Saturday 30th August 2014

**Session 1**

Chairman: Maria Nittis President of FAMSACA

09:00-09:40  
**Key note address:**  
To compare the outcomes of medical and forensic evaluation of girls and boys under 8 years seen at a SARC  
Catherine White OBE

09:40-10:00  
**Assessment of risk of serious injury or death in clients attending a sexual assault service following sexual assault by an intimate partner or ex-partner**  
Lyndall Young

10:00-10:20  
**The seriousness of injury**  
Jason Schreiber

10:20-10:30  
Discussion

10:30-11:00  
Refreshment break

11:00-11:20  
**Hair drug analysis to identify cases of drug facilitated sexual assault**  
Greg Dayman and Elizabeth Gebler-Hughes

11:20-11:40  
**Early Evidence Kit (EEK) to maximize collection of forensic biological material from complainants of sexual assault**  
Sanjeev Gaya

11:40-12:00  
**Early evidence kits in sexual assault: an observational study of spermatozoa detection in urine and other forensic specimens.**  
Debbie Smith

12:00-12:20  
**An unbeaten century of clinical forensic sexual assault examinations**  
Paul Gaudry

12:20-12:30  
Discussion

12:30-13:30  
Lunch
Saturday 30th August 2014

Session 2  
Chairman: Morris Odell President of AAFP

13:30-13:50  
**Return to Uranus – have we got there yet?**
Min Lo

13:50-14:10  
**A case of infant sexual assault with documented healing of the hymen**
Rosemary Isaacs

14:10-14:30  
**Potential for environmental contamination of urine samples used for diagnosis of sexually transmitted infections – relevance in child sexual abuse cases**
Tracy Johns

14:30-14:50  
**Translating Recommendations from the Goudge Inquiry to Forensic Practices of Child Protection Paediatricians**
Catherine Skellern

14:50-15:00  
Discussion

15:00-15:30  
Refreshment break

15:30-15:50  
**A sudden unexpected increase in sudden unexpected deaths of babies in 2013 in the ACT**
Cath Sansum

15:50-16:20  
**24 hour watch house nurses: Does a Watch House Emergency Nurse (WHEN) model improve health outcomes?**
Julia Crilly and Cathy Lincoln

16:20-16:50  
**Safety and glycaemic control: diabetes management in the watch-house**
Nelle van Burren

16:50-17:00  
Discussion end of first day
Sunday 31st August 2014

Session 3

Chairman: Dr Lyndall Young
Medical Co-ordinator
Yarrow Place Rape and Sexual Assault Service Adelaide

08:30-09:10 Keynote address:
Great Expectations versus Hard Times
“Experience is simply the name we give our mistakes.”
(Oscar Wilde)

Catherine White OBE

09:10-09:30 Evidence-based malpractice
Bob Hoskins

09:30-09:50 Presentation of oral evidence in NSW Courts
Maria Nittis

09:50-10:00 Discussion

10:00-10:30 Refreshment break

10:30-10:50 Australian Defence Force – a pilot training program in clinical forensic medicine
Vanita Parekh

10:50-11:10 Evaluation of a ‘Decontamination Kit’ in NSW
Margaret Stark

11:10-11:50 "A Death in Custody in the Alice - A preventable tragedy"
Morris Odell

11:50-12:00 Discussion

12:00 Lunch
Sunday 31st August 2014

Joint Session with the Forensic Pathologists

Session 4 Joint Chairmen: Neil Langlois Consultant Forensic Pathologist at Forensic Science South Australia & Margaret Stark Education Officer FAMSACA

13:00- 13:35 Domestic Violence Death Review Mechanisms: What do they add?
Heidi Ehrat

13:33-14:10 Post mortem sexual assault examinations
Angela Williams

14:10-14:45 Herbal medicines and death
Roger Byard

14:45-15:00 Working together - the establishment of a new Faculty of Clinical Forensic Medicine FM with RCPA
Morris Odell
Abstracts

Saturday 30th August 2014 Session 1

Keynote address

To compare the outcomes of medical and forensic evaluation of girls and boys under 8 years seen at a SARC

Catherine White

St. Mary’s Sexual Assault Centre, Manchester

The evidence base regarding child sexual abuse is not as robust as it should be. In particular the findings from research papers are sometimes difficult to interpret as they contain a mixture of pre and post pubertal children and both acute and historical assessments. The St Mary’s SARC Under 8 study set out to look at pre pubertal children only. There were numerous objectives including a study of:

- the nature of the alleged sexual assault in this group of clients
- how the disclosure occurred,
- the rate and type of injuries seen and their anatomical location,
- the dependence of recorded injuries in relation to length of time between alleged assault and examination,
- the criminal justice system outcomes
- comparison of differences between boys and girls and in respect to other demographic characteristics

A descriptive retrospective study was undertaken looking at children aged 7 years and younger who attended St Mary’s SARC from 1st April 2010 until March 31st April 2013. 365 children met the inclusion criteria. Data was extracted from medical records, DVDs of ano-genital examinations were reviewed and criminal justice outcomes were sought. The results should help with the interpretation of physical findings and also stimulate discussion on the management, both medically and within the wider social context, of this group of vulnerable children.

Assessment of risk of serious injury or death in clients attending a sexual assault service following sexual assault by an intimate partner or ex-partner.

Lyndall Young

Yarrow Place Rape and Sexual Assault Service, South Australia

The majority of female homicide victims in Australia are killed by their partners. A history of domestic violence is common in intimate partner homicide and it has been recognised that integrated service responses to women experiencing domestic violence can greatly improve the safety of women and their children. The Family Safety Framework (FSF) has been introduced in South Australia to provide such consistent and integrated service responses.
Approximately 20% of clients attending for a medical service at Yarrow Place Sexual Assault Service between January 2011 and 2013 were raped by either an intimate partner or ex-partner. This presentation will briefly outline the Family Safety Framework process and highlight the initial stage which is risk assessment. The severity of potential future harm for those women attending Yarrow Place after rape by a partner or ex-partner will be presented. It will review of the implementation of the Family Safety Framework at Yarrow Place and the early recognition that the perceived level of risk without the use of the formal risk assessment tool provided by the Family Safety Framework often under-estimated the actual risk of harm.

