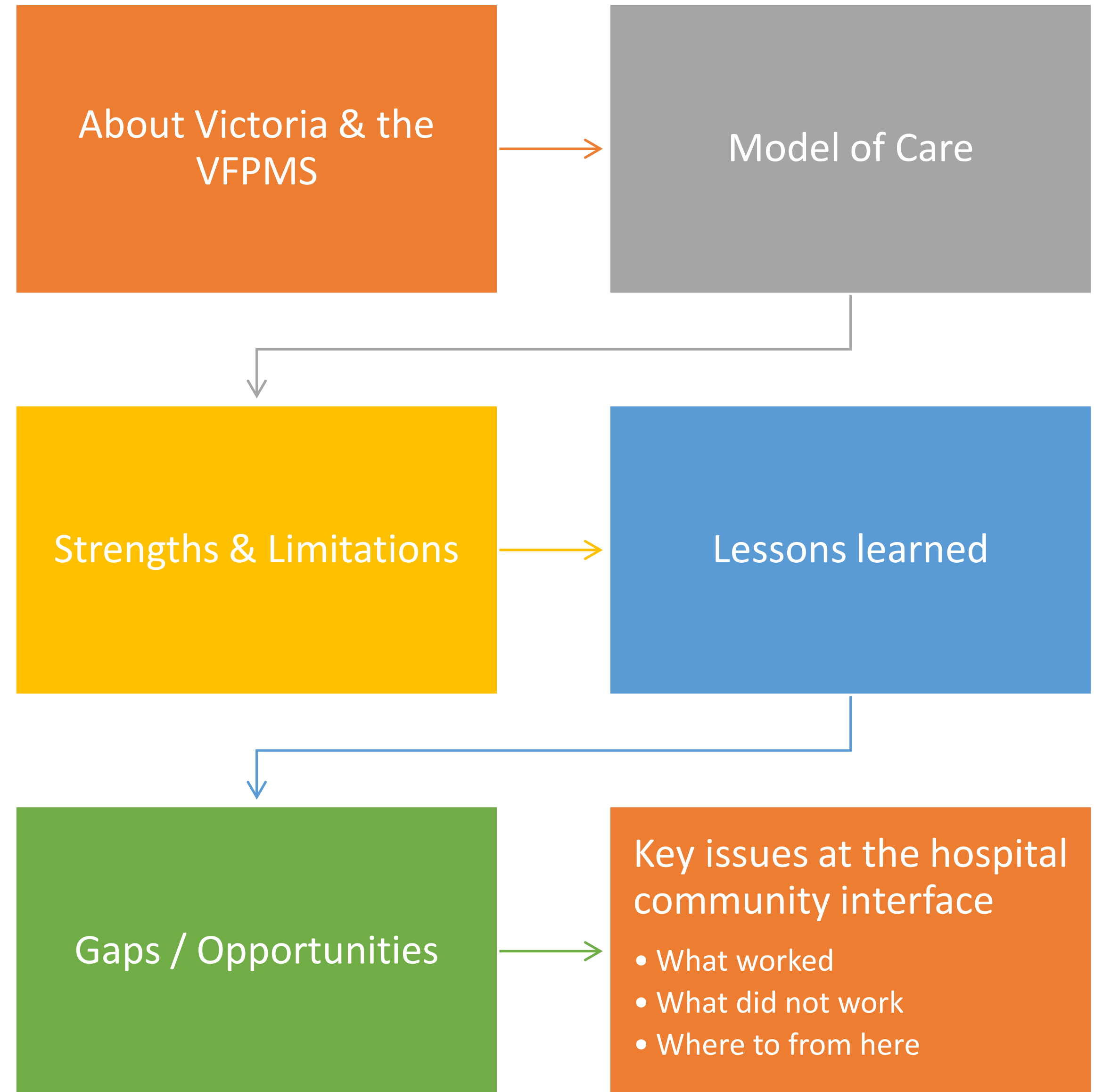
The strengths and limitations of the Victorian Forensic Paediatric Forensic Medical Service

Model of care with a focus on the hospital-community interface.

