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FORENSIC PHYSICIAN

[redacted]

[redacted]

21 December 2020

Victorian Law Reform Commission
Level 3
333 Queen Street
Melbourne Victoria 3000

By email only: law.reform@lawreform.vic.gov.au

Dear Sir/Madam,

Re: – Improving the Response of the Justice System to Sexual Offences

Please find attached my submission in relation to the inquiry into *Improving the Response of the Justice System to Sexual Offences*.

By way of introduction, I am a consultant forensic physician and have been involved in the examination and review of persons alleging sexual assault, both adult and children, and the subsequent presentation of evidence within the court system, for the last 28 years. During this time, I would have examined between 2000-3000 victims. I have been a Forensic Medical Officer for Victoria Police, a consultant forensic physician within the Department of Clinical Forensic Medicine, Victorian Institute of Forensic Medicine, and am currently a senior staff specialist within the Victorian Forensic Paediatric Medical Service located at both the Royal Children's Hospital and Monash Children's Hospital, and an Associate Professor within the Department of Paediatrics, University of Melbourne. I am also engaged as a private consultant forensic physician and provide opinions in relation to allegations of sexual assault throughout Australasia. In addition to working as a consultant forensic physician within Victoria, I am President of the International Association of Clinical Forensic Medicine and have some knowledge of the provision of acute sexual assault services worldwide.

It should be noted that in making this submission, I do so as an individual forensic practitioner and as President of the International Association of Clinical Forensic Medicine. The views and opinions expressed do not in any way represent the Victorian Forensic Paediatric Medical Service, the Royal Children's Hospital, Monash Children's Hospital or the University of Melbourne.

Yours sincerely,

[redacted]

Assoc Prof John AM Gall
Consultant Forensic Physician
President, International Association of Clinical Forensic Medicine

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IMPROVING THE RESPONSE OF THE JUSTICE SYSTEM TO SEXUAL OFFENCES
SUBMISSION BY: ASSOCIATE PROFESSOR JOHN AM GALL, CONSULTANT FORENSIC PHYSICIAN

This submission addresses only Issues Paper A and Questions 7 and 1 of Issues Paper B and D, respectively.

ISSUES PAPER A. WORKING TOGETHER TO RESPOND TO SEXUAL OFFENCES: SYSTEMS

NOTE: Please note that the response to this Issues Paper is from the perspective of acute cases of sexual assault and not historical cases of sexual assault. The distinction between acute and historical cases is that acute cases may have occurred within the previous 5 – 7 days prior to notification and that, unlike historical cases of sexual assault, may involve a forensic medical examination and the collection of appropriate forensic specimens. The management of historical cases of alleged sexual assault/abuse do not usually involve acute medical services but may involve Victoria Police and/or a counselling/mental health service.

Principal abbreviations:

CASA	Centre Against Sexual Assault
DHHS	Department of Health and Human Services
MDC	Multidisciplinary Centre
VFPMS	Victorian Forensic Paediatric Medical Service
VIFM	Department of Clinical Forensic Medicine, Victorian Institute of Forensic Medicine
VPFSC	Victoria Police Forensic Services Centre, Biological Division, McLeod

Background

Statistics. Sexual offences in Victoria are not an unusual event and according to the Crime Statistics Agency[1] , in the year ending 31 December 2016, Victoria Police recorded 12,956 sexual offences across the state. In the five years between the end of 2012 and the end of 2016, there had been a 45% increase in the number of sexual offences. These numbers included both acute and historical incidents of sexual offences. Of the 7788 victim reports in 2016, 79.7% involved a female victim while 18.8% involved a male victim. It is assumed that the number of offences has continued to increase to 2020.

Current management of victims of alleged sexual assault both adult and children in Victoria. For acute cases (i.e. up until about 5-7 days post assault) of alleged sexual assault/abuse, the management of the victim may involve one or more agencies including a counselling/mental health service (usually a Centre Against Sexual Assault or the Gatehouse Centre), Victoria Police, and a forensic health service. The forensic health service involved will be either a doctor/nurse from the Department of Clinical Forensic Medicine, Victorian Institute of Forensic Medicine (VIFM), or a doctor from the Victorian Forensic Paediatric Medical Service (VFPMS). The former (VIFM) manages all adult victims aged 18 years and older and the latter (VFPMS) manage all child and adolescent victims aged up to the age of 18 years. Most but not all cases of acute sexual assault will require a medical assessment.