Changes to practice will be presented as will a discussion about the role of the sexual assault service when responding to victims of intimate partner violence.

The Seriousness of Injury
Jason Schreiber
Victorian Institute of Forensic Medicine, Victoria

The argument regarding seriousness of injury during a court hearing may follow an altercation during which injuries are sustained or inflicted. Regarding sentencing for physical assault, Australian Law (and particularly the law in Victoria) distinguishes between injury and serious injury. Serious injury is defined as either “protracted”, “substantial”, “of cumulative effect” or “endangering life” in Victorian Law. Thus, the definition for serious injury is kept vague and remains dependent on the interpretation of these somewhat ambiguous terms.

Forensic physicians are frequently asked by law enforcement agencies to assist in determining whether an injury is considered serious. This presentation deals with the difference between “severity” and “seriousness” and the questions the forensic physician may face in the witness box.

With regard to severity and seriousness, there are both differences between the English and Australian approach and between common law and civil code countries. Victorian jurisdiction leaves the ultimate decision to the members of the jury who are not medically or legally trained but are to use their common sense for their determination having heard the evidence with regard to whether injuries should be regarded as “serious”.

A number of cases are presented and assessed as to the criteria which may be used to determine “serious injury” as well as possible verdict outcomes. From an analysis of these cases the conclusion can be drawn that “seriousness” may not always correlate with “severity”. The aim of the presentation is to develop more confidence in stating an opinion with respect to the question of “serious injury” in cases of alleged physical assault and giving reasons for this during a cross examination.

Hair drug analysis to identify cases of drug facilitated sexual assault
Greg Dayman¹, Lyndall Young¹, Elizabeth Gebler-Hughes²
¹Yarrow Place Rape and Sexual Assault Service, ²Modbury Hospital, South Australia

Sexual assault is sometimes facilitated by having the victim unknowingly ingesting a substance that may affect factors such as memory or cognitive ability. Generally only blood and urine samples are
tested for evidence of such substances. The aim of this study was to determine with there was any additional benefit to also testing hair samples.

People attending Yarrow Place with a suspected drug facilitated sexual assault between August 2011 and September 2013 were invited to participate. Consenting individuals completed a questionnaire and gave blood and urine samples if present recently enough after assault (blood <72 hours; urine <96 hours). Participants returned after four weeks to complete another questionnaire and provide a hair sample. Samples were processed by Forensic Science South Australia, and tested for ethanol, drugs of abuse (amphetamines, THC, opiates and cocaine) and a range of chemically basic and neutral drugs using a variety of techniques.

A total of 32 participants were recruited and 10 provided hair samples. Alcohol use was reported by 97% of participants and illicit drug use by 19%. Memory loss was the most common symptom (81%), followed by confusion and drowsiness (59%). 23% of blood, 56% of urine and 50% of hair samples contained drugs which were not accounted for participants.

Statistically significant results were not obtained. A number of substances were detected in hair samples, but not in urine or blood. High rates of alcohol and prescription drug use were reported.

Disclosure of Interest Statement:
This study was funded by the National Drug Law Enforcement Research Fund.

**Early Evidence Kit (EEK) to maximize collection of forensic biological material from complainants of sexual assault**

Sanjeev Gaya

Victorian Institute of Forensic Medicine

In collaboration with Victoria Police, the Victorian Institute of Forensic Medicine has developed and recently implemented an Early Evidence Kit (EEK). An EEK is a forensic self-sampling kit used by a complainant of sexual assault to recover biological material that may be lost due to time (e.g. delay before a forensic examination) and/or complainant activity (e.g. eating, drinking, voiding and defaecating). An EEK has three components: mouth swab, genital/anal gauze wipe and urine sample. The EEK is not a substitute for a comprehensive forensic examination by a doctor or a nurse and is for the exclusive use of police officers that have received instructions in its use. This paper will explore the contents of the EEK, the indications for its use and its acceptability by police and complainants. Furthermore, this paper will outline early data on its use and findings following analysis of samples.

**Early evidence kits in sexual assault: an observational study of spermatozoa detection in urine and other forensic specimens.**

Smith D ¹, Webb L ², Fennell A ², Nathan E ³, Bassindale C ¹, Phillips M ¹.

¹ Sexual Assault Resource Centre, Perth, Western Australia, ² Forensic Biology PathWest, Laboratory Medicine Western Australia, ³ Women and Infants Research Foundation, Perth, Western Australia.
The aim of the study was to determine the detection frequency of spermatozoa in early evidence kit specimens and in subsequent full forensic specimens in alleged sexual assault.

An observational cohort study was conducted of 100 consecutive alleged sexual assault cases, presenting in Western Australia between 19th July 2008 and 6th February 2012, with both early evidence kit and full forensic evidence specimen collections. Eighty-eight cases were included in the study.

Smears from all forensic specimens were analysed by light microscopy to determine the detection frequency and structural characteristics of spermatozoa. Patient demographic features, characteristics of the alleged assault and details and timing of forensic collections were also collected.

Spermatozoa were detected in early evidence kit specimens in 35% (31/88) and in full forensic specimens in 42% (37/88) of all cases (irrespective of type of alleged penetration). In alleged penile-vaginal penetration, spermatozoa were detected in early evidence kit specimens in 40% (21/53) of cases when both first void urine and vulval gauze wipe were collected. By comparison spermatozoa were detected in full forensic specimens in 45% (31/69) of cases. Spermatozoa were detected in early evidence kit oral rinse specimens in 6% (1/18) cases of alleged penile-oral penetration and in early evidence perianal gauze wipe specimens in 33 % (2/6) cases of alleged penile-anal penetration. Spermatozoa were detected in the early evidence kit first void urine specimen in a single case, 11% (1/9), in which the nature of the alleged assault was unknown. Spermatozoa were detected in early evidence kit specimens and not in full forensic specimens in 3 of 88 (3%) cases.

Early evidence kit specimens are effective in recovery of spermatozoa and in particular urine and vulval gauze wipe are worthwhile early forensic specimens for the detection of spermatozoa. Collection of early evidence specimens led to detection of spermatozoa-positive cases, which were not detected by subsequent full forensic specimen collection.

Disclosure of Interest Statement:
This study was funded by the Women and Infants Research Foundation Grant.