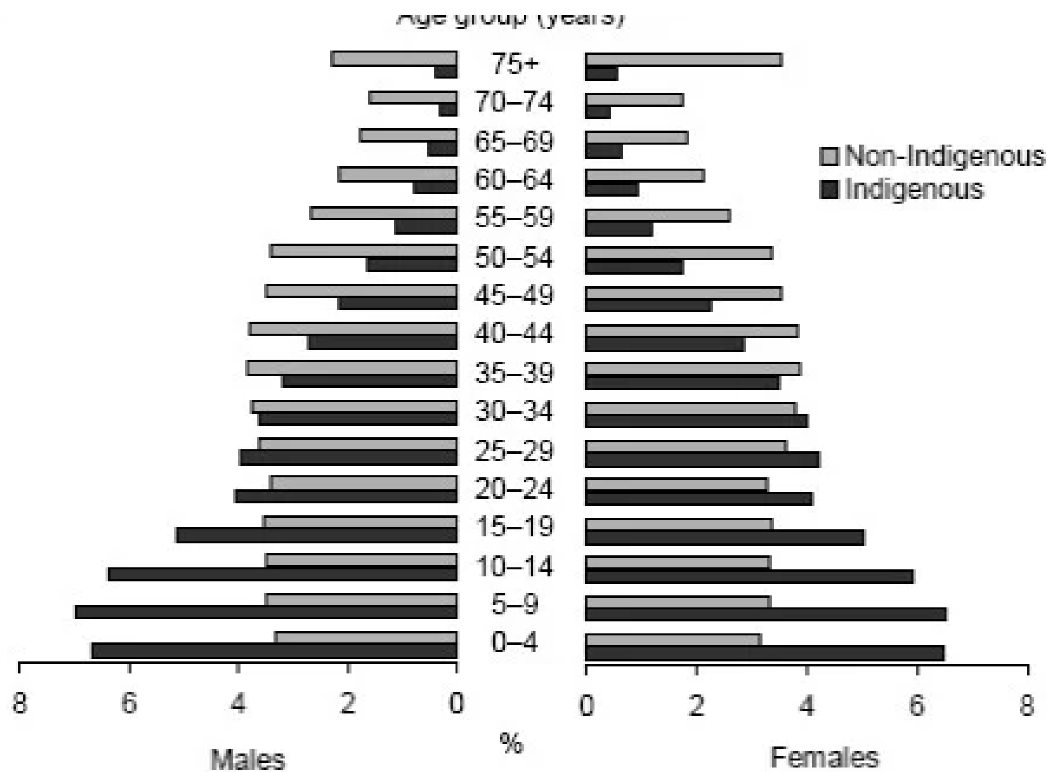
Content



Victoria, Australia

>80% Australians live on the East coast

Statistics

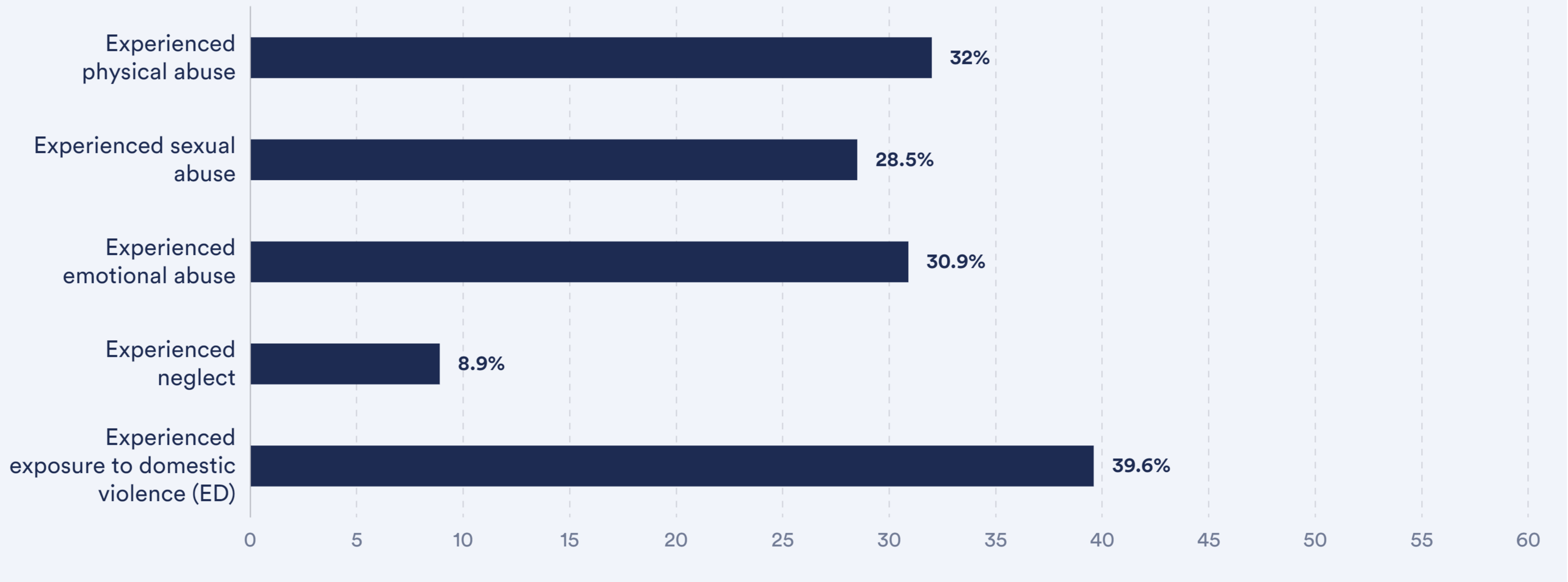


- Australian Population: 26,473,055 (Mar 2023) Victoria 6,766,600
- 3.8% Indigenous
- GDP 0.4% CPI 5.4% (Sep 23)
- Unemployment rate 3.7%
- Average weekly earnings $1,838 ($90,800 pa)

- 18.3% aged 0-14 years, 5.8% aged 0-4 years
- Infant mortality rate 3.2 per 1,000 live births

- 37% children 2-14 years = overweight/obese

ACMS Australian Child Maltreatment Study



Mathews B, Pacella RE, Scott JG, Finkelhor D, Meinck F, Higgins DJ, Erskine HE, Thomas HJ, Lawrence D, Haslam DM, Malacova E, Dunne MP. The prevalence of child maltreatment in Australia: findings from a national survey. Med J Aust 2023; 218 (6 Suppl): S13-S18. https://doi.org/10.5694/mja2.51873.

