Letterhead

Date (report signed)

**Report prepared for**

Title, Name

Organisation

Address

Email address

**RE**  Name: full name and also-known-as names.

Date of birth

Hospital unit record number

**Author of report**

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

**Reason for Medical Assessment**

**Consent**

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

**Observers**

**Sources of information**

**Presenting complaint**

**Past Medical History**

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

**Examination findings**

**Medical Investigations and interpretation of results**

**Medical Management and progress**

**Information sharing**

**Limitations to opinion**

**OPINION**

**Recommendations**

**Signature & date**

**+/- Jurat (optional)**

# Guidance for authors writing VFPMS medico-legal reports

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

Date (report signed)

**Report prepared for**

Title, Name

Organisation

Address

Email

**RE**  Name: full name and also-known-as names.

(also provide variations in spelling, if any)

Date of birth

Hospital unit record number – the hospital where the child was seen or the case file review or evaluation was conducted

Also include RCH-assigned number if child was not seen at RCH

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

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

(approximately ½ page maximum)

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 (note, modify “she” to “he” or “they” as appropriate)

**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 she has read Form 44A **Expert Witness Code of Conduct** and agrees to be bound by it.

The author declares that, at the time of preparation of this report, she has made all the inquiries and considered all the issues which she 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 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)

**Consent**

Who provided consent and for what procedures?

Time, date, manner, use of what consent forms (eg VFPMS mature minor consent form)

Details of how consent was obtained and by whom.

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

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

Location where service provided.

Time and date assessment commenced and concluded.

**Observers**

Who, for what part of assessment / examination?

Document when and how assistance was provided.

**Sources of information**

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

Reports – medical reports and others

Medical files and hospital records

Photographs

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

Minutes of multiagency case conferences.

**Presenting complaint**

Identity of who requested service, time and date, manner of enquiry (who, when, how and why?)

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.

Information from whom (may be more than one person, separate paragraph or section for each person, clearly indicating who provided the information)

Who did what to whom?

Where?

When?

What symptoms occurred at what time(s)?

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

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
* suspected ingestion of foreign substance(s)

**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 immunization)

Allergies

For adolescents use HEEADSSS structure to enquire about psychosocial factors, alcohol and drug use, sexuality 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

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 expiry dates

**Examination findings**

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

Odour, state of clothing, cleanliness

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

Quality of interpersonal interactions and engagement, eye contact

Measure height, weight and head circumference, plot on growth charts, record percentiles

Describe clothing cleanliness and appropriateness for weather conditions

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

thoroughly examine skin

CNS

Development

Behaviour

**Descriptions of injuries**

Note lighting and magnification

Use of any equipment (magnifying lights, torch, colposcope)

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

Use Body diagrams. Selected photographs may be included.

Document injuries and use a structured format such as grouping under anatomical location with numbering to make identification / referencing as easy as possible.

**Photodocumentation**

Videorecording of colposcopic examination

(Note that we MUST indicate whether a recording was made)

Photographs – where? when? what region of patient’s body? Who took them?

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 with names of reporting radiologist(s) upon whom you rely for your opinion.

**Medical Management**

Treatment

Prescriptions given and medications dispensed

Specialist referral (who, where? what opinion and treatment is 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

**OPINION**

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

Comment in terms of likelihood or probability.

**Recommendations**

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

For improved safety and well being of this child

For improved safety and well being 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

Contact details of author

Date signed

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