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Dr Catherine Nixon MBBS DRANZCOG FRACGP Dip Forens. Med
Detective Senior Sergeant John Hindriksen WA Police
Forensic Biology staff at PathWest WA

An unbeaten century of clinical forensic sexual assault examinations

Gaudry P1,2, Nittis M3.

1Visiting Medical Officer, Forensic Medicine Unit, Western Sydney Local Health District and Nepean and Blue Mountains Local Health District, 2Forensic Medical Officer, Clinical Forensic Medicine Unit, Forensic Services Group, NSW Police, 3Department Head, Forensic Medicine Unit, Western Sydney Local Health District and Nepean and Blue Mountains Local Health District

“An unbeaten century of clinical forensic sexual assault examinations” is an audit of 116 sexual assault examinations performed by the presenter as a member of the After-Hours Sexual Assault Service Team, Forensic Medicine Unit, Westmead Hospital and Nepean Hospital, Sydney NSW.
The unit does approximately 180 forensic examinations per year and 90% are female patients. 126 of the cases are for adult sexual assault. 60% of the adult sexual assault cases are seen after hours (outside 08:30 to 17:00 hours on weekdays). 30% of the after-hours examinations (in 2013) were seen by the presenter. 116 forensic examinations by the presenter between June 2009 and January 2014 were reviewed. Demographic data collected included age, gender, the time between the assault and the examination and whether the victim had ingested alcohol or drugs or had amnesia.

The contemporaneous records of the general examination were reviewed with respect to the hand-written documentation and photography of injuries. The ano-genital examinations were reviewed with respect to whether a speculum examination was offered and completed successfully or not and the hand-written documentation of injuries. The adequacy of forensic specimen collections were reviewed with respect to neglected omissions of swabs and toxicology samples and unnecessary collections. The adequacy of the follow-up services offered was also reviewed. All the certificates of evidence prepared for police were reviewed in real time by the co-author in terms of content, formatting, follow-up advice offered and the summary, opinion and conclusion.

Trends over time regarding record-keeping, specimen collection and the certificates of evidence were retrospectively noted by the presenter. Valuable lessons were learned. Those highlighted are the need for comprehensive documentation of injuries, complete ano-genital examination when possible, appropriate swab and toxicology specimen collection and adequacy of follow-up. These lessons could be applied to the training and assessment of “neophyte” forensic examiners.
Allegations of anal sexual assault are relatively common but there is a paucity of recommendations on the systematic examination, recording and interpretation of findings in this area of the body. This can lead to confusion, and both under and over-interpretation regarding the significance of clinical findings (in particular minor or non-specific findings). There is a lack of consensus between many textbooks and within the medical literature regarding the anatomical terms used to describe the lower end of the anal canal and anal area. The implications for court cases are significant as lawyers want the question answered as whether ‘penetration’ occurred or not.

In 2009, DSAC presented a discussion entitled “Journey to Uranus” at the FAMSACA conference in Sydney. At that time, we were attempting to reach some conclusion to the questions “where exactly is the ‘anal verge’ and therefore ‘what defines penetration’.

We would like to present “Return to Uranus” and discuss our progress since 2009. Since 2010, Doctors for Sexual Abuse Care (DSAC), the NZ organisation responsible for training sexual assault clinicians, has promoted a new system for examination and documentation of examination findings in the anorectal area. This approach is based on internationally accepted terminology developed by colorectal surgeons. It allows clearer communication between doctors across different specialties, who can perform a simple examination and document findings without the need to refer to inconsistent landmarks such as the anal “verge”.
We also discuss a practical approach to documentation and interpretation of clinical findings and ask the question “when is a fissure not a fissure?”

A case of infant sexual assault with documented healing of the hymen

Ramoo, S1, Isaacs RA1,2

1 Brennan Centre Liverpool Hospital, 2University of Sydney

LB, a 13 month old female, presented with her mother to Liverpool Hospital Emergency Department on the night the late evening of “Day 1” January 2013 when blood was found in her nappy. LB’s mother stated that she had noticed blood mixed in with faeces when she had changed her nappy at approximately 15:30 hours on the “Day 1” of January 2013.

A forensic collection and preliminary examination was performed at 0100 on Day 2 and the child was admitted. Detailed examination with two doctors at 0900 on Day 2 noted multiple circular bruises on both her buttocks, and excoriation of the skin in the natal cleft from nappy rash. The genitalia were examined using the labial traction method in the supine position. Genital examination revealed a laceration of the hymen at 6 o’clock extending into the fossa navicularis, with bruising and haematoma. There was mild active bleeding on examination. Other genital findings include an
abrasion in the fossa navicularis, and a 0.5cm laceration of the posterior fourchette. Anal examination revealed a tender laceration at 12 o’clock.

LB was admitted to the paediatric ward for bloods, skeletal surveys, bone scans and ophthalmology review. She was removed from the care of her mother by Family and Community Services, and was eventually placed in foster care.

LB was reviewed at Days 10, 28 and 203 post-initial presentation. Examination findings were recorded using a colposcope with DVD recording. We present for discussion the hymenal findings at day 28 and 203 which show the healing transaction. We raise for discussion the limitations of any medical opinion that could be provided based on the photographs of day 28 and 203 alone, or if the child had been first examined 28 days after a history of genital bleeding.

The injured hymen undergoes a remarkable complex healing process, and, it is difficult to assess the age of injury due to the lack of consistency of pattern or time sequence. A literature review will be presented of evidence of hymeneal healing in pre-pubertal children.

**Potential for environmental contamination of urine samples used for diagnosis of sexually transmitted infections – relevance in child sexual abuse cases**

Andersson P1, Tong S1, Lilliebridge R1, Brenner N1, Martin L3, Delima J5, Singh G2,3, McCann F4, Hudson C5, Spencer E3, Johns T4, Giffard P1

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The detection of a sexually transmitted infection (STI) agent in a urine specimen from a young child is often regarded as an indicator of sexual contact. However, the key parameter is the positive predictive value (PPV) for sexual contact of a positive STI test. The PPV can be extremely sensitive to the frequency of positive STI tests in the absence of sexual contact. False positives may conceivably arise from the transfer of environmental contaminants in clinic toilet/bathroom facilities into urine specimens.