History of the VFPMS

- Before 2006 – varied quality of patient care, no co-ordination, no data, no oversight
- Steering committee - “buy-in” from Govt (Health, Police, Child Protection, Courts)
- 2006 – VFPMS. (Health) Grant 6.4M over 4 years – Management by consortium
- 2010 – Review of VFPMS -> Governance transitioned to Royal Children’s Hospital
- Reporting via RCH CEO to Dept of Health
- Collaborations
  - Within Health (across VFPMS network)
  - With Child Protection Services, Police, counselling, mainstream paediatric health services

Role of the VFPMS re patient examinations

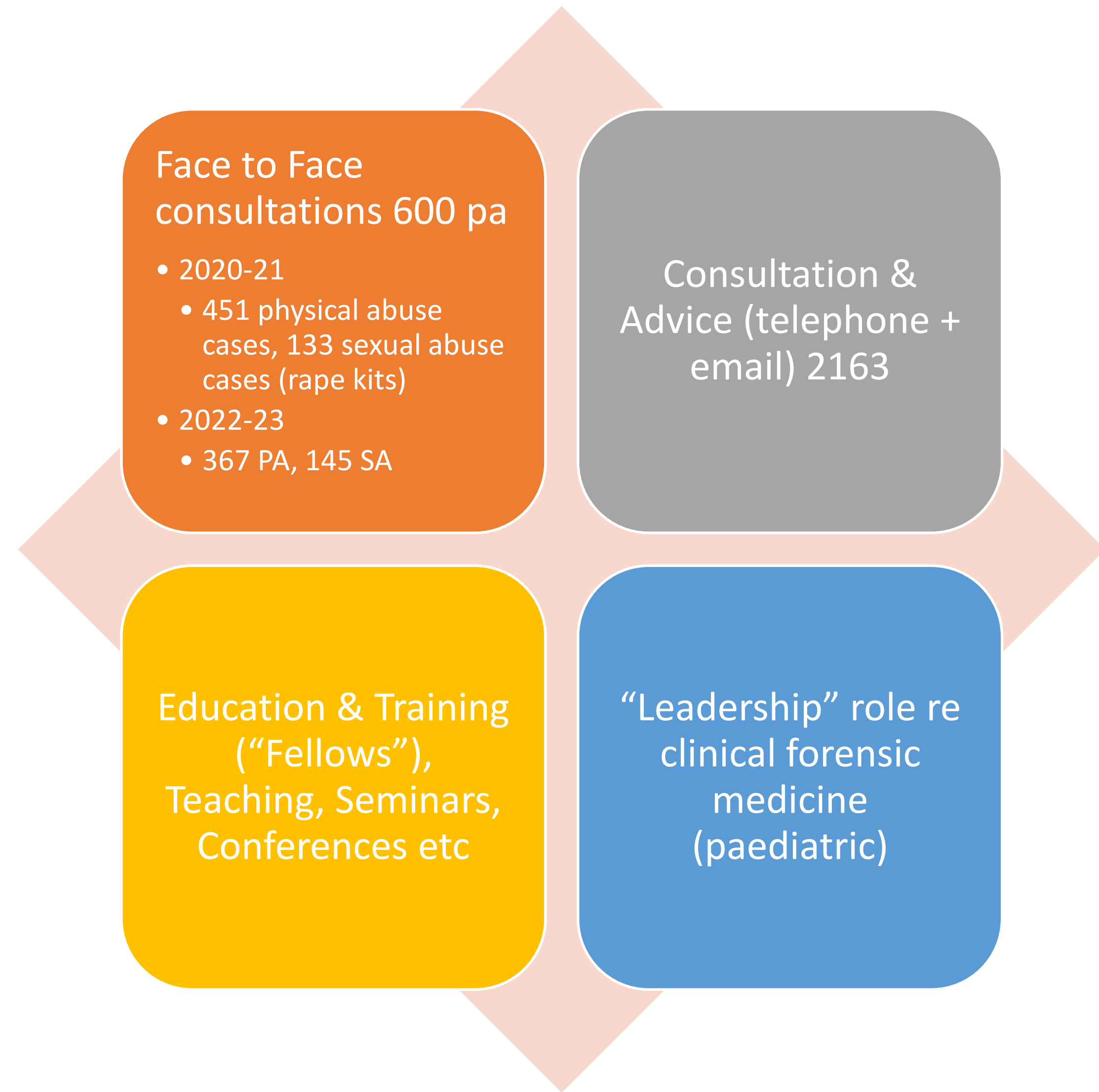
(Forensic **Medical** Service for < 18 yo Victorians)

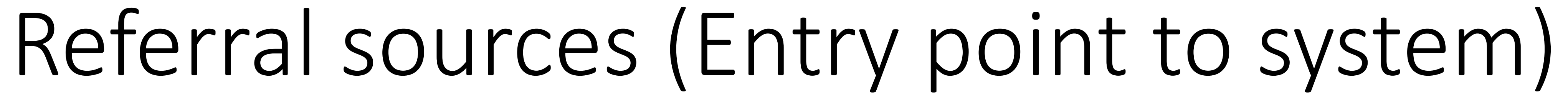
Purpose: To determine (if possible) the cause, timing & consequences of injury

- Physical injury
- Sexual abuse
- Child neglect
- Emotional abuse

Has this child experienced child abuse, an accident or were findings caused by a medical mimic?

