How to write a medico-legal report for VFPMS

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Aims and Objectives

After reading this document you should be able to

- Describe the aims and objectives of writing a medical report
- Structure a medical report to include all the important information
- Understand the reasons for diligently documenting all aspects of the consultation
- Identify risks to patient care and your reputation (and clinical responsibilities) when documentation is suboptimal

The process of documenting a consultation and preparing a medico-legal report

Every forensic medical practitioner seeks to document all aspects of the consultation, and the process of forming an opinion, in a comprehensive manner that is easily understood by non-medically-trained individuals. The effort undertaken to produce a high-quality medical report is usually worth the effort.
A well-structured, well-presented, high-quality medical report forms the basis of good testimony in court. Presenting evidence in court can be extremely challenging in the absence of a carefully- considered forensic medical opinion within a well-prepared medico-legal report.
This document contains the author's personal advice. It is not a "rule book" and there may be contentious advice with which you do not agree. The author merely provides a suggested framework for use as a foundation from which to develop your own approach. It should be modified by your personal preference and the demands of the socio-political system in which you work.

The process of documentation of a consultation starts, not with pen in hand or fingers to the keyboard, but with the early thinking about the consultation process. Fortunately, medical schools equip us during undergraduate training with the frameworks and tools used to engage in consultations and we are taught how to form diagnostic opinions. For many of us the process of opinion formulation in clinical practice is intuitive and subconscious rather than a deliberate action. That said, it can be useful to consider the steps involved in the diagnostic process. Awareness of the diagnostic pathway might prevent failure to perform a vital step in the diagnostic process; a step that might subsequently lead to diagnostic error. It is particularly important that forensic practitioners use both fast-thinking (intuitive thinking and "spot diagnoses") as well as slow-thinking (analytical, step-wise processes involving hypothesis testing, and the application of logic and reasoning) to reach conclusions that are forensically sound.

Step 1: Gather information.

This step includes:

- Pre-consultation information gathering from a range of sources
- Asking questions (general and specific)
- Listening and recording answers
- Seeking additional information and sharing information with others
- Documenting what you hear and read about the child's story.

Step 2: Examine the child.

Think about what to look for before you start. Seek, observe, detect.

- DESCRIBE what you see, hear and feel
- INTERPRET what you see, hear and feel

Step 3: Formulate hypotheses

(usually more than one hypothesis at the same time)

- COULD THIS BE A… or B… or C….

Step 4: Order investigations:

- Order tests wisely considering a broad differential
- Interpret test results mindful of ALL possible scenarios that might account for these results (ie false positives and false negatives) and test sensitivities and specificities

Step 5: Put it together:

- Test hypotheses, ascribe weight and weigh up all the evidence.

What do we want to know?

Fundamental to the process of good report-writing is the author's clarity of thinking and sense of purpose. In order to present a sensible and defensible opinion, doctors should clearly identify the audience for whom the report is written and the purpose of the report (how it might be used). The following questions often require consideration when forensic assessments are conducted.

- Does injury exist? Is there a recognisable pattern to the injuries?
- Are there other injuries?
- What forces are likely to have caused it/them?
- Is there a differential diagnosis? What might better explain it?
- When did it happen?
- Does the 'explanation' account for the injury?
- If not, why not?
- How well do the injuries "fit" a particular mechanism and time/date?

At the end of assessment process the doctor forms an opinion and justifies his /her conclusions. The often unspoken question, "Has this child been abused?" might be answered in the negative, the affirmative or with a qualified but noncommittal answer. Phrasing opinions in terms of likelihood or probabilities (of individual injuries and the overall situation) is often appropriate and sometimes the cause and timing of injury cannot be determined. An overall "yes/no" answer to this question is not an essential component of a good medico-legal report.

The evidence on which a doctor bases an opinion includes background information such as theories as to possible causes of a phenomenon, epidemiological data, published case reports and systematic reviews. Few conditions associated with child abuse and neglect have been sufficiently well studied for levels of

evidence to be used to assign a positive predictive value (or odds ratio) to an elicited symptom or sign. When data have enabled OR and other statistics to be used to convey information about likely diagnoses, then it may be relevant to reference these statistics and data.

Published data forms the foundation upon which "evidence informed" policy and practice is built.
The author's knowledge, training and experience form the foundation for the author's forensic opinion.