This was tested empirically in ten Northern Territory Clinic toilet-bathrooms, on seven occasions each. The environmental contamination with *Chlamydia trachomatis*, *Neisseria gonorrhoea* and *Trichomanas vaginalis* nucleic acid was determined. In addition, urine collection was simulated using a synthetic urine surrogate. This encompassed contact between the gloved hands and the environment and gloved hands and the inside of the urine collection jar lid.

The most contaminated toilet-bathrooms were in remote Indigenous communities. No contamination was found in the Northern Territory Government Sexual Assault Referral Centre clinics, and intermediate levels of contamination were found in sexual health clinics, and clinics in regional urban centres. In general, *T. vaginalis* was the most abundant contaminant, and *C. trachomatis* the least abundant. The frequency of surrogate urine sample contamination was low but non-zero. For example, 4/558 (0.7%) of the urine surrogate specimens from remote clinics were STI positive.
Positive STI tests arising from environmental contamination or urine specimens cannot be ruled out. A very conservative (i.e. high) estimate for the upper boundary for the frequency is 0.7%. To our knowledge, this is the first meaningful numerical estimate of this parameter. This suggests that urine specimens from young children taken for STI testing should be obtained by trained staff in clean environments.

Disclosure of interest statement: This work was supported by project grant 1004123 of the National Health and Medical Research Council, and the Northern Territory Research and Innovation Board.

This paper was recently published in the Journal of Paediatric Infectious Diseases and can be accessed via this link: http://jpids.oxfordjournals.org/content/early/2013/12/19/jpids.pit085.short?rss=1

Translating Recommendations from the Goudge Inquiry to Forensic Practices of Child Protection Paediatricians

Catherine Skellern, Terence Donald

1Child Advocacy Service, Royal Children’s Hospital, Children’s Health Queensland, Senior Lecturer, University of Queensland, 2Child Protection Unit, Women’s and Children’s Health Network, Adelaide.

In 2008 Ontario Canada the Goudge Inquiry arose following increasing concerns about practices surrounding forensic pathology and the investigation of paediatric deaths. The Inquiry resulted in recommendations seeking systemic reform by addressing training issues, challenges of working in isolation and cultural issues in institutions and professionals involved in forensic pathology. Some of the recommendations from this Inquiry have relevance to paediatricians with child protection responsibilities who are required to communicate opinion regarding injury causation into legal jurisdictions.

This paper examines and expands on some of those recommendations applied to a child protection context, highlighting how to enhance objective, safe and reliable forensic practices in child protection assessments that follow identification of suspicion of harm. The paper defines the difference between diagnosis and formulation of opinion in relation to opining causative mechanisms of injury, by differentiating the use of heuristic from cognitive problem-solving methods in expressing opinion.

The unique challenges for paediatricians working in regional and remote areas are identified alongside the challenge of providing timely opinion to statutory child protection agencies whilst an investigation is in progress. Issues of how to improve regulation and oversight is included, such as setting standards, monitoring compliance and correcting short-comings as important mechanisms of quality control. Goudge provides clear guidance on the use of language in communicating opinion which is equally as relevant to child protection assessments as it is to forensic pathology. The paper concludes with an adaptation of key recommendations directly from those of Goudge, applied to the context of paediatric forensic medicine undertaken in child protection assessments.

A sudden unexpected increase in sudden unexpected deaths of babies in 2013 in the ACT

Cath Sansum
The Canberra Hospital, Clinical Forensic Medical Services, The Child At Risk Health Unit

In 2013, the ACT saw a 3 – 4 fold increase in the number of babies dying suddenly and unexpectedly. This increase brought to light a significant gap in services available in the ACT to investigate these tragic deaths. This talk will discuss the changes made to improve the initial response to these deaths (involving an agreement between the adult and paediatric forensic services in the ACT then liaising with the forensic pathology services offered by VIFM.

In addition, several areas of risk and similarity (including parental drug and alcohol use and unsafe sleeping) were identified in the demographics of the majority of these babies. This prompted a response by the ACT Children and Young People Death Review Committee and various ACT Community Health divisions, further education has ensued. A few feathers went flying as a result. (De-identified cases will be presented to high-light some of the major areas of concern).

The increase in deaths in the community also corresponds with a survey completed at the Canberra Hospital in 2013 with regard to how babies are put to bed whilst inpatients at TCH – once again alarming and unexpected results came to light. Whilst we have hopefully improved the situation, there is still more work to be done. 2014 will see increasing education at community, hospital and individual professional levels.

24 hour watch house nurses: Does a Watch House Emergency Nurse (WHEN) model improve health outcomes?

Lincoln C A1, Crilly J2,5, Timms J2, Fisher A2, Becker K3, Green D3, Murphy D3, van Buuren N1, Scuffham P5

1Clinical Forensic Medicine Unit, Gold Coast, Forensic and Scientific Services, Queensland Dept of Health, 2Emergency Department, Gold Coast Hospital and Health Service, Queensland Dept of Health, 3Southport Watch house, Queensland Police Service, 4Queensland Ambulance Service, Queensland Dept of Health, 5Griffith Health Institute, Griffith University.

The acute custodial detention period can be a time of increased risk from a health care perspective. The utilisation of triage-competent Emergency Department (ED) Registered Nurses to supplement the existing daily domiciliary nurse service in the second largest Police watch house in Queensland, by covering an additional eight hour late shift and ten hour night shift, was trialled to provide a 24 hour watch house nurse presence (WHEN trial).

The aim was to identify changes in outcomes for prisoner/patient health care, and local health service and police custodial service operation during the 66 day WHEN trial period. Sixty six (66) day periods pre-, during and post-WHEN trial implementation were evaluated as well as the same time period one year previously. Sub-group analyses were undertaken to compare clinical profiles and health outcomes for police-escorted prisoner/patients presenting to ED from the watch house with police-escorted prisoner/patients presenting to ED from the community. The primary outcome measured was the number (%) of prisoner/patients presenting to the ED from the watch house via QPS vehicle or Queensland Ambulance Service (QAS).

Although comprehensive analysis is currently in preparation, preliminary results indicate that during the time of the WHEN trial, prisoner/patient transfers from the watch house were reduced with positive implications for police and ambulance services.
A WHEN model for custodial health care may prove a useful means of improving health outcomes for prisoners in the ‘high risk’ police watch house setting.

