CHILD SEXUAL ASSAULT
MODELS OF CARE

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Model of Care (Forensic Medical)

- What does a child (victim) need from Health?
- What are the Drs/nurse’s tasks?
- Who does what?
- Where?
- When?
- How?
- Why?
- Can it all be done at once, by one person?
- If not, how can child best access what is needed?
Drivers & Determinants of model of care

- Politics – turf and territory / power and support
  - Govt policy / initiatives – State and Federal
  - “Centralism” vs “Regionalism”
  - Hospital-based vs Community-based
  - Co-location of Sexual Abuse (all ages) v Child Abuse (all varieties) within paediatric mainstream Health services
  - Child rights – Avoid lowering / watering down quality, access or scope just because child’s injury caused by assault not an accident
Drivers & Determinants of model of care

- Money
  - Recurrent funding v Project funding
  - Best bang for buck – “rational economics”
  - Avoid duplication / piggyback on existing services
  - Who holds the purse strings?
    - Golden Rule

*He who holds the gold, makes the rules*
Drivers & Determinants of model of care

- “Acceptable” time to gather forensic evidence & perceived importance of this aspect of care
  - Evidence-informed practice standards

- Perceived importance of
  - Medical and family history (and why this might matter / affect outcome)
  - Developmental and behavioural assessment
  - Safety
  - Risk assessment & recommendations for intervention / changes to improve trajectory
Drivers & Determinants of model of care

- Site - options
  - Access – how close to home? How close to experts?
  - DNA-cleaned room / specialist facility
  - Security

- Scope - options
  - One stop shop? Holistic paediatric care
  - Segmented & compartmentalised? Swabs + what?
  - Basic only

- Prioritising relationships / integration Healthcare with
  - Police and child protection workers
  - Mainstream health services (Paed hosps)
  - Community based child health services
Who pays the price?

- Quality and safety matters to Health
- Wrongful convictions matter to Justice
- Risk is not evaluated equally across services
- Differing frameworks for risk management /sector
- What value / cost to Health?
  - Sacrificial lambs - children or doctors/nurses or accused?
- Service monitoring & evaluation of effectiveness
  - How, when and why?
“Landscape” factors

- Existing structure = very important!!!!
- Networks (medical) – existing and potential
- Legislative framework
- Memoranda of understanding and protocols
  - Police
  - Child protection
  - Other health services
    - Referral pathways and criteria
- One shape fits all vs tolerate regional difference
Workforce – who and why?

- Task -> Skillset -> Credentials -> Training
  - Form follows function
  - Best single individual/pair/team to do all? Most?
  - Tasks shared across disciplines / between staff?

- Workforce Expertise
  - Build on currently available talent / willingness
  - Forensic training
  - “New” workforce – bottom up or top down?
  - Who pays?

- 24 hour availability vs limited
- Different for in hours & after hours?
child sexual assault

Time of last contact:
- Historical > 1 week ago
- 3 days to 1 week ago
- < 3 days - no DNA or fluids
- < 3 days - COLLECT DNA or fluids

Data for illustrative purposes only
Sample (swabs / STI) collection

- none
- microbiology and serology
- forensic DNA (semen and other)
- forensic body fluid (other)
- forensic non-body sample

Data for illustrative purposes only
THE TASKS TO BE UNDERTAKEN WHEN CHILD RECEIVES MEDICAL CARE

- Epidemiology
- Psychosocial
- ASSESS RISK & safety
- Development
- Behaviour
- Medical Hx Family HX
- History of sexual assault
- Swabs
Questions to consider

If Dr writes medicolegal report based on nurse’s / others’ examination findings and interpretations:

- Can one professional form a valid, accurate and reasonable opinion based on another person’s work?
  - What evidence exists to support this answer?

Balancing competing priorities - Who decides?

- How much diagnostic error is tolerable?
- How inadequate/poor quality a service is acceptable?
  - Is merely collecting swabs enough?
  - How poor/unsuitable a facility is tolerable?
  - How much risk is tolerable?
  - How much cost is tolerable?

What will be lost /gained if model A trumps B? Or if B trumps A?
CENTRE OF EXCELLENCE MODEL
Further / More travel time
Greater expertise / scope
Purpose built facility / safer
Skilled Workforce?
Better holistic service
Higher quality forensic care
Less risk

SHOP FRONT MODEL
Closer / Less travel / less inconvenience
Less medical expertise / less scope of service
Facility less suitable / risks are higher
Hard to maintain workforce skill / willingness
Partial service (swabs only) is possible
Lower quality overall paed + forensic?
Much higher overall risks
COMPONENTS OF FORENSIC PAEDIATRIC MEDICAL CARE
ALL ELEMENTS ARE REQUIRED

- history (basic / CSA only)
- history (integrated)
- development/behaviour
- sample collection / STI
- safety / risk assessment
- ongoing care / case plan
- legal report/testimony
Conclusion

The Centre of Excellence Model is preferred because

- Victims obtain a prompt holistic medical response (one-stop-shop where health needs are addressed). Service components are not fragmented.
- It is of higher quality overall.
- It is located in purpose built facilities that lessen risk of DNA contamination.
- Greater workforce expertise is increases the chance of accurate diagnosis and avoidance of mistakes / contamination when collecting samples.
- The system is more robust because a willing & skilled medical workforce is maintained. Professional development is ongoing.
- Integration with mainstream paediatric health services is valued and supported with downstream benefits across the entire paediatric health system to increase capacity to recognise and respond to child abuse and neglect.
- Greater security is provided for health records, forensic samples, the facility.
- Monitoring of service quality and enforcing adherence to practice standards is easier.
- Accountability and data management (including reporting) is easier.
- It may be more “bang for buck” – but cost effectiveness requires evaluation.
- Overall risks are lower.