Case-related information forms the building materials for the opinion (which is the pinnacle of the construction). The child's story of alleged assault, the history of their life and circumstances, their examination findings and investigation results often comprise the bulk of these construction materials. Other direct evidence, for example DNA obtained from a bite mark, witness accounts and circumstantial evidence can be important (relevant) building blocks and might be probative in some cases.

Interpret the story.

Doctors should carefully consider the nature of the information provided to account for a child's injury or condition. This is known as the anamnesis (the story about the actual mechanism and timing of injury) It is then necessary to ascribe weight to this evidence (which can either support or challenge (refute) the doctor's working hypothesis). Some people might find to useful to "grade" the historical information on a Likert scale of zero to 10 where zero weight is of no value in "explaining" an injury and 10/10 is a very strong sense that the story is an accurate (truthful and detailed) account of the cause of the injury.

Sometimes there is no offered explanation for a child's symptom or condition. The child with an unexplained injury might present with a caregiver who says, "*I have no idea" "It is a mystery!".* When considering this "explanation" as a valid story to account for the child's injury, this story would carry almost zero weight. It could, however, be an entirely truthful statement from a person who was not present when an injury occurred so has no idea what happened.

Sometimes a putative cause is offered only after a search or suggestion is made by others. A caregiver might hesitatingly suggest, *"maybe it happened last Thursday when…".* This could be a hint (the person knows more than they are telling) or it might merely be speculation or a guess.

Sometimes a caregiver provides a clearly stated impression or belief but the event that allegedly caused the injury was not witnessed. For example, a caregiver might state, "*I heard a bang then the baby cried. I reckon his brother hurt him".* This could be a reasonable hypothesis, a mistaken belief, a vexatious comment or simply wrong.

On other occasions caregivers provide clear and unambiguous statements that are offered as witnessed accounts. *"I saw him roll off the bed"* is an example of this.

The story that should be weighted most highly is that of multiple concordant witnessed accounts. Few people would be disbelieving of a group of adults who stated, *"we all saw him kick her".* When categorising the nature of the story in order to assign weight to it, the doctor determines whether the story is

- an allegation
- a witnessed account
- a proposition, hypothesis or suggestion (or a mere thought bubble…)

Examples of the different types of stories are:

- an allegation. “She slapped me”
- a witnessed account. “I saw her slap him”

Other types of stories are less clearly defined.

- a proposition. “I think/suggest/believe/consider it probable that she slapped him”
- a comment that someone else interprets as suggesting, inferring or indicating a proposition (there could be varying levels of confidence that the inference is valid) “He said that she hurt his arm and I think he meant that she slapped him”
- a hypothesis “He could have slapped himself”
- merely a suggestion “I don't know. Perhaps she slapped him”

Remember that in a forensic context, it is not the doctor’s role to determine the veracity of someone’s statement. The truth or otherwise of an allegation is for the judge or jury (the tribunal-of-fact) to determine.

That said, the doctor also has a legitimate role in questioning,

- Is the story possible? Has it happened before? Could this be the first time that such an event has ever occurred?
- Is the story probable? This involves the determination of likelihood that the story
- provided is a true explanation for the child’s condition. Common things occur commonly.
- Is the story plausible? Can I believe it? This is not an important feature of any story because some people can believe the most irrational ideas (alien abductions, harmful Covid-19 vaccines, conspiracy theories about 5G capacity for mind control)

The next vital steps in the process of forensic opinion formulation involve

- Examination and interpretation of examination findings
- Investigation and interpretation of results of investigations

Form an opinion and demonstrate reasoning

In order to determine whether an injury is likely to have been caused by the offered explanation doctors need to explore and understand the knowledge base relevant to that type of injury.

The injury: correctly classify and then determine the cause

Correct identification of the type of wound or injury is essential. There is a world of difference between the forces that cause a scratch abrasion, a laceration and a stab wound. Correct wound classification is an important step in the injury interpretation process.

Some forces cause particular types of injuries and particular injury patterns. Knowledge about mechanisms

of causation for an observed injury type and pattern is essential. For example, doctors must understand the how mechanical forces cause lacerations and buckle fractures of long bones. Doctors must also know about how forces can result in uncommon patterns of injury. For example, one assailant can result in different types of human bite injury (bruises, abrasions and puncture wounds) and significantly differing patterns of injury on the one victim.

The forensic evaluation of injury in light of published information (examining the features of your case compared to the knowledge base)

Knowledge of published literature enables a forensic practitioner to answer questions about possibility. "Are there any recorded instances of this happening before?" If something has happened before, it is POSSIBLE that it might happen again.