**Safety and glycaemic control: diabetes management in the watch house**

Nelle Van Burren

Clinical Forensic Medicine Unit, Gold Coast, Forensic and Scientific Services, Queensland Dept of Health

The challenges of appropriate management of insulin dependent diabetes are magnified by the custodial environment of the watch house and safety issues must take precedence over long term glycaemic control. The management of detained diabetic persons has disproportionately increased the clinical workload for attending forensic medical officers. It is unclear whether this is due to an overrepresentation of diabetes in the watch house population or whether this is determined by the demands of the disease and co-morbidities.

This paper investigates the frequency of diabetes in the watch house population and the clinical issues associated with diabetes care in this custodial environment. The results of this retrospective chart audit provide a statistical description of diabetic persons detained in the watch houses in the South East Region over the 3 years, 2011 – 2013. Clinical management issues are identified and discussed.
Sunday 31st August 2014 Session 3

Keynote address

Great Expectations versus Hard Times
“Experience is simply the name we give our mistakes.”
(Oscar Wilde)

Catherine White
St. Mary’s Sexual Assault Centre, Manchester

Patients and the public expect a certain level of quality from health services. There have been a number of high profile examples in the UK where service delivery has fallen well short of these expectations\(^1,2\). Having been involved in several Sexual Assault Referral Centre (SARC) service reviews, including the external inquiry into the London Haven Whitechapel SARC failures, the aim of this session is to:

- Explore recurrent themes when things have gone wrong
- Discuss what the standards in SARCs ought to be
- Give an update on what work is being done to establish a monitoring system for SARCs in the UK

\(^1\) Mid Staffordshire NHS Foundation Trust Public Inquiry. “The Francis Report”
http://www.midstaffspublicinquiry.com/report

\(^2\) Investigation into Whitechapel sexual assault referral centre

Evidence-based malpractice

Bob Hoskins
Independent Forensic Physician
Tannum Sands, Queensland

As at the beginning of 2014 there are over 120 synthetic cannabinomimetic drugs capable of being identified with validated methods in Australian laboratories. This proliferation is unlikely to be driven by unmet user needs in a pharmacodynamics sense. It contrasts quite markedly from the relatively slow growth in the number of substituted amphetamines. Most of these drugs were (relatively) unknown five years ago.

Over the last five years there has been a dramatic increase in the number of seizures of synthetic cannabinoids. This is coupled with a geographical concentration of alleged intoxicated driving in Queensland across what is approximately the middle third, horizontally. This presentation aims to demonstrate: the prevalence of synthetic cannabinoid use; the likely reason(s) for proliferation; the impact of workplace drug screening on consumption patterns; and some of the frightening prescribing behaviours generated by physicians’ desire to “beat” workplace drug testing.
Data will include: results of a self-reporting questionnaire amongst employees at sites where drug-testing is in place; an overview of some of the common prescribing patterns used to mask impairment by using drugs that are unlikely to be detected; and a surprising diagnostic tool that may be a proxy for consumption patterns at a community level.

**Presentation of Oral Evidence in NSW Courts**

Maria Nittis, Kara Shead, Margaret Stark

Head of Department, Forensic Medical Units WSLHD / NBMLHD; Senior Counsel ODPP; Director, Clinical Forensic Medicine Unit, NSW Police Force

Despite NSW legislation, Court Practice Notes and ODPP Guidelines all paving the way for Sexual Assault examiners (as well as other government witnesses) to give oral evidence via AVL, this rarely happens.

This paper will review the legislation; the different ways of giving AVL evidence, the reasons counsel give for refusing these requests and ways to improve the chances of being allowed to present in this way.

**Australian Defence Force – a pilot training program in clinical forensic medicine**

Parekh V., Stark MM. & Williams A.

1 Senior Specialist Sexual Health and Forensic Medicine, Director, Clinical Forensic Medical Services (CFMS), Forensic and Medical Sexual Assault; 2 Director, Clinical Forensic Medicine Unit, NSWPFO, Adjunct Professor, University of Sydney; 3 Forensic Physician, Clinical Forensic Medicine, Victorian Institute of Forensic Medicine, Adjunct Senior Lecturer, Department of Forensic Medicine, Monash University

It is widely recognised that sexual violence is prevalent in the Australian community including the Australian Defence Force (ADF). Current literature suggests that up to 30% of military women will experience sexual violence. This may be due to a variety of factors particular to the military communities such as the age of members, as well as living and working conditions of ADF personnel.

There are a number of significant adverse health, operational, occupational and social outcomes that affect military personnel (men and women) who experience sexual violence. Other adverse outcomes include risk taking behaviours such as unsafe alcohol consumption, decreased quality of working life resulting in attrition from the military and decreased job satisfaction.

Many clinicians do not consider or fail to recognise those who are experiencing the impacts of sexual violence. Trained health care providers can provide a first line of support, facilitate medical care, ensure accurate collection of forensic evidence and promote engagement with victim support and investigative agencies. Evaluated training may improve health and wellbeing, therapeutic and legal outcomes. A need for such training for ADF healthcare providers was identified and encompassed the attitudes, knowledge and skills relevant to the forensic and medical management of sexual violence.

We designed, delivered and evaluated a pilot Clinical Forensic Medicine (CFM) Program with an emphasis on the forensic and medical management of sexual violence in the military context. The
first CFM training program was delivered jointly to ADF health and investigative personnel in 2013. The program was evaluated from a number of parameters including previous experience in caring for people who have experienced sexual assault, accomplishment of learning objectives through changes in attitudes, skills and knowledge, the ability to provide evidence before ADF tribunals and civilian courts as well as aspects of provider self care. The results, analysis and recommendations of the pilot training program will be presented.

Disclosure of Interest Statement:
VP & MS were partially funded by the ADF for their work on delivering this course.

Evaluation of a ‘Decontamination Kit’ in NSW

Stark MM.1, Nittis M.2

1 Director, Clinical Forensic Medicine Unit, NSWPF, Adjunct Professor, University of Sydney; 2 Department Head, Forensic Medical Units, Western Sydney Local Health District & Nepean Blue Mountains Local Health District

Dedicated facilities of a high standard should be available for the examination of complainants and suspects where forensic samples are to be taken to ensure that the risk of contamination is kept to a minimum. The need for a decontamination kit came about because of the variable quality of examination facilities for complainants of sexual assault and suspects (persons of interest) within NSW. Overall the kit has been found to be useful and easy to use but there is still a need to increase awareness of its availability.

