please use the VFPMS report naming conventions.

Whenever trainees' reports are peer reviewed, the patient's images and colposcopy recordings should also be reviewed in conjunction with the written report. It is really helpful to the peer reviewer if relevant images can be either inserted into the report or provided at the time the report is sent for peer review (easily added to a few PowerPoint slides and attached to an email).The case notes and proforma are not usually perused as part of this report review process; however, supervisors are expected to review trainees' case notes from time to time as part of the supervision process. (Review of all case-related source material does not routinely occur when SMS reports are peer reviewed). This lack of peer scrutiny of case notes is a tiny limitation of our peer review process, but case notes do ensure accuracy and validity of information obtained, and on balance we considered that the additional time required to review case notes would not be justified. It is for this reason that our report peer review process focuses only on the final product — the VFPMS report — and we subject every report to peer review before release. Peer review of clinical work and clinical decision making occurs at peer review meetings.

The medicolegal report peer reviewing process does not aim to be a "second look" / "second independent opinion", verification or repetition of the entire assessment process. It is an opportunity for authors to seek colleagues' opinions about conclusions drawn and recommendations made. It is a key quality assurance activity that has its limitations.

A final reconsideration of the phrases used in the opinion section:

When a peer-reviewed report is returned to the author, it is then up to the author of the report to accept or reject the peer reviewer's suggestions and recommendations. Each "reject or accept" decision is the author's choice and must be thought through, mindful that peer reviewers can misunderstand or misinterpret authors' words so new errors can be introduced. It is up to the author to carefully consider each "reject or accept" decision and, furthermore, to consider the impact of these changes on their final opinion, which might also require modification. When a misunderstanding has occurred and/or a reviewer has misinterpreted something, then this should serve as a flag to authors to consider changes that provide greater clarity. **The person responsible for the opinion in the report is the author of the report,** so it is important for authors to ensure that everything in the report is accurate and is not potentially misleading.

Peer reviewers might be subpoenaed to court to explain the contribution that they have made to reports.

When authors are entirely satisfied with their completed report (formatted, signed and dated), then it is sent to the administration staff at RCH or MCH for printing and distribution. The administration team maintain an audit trail (basically a database of dates of work completed, i.e. they track progress regarding the production of reports) so that we know when and to whom (and how) reports have been sent. It is extremely important that VFPMS staff do not subvert this process by emailing or otherwise distributing reports.

9.3 The opinions expressed within the forensic opinion section

The key question to address is, "Has this child been assaulted/abused?" The opinion section should enable readers to clearly understand authors' thoughts about this matter, even when the cause is undetermined. This uncertainty might include uncertainty as to mechanism, timing and/or circumstances of injury. It might (and often does) include uncertainty as to the identity of the individual (if any) who was involved at the time the child sustained injury.

Comments about probability and likelihood are usually appropriate, but there should be a sound scientific basis for such comments. Reasoning should be demonstrated and references made to the knowledge base that underpins comments about causation.

Comments about authors' "suspicions" and "concerns" are best avoided. For example, "this injury is suspicious for abuse" and "this is a very concerning injury" should be reworded to convey a sense of probability (based on observational studies) that the injury was inflicted rather than caused by an accident. The science should be mentioned, and findings interpreted in light of the science. The author's feelings or worries should not be the focus of attention.

Comments about someone's guilt or lack of guilt are entirely inappropriate and should never be made (verbally or in writing). It is legally very important not to stray too close to the "ultimate issue", which is whether an individual has committed a crime and is guilty of an offence. All words that imply that an individual has committed a crime are best avoided (words such as "offender", "perpetrator", "victim" etc. ought not be used).

Notes/tips regarding the formulation of forensic opinion and presentation of evidence are provided to trainees at the start of their VFPMS rotation.

Note: The opinion section of VFPMS reports should answer the following questions:

- What is the story?
- Is the child injured?
- What are the injuries?
- What else (physical damage) might be injured? Harmed?
- How did it happen? (**Mechanism**)
- What **forces** were/might have been involved?
- When did it happen? (**Timing** of all injuries)
- What consequences might result? How **serious** are the injuries?
- How do the findings and the story "match up"? Consider each injury in turn, then consider combinations of injuries.
- What are all the possible differential diagnoses, and how are they weighed in terms of likelihood? What is the evidence upon which you base your opinion?
- What is the overall probability of **causation** by assault versus accident versus other cause(s) for findings? Why is your conclusion favoured over other possibilities?

The VFPMS proformas are available via the VFPMS website. Updated proformas for suspected sexual abuse and suspected physical abuse have been in use since 01/01/2020.

Body are available for three sizes of children: infants, children and adolescents. Pages may be individually printed in order to document injuries using body diagrams or added to diagrams available via EMR (e.g. EPIC and CERNER).