The incidence of a particular finding affects diagnostic certainty. Something that occurs frequently is more likely to explain a common finding than something that occurs infrequently. The saying "when you hear hoof-beats, think of horses not zebras" springs to mind. Forensic practitioners are usually more confident that they have correctly identified the cause of the injury when encountering common patterns of injury.

Congruence

Congruence is key consideration in the process of injury evaluation. Are the examination findings and investigation results in keeping with the story? Does everything "fit"? If not, why not?

Many doctors are tempted to stop thinking at this point. Beware. It might be reasonable and economical in every-day medical practice to stop the diagnostic process when you are 80% to 90% certain, but it is "too soon" to stop when you are working in forensic medical practice. Just because the pieces of a jigsaw puzzle fit together, (the story "explains", "is in keeping with", or "is consistent with", the findings) does not mean that this is the only possible solution to the puzzle. Forensic practitioners must ask the question, "Are other explanations possible?"

Alternative explanations

The next critical step is to evaluate other possible "explanations" or "causes" for an injury. A list of differential diagnoses must be developed. Consideration must be given to accidental causes of an injury and to medical conditions that can be confused with abuse.

An understanding of the incidence and typical presentations of accidental trauma in children, the scope of patterns of accidental injury in childhood and an understanding of paediatric medicine (particularly the conditions that mimic features of child abuse) is required in order for forensic practitioners to accurately determine cause of injury. For example, doctors must know about the many causes of bullae and ulcers when evaluating a child with suspected inflicted cigarette burns or suspected STI associated with genital ulcers.

Diagnosis and probability

Diagnostic certainty exists along a continuum. At the lowest end is absolute uncertainty. At the highest end is absolute certainty which can be either (1) that an alleged cause is the definite and only cause for the child's condition or (2) that the alleged cause is impossible and cannot be the cause for the child's condition.

The doctor must avoid bias if he/she is to provide an impartial and objective opinion. There are many forms of bias, all of which might interfere with (impede) a doctor's evaluation of suspected abuse.

A comprehensive discussion about types of bias and how best to avoid it is beyond the scope of this document but students of forensic medicine are encouraged to explore this topic further because it is such an important issue in clinical practice. Confirmatory bias, contextual bias and other cognitive biases have the capacity to seriously distort and derail an assault assessment unless the doctor is aware of the risks and guards against them. Implicit (unconscious) biases cannot be totally avoided.

Some examples of bias include:

- People apply a high evidential standard ("Must I believe this?") to unpalatable ideas & a low standard ("Can I believe this?") to preferred ideas
- Excessive drive for consistency is another potential source of bias because it may prevent people from neutrally evaluating new, surprising information
- People can overlook challenges to their existing beliefs

Fallacies of logic pervade much of the child abuse literature. Of particular concern is "circular logic". Circular reasoning occurs when the conclusion is assumed in at least one of the premises and the argument assumes (explicitly or not) what it is trying to prove.

In the child abuse field another frequently encountered fallacy of logic is the "post hoc, ergo propter hoc" argument when an event (B) that occurs after an event (A) is interpreted as having a causal relationship (A caused B). In the recent past there were hundreds of children subjected to forensic medical examinations because they were noted to have reddened genitals following contact visits with non-custodial parents.

There are many other threats to sound reasoning when forming forensic opinions. For example, many people find it difficult to focus on more than one thought at a time, so find it difficult to test alternative hypotheses in parallel.

The language used in medico-legal reports

Some words carry hidden assumptions as baggage. The word "disclosure" assumes the statement is factual. The word "victim" assumes something bad happened to this person. The word "offence" assumes a crime has been committed.

To refer to an identified individual as "an alleged perpetrator" or "an alleged offender" is potentially so prejudicial that a medical report might be excluded as evidence or the credibility of the author might be seriously threatened. Doctors are encouraged to cast a critical eye over their reports to ensure that impartial language is used.

All language should be understood by "lay people" who might serve on a jury. Explain medical terms anatomy and medical procedures in plain English.

Aims and objectives when writing a medico-legal report

When writing a report it is important to remain mindful of four key questions.

- Why am I writing it?
- Who is the report for?
- Who else will read it?
- How might it be misused?