Disclosure of Interest Statement:
The decontamination kits were developed by Multigate in 2011 at the request of NSW Police Force (NSWPF).

"A Death in Custody in the Alice - A preventable tragedy"

Morris Odell

Acting Head of the Clinical Forensic Medicine Service, VIFM

In January 2012 a young aboriginal man was found dead in his cell at the Alice Springs watch house. He had been arrested a few hours earlier for being drunk and unbeknown to police was able to consume a large amount of alcohol en route to the police station. While in custody he sustained a head injury in a fall and his conscious state deteriorated. He was then locked in a cell where he was found dead a few hours later. This presentation will detail the course of events, present the pathological findings and discuss risks associated with detention of intoxicated persons. This case has lessons and policy implications for risk management of detainees health in the acute setting.
Domestic Violence Death Review Mechanisms: What do they add?

Heidi Ehrat

Senior Research Officer (Domestic Violence), SA Office for Women & SA Coroner’s Court

Domestic Violence Death Review mechanisms have operated in Australia for the past 6 years. In 2011, South Australia initiated these reviews which were integrated into South Australia’s A Right to Safety Strategy agenda. This work is conducted in partnership between the Office for Women and the South Australian Coroner’s Court.

The Australian Domestic and Family Violence Death Review Network was established in 2011 and is currently finalising systematic and cohesive review definitions, case identification and data collection. The Network’s recently published manuscript (Journal of Homicide Studies, July 2013) places Australian processes firmly into the international context and offers several points of difference from existing international domestic violence death review processes.

The purpose of South Australia’s death review process is twofold. Firstly, to improve current system responses through supporting Coronial Inquests examining service system adequacy and making prevention recommendations regarding systemic improvements. Secondly, systematic review domestic violence deaths (both homicide and suicide) and capture data to identify trends, patterns or conduct research relating to the dynamics, risk and escalation factors to build a robust Australian evidence base around these types of deaths.

To date, there have been three completed coronial inquests involving the interrogation of forensic evidence and systemic contacts against a background of domestic violence dynamics. These Inquests have highlighted systemic gaps/failures in identifying risk, inter-agency communication and co-ordination amongst services involved prior to the deaths. To date, there have been 20 specific Coronial recommendations for systems improvement and other reforms.

This presentation overviews current investigative methodology and review processes while using a recent Coronial Inquest into the death of a 2 ½ year old child (against a parental background of mental health, substance abuse, homelessness, domestic violence and child protection interventions) to demonstrate the application of reviews in the context of an individual death in the Coronial jurisdiction.

Post mortem sexual assault examinations

Angela Williams

Senior Forensic Physician, Victorian Institute of Forensic Medicine

This paper will describe examinations of suspected sexual assault in the deceased, using case presentations where clinical doctors and pathologists have worked together in the mortuary. A discussion will follow of the value in working together on genital examinations in such cases, alongside some of the inherent difficulties in translating the practice of sexual assault examinations in...
the living to that in homicide cases or unnatural deaths.

**Herbal medicines and death**

Roger Byard

Marks Professor of Pathology, University of Adelaide, Senior Specialist Forensic Pathologist at Forensic Science SA, Adelaide

While there is no doubt that pharmaceutical drugs carry with them significant risks of morbidity and sometimes mortality, a recent review of traditional herbal medicines has shown that ‘natural’ does not always equate with ‘safe’. Herbal medicine has become part of the global marketplace and as such it is sometimes difficult to know where a particular medicine may have come from, what it may be composed of, and what other ingredients or contaminants may be present. These issues will be discussed.

Forensic issues that have arisen around the world with Asian herbal supplies include contamination with heavy metals such as mercury and lead, substitution of cheaper for more expensive and more toxic ingredients, and the addition of standard pharmaceutical drugs such as steroids, antihistamines and antiepileptics. In addition there have been well-documented interactions between certain herbs and prescription medications. It is the latter two issues that are of particular concern.

The pathologist performing a coronial autopsy relies on information provided by investigating police officers at the death scene which often includes a list of prescribed medications. If there is concern about possible drug interaction, toxicological testing will be performed. Unfortunately this information rarely, if ever, includes herbal remedies. Other problems that occur in clinical assessments are that herbal preparations may alter laboratory test results and also predispose to bleeding problems. It is for this reason that the American College of Anesthesiologists recommends that herbal medicines should be stopped for at least two weeks before any surgical operation.

As it is not standard practice to check for herbal medicines in forensic evaluations, and as toxicological testing for organic molecules is very difficult, it is simply not clear what role herbal medicines may be playing in medicolegal cases.

**Working together**

the establishment of a new Faculty of Clinical Forensic Medicine with RCPA

Morris Odell

Acting Head of the Clinical Forensic Medicine Service, VIFM

In a historic move, the RCPA has established a Faculty of Clinical Forensic Medicine (FCFM) to further the development and practice of Clinical Forensic Medicine (CFM) in Australasia. There are many situations where CFM is complementary to the practice of Forensic Pathology and both disciplines stand to reap benefits from working in partnership. Forensic Pathologists provide CFM services in some jurisdictions and CFM doctors work together with forensic pathologists in others, such as at the VIFM. This presentation will describe the history of how the FCFM came to be established and explore the potential for benefits to be gained from the two disciplines working together.
Keynote presenter

Catherine White OBE MB ChB, FFFLM, FRCOG, MRCGP, DCH, DMJ, DFFP

Catherine White is an experienced forensic physician who has worked in forensic medicine since 1995. She specialises in examination of women, men and children following an allegation of rape or sexual assault and takes a local, national and international lead in SARC regulation and development.