4 key deliverables (Health Dept perspective)





For Face-to-Face examination (2022-23, n = 366 – NB percentages > 100%)

- Child Protection (24%)
- Victoria Police (all sexual assault) (39%)
- Health professionals (47% - almost all concurrently referred to Child Protection)

- NOT family, others

OUR FOCUS: It's all about the medical evidence…

Not social circumstances

- Social circumstances impact discharge plans

Underpinning principles. We must…

- Be independent
- Be open-minded
- Be objective & impartial
- Be thorough
- Be balanced & fair
- Take a holistic view of the child in the context of their family and community

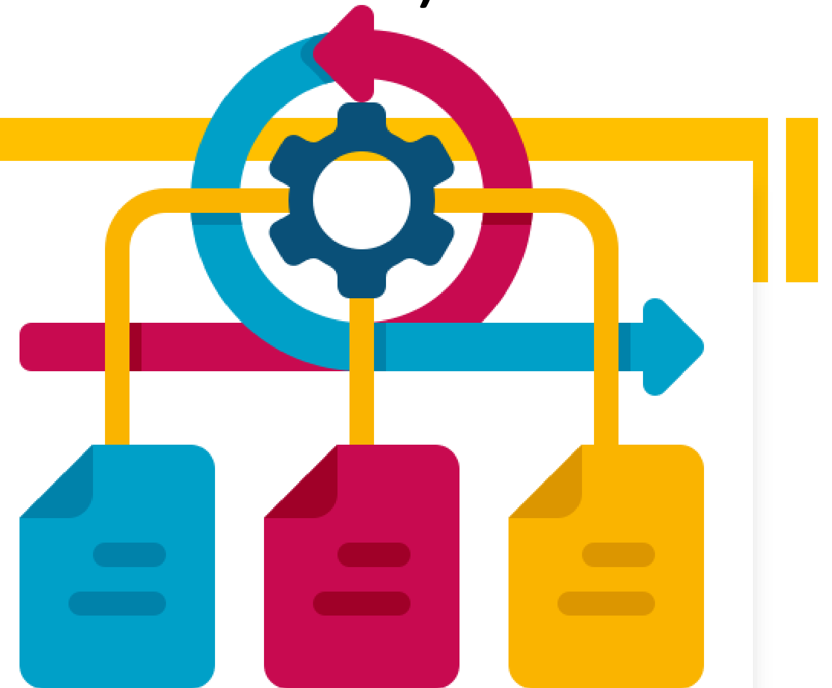
It’s also about quality (and safety)

Health service

- Centre of Excellence
  - Standards & CPG
  - Data – reporting
  - Leadership (research, collaboration, influence)
  - Education & training
  - Advice & consultation

- Hub & spoke network

Policies and procedures (A framework)



- Vulnerable child (at risk of harm…) Policy and Procedure
- Child Abuse policy
- Child Abuse procedure
- Child Abuse Clinical Practice guideline (RCH)
- VFPMS Clinical Practice Guidelines
- Interagency agreements (Police & Child Protection, RCH & CP)
- VFPMS responsibilities
  - Hub – policies, procedures, guidelines, tools, templates, 24/7 support and advice, peer review reports, interagency liaison meetings (quarterly) , support court testimony
  - Spokes – agree to provide the forensic service, provide the workforce, ENABLE and support the workforce, support VFPMS standards.
- VFPMS standards

VFPMS Tools and Templates

- Proformas
- Body diagrams (x3 sizes)
- Report templates
- Standard physical injury
- Sexual abuse
- Image interpretation
- Tables
  - Neglect
  - Emotional abuse

VFPMS Team

Hub

“Units” at RCH and MCH – business hours + 24/7 for SA cases & inpatients at RCH&MCH