Detail your description of injuries according to:-

- site (reference body landmarks, anatomical position of the body, cm from a joint)
- size (use one measurement — either cm or mm, and remain consistent)
- shape
- surrounds
- surface
- edge (margins)
- colour
- contour
- contents
- pattern
- swelling
- blanch/stretch/movement
- tenderness/pain on movement
- discharge/fluid/debris

A proforma is available for use when assessing vulnerable children; for example, children seen in relation to suspected child neglect. The N.E.G.L.E.C.T.I.N.G. acronym (available on the VFPMS website) can be useful during the assessment process. This acronym also provides a framework for writing medical reports regarding child neglect.

9.4 Timely production of VFPMS reports

Reports for inpatients must be completed promptly. When reports are produced promptly, they are more likely to be used effectively by other professionals. **The KPI regarding report production is that VFPMS reports should be finished and sent within two weeks of outpatient consultations and as soon as practicable for inpatients.** Tolerance is shown for reports regarding inpatients and for case file reviews where report production routinely takes longer than two weeks, but tolerance fades when production of reports takes longer than four weeks.

A monthly audit is conducted of reports not released more than one month after the consultation regarding the child.

Reminder emails regarding overdue reports are sent to doctors who have reports that are overdue (i.e. more than a month has passed since the child was seen but a report is yet to be finalised and sent). This process has been implemented to minimise the risk of reports being "forgotten", particularly when reports are close to finalisation. Data regarding overdue reports are reported and discussed at monthly VFPMS Management meetings.

Note that a template exists for <u>interim</u> reports when Child Protection requires a written interim opinion from VFPMS for court. Production of an interim report does not obviate the need for production of a final VFPMS report, except under very exceptional circumstances.

10. Legal matters

10.1 Consent

Forensic assessments require explicit consent. Signed confirmation of consent is highly desirable. Implied consent should not be assumed on the basis of a parent's attendance at VFPMS clinic. The VFPMS consent forms are designed to elicit explicit consent for each aspect of the forensic evaluation process, and they should be used to collect information about consent provided/withheld, by whom, and for what aspect of the procedure. Note that information regarding consent for medical procedures is available from a variety of sources. VFPMS staff are encouraged to read and understand the Department of Health (2014) document 'Informed Consent. Standard 1: Governance for Safety and Quality in Health Service organisations'.

At times, Child Protection practitioners and police arrive at VFPMS clinics with signed consent forms that may or may not be VFPMS consent forms. Arguably, this "consent" for a VFPMS evaluation may not be legally valid and perhaps not adequately "informed". A telephone call from the doctor performing the procedure to the person who signed the consent form might be required so that the doctor can determine whether or not consent is valid and, if necessary, further explain the procedure and obtain consent for it to go ahead.

Children should not be examined in the absence of consent. Emergency treatment is rarely justification for a forensic medical examination.

Verbal consent is acceptable if, under certain circumstances, written consent cannot be obtained. A third party might act as a witness to a telephone conversation and attest to this on the consent form.

In an emergency, the wellbeing of the child must take priority over all other considerations but note that an examination of a child without adequate informed consent leaves the doctor open to an allegation that the doctor "did the wrong thing" (trespass/battery).

Consent for forensic medical examination must be obtained:

- By the doctor/nurse conducting the examination/forensic procedure.
- From the right person.
- After ensuring that this person has the **capacity to consent.**
- For each specific aspect of the procedure (informed and specific).
- After informing about all aspects of the procedures, including risks of adverse outcomes that might eventuate if the patient proceeds, and risks/consequences if the patient does not proceed.
- Must be freely given (and able to be retracted at any time during the procedure).

10.1.1 Mature minors

Note that consent for forensic medical procedures may be provided by mature minors in some circumstances, and it is the duty of the doctor who discusses matters of consent with the minor to determine the minor's capacity to consent or withhold consent. Factors used by the doctor to determine a minor's capacity to consent (or lack of capacity to consent) should be documented in the VFPMS file notes. (See RCH Handbook for information about doctors' assessments of mature minors' capacity to consent. Use the VFPMS Mature Minor Assessment Consent Form to document this).

As circumstances change, so too might a minor's capacity to consent. For example, temporary conditions such as intoxication, drug withdrawal, extreme tiredness, illness, emotional upset and pain might temporarily reduce a minor's capacity to consent to medical procedures.

Specific consent is required for genital examination and videocolposcopy. Note that observers/chaperones should be present during genital examinations of mature minors (all children and adolescents) and support persons of the children's/mature minor's choice should also be present if the patient wishes.