She is currently the Clinical Director of the St Mary’s Sexual Assault Referral Centre (SARC), Central Manchester University Hospitals NHS Foundation Trust (2003 – present); Deputy Chief Examiner for the Membership Exam of FFLM, responsible for Sexual Offences Medicine; Member of the Academic Committee and the Forensic Science Committee for FFLM; Member of ACPO (Association of Chief Police Officers) Rape Working Group and National SARC Steering Group; Guest lecturer for the Judicial Studies Board, Serious Sexual Offences seminars and Family Courts; Member of UK team delivering training to the French Judiciary (2012); UN Expert on Sexual Violence involved with developing forensic medical training for the Palestinian National Authority (2012- present); provided training in Cambodia sponsored by UNICEF and CEOP (Child Exploitation Online Protection) (2006, 2008, 2010) and in Moldova (2008); Vice President of the Faculty of Forensic and Legal Medicine (FFLM), May 2010 – 2013.

SELECTED PUBLICATIONS AND BOOKS


- Books

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Roger Byard

Professor Roger Byard holds the Marks Professor of Pathology at the University of Adelaide and is a Senior Specialist Forensic Pathologist at Forensic Science SA in Adelaide, Australia. Prof Byard has published a number of papers, books and chapters on a variety of forensic and other topics and is the Editor-in-Chief of Forensic Science Medicine and Pathology.

Julia Crilly

Associate Professor Julia Crilly is a Nurse Researcher based in the Emergency Department at the Gold Coast University Hospital since 2007. Her role includes developing and facilitating a multi-disciplinary emergency care related program of research that is focussed on service delivery, clinical, and workforce related issues. Affiliated with Griffith University, A/Prof Crilly is also responsible for supervising Masters and PhD students. Julia is a Fellow of the College of Emergency Nursing Australasia.

Greg Dayman

Dr Dayman graduated in 1992 from Adelaide University and became a Fellow of the Royal Australian College of General Practitioners (RACGP) in 1998. He is a senior examiner for the Australian Medical Council and the RACGP. He has worked in a variety of forensic settings in South Australia, undertaking drug and alcohol assessments for the courts, providing medical care of detainees in police custody and has worked for the Prison Health Service in South Australia for seven years. He is currently the co-Medical Coordinator at the Yarrow Place Rape and Sexual Assault Service in Adelaide and is undertaking the Masters of Forensic Medicine through Monash University.

Heidi Ehrat

Heidi Ehrat is a Social Worker with over 20 years of direct practice; evaluation and research; policy and human service development; and management experience across child protection, victim support services, family services as well as primary and tertiary health systems. Heidi has extensive experience working with victims of domestic violence and sexual assault who are navigating through Criminal justice and Family law legal systems and has been in her current role as Senior Research Officer (Domestic Violence), based in the South Australian Coroner’s Court, since January 2011. Heidi is the current Chairperson of the Australian Domestic and Family Violence Death Review Network (ADFVDRN).

Paul Gaudry

Paul Gaudry works in Sydney as a Forensic Physician. He was in full time private anaesthetic practice before his mid-life crisis led him to becoming director of emergency medicine at Westmead Hospital in 1980. For a time he was deeply involved in the establishment of the Australasian College for Emergency Medicine, as Censor in Chief and later as Honorary Secretary. His later-in-life crisis foreshadowed his current foray into drugs, sex and rock’n’roll. Along the way he completed the Master of
Forensic Medicine and Master of Business Administration. He is currently the Honorary Treasurer of the Australasian Association of Forensic Physicians.

Sanjeev Gaya
Dr Sanjeev Gaya is a Forensic Physician in the Division of Clinical Forensic Medicine at the Victorian Institute of Forensic Medicine and an Adjunct Senior Lecturer in the Department of Forensic Medicine at Monash University. He joined the Victorian Institute of Forensic Medicine in April 2010. He spent the previous 10 years delivering clinical forensic services to the Metropolitan Police Service in London, United Kingdom, where his activities covered the full span of clinical forensic medicine and the delivery of medical education to healthcare professionals. He is a Foundation Member of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London.

Clare Healy
MB.BS, DCH, FRNZCGP, FFFLM, MForensicMed (Monash)
Clare Healy is a G.P. and Forensic Physician working in Christchurch, New Zealand. She is the Clinical Director of the Cambridge Clinic, where all age ranges of patients are seen following alleged sexual or physical assault. She has been on the executive of Doctors for Sexual Abuse Care (DSAC) for 15 years and enjoys teaching in this area of healthcare. Whilst completing her Masters in Forensic Medicine, she developed a web-based tool to assist all front-line clinicians in assessing patients following alleged assault. She is on several local committees concerned with child and youth health.

Bob Hoskins
Over 30 years in medicine with more than half in forensic medicine and more than half the reminder in occupational health. Approximately 10 years leading Queensland Clinical Forensic Medicine Unit.

Rosemary Isaacs
Rosemary Isaacs is the Medical Director of the Sexual Assault Service for Sydney and South West Sydney Local Health Districts providing forensic and medical care to child victims of sexual assault at the Brennan Centre Liverpool and adult victims of sexual assault. Rosemary is involved in quality assurance and service development for victims and of interpersonal violence through developing local and NSW state wide education, research, resources and support in quality care both within the sexual assault medical professions and education and involvement of the wider health-care professions. Rosemary is a member of FAMSACA and is the Secretary of AAFP.

Tracy Johns
Dr Johns is a General Practitioner and a Forensic Medical Officer. She graduated from the University of Queensland in 1994 and gained her GP Fellowship in 2001. She has a Diploma of Obstetrics and Gynaecology (2000) and is currently completing her Masters of Forensic Medicine through Monash University. She worked in an on-call capacity for the Darwin Sexual Assault Referral Centre (SARC) for 10 years and from 2008 to 2012 was employed as the Medical Coordinator for Darwin SARC.
She then moved to Canberra and joined the Clinical Forensic Medical Unit there. During her time at SARC she saw both adult and child victims of sexual assault for forensic medical examinations.

Neil Langlois

Neil Langlois is a consultant forensic pathologist at Forensic Science South Australia, where he has worked for 5 years; prior to that he was based at the Westmead Department of Forensic Medicine in New South Wales. He is also an adjunct associate professor in the School of Health Sciences, University of Adelaide. In addition to performing his autopsy work he is a keen researcher, with an interest in bruises and he is actively involved with the teaching of medical students.