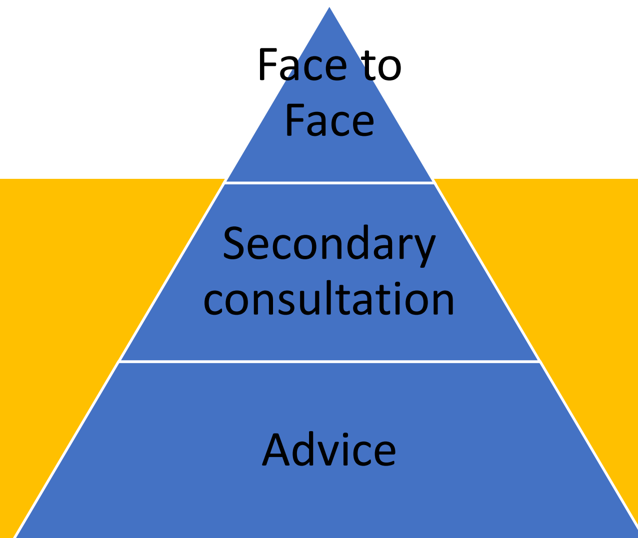
- Doctors – forensically-trained paediatricians (Monash Uni MForMed)+ trainees
    - Total Dr EFT = 1 Director, 1 Dept Dir, 2 EFT Consultants & 1.5 EFT trainees
- Nurses (2)
- Admin (1.6)

Spokes

- Fee-for-service x ~30-40 cases per year (additional cases managed as “’routine” patients)

Model of Care

Face-to-Face cases



Health focus + forensic purpose

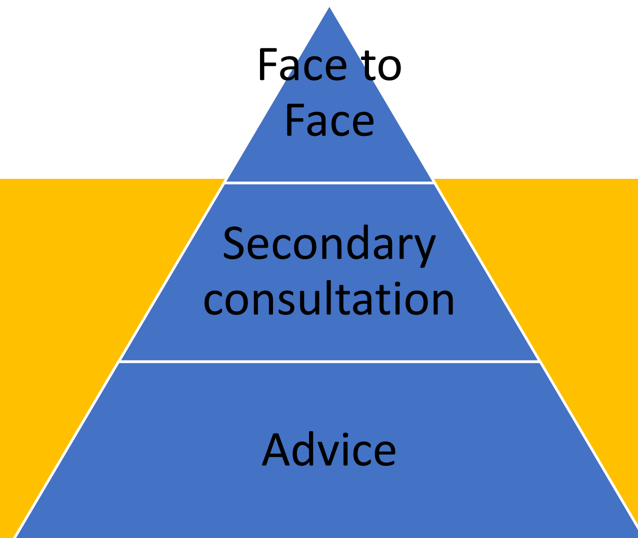
- We evaluate health, wellbeing (mental health), growth, development, behaviour, relationships, impact of abuse & deprivation/adversity, safety

Forensic matters. We

- Gather information (multiple sources)
- Examine (search for injury/signs of neglect)
- Order medical investigations
- Collaborate with other investigators
- Write medicolegal reports
- Testify in court

Model of Care

Face-to-Face cases



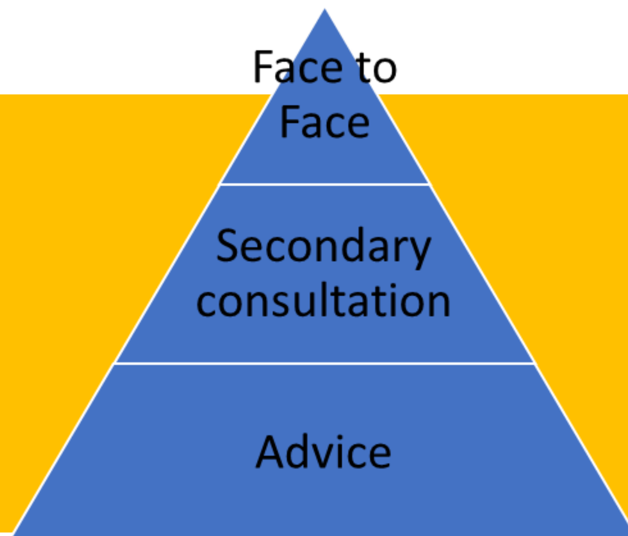
PRACTICALITIES

- ACCESS 24/7 (only for professionals)
    - Statewide phone number 1300 661142
    - Email address “VFPMS-Enquiries”
- Triage
    - Urgent
    - Semi-urgent
    - Next available
- Location – closest to patient’s residence
- Balance need to travel with highest available expertise

- AIM: build workforce clinical capabilities over time
- Match patient need with available workforce skillset
- REFER on to others for ongoing medical/health care

Model of Care

Consultation and advice



Health focus – We guide our Health colleagues regarding

- Evaluation of child's health, wellbeing (mental health), growth, development, behaviour, relationships, impact of abuse & deprivation/adversity, safety
- VFPMS Tools, Templates, Guidelines, Standards
- We educate & support (Peer review reports)

Forensic matters. We help our colleagues to

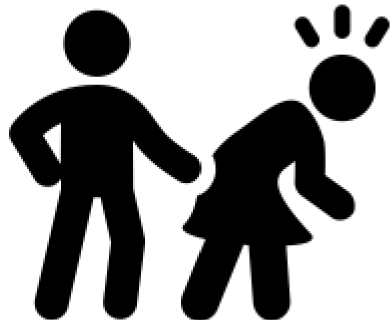
- Gather information (multiple sources)
- Examine (search for injury/signs of neglect)
- Order medical investigations
- Collaborate with other investigators
- Write medicolegal reports
- Testify in court
- Understand the system