[1] Sexual offences in Victoria. Sexual offences in Victoria | Crime Statistics Agency Victoria

Medical assessments, if required, are undertaken in different locations depending upon whether the victim is an adult or child/adolescent. Within the Melbourne metropolitan region and some regional areas, adult victims will receive care either within dedicated areas within certain major hospitals or in the Victoria Police managed Multidisciplinary Centres (MDC). In other regional and rural areas, there may be a need for the victim to travel to an appropriate location (usually a regional hospital) for a medical examination. In the case of children and adolescents, all consultations for the Melbourne metropolitan region are undertaken in dedicated facilities at either the Royal Children's Hospital or Monash Children's Hospital. In regional and rural areas, children and adolescents may be examined in a nearby hospital facility by an appropriately trained paediatrician or, in the absence of a suitable paediatrician, will usually require transportation to either the Royal Children's Hospital or Monash Children's Hospital for a medical examination.

The purpose of the medical assessment, undertaken by a forensically trained health professional (usually a medical practitioner but in some circumstances a nurse), is twofold:-

1. Medical:-
    a. It enables timely treatment and management of any physical injuries that may have been sustained during the assault /abuse.
    b. It provides an opportunity to address appropriate medication to prevent unwanted pregnancies and sexually transmitted infections.
    c. It provides information to the victim regarding any medical concerns that they may have in relation to the assault/abuse.
    d. It enables the arrangement of appropriate follow-up for medical and mental health care.

2. Investigative:-
    a. Documentation of the victim's account of the events of the alleged sexual assault (NB. not all medical practitioners take a detailed history of these events and it is not always possible in younger children).
    b. Collection of appropriate forensic specimens for later analysis by the Victoria Police Forensic Services Centre, Biological Division, McLeod (VPFSC).

The current sexual assault system. Ideally, a sexual assault system should function with the interests and well-being of the alleged victim being foremost. The system should provide a service that is timely, cost-effective, competent and free of conflicts of interest. The service in Victoria for both adults and children has been provided on a 24 hour, seven day a week basis. During the Covid-19 pandemic, the forensic medical services were required to modify the availability of services for infection control purposes, generally restricting them to between the hours of 8 AM – 10 PM, seven days per week. The service generally works well but there are a number of areas, with modification, that would provide for increased professionalism and competence, ease of access, less trauma, stress and inconvenience to the victim, and a possible better outcome within the court system.

Room for improvement (Ref: Question 8). To optimise the current sexual assault system, there are a number of issues that need to be addressed:–

1. Conflict-of-interest. To enable a victim (excluding those cases subject to mandatory reporting) to feel free to determine the direction of any investigation and whether or not Victoria Police should be involved, services to both historical and acute allegations of sexual assault should be managed in an environment remote from the investigative and judicial arm of the justice process. Similarly, professionals providing either counselling/mental health services and/or

medical services must be independent of the investigative and judicial arm of the justice process. It is inappropriate for any Department of Justice to directly provide and manage any health service not only for conflict-of-interest issues but also for health professional reasons. Although the counselling/mental health services and the Paediatric forensic medical services (children up to the age of 18 years) are funded through the Department of Health and Human Services (DHHS), the medical services provided by the VIFM to adult victims is funded by Victoria Police. Further, many adult cases of sexual assault are assessed at the Multidisciplinary Centres (MDCs), units that are essentially annexes of regional police stations. Experience has shown that Victoria Police do exert their power and influence, either intentionally and directly or in a subliminal manner, in relation to sexual assault medical assessments. This power and influence is seen by the alleged victims and does have an effect upon their freely engaging in the medical aspects of any investigation and subsequently determining whether they wish to continue or withdraw from any investigative process.

The recommendations to address conflict-of-interest is: –

a) transfer the management and funding of MDC's to DHHS; and
b) transfer funding for the Department of Clinical Forensic Medicine, VIFM, to DHHS.

These two recommendations are discussed in greater detail below.