10.2 Protective orders

Children on protective orders from the Children's Court of Victoria require "special consideration" regarding consent for medical procedures because parents are not always the persons who hold parental responsibility for decision making.

Consent must be obtained from the right person regarding medical procedures provided to children on protective orders.

In general terms, consent must be obtained from a person who holds parental responsibility for the child. The Children, Youth and Families Act (CYFA) describes parental responsibility as "all the duties, powers, responsibilities and authority that parents have, by law or custom, in relation to children". The Child Protection manual explains that "Section 172 of the CYFA sets out the powers of the Secretary when the Secretary has parental responsibility for a child. Section 18 of the CYFA enables the

Secretary to authorise the principal officer of an Aboriginal agency to exercise these powers in respect of a child or young person who is part of the Aboriginal Children in Aboriginal Care program".

In simple terms, the following applies:

- Care by Secretary orders = ONLY the Dept/"the Secretary" i.e. DFFH can give consent.
- Long-term care order = ONLY the Dept/"the Secretary" i.e. DFFH can give consent.
- Permanent care order = ONLY the permanent carers can give consent (it is like being adopted).
- An order requiring a person (i.e. caregiver/parent) to give an undertaking to the court (Children's Court of Victoria) = ONLY the parents can give consent (parents retain all parental responsibility to the exclusion of all others; DFFH are not usually involved after the order is made).
- Family Preservation order = ONLY the parents can give consent.

Then there is the group where either the Department (DFFH) OR parents can give consent (both DFFH and parents have parental responsibility, which means that the Department has parental responsibility but NOT to the exclusion of all others) —

- Family Reunification Order.

For all other children on protective orders, and when situations appear to be confusing or unique, seek advice and consult with the child's allocated DFFH team.

Sometimes a Temporary Treatment Order might be required to enable a child to undergo a forensic medical evaluation.

Parents of children on Interim Accommodation Orders usually retain parental responsibility. When this is not the case, it will be written on the order.

10.2.1 Instruments of authorisation

Instruments of authorisation can be used by CSOs or ACCOs to provide consent regarding Aboriginal children in care. The instrument specifies by role (the person in the CSO or ACCO, such as executive director, chief executive officer, director or manager) who can give medical consent, and this person must personally consent. An authorised person cannot delegate the authorisation to a person in another position within the organisation. Prior to providing consent to medical treatment, the authorised person must satisfy themselves the treatment has been recommended by a registered medical practitioner as necessary, is appropriate treatment and that all reasonable effort has been made to obtain the views and, where possible, the consent of a parent. Prior to providing consent to treatment, the authorised person will consider the appropriateness of seeking advice from Child Protection. The authorised person will ensure that there is appropriate documentation of the consent process.

10.3 Confidentiality and privacy

Only work email addresses may be used for patient-related information. Under no circumstances should patient-related information be sent to personal email addresses.

It may not be possible (wise or safe) to guarantee confidentiality, especially when it might jeopardise a child's safety or the safety of another person.

As a general principle during most consultations between doctors and patients, it is acceptable to offer confidentiality to children and adolescents (and their parents/guardians), provided that there are no concerns about the child's safety or the safety of another child. In this line of work, there are usually concerns about safety and it is not possible to offer confidentiality because of the Mandatory Reporting requirements in the *Children Youth and Families Act 2005*.

It is wise to be cautious and sensible about sharing information (verbally and in medicolegal reports). When people ask that personal information be not documented or not included in a report, this may be documented in notes with reasons given for action taken. Notes written by doctors (particularly in a forensic context) are usually legally discoverable, which means that information in case notes can be discovered/obtained under subpoena or warrant for use in a legal context (this includes court hearings).

Some lawyers have argued that VFPMS medical notes might constitute "confidential communications" and therefore ought to be protected from release under subpoena under section 32C of the *Evidence (Miscellaneous Provisions) Act 1958*. This matter has not been tested in court. Many other lawyers hold an entirely different opinion and believe that all VFPMS notes are discoverable and that the forensic purpose of the VFPMS consultation is self-evident.

On rare occasions, lawyers have subpoenaed reports in development, email communications between professionals and family, and all documentation or records of any sort relating to a child's case. VFPMS staff should not write anything (including in emails) that they would not be prepared to defend in court.

11. Case conferences, including SCAN meetings

Doctors are expected to attend case conferences in relation to children that they assessed, whenever practicable.

Given the sessional nature of most SMS contracts/appointments, this may not always be possible. Handover of information in order that another member of the VFPMS care team attend the case conference may be considered when VFPMS staff are not employed by VFPMS at the time/date of the case conference. However, it should be noted that the delegated VFPMS doctor should 1) receive handover and read the child's EMR to ensure that he/she understands key information about the case and has the latest results, and 2) makes it clear to meeting attendees that the VFPMS case-responsible doctor retains responsibility for the VFPMS opinion and report production. The case-responsible doctor is obliged to handover case information to another VFPMS consultant whenever they are unable to attend a case conference/SCAN meeting.