Process of VFPMS case evaluation

- Consent for child's evaluation = "voluntary" & MUST be legally valid.
- Information – from family and professionals
- Documentation – EMR + written on proforma (scanned into EMR)
- SCAN meetings – interagency collaboration, professionals-only, early
    - Health + Child Protection + Police
- Interdepartmental care team – investigation by various medical disciplines
- Test various hypotheses
- Form opinion regarding likely cause(s), timing, & consequences of injury…
- Write report (recommendations for ongoing safety and healthcare)

Example of process: Recent sexual assault

No wrong door



Child's parent contacts police

Police contact VFPMS

Urgent FtF consult RCH or MCH

Dr + Social worker (+/-nurse)
History re complaint
Paediatric medical Hx
DNA cleaned suite for examination – top to toe
Video-record genital exam
Sample collection (rape kit)
STI testing
Azithromycin
Pregnancy test
"Morning after pill"
Plan ongoing medical care
Counselling (crisis + ongoing)

Example of process: Recent physical assault

Professional contacts VFPMS

Triage – Does child need examination?
VFPMS or other (ED, GP, other)

Opinion re photographs?
(NB: is second rate cf real life)
Email images
Arrange for child to be examined in ED / GP / other

Arrange ongoing communication with other health service providers
What tests?
Interpretation?
phrasing opinion
Communicating with police and child protection practitioners

IN HOURS:
Examination by VFPMS is possible

Example of process: Recently assaulted child admitted to tertiary paediatric hospital

Doctor contacts VFPMS
Re patient's admission

Triage: Urgent or next day VFPMS?

Consult

- What information to seek?
- Which tests?
- Any precautions?

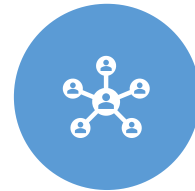
Consider
Forensic standard physical exam
Early > late (iatrogenic injuries)
Access to whole body (ventilated)
PICU/NICU procedures (hypothermia)
Minimising distress to parents if death imminent
Advising re police taking a step back

VFPMS produces a medicolegal report for each child seen

Proformas for documentation of consultations

Report templates

Guidance for satisfactory completion (recipe)



Each report is reviewed by a peer or supervisor.

Signed, dated report = version 1.

Amended report = Version 2 or Addendum

Court testimony = infrequent.
2022-23 = 15 (Melb hub)
88 Subpoenas – 49 to attend + 39 notes only

Children's Court of Victoria

Criminal courts

- Magistrates court
- County Court
- Supreme Court

Rarely other

- Coroners Court
- Family Court

- Health professional – present medical evidence as an expert medical witness
- Talk to contents of VFPMS report
- Explain, inform, expand and justify opinion & respond to questions

- Independent. Not partisan.   Duty is to the Court.
  - Many presume that in CCV, VFPMS = aligned with Child Protection
  - Many presume that in Criminal Courts, VFPMS = aligned with police

- Role varies somewhat according to Court and circumstances of each case

Interactions with legal professionals
Process - when things go well… (Children's Court of Victoria)

- Telephone call from Protective worker as soon as hearing dates known
  - Request for unavailable dates
  - CPP familiar with case, read the file, knows the contents of VFPMS report.
  - Discussion about key protective concerns and medical evidence in issue

- Subpoena served well in advance of hearing

- Email contact + Telephone conversation with CPLO – Barrister/Solicitor. Questions asked & answered
- Email and conversation with Parents legal team/ Legal aid solicitor. Questions asked and answered

- Scheduled attendance at pre-arranged half day. (Least disruptive to other commitments).
- Via Videolink

Interactions with Police Process - when things go well…

- Telephone call from Police who already interviewed the child & caregivers, know key issues.
- Time and location of service arranged by agreement mindful of medical need
- Courteous respectful interaction
- Police provide (share) information then Drs provide (share) information (with consent) with police
- Police accept rape kit when kit handed over by Dr (Chain of Custody forms completed)
- Kit transferred to forensics lab asap.
- QA checks – checklist provides feedback to DRs
- Police keep medical service informed of investigation progress & outcome.