2. Health professionalism and competence. To provide an optimal counselling/mental health service and medical service to victims of sexual assault it is essential that the mental health professionals not only have specialised training to manage sexual assault victims but also have an appropriate generalised knowledge in the area of practice. Experience has shown that medical practitioners who sub-specialise in undertaking only sexual assault examinations lack an appropriately broad understanding of forensic medicine generally leading to a failure to identify and understand situations before them. Beyond purely forensic medicine, it is important that the medical practitioner also has a good understanding and experience in the provision of general medical services whether this be for adults or children. The optimal management of victims of sexual assault does not involve just the sexual assault issues but may also involve aspects of general medicine for which the practitioner needs to address. This may require follow-up consultations and appropriate referrals. Although this used to function for adult victims, this service is not regularly provided and reduces the effectiveness of the medical consultation. For child victims of sexual abuse, because the paediatricians/forensic physicians within the VFPMS unit also provide clinical services, the management of these victims is optimised through an holistic approach to the care with appropriate referral if required. The absence of a more holistic and clinical approach to adult victims leads to their being viewed more as a crime scene rather than a person leading to a potential suboptimal outcome for the victim.

   A similar situation applies to counselling/mental health. Counsellors, who often only have either limited training or studies in Social Work, do not necessarily have the breadth of experience and knowledge to manage the not infrequent accompanying mental health issues that may be suffered by some victims. To optimise the mental health management of victims, management should be undertaken by appropriately trained clinical psychologists and/or psychiatrists with counselling provided by social workers under the direction of the clinical psychologists/psychiatrists.

The recommendations to address these issues of competence and ensure a more professional and holistic service is to: –

a) ensure all medical practitioners providing sexual assault services are trained in all aspects of clinical forensic medicine (this may be undertaken through the Faculty of Clinical Forensic Medicine, Royal College of Pathologists of Australasia or Monash University);
b) ensure all full-time clinical forensic medical practitioners are engaged in or are associated with other clinical services (ideally this would require a relocation of the Department of Clinical Forensic Medicine, VIFM, and embedding their practitioners within the major teaching hospitals – see below for further comment);
c) disband the CASAs and the Gatehouse Centre and integrate these services into current mental health services.

3. Access to acute sexual assault services. Ideally, sexual assault services should be available within a reasonable geographical distance from where the victim lives. In considering a victim's geographical location, the provision of both mental health and medical services needs to be undertaken by appropriately trained and experienced personnel. To maintain experience for forensic medical practitioners, an essential aspect of being an expert witness within the court system, a suitable forensic caseload is required. Thus, it is not always possible to provide a mental health and medical sexual assault service within a victim's geographical location but a service in designated larger regional areas does address this problem. Adult sexual assault services generally have practitioners (either medical practitioners or nurses) in most major regional centres. For child victims, the availability of suitably trained forensic physicians or paediatricians is limited often requiring these victims to travel significant distances to either the Royal Children's Hospital or Monash Children's Hospital for initial mental health counselling and a medical assessment.

   Recommendations to ensure facilities for the forensic examination of child victims of sexual assault victims in regional and remote areas and reduce the requirement for some children to travel to Melbourne for their acute assessments are: –

   a) to ensure appropriate recruitment and funding to train regional paediatricians and forensic physicians to undertake the examination of child victims of sexual assault (funding is currently available but recruitment, training and retention is problematic);
   b) engage forensically trained nurses to undertake examinations of postpubertal adolescents under the supervision of either a forensically trained paediatrician or forensic physician in designated regional centres (it should be noted that it is not appropriate for a nurse to undertake forensic examinations of prepubescent children).

4. Stereotypes and male rape (Ref: Question 5). Within society there are some well-established stereotypes. The judicial system has tended to contribute to this with the apparent more harsh sentences issued to male perpetrators of sexual assault compared with female perpetrators. Generally, the view is of the male perpetrator and the female victim which leads to bias within investigations. Although the male predominance may be the situation in a significant majority of cases, female perpetrators of sexual assault exist and this requires appropriate acknowledgement. Investigators, including health professionals, need to be cognisant of this and it should be part of their training.

As noted from the statistics provided above, despite males representing 50% of the population, females are the predominant group reporting a sexual assault. With respect to acute presentations of sexual assault, over the 28 years that I have been involved in providing these services, the number of post pubescent males presenting for a forensic examination would number no more than about five in a sexual assault caseload of in excess of 2000. There are multiple reasons as to why males will not present and report post sexual assault. Part of this may be due to the stereotypes and perceived views held by the investigators. The development of the SOCIT units within Victoria Police has been a marked improvement but the counselling services may be perceived as being female oriented and not necessarily accommodating of males. It may also be suggested that the predominance of female medical sexual assault examiners and nurses may be a deterrent for males to report their sexual assault and enter within the current system.

