(YOUR REGION) Letterhead

Date typed

**CONFIDENTIAL MEDICAL REPORT**

**Report prepared for**

Title, Name

Organisation

Address

Email address

**RE**  **Name:** (Patient’s full name and also-known-as names)

**Date of birth:**

**Hospital unit record number:**

**Author of report**

I, (author’s full name) am a medical practitioner registered with the Australian Health Practitioners Regulation Agency (Ahpra) to practice in Australia. I hold the qualifications list author’s qualifications). I am currently employed as (current title and place of employment). My training and experience in relation to child abuse assessments is (briefly list all relevant training and experience – 1-2 sentences).

This report was prepared in consultation with …. / (for trainees write “under the supervision of ...” (name the person and their position - delete this paragraph if not applicable ….).

**Acknowledgement of Code of Conduct Form 44A**

Should this matter be heard in the Magistrates Court of Victoria, County Court of Victoria or Supreme Court of Victoria then the author acknowledges that they have read Form 44A Expert Witness Code of Conduct and agree to be bound by it.

The author declares that, at the time of preparation of this report, they have made all the inquiries and considered all the issues which the author believes are desirable and appropriate, and that no matters of significance which the author regards as relevant have, to the knowledge of the author, been withheld.

The opinion expressed is based on the author’s knowledge, experience and sources of information listed in this report.  Should, however, additional information become available that might have a bearing on the author's conclusions, the author retains the right to modify the opinion expressed.

**Reason for Medical Assessment**

(subject’s name) is (number) years and (number) months old (male / female / non-binary person / transgender person) who was referred by (name of referrer – include title such as DSC Max BROWN) at (time) on (date) for a forensic medical assessment in relation to (select alleged / suspected / possible) (specify type of maltreatment).

**Site and time of assessment(s)**

I assessed (subject’s name) on (date) between the hours of (number – starting time) and (finish time) at (site where examination occurred).

**Consent**

At (time when consent form signed) on (date), (name of subject’s parent or person who has parental responsibility. Job title of whoever signed the consent form and indicate the source of this authority if not a relative with parental responsibility) signed the VFPMS Assessment Consent Form, providing consent for the following:

1. A complete medical evaluation including physical examination of (subject’s name)
2. Collection of medical and medico-legal specimens.
3. Photographic documentation.
4. Investigations as recommended by the examining doctor.
5. Treatment.
6. Release of a Medical Report to Child Protection and Victoria Police.
7. Information associated with the examination being used for teaching and audit purposes, if all identifying information is removed.
8. (Consenting person’s name) also provided consent for me to contact other individuals (or list all names and organisations) to obtaining information regarding (subject’s name).

**Observers**

(List names and state who they are in relation to the subject or their professional role).

**Sources of information**

(List all sources + dates information obtained).

**Presenting complaint**

*Information was obtained from (name source/s).*

(Tell the story in chronological order using simple past tense. Include information about symptoms and signs).

**Past Medical History**

(List. Dot points are acceptable).

**Psychosocial information (including genogram and family medical history)**

(NB: Child-care arrangements relevant to child’s safety and circumstances surrounding injury. Family history relevant to the child’s medical problems / findings).

**Examination findings**

(Include growth measurements and centiles).

(Describe skin injuries using a systematic approach so it is clear what part of the body and what class of finding you are referring to).

**Medical Investigations and interpretation of results**

(List. A simple statement about normal test results might be sufficient, however abnormal results including radiology reports should be included in full).

**Medical Management and progress**

(A brief statement might be sufficient. Omit this section if single outpatient consultation).

**Information sharing**

Information in this report was provided to SOCIT officers and staff of the Department of Families Fairness and Housing at the time of the consultation. (alter as needed)

**Limitations to opinion**

(List or state ‘nil’ EG, “I have not examined the subject”. “I am reliant on the opinions provided by radiologists, pathologists and the ophthalmologist”).

**OPINION**

(Subject’s name) is a (number) year old (male / female / gender-fluid / non-binary / transgender person) who presented because (tell the story of the presenting complaint in up to 2-3 sentences).

On examination ..... (findings and relevant negative findings).

Investigations revealed ...... (summary and key findings).