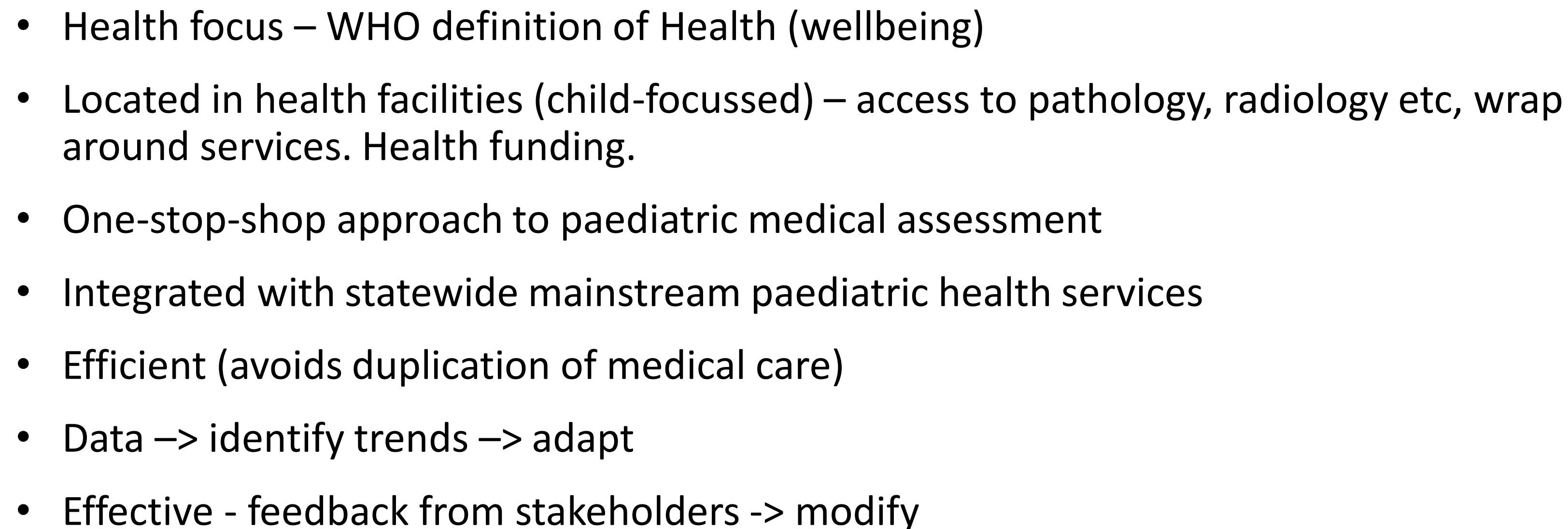
Interactions with Child Protection practitioners
Process - when things go well…

- Telephone call from Protective worker – willing engagement, extensive information sharing
  - CPP familiar with case, knows contents of child's file, understands the main concerns.
  - Two-way discussion about key protective concerns and medical evidence / recommendations.
  - CPP telephones to discuss VFPMS report / recommendations. Joint health & safety plan.

- CPP keeps VFPMS informed as protective investigations progress, as decisions are made
- Caregivers cooperative, voluntary engagement with supports, positive change deemed likely
  - Proven record of parental capacity to change to improve child's safety, health and wellbeing
- CPP closes case ONLY AFTER VFPMS report received and agreement reached re closure.

- CPP informs VFPMS at time of case closure of referrals made, risks mitigated and planned interventions

Strengths of this model of care



- Health focus – WHO definition of Health (wellbeing)
- Located in health facilities (child-focussed) – access to pathology, radiology etc, wrap around services. Health funding.
- One-stop-shop approach to paediatric medical assessment
- Integrated with statewide mainstream paediatric health services
- Efficient (avoids duplication of medical care)
- Data –> identify trends –> adapt
- Effective - feedback from stakeholders -> modify

Strengths of this model of care

- **Centre of Excellence structure** (integrates research, innovation to improve quality, standards development, development of CPG, workforce support, data collection & reporting, etc into a service delivery model)
- Forensically-trained paediatricians (MForMed)
  - High level of expertise for case work
  - High level of expertise for teaching, training & supporting others
- “Narrow” focus on Paediatric Forensic Medicine not social care / social work / therapy (remediation of harm)
- Partners /stakeholders help us improve tools & medicolegal report templates
- Economical use staff/expertise @ higher hourly rate, one doctor, one opinion, holistic approach to patient care

Tensions, Competing ideologies

- Doctors are expensive & in short supply. Optimal use?
    - Management? Oversight? Sign off on others' work/reports?
- Nurses can do the work (workforce skills transfer)? & cheaper?
    - Nurse practitioner model, CNC, CNS
    - SANE & SANE-p
    - Physician assistant (USA)
- Multidisciplinary Centres, Child Advocacy Centre model (sexual abuse)
    - Office-based (or "suite" in office block)
    - Problem based separation from mainstream health services – assumes "walking well patients.
    - Co-located with Police and Counsellors (+/- Child Protection)
    - No direct access to investigative / other health facilities (tests not performed)

Limitations of VFPMS model of care

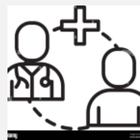
Cost

Pressure of Health budget (especially post Covid-19)

Health executives too distant & disengaged

Minimal capacity for growth

DoH pressure = efficiencies/shrinkage



Consultative model (no resident staff in hospitals)

RISK: Other Health professionals might not follow VFPMS advice

Limitations of VFPMS model of care

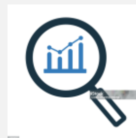
Small pool of potential forensic specialists.

Train our own.

Regional Victorian doctors poorly paid (fee for service)

Little incentive to upskill

Hospitals minimally engaged in QA



Elusive research funding / time

Teaching commitments compete with service to patients

Limitations of VFPMS model of care

Insufficient administrative & business support

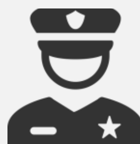
Reliance on hospital HR/Finance
Statewide model runs as department -> "clunky" operations

Hospital Executives engagement varies

In governance

Advocating for growth/capacity building

Ineffective "bridge" to leaders(Police / CP) & govt



Police seek to "manage" / influence Health professionals

CPP – poor health literacy, lack understanding.