The recommendation is that greater education needs to be provided noting that perpetrators of sexual assault may be both male and female. Further, the acute services need to be more accommodating of male victims and this may necessitate a change in advertising and general information regarding the services provided. The CASAs have always been very female oriented. Little information, either in hard copy or on their websites, is dedicated to male rape whether it be male on male or female on male. An example of this may be seen on the CASA House's website[2]. In this era of equality and diversity, this approach is in need of urgent revision.

5. School education. One issue not specifically raised within this Paper but that has a bearing upon the incidence and subsequent cost of investigation of reported cases of 'sexual assault' is that of education of the population. Based upon very extensive experience of examining child and adolescent (as well as adult) cases of alleged sexual assault/abuse, a repeated observation is that, particularly amongst the adolescent population, a lack of understanding of what rape is and of the potential implications of alleging that rape has occurred. Too frequently adolescents resort to the term 'rape' to justify a poor or unsatisfactory sexual experience, post-sex remorse, or as an excuse to justify failing to follow parental instructions/rules. Investigating these cases occupies the time of many agencies with an attendant and significant cost. It is also time that could more beneficially be spent investigating real allegations of sexual assault.

   The recommendation is that appropriate education should be either introduced or intensified as part of the school curriculum for all children in Victoria aged about 14 – 15 years to provide appropriate information in relation to sexual assault, its meaning and potential implications. This education should include advice on how adolescents may minimise the risk of being subjected to sexual assault/abuse and the responsibilities and limitations of involvement in sexual activities.

6. Data and review (Ref: Questions 6 and 7). To ensure that an optimal and relevant service is provided, particularly in the light of changing technology (e.g. the advent of DNA 'fingerprinting'), a periodic review of that service backed by appropriate research is essential. Within Victoria, obtaining information from the various agencies involved to ascertain whether victims of sexual assault/abuse are in fact receiving an optimal and relevant service is impossible. Each service operates independently of the other and information sharing is limited.

[2] CASA House: Information for Men who are Raped/Sexually Assaulted

The medical examination of victims of a recent sexual assault provides an ideal example of the situation. Police generally bring the victim for the medical examination. They provide limited information (ie the only information available at that time) regarding the alleged assault to the doctor. The CASA counsellor sees the victim and makes arrangements for follow-up counselling, if required, but that information is not necessarily passed to the doctor. The doctor undertakes a medical examination including obtaining a medical and forensic history and the collection of forensic samples. After-care is arranged as appropriate for child victims of sexual assault. After-care is not regularly arranged for adult victims of sexual assault. The information obtained by the examining doctor regarding the sexual assault is provided to police by way of a report. The next the doctor may hear of the case is that they are required for court. The number of cases reaching court and requiring attendance by the doctor is probably less than 10%. Little information, if any, is provided to the doctor prior to court. Forensic specimens collected by the doctor during the sexual assault examination are taken by Victoria Police and held for possible analysis within their laboratory. No information is provided to the doctor with respect to these specimens and the analysis obtained. It should be noted that in a majority of cases, no analysis of the specimens collected is ever undertaken.

The collection of forensic specimens can be quite traumatic for the victim. For some, particularly children, it may mean police removing a particularly favourite piece of clothing or footwear. This is given to police and in the majority of cases the clothing is not returned to the victim. Victims may also be subject to intimate specimen collection (e.g, anal, vaginal, breast, and other parts of the body). Some victims refer to this as like being 'raped all over again'. Despite the progress in DNA technology, there is a dearth of meaningful research as to what specimens should be collected and what the optimal and maximum time post assault is for this collection. Based upon the very minimal information provided by the Victoria Police Forensic Services Centre to the medical service, only a few of the specimens that are analysed produce a positive return for an alleged assailant. There has been absolutely no information available to the medical service to indicate the value of any of these collected specimens in the conviction of an offender - with one exception, that of a Somali male, Farah Abdulkadir Jama, an infamous failure of both the forensic and judicial system[3].