These findings ... (opinion about likely cause, timing and consequences of injury) Consider using words such as “is”, “typical of XX caused by YYY”, “strongly associated with”, “highly likely”, “probable”, “possible”, “undetermined”, “unlikely” “highly unlikely” and “not possible”.

Overall, these findings are (comment on the strength of association between findings and child abuse or assault using words about probability like paragraph above).

**Recommendations**

**Signature & date**

**+/- Jurat (optional)**

# Guidance for authors

*The following instructions might be useful for authors writing comprehensive medicolegal reports.*

*Compared to succinct medical reports that summarise key information, findings and conclusions, comprehensive medical reports contain more detailed case-based information, more discussion around findings, more information about medical literature and more explanation about forensic opinion formulation.*

*Authors should ensure that their medical reports are, in their opinion, fit for purpose.*

Letterhead (use your own hospital’s / health service letterhead)

**Report prepared for**

Title, Name

Organisation

Address

Email

**RE**  **Name:** full name and also-known-as names + spelling variations

**Date of birth:**

**Hospital unit record number:** – where child seen or work performed

Include RCH-assigned number if child has one

**Author of Report = Personal details of consultant doctor writing the report**

(approximately ½ page maximum)

While trainees may write medicolegal reports for the experience, it is **NOT** recommended that trainees take responsibility for forensic opinions in child abuse cases.

Full name.

Qualifications and medical registration (where registered – not the registration number).

Work address.

Position title.

Employment history as it relates to this case.

Experience relevant to this case.

**Acknowledgement of Code of Conduct**

In Victoria include as follows

**EXPERT WITNESS CODE OF CONDUCT**

Should this matter be heard in the Magistrates Court of Victoria, County Court of Victoria, or Supreme Court of Victoria then the author acknowledges that they have read Form 44A Expert Witness Code of Conductand agree to be bound by it.

The author declares that, at the time of preparation of this report, the author has made all the inquiries and considered all the issues which they believe are desirable and appropriate, and that no matters of significance which the author regards as relevant have, to the knowledge of the author, been withheld.

The opinion expressed is based on the sources of information listed in this report.  Should, however, additional information become available that might have a bearing on the author's conclusions, the author retains the right to modify the opinion expressed.

**Reason for Medical Assessment**

Who requested the medical evaluation, and why? (1-2 sentences about the case).

Time and date of referral, who from, when, how and why?.

**Site and time (record information for each event)**

Location where service provided.

Time and date assessment commenced and concluded.

**Consent**

Who provided consent and for what procedures? (be precise).

Time, date, use of what consent forms (eg VFPMS mature minor consent form which may be used for Gillick competent minors).

Details of how consent was obtained and by whom.

Note if consent was given to obtain information from other professionals. Specify.

Comment on assent from subject if they are not competent to provide consent.

**Observers**

Who, for what part of assessment/examination? Name and identify who they are.

Document when and how assistance was provided.

**Sources of information**

Full details of all people who provided information, (face-to-face, video and telephone conversations, email and letters, diary entries, drawings, images captured on mobile phones, photographs etc).

Reports – medical reports and other reports.

Medical files and hospital records.

Investigations and reports / correspondence / opinions obtained from other professionals.

Minutes of multiagency case conferences.

**Presenting complaint**

History of complaint and involvement of person requesting the medical assessment (chronological order, dot points may be used).

History of complaint from the person being assessed and/or the accompanying person who might be the person with parental responsibility.

Information from other individuals involved in the case (when more than one person, separate paragraph or section for each person, clearly indicating who provided what information).

Who did what to whom?.

Where?.

When?.

What symptoms occurred at what time(s)? What signs were observed and by whom?.

What symptoms developed between time of alleged assault(s) and now? Signs?.

Current symptoms – physical and mental health.

**Specific questions related to alleged assault**

Note specific questions about symptoms and signs might be asked in relation to the following. Consider special circumstances such as the following:

* significant blood loss (including loss into tissues and extravascular spaces)
* head injury
* Strangulation
* drug and alcohol use
* treatments
* suspected ingestion of foreign substance(s)
* neglect
* emotional abuse
* harm to witnesses / other children.