Cathy Lincoln

Dr Cathy Lincoln is Deputy Director of the Clinical Forensic Medicine Unit on the Gold Coast and has provided clinical forensic medical services in South East Queensland since 2004. Her role includes the co-ordination of nursing and medical services to two police watch houses. Prior to 2004, she directed the Sexual Assault Medical Forensic Service in Western Australia for 10 years. She has a PhD (UWA) and Masters degree (Monash University) in Forensic Medicine, holds a senior lecturer position at Griffith University and is a Fellow of both the Australasian College of Legal Medicine and the Faculty of Forensic and Legal Medicine (Royal College of Physicians, UK).

Min Karen Lo

MBChB 1994 (Auckland), FAChSHM (RACP) 2004, MforensicMed (Monash) 2010

Min is a Sexual Health Specialist at Auckland Regional Sexual Health Service, based at the Greenlane Clinical Centre. She is the Clinical Director of the Adult Sexual Assault Service and is the Co-Chair of DSAC. She is a colposcopist at Counties Manukau District Health Board. She has a Masters in Forensic Medicine from Monash University in Melbourne.

Maria Nittis

Dr Maria Nittis is President of FAMSACA and holds the Masters in Forensic Medicine (Monash) and Masters in Legal Medicine (Griffith). She is Fellow of the Australasian College of Legal Medicine and in 2013 was awarded Fellowship of the Faculty of Forensic and Legal Medicine (UK). She is Department Head for the Western Sydney and Nepean/Blue Mountains Local Health Districts seeing victims of sexual assault and domestic violence.

Morris Odell

Dr Morris Odell is the Acting Head of the Clinical Forensic Medicine Service at the Victorian institute of Forensic Medicine. He has over 20 years’ experience in all areas of CFM including custodial health and has special interests in traffic medicine and toxicology. Dr Odell is the President of the AAFP.

Vanita Parekh

March 2014
Associate Professor Vanita Parekh is a senior staff specialist in sexual health and forensic medicine based at the Canberra Hospital. She is the director of the Clinical Forensic Medicine Services which includes the provision of medical and forensic care to victims of sexual assault and domestic violence (FAMSAC) under health funding. The general forensic medicine service (CFACT) is police funded and includes the provision of forensic medical services to suspects and victims in criminal matters, medical care to those in police custody and attendance at death scenes. Vanita was responsible for the development and implementation of these services in 2001 and 2006 respectively. She has successfully combined these two services funded through different agencies under her directorship.

Jason Schreiber

Jason Schreiber has been a Forensic Physician in the field of clinical forensic medicine since 2007, covering South English and Scottish police forces. Since April 2013, he has worked as a Clinical Forensic Physician at the Victorian Institute of Forensic Medicine, Victoria. The author, of German origin, passed his German Medical State Examination in 1998 and is an Australian Medical Council certificate holder. He has been a Member by examination of the Faculty of Forensic and Legal Medicine (General Forensic Medicine) in London, UK, and obtained his Postgraduate Diploma in Forensic and Legal Medicine at the University of Ulster, Northern Ireland, in 2011.

Cath Sansum

Dr Sansum holds the position of Staff Specialist at The Canberra Hospital in the area of Clinical Forensic Medicine (Adult) and in paediatric forensic medicine at the Child at Risk health Unit. She has worked as a doctor in the ACT for the past 26 years, initially in paediatrics, obstetrics and gynaecology, general practice and then specialising in forensic medicine. Dr Sansum is a Clinical Lecturer at the Australian National University Medical School.

Catherine Skellern

Dr Catherine Skellern is a forensic paediatrician who works in child protection at a tertiary paediatric hospital in Brisbane. She is involved in the forensic assessment of children presenting to the Royal Children’s Hospital with findings considered suspicious of harm and also undertakes expert review opinions for cases without direct clinical involvement. In 2011 she completed Master of Forensic Medicine through Victorian Institute of Forensic Medicine and has published several papers and presented at national and international conferences on medico-legal issues relating to forensic practices in child protection. Through accreditation by the Royal Australasian College of Physicians Dr Skellern is also recognised as a Specialist in Community Child Health.

Debbie Smith

Dr Debbie Smith has been a Medical Practitioner at the Sexual Assault Resource Centre (SARC) in Perth, Western Australia since 2004. She is currently studying a Masters in Forensic Medicine through Monash University and is a member of FAMSACA.

Margaret M Stark
Margaret Stark is the Director of the Clinical Forensic Medicine Unit for NSW Police Force (since May 2011). In June 2012 she was made an Adjunct Professor in the Faculty of Medicine of The University of Sydney. Previously, she worked with the Metropolitan Police Service for 22 years as a forensic physician and was the first Medical Director of the Forensic Healthcare Service from 2010-2011. She has an extensive history of training professionals in the discipline of Clinical Forensic Medicine and has written extensively in the field, forthcoming in 2014 the third edition of Symptoms and Signs of Substance Misuse.

Nelle van Buuren

Dr van Buuren has been a GP for over 20 years in rural Far North Queensland and Fiji and has worked part time in forensic medicine since 1985. She is currently a forensic medical officer with the Clinical Forensic Medicine Unit in the South East Region of Queensland, which provides forensic services to the Gold Coast and Logan.

Angela Williams

Angela Williams is a Senior Forensic Physician with the Victorian Institute of Forensic Medicine and an Adjunct Senior Lecturer in the Department of Forensic Medicine at Monash University. She has also worked as a certified Consultant to the Victorian Forensic Paediatric Medical Service. Dr Williams has coordinated both medical and nursing postgraduate studies in Sexual Assault with Monash University and is a Fellow of the Faculty of Forensic and Legal Medicine UK and a member of the Australasian Association of Forensic Physicians. Her professional interests cover the full span of clinical forensic medicine but current activities are centered on sexual assault, injury interpretation, child abuse and forensic medical education. Her qualifications include Masters in Forensic Medicine and a Graduate Diploma in Law.

Lyndall Young

Dr Lyndall Young has worked in sexual assault medicine since 1995. She has a Masters Degree in Clinical Forensic Medicine from Monash University in 2001. She provides medical and forensic services to adult sexual assault victims, supervises the forensic clinicians in the service, and has a long history of medical education in the area of sexual assault medicine. Dr Young is a committee member of the Forensic and Medical Sexual Assault Clinicians Australia (FAMSACA), a member of the Australasian Association of Forensic Physicians (AAFP) and the Faculty of Forensic and Legal Medicine in the United Kingdom (FFLM).