To ensure optimal management of acute sexual assault victims and to minimise the trauma that they may experience during any forensic medical examination, appropriate research needs to be undertaken. This requires full data collection throughout the process of sexual assault assessment from the point of initial notification to the final case outcome. Accompanying this, and as part of the research, is a need for confidential victim feedback regarding the process. The following is recommended:–

a) that the forensic medical service (i.e. VIFM or VFPMS) be the responsible agency for the collection and documentation of data related to the health management (mental health and medical), results of forensic specimen examination and analysis (this would require the VPFSC providing analysis data to the medical service – see below), and case outcomes (this would require the DPP providing case outcome data to the medical service – see below);
b) that the forensic medical service provide the victim with and manage appropriate after-care;

[3] Report : inquiry into the circumstances that led to the conviction of Mr Farah Abdulkadir Jama / [F.... | National Library of Australia (nla.gov.au)

c) that the forensic medical service be provided with information from the counsellors/mental health service involved with each case to ensure that appropriate after-care is provided;
d) that Victoria Police, and specifically their laboratory, provide an analysis report of all forensic specimens analysed to enable the forensic medical service to collate the data to enable optimisation of type of specimen collected, and the maximum time post assault for forensic specimen collection (this would ensure that victims are not put to unnecessary trauma in the collection of specimens that are of no investigative value);
e) that the DPP provide details (i.e. copy of the judgement) of the outcome of all cases heard in court to the relevant forensic medical service;
f) that the relevant forensic medical service analyse all data collected, and conduct appropriate surveys, to periodically review the system's full response to sexual assault; and
g) appropriate funding be provided to both medical services to undertake the necessary research and subsequent provision of a full report to all stakeholders.

7. Family violence services/child protection/sexual assault system (Ref: Question 3). There is significant overlap between family violence, child protection and sexual assault/abuse. Having two police units (SOCIT and family violence), with the exception of child protection, investigating these issues leads to inefficiencies. Victims of family violence/sexual assault/abuse risk either being over investigated or under investigated. For example, a victim may be subjected to multiple interviews by different agencies regarding the same event. This may lead to differing accounts which may be detrimental to any case later heard in court. Repeated interviews by different agencies may also dissuade the victim from proceeding with their complaint due to perceived harassment. At the other end of the spectrum, the differing agencies may believe that the other agency has undertaken the investigation were in fact it hasn't leading to the case being under investigated and no prosecution or intervention proceeding. The management approaches needed by both family violence units and SOCIT are similar and it is recommended that both units be amalgamated into the one unit. This is discussed below.

8. Responding to sexual harm (Ref: Question 2). The questions within this Paper perhaps indicate a role for the justice system in the health management of sexual assault victims. The medical and mental health care of victims of sexual assault, as for any other health related issue, should be managed by the appropriate health department. There is a very clear conflict-of-interest for any justice system to be the health carer of the complainant of sexual assault as well as the investigator. It is not the role of the justice system to respond effectively to reduce sexual harm to an individual other than to competently and sensitively investigate and prosecute as appropriate, and utilise services of the relevant health department to independently manage the health and welfare of the victim.

9. Other issues. It has been indicated above that there are four agencies directly involved in the provision of services to victims of sexual assault/abuse. The operation of three of these agencies warrants review. Two of these, the Department of Clinical Forensic Medicine, VIFM, and CASA/Gatehouse have been in existence for a very long period of time and a third, the MDCs, for only about five – six years. It is acknowledged that reviewing the function (and existence) of these agencies may be politically unacceptable (and would be fiercely defended by the respective agencies) but it is suggested that the agencies in their current format are not providing an optimal service to victims of sexual assault/abuse and to continue these agencies without review and restructure defeats the purpose of seeking optimisation of the

care and well-being of victims and potentially exposes these victims to additional harm both in the short term and long term.

Regarding the four agencies: –

a) VFPMS. VFPMS is a statewide forensic service for children and adolescents aged up until their 18th birthday. It manages child abuse, sexual abuse and neglect. It has been operational as an entity since 2006, is co-located at (an integrated into) the Royal Children's Hospital and Monash Children's Hospital, is managed by the Royal Children's Hospital and funded by DHHS. The service is staffed by forensic paediatricians, a forensic physician and trainee paediatricians. In rural and remote areas, services are provided by paediatricians who have received some forensic training and are provided with direct access to VFPMS consultants for advice when required. Not all major regional areas have an appropriate forensically trained paediatrician. The service is a clinical service and actively engages in peer review. Cases, including sexual assault cases, are managed on an outpatient or inpatient basis with appropriate after-care being arranged. The service operates 24 hours a day, seven days per week and provides advice to doctors on a statewide basis. It is the only forensic paediatric facility in Australia that is accredited for the training of forensic paediatricians. This unit is funded for clinical services only and any research undertaken is done above and beyond the clinical service.