**Past Medical History**

Birth and neonatal history.

Illnesses and injuries.

Operations.

Development (cognitive and emotional) including milestones for younger children and school progress for older children.

Behaviour (including problems with attachment).

Puberty and menstrual history.

Medication (including contraception and immunisation).

Allergies.

For adolescents consider using HEEADSSS structure to enquire about psychosocial factors, alcohol and drug use, sexuality, social media use, and other factors relevant to this age group.

**Psychosocial information (including genogram and family medical history)**

Genogram and family history.

Medical

Family history of medical conditions.

Ask specific questions in relation to trauma if subject has physical injury.

Ask specific questions related to neglect and emotional maltreatment.

Psychosocial

Parenting practices and factors that might reduce parenting capacity (eg, ill health, poor mental health, ID, medication, drug and alcohol use, stress, IPV, coercive   
control, isolation).

History of subject’s transitions between care-givers – when & why?.

Subject’s prior involvement with Child Protection (chronology of past engagement, investigations and outcomes).

Full details of current Children’s Court orders and order expiry dates.

**Examination findings**

Appearance and demeanour, cooperation, affect, clarity of speech, movements & functional impairments.

Odour, state of clothing, cleanliness, weather-appropriate.

Orientation and mentation (mini mental state exam if required), memory.

Quality of interpersonal interactions and engagement / attachment, eye contact.

Measure height, weight and head circumference, plot on growth charts.

Record general exam findings – systems exam findings and ear, nose, throat, mouth.

Thoroughly examine skin including scalp.

CNS.

Development.

Behaviour.

**Descriptions of injuries**

Note if additional light source and magnification used.

Use of any equipment (magnifying glass / light, spotlight, torch, colposcope).

Fully describe individual injuries / pattern of injury with reference to the body in the standard anatomical position.

Use Body diagrams. Selected photographs may be included (**NOT** genital photographs).

Document injuries and use a structured format such as grouping of listed injuries under headings indicating anatomical location with numbering to make identification / referencing of individual injuries as easy as possible in court or case conferences.

**Photo documentation**

Photographs – where? when? what region of body? Who took them? Time/ Date.

Special photographic techniques?

If possible, include information about where the images are stored / located (eg in EMR).

**Investigations and interpretation of results**

How you present this is up to you. Tables can be useful when multiple investigations have been performed and results are complex. A simple list of investigations or a sentence of two can suffice when investigations are few and results are normal.

Radiology - include each test and date performed. Results other than entirely normal findings should be included in full with names of reporting radiologist(s).

**Medical Management**

Treatment.

Prescriptions given and medications dispensed.

Specialist referral (who, where? what opinion and treatment are sought?).

Planned review and medical follow up – document your case management plan.

**Information sharing**

Information provided to investigators (Who? When? What?).

Information provided to subject’s healthcare provider(s).

Information provided to subject and care-givers.

**Limitations to opinion**

List any omissions or limiting factors.

List experts whose opinions form the basis for some of your opinions.

**OPINION**

**This is the most important part of the report and must be very carefully worded!**

Comment on the following:

* Cause of each individual injury as well as injuries in combination
* Timing of injuries
* Consequences
* Overall compatibility with a medical diagnosis of child abuse (and/or features of assault) with specific comment about the strength of association between the findings and inflicted trauma.

Comment in terms of likelihood or probability. It is not good practice to use words such as “suspicious for”, “concerning for” or ”raise concerns about non-accidental”.

**Recommendations**

(This is also **REALLY** important and must be carefully considered)

For improved safety and wellbeing of this child.

For improved safety and wellbeing of siblings.

Intervention from Child Protection.

Intervention from Vic Police.

Intervention from health service providers.

Intervention from community-based agencies.

Parenting assessments, psychological evaluation of parent(s).

Services / for parents / carers.

Other (including psychological interventions / counselling).

**Jurat with witness details (for court reports)**

I hereby acknowledge that this statement is true and correct and I make it in the belief that a person making a false statement in the circumstances is liable to the penalties of perjury.

**Signature**

Typed name and title as well as signature.

Date signed (indicate if electronically signed).

**Witnessed by** (name) at (place) on (date and time) + stamp.