Challenges of VFPMS model of care

One hub: Two sites

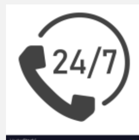
RCH & MCH

Small team – managing leave

LSL

Sick leave

Court time



24/7 response

Industrial relations – workforce pressures re oncall commitment and work conditions

Pressure on leadership

Oversight of research, teaching, run the service

Building capacity in the Health (medical) system
Increase practitioner knowledge, skill, networking, quality of care

- Education & training – Annual VFPMS seminar + each case
- Fellows – Train 3-4 RACP advanced trainees per year (0.5EFT x 12 mo)

- **24/7 support**, provide advice, tools, templates, standards, CPG
- Encourage regular local interdisciplinary (police, CP) liaison meetings

- Australian Child Abuse Paediatricians on-line group (quarterly mtgs)
- Under development - Aust + NZ society - CPPSA
- Lobby government (“set and forget” attitude is problematic)
  - Priorities = children in out of home care / primary prevention

Lessons learned – The value of peer review

- Case based discussions in peer review meetings
  - There are significant limitations!
  - Goal = diagnostic accuracy + education for all
  - Selected cases /set criteria + at presenter's choice
    - All abnormal genital examination findings
    - All inpatients

- Peer review of medical reports*****
  - Quality of presentation, structure, any gaps?
  - Editorial review
  - Technical review – validity of opinion given the content (basis), reliability of opinion

Lessons learned – The value of good networks

Health

- Emergency Medicine specialists
- General paediatricians & Neonatologists
- Intensivists
- Medical specialists – Radiologists, Ophthalmologists
- Surgeons – Neurosurgeons, Trauma, Orthopaedic etc
- Rehab specialists

- General Practitioners &MCHN (Primary care)

Beyond Health

Within the "industry" that protects children (police, CP, Courts, Support agencies)

- Within the community
    - that works to reduce/prevent maltreatment
    - that works to remediate harm
    - That build parenting skills

Lessons learned – The importance of impartiality

Be aware of bias (act to minimise)

Duty is to the Court – not either party

We are not agents of police, child protection or courts

Code of Conduct – acknowledge in each report.

See AAP and Helfer Group Code of Conduct

Independence matters (funding by Health not Police)

- Same availability to Defence and Prosecution
- Same conversation with Defence as Prosecution
- Not aligned with a particular view or seeking a particular outcome

Lessons learned – An eye on the end game (Court)

ALL work (written and otherwise) must withstand high-level scrutiny in Court

EACH WORD MATTERS

Court

- Criminal
- Protective

Watch the legal landscape – Common law judgements

- International courts - legal precedents / judgements
  - Admissibility of evidence
  - Tendency evidence
  - “AHT” diagnosis
  - “Junk science”
- Court of Appeal

Lessons learned – We failed to build for growth

- Funding model – consider regular re-evaluation and revision of funding model
- >CPI increases (increases in salary / facility fees /costs) built in to annual increases

- Vision & Mission can be reconceptualised over time
- Strategic plan – SMART goals
- Set targets
- Monitor deliverables
- Review successes (and failures) annually
- 5 yearly review of workforce mix / skillsets / trends
- Aim to strengthen the leadership group
- Succession plan

Lessons learned – Squabbles over turf & territory

“Ownership” of the ”child abuse” space – Partnerships or Competition?

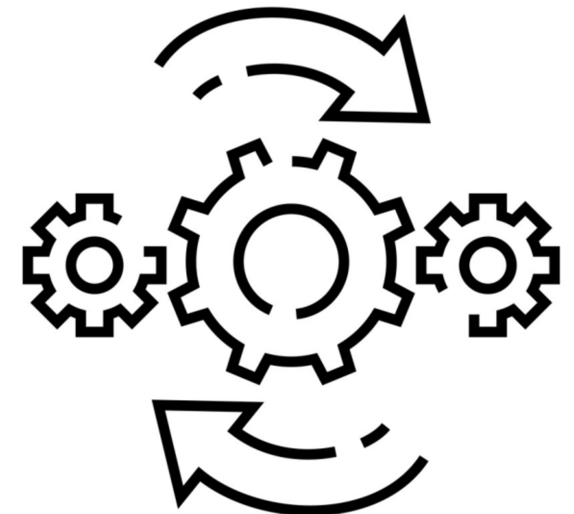
- Nurses / SANE
- Social workers (social care)
- Psychologists / counsellors (therapy)
- Community paediatricians
- Police
- Child Protection practitioners
- Lawyers / Court officials
- Government bureaucrats
- Hospital Executives

We all need friends in high places…

Lessons learned – Modifications

<u>Trends</u>

- Fewer cases examined face to face
- More cases managed by paediatricians in other hospitals (network, 2ndary consultation)
- More cases managed by 2ndary consultation in RCH and MCH
- More cases assessed on basis of photographs
  - (emailed "provisional opinion")
- Fewer sexual abuse cases (less "historical sexual abuse")



More sessions for senior medical staff, fewer sessions for trainees

Funding increases = unable to maintain staffing (Drs, nurses, admin)

Limited capacity to assess fabricated & induced illness cases

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Questions?