   A recommendation, in addition to those listed above, that would assist in optimising the provision of sexual assault/abuse services to victims, is a formal integration of the unit with the co-located Department of Paediatrics, University of Melbourne. This would provide the unit with academic status and would facilitate paediatric forensic research and particularly that related to child sexual assault/abuse.

b) Department of Clinical Forensic Medicine, VIFM. Up until 1996, forensic medical services for both adults and children were provided by Forensic Medical Officers engaged by Police Victoria. From the beginning of 1996, this unit moved to the then, Victorian Institute of Forensic Pathology. The Institute subsequently changed its name. Part of the reason for the transfer of the service was to ensure that clinical forensic medical services were provided in Victoria independent of police to ensure an absence of conflict–of–interest. Funding, however, remained with the Department of Justice and, more specifically, Police Victoria. Thus, one of the purposes for the move to the Institute was defeated and, although the health professionals within the Department may operate independently, the public perception is that they are an arm of the police and are, therefore, not independent.

   A similar situation existed within the United Kingdom. In 2010, Baroness Stern undertook an independent review into how rape complaints are handled by public authorities in England and Wales. The Government's response to Baroness Stern's review[4] of rape victims specifically stated:

   "*We support wholeheartedly the recommendation that the funding and commissioning of forensic and clinical services for victims of sexual assault should be transferred from the police to the NHS. We also endorse the view of*

[4] Government response to Stern Review (publishing.service.gov.uk)

the taskforce led by Sir George Alberti that forensic physicians should be employed by the NHS, have better access to high-quality training, be an integrated part of the new NHS clinical governance framework and commissioned in sufficient numbers to meet the needs of victims of rape."

Transfer of funding from police to the NHS has occurred ensuring greater independence for practitioners and an absence of a perceived conflict-of-interest.

It is noted in Baroness Stern's report that forensic physicians should be employed by the National Health Service (NHS). VIFM forensic physicians are employed by the Department of Justice (rather than DHHS). The VIFM functions as the academic Department of Forensic Medicine, Monash University, and the facility is able to provide high-quality training. Notably, however, the full-time forensic physicians in particular, only engage in very limited clinical medicine and due to their location tend to be remote from general clinical medicine. Further, involvement by the VIFM in clinical forensic medical research since the Department's inception has been disappointingly minimal. For an academic department, it is also disappointing that not one of its listed full-time clinical appointees holds an academic research degree (i.e. PhD or equivalent). The service functions solely as a teaching unit, documenter of injuries, collector of forensic specimens and provider of clinical opinions. Notably missing is the provision of clinical management of patients (including victims of sexual assault), appropriate after-care and relevant research. The clinical unit also provides opinions to the coroner and other courts on clinical matters but an absence of involvement in general clinical care raises questions regarding the basis upon which some opinions are provided.

The basis for the recommendations in relation to this to enable an improved sexual assault victim care and after-care are long and detailed and beyond this submission. The recommendations, however, to assist in optimisation of sexual assault victim care include: –

i. transfer to funding for the VIFM clinical forensic service from Victoria Police (i.e. Department of Justice) to DHHS together with employment of forensic physicians by DHHS;
ii. embed the clinical forensic medical service within the emergency department of the major teaching hospitals (this would expose forensic physicians to current medicine, update and improve their clinical knowledge and skills, and facilitate management and after-care of sexual assault victims);
iii. ensure engagement of consultant forensic physicians with an appropriate postgraduate research degree; and
iv. facilitate the involvement of physicians in relevant research.

c) CASA/Gatehouse. These two agencies provide counselling services to sexual assault victims, both adult and children (the latter being specifically children). Although the Gatehouse centre provides counselling services to both males and females, the CASAs provide services predominantly to females. Issues regarding their emphasis on female counselling has been discussed above. Both agencies engage principally social workers to provide counselling rather than more highly trained mental health professionals such as clinical psychologists and psychiatrists. About 40% of people

presenting post sexual assault have pre-existing mental health conditions[5]. Optimal management of these victims warrants the use of mental health professionals with the necessary breadth of experience to manage not only the trauma of the sexual assault but also to manage that trauma in relation to pre-existing mental health conditions. Providing counselling with persons without the necessary training in mental health management is not ideal and may be potentially harmful.