Data is collected in relation to staff attendances at case conferences (including SCAN meetings). It is the responsibility of VFPMS staff to ensure that Nurses and administration staff are informed about scheduled case conferences so that scheduling of face-to-face consultations is not disrupted, workflow can be managed, and data around work undertaken can be accurately recorded for reporting purposes.

12. Court appearances

Trainees should discuss all potential court appearances and all concerns about potential court testimony with their supervisors.

VFPMS remunerates VFPMS staff for time in court at the usual hourly rate of each half day (3.5 hours) when it relates to VFPMS business. Time in Lieu arrangements might also be possible, however this would need to be authorised as for other leave requests.

Data in relation to time in court is collected for reporting purposes. VFPMS Nurses and administrative staff must be informed of scheduled court appearances to minimise the risk of scheduling errors involving face-to-face appointments. A database exists to collect information about subpoenas received. VFPMS staff are expected to promptly inform VFPMS administrative and nursing staff of all subpoenas received, court dates scheduled and cancellations in planned court attendances.

13. Team and Peer Review meetings

VFPMS Team and Peer Review meetings occur on the 1st Thursday and 3rd Tuesday of the month from 9:30am – 11:00am. These meetings are held on MS Teams.

It is expected that all abnormal videocolposcopy findings, all inpatient cases and other interesting cases (to be selected by individuals at their discretion) will be presented and discussed.

A record of attendance is kept.

Minutes of the Team and Peer Review meetings are distributed (via email) to the VFPMS clinical team.

Minutes of the Management meetings are distributed to the VFPMS Management team, are stored on the VFPMS network drive at RCH, and are available for review by all VFPMS staff.

14. Rosters

The VFPMS after-hours rosters are produced 6-monthly, informed by requests from doctors regarding their availability. Although most requests are met, on occasion this is not possible and options must be negotiated. Doctors must communicate their needs to the Administrator compiling the roster in a timely fashion, or accept allocated days and arrange swaps as required.

After the roster is finalised and distributed, it is the on-call doctors' responsibility to swap allocated on-call periods. The exception to this is sick leave and other unexpected, unplanned personal leave, in which case the VFPMS Administration staff and managers will organise replacements.

Because of other commitments, some doctors may request a preference for particular days of the working week (i.e. Monday to Thursday evenings and overnight). Some doctors prefer a maximum of 2–3 on-call periods in a week, while others prefer 3–4 on-call periods in a week. Some senior medical staff may request a combined on-call period inclusive of Friday evening and Saturday, ending at 9am Sunday. This option is generally not offered to trainees as the length of the continuous on-call period

exceeds the period permitted under the Doctors-in-Training award. Weekend days will be shared as evenly as can be arranged across the team.

Trainees are not rostered on call for the first month (senior medial staff are rostered to be on call more frequently than average during this time), but are rostered on more frequently than senior medical staff during the remainder of their rotation with the VFPMS.

The VFPMS Administration Officer must be informed of swaps as soon as possible so that the after-hours call service at VIFM can be updated with this new information.

15. Medical indemnity insurance

VFPMS doctors must maintain their medical indemnity insurance. This is a condition of employment.

16. Fit2Work and other HR requirements

It is a condition of employment that Fit2Work checks (involving police checks) are conducted prior to commencement of employment.

All VFPMS employees must have a current Working with Children Card.

Medical staff employed at RCH also have honorary appointments at MCH. An honorary appointment involves a separate contract with MCH to cover VFPMS work onsite at MCH.

Credentialling by Medical Appointments Committees is required at both hospitals.

All clinical staff must have a defined scope of practice, and they must work within their scope of practice and that of their profession.

Annual PDAPs must be undertaken with managers.

17. A safe work environment

VFPMS work can be stressful and challenging. It can also be extremely intellectually stimulating and emotionally rewarding. Sometimes, in spite of our best intentions, situations arise that can negatively impact workforce safety and performance (including psychological wellbeing), and this in turn can negatively affect patient care. We therefore ask that staff let managers know if they have any concerns or become aware of any warning signs of a compromise to workplace safety, so that we can promptly intervene as a matter of priority to address these problems. This includes letting us know about situations at work and outside the workplace that result in staff feeling stressed or uncomfortable.

Please note that VFPMS is acutely aware of the need to “take good care of ourselves”, so we encourage a good work–life balance and good “self-care”. We aim to be the most resilient, caring, psychologically supportive team in the Victorian Health system!