The recommendation is that to optimise mental health care and ensure ongoing care and minimisation of harm, sexual assault victims should have their mental health care managed under the supervision of either a clinical psychologist or psychiatrist and not a social worker. Care of these victims would optimally be available within the public health system and should be directed to mental health units and not to social work units. As the sole purpose of these two agencies is the counselling of principally assault victims, integration of these agencies into existing mental health units is recommended and that counselling by social workers only be undertaken under the supervision of a clinical psychologist or psychiatrist.

d) MDC's. It is understood that there are currently 7 MDC's. These units are managed by police in which there are counsellors from CASA, child protection staff, community health nurses and, in the Dandenong MDC only, a forensic physician from VIFM. Although these units may be satisfactory for addressing historical cases of sexual abuse, they fail in their stated task of providing a single location to provide victim-centred, integrated and holistic responses to victims of sexual crimes and child abuse. Acute cases of sexual assault/abuse should not be seen remote from a suitable clinical setting which ideally should be dedicated units within the major hospitals in the metropolitan region and appropriate hospitals in rural and remote areas. Acute patients need to have ready access to acute medical and mental health care. Utilisation of MDCs removes an important safety provision by isolating acute cases from necessary medical services and, in time, is likely to result in a death or aggravation of a serious injury.

   From a medical perspective, the MDCs are unsafe and the submission is that, for acute cases, they not be utilised.

ISSUES PAPER B: KEY ISSUES IN THE CRIMINAL JUSTICE SYSTEM

In relation to Question 7:

The pursuit of, wrongful conviction of, and incarceration of Cardinal George Pell on charges relating to child sexual abuse adversely affected the standing of the criminal justice process within this state. Perceptions were of mob rule and pursuit for political purposes. Any changes to the legislation or judicial process must ensure that the potential for wrongful convictions is minimised.

[5] Mental health, sexual violence and the work of Sexual Assault Referral centres (SARCs) in England - ScienceDirect

ISSUES PAPER D. SEXUAL OFFENCES: REPORT TO CHARGE

In relation to Question 1, as discussed above:

The SOCITs generally function very well (and provide a very good and valuable service) and are a vast improvement on the investigative teams prior to their implementation. The family violence unit also appears to function very well. As stated above, given the nature of cases that both the family violence units and SOCITs attend and investigate, there is often overlap. Both units require officers that understand the cases before them and have the sensitivities to manage them effectively.

The situation regarding MDCs is slightly different. It is understood that there are currently 7 MDC's. These units are managed by police in which there are counsellors from CASA, child protection staff, community health nurses and, in the Dandenong MDC only, a forensic physician from VIFM. Although these units appear to be ideal for addressing historical cases of sexual abuse they fail in their stated task of providing a single location to provide victim-centred, integrated and holistic responses to victims of sexual crimes and child abuse. Acute cases of sexual assault/abuse should not be seen remote from a suitable clinical setting which ideally should be dedicated units within the major hospitals in the metropolitan region and appropriate hospitals in rural and remote areas. Acute patients need to have ready access to acute medical and mental health care. Utilisation of MDCs removes an important safety provision by isolating acute cases from necessary medical services and, in time, is likely to result in a death or aggravation of a serious injury. From a medical perspective, the MDCs are unsafe for acute cases of sexual assault.

To provide a brief example of a near fatality that occurred some years ago where the assessment of an acute case of sexual assault was initially examined away from a suitable medical service. The victim was a young female who had been both sexually and physically assaulted. She was assessed by a social worker from a CASA. Although a forensic physician had been called to examine the victim, the social worker would not allow the doctor to speak to the victim because she was drowsy and had not agreed to this. The doctor was advised that she needed to sleep first. Based on information provided by police, the doctor insisted on seeing the victim and noted that her sleepiness was due to her being semi-comatose resulting from significant internal blood loss. She was transferred to an Emergency Department for resuscitation and survived. Surprisingly, the social worker formally complained that the doctor intervened without the patient's consent. During my years providing forensic services, this was not the only example of potentially fatal outcomes when acute victims are assessed away from appropriate medical care facilities.

The recommendations are that:-

i. SOCIT and family violence units be amalgamated into a single unit; and
ii. MDCs not be used for the assessment of acute cases of sexual assault/abuse.