There are several excellent examples of well-constructed medico-legal reports that might be used to guide forensic practitioners who are preparing reports for the criminal justice system. For a police- report style report see Helen Louise Parker: Writing a Police Statement. Forensic Series Clinical Practice Australian Family Physician Vol 33 No 11 Nov 2004 927-930. For reports for Children's Courts and for reports regarding sexual abuse (and most other reports) the VFPMS templates are recommended.

Most doctors include only a brief account of the alleged offence when they write reports for adult victims of sexual assault. Information about the alleged assault will be provided at trial when the adult complainant testifies. Usually no information about the adult's past history, cognitive ability or psychosocial circumstances is included in this style of medical report. Assaults of adults are more likely to be "one of" events than assaults on children (victims of gender-based family violence aside), assumptions are frequently made by forensic physicians that pre-existing injury is unlikely and examination of an adult is more likely to occur closer to the time of the alleged assault.

Children, on the other hand, are different.

The reality is that very few people who assault children are ever held to account at trial. There is a far greater probability that a forensic doctor who assessed a neglected or abused child will be required to provide a medical report for a child protection investigation or a Children's Court hearing than a criminal court. For this reason, many doctors working with abused children choose to use a report format structured to better meet the needs of a protective investigation than a criminal investigation or prosecution. Sometimes it is necessary for a doctor to write two reports to meet the differing needs of both systems.

Suggested report format for Child Protection and Children's Court

The following format is based on the medical report format currently used by the Victorian Forensic Paediatric Medical Service. It is provided merely as a basis for modification to suit your requirements. The headings in the box at the end of this section provide the template.

Author of report

When providing personal details of doctor (author of report) include your full name, qualifications and medical registration (where you are registered and by what board e.g. Medical Practitioners Board of

Australia, not the registration number). Include your work address, your position title and employment history as it relates to this case. Also include experience relevant to this case. Unless you have a particularly impressive Curriculum Vitae, do not exceed one page. A lengthy CV could be attached as an appendix.

Circumstances of the consultation

Provide information about the person who requested the medical evaluation, when and why. Summarise the reasons for the request in 1-2 sentences.
Provide information about the location where the service was provided, the time and date you were called out, the time and date assessment commenced and concluded.

It is particularly important when working with minors to indicate the identity of the person providing consent and the procedures to which they have consented (and to which they have not). Also indicate the manner in which consent was provided (in writing, using a standard consent form, signed and dated). Any factors that might influence a person's capacity to provide valid consent should be clearly identified. A child's assent to examination, photo-documentation, investigations and collection of samples for forensic analysis should also be noted.

The identity and role of any observers (including support people for the child) must be stated. The report should include details about the observers' identity, their presence for what aspects of the procedure and any influence they might have had on the assessment process (assistance or otherwise).

Sources of information

Full details of all people who provided information, (face-to-face conversations, telephone conversations, teleconferences, email and letters) must be listed. All sources of information (verbal and written) including all reports (medical and other reports), medical files and hospital records as well as results of investigations should be listed.

Presenting complaint

The history of complaint and involvement of the person requesting the medical assessment (in chronological order) could be provided as dot points.

Details of the complaint are usually obtained from the person being assessed. Record verbatim if possible. Document when additional information is obtained from others. (Use a separate paragraph or section per person).

Specifically, you want to know who did what to whom? Where and when "events" occurred and what symptoms occurred at (and after) the time of the alleged assault.

Subjective symptoms such as pain, tenderness and discomfort that developed between the time of alleged assault and the examination can have forensic significance. In some situations, such as alleged strangulation, symptoms such as dyspnoea and difficulty swallowing can also alert the practitioner to possible life-threatening complications. Enquire about current symptoms. Evaluate pre-existing physical and mental

health. Collecting details regarding multiple episodes of assault or of assaults by multiple assailants can be time consuming but this detail must be obtained and included in the report.

It is considered good practice to conduct a comprehensive paediatric medical evaluation in order to determine (if possible) whether symptoms or signs might be due to conditions OTHER THAN alleged or possible abuse.

Past Medical History

- Birth and neonatal history
- Illness and injury
- Operations
- Development (cognitive and emotional) including milestones
- Behaviour (including problems with attachment)
- Genogram and relevant family history – medical and psychosocial
  - Þ Include history of transitions between care-givers – when, why?
  - Þ Include prior involvement with Child Protection (index child and siblings) Þ Include details of current Children's Court orders
- Puberty and menstrual history (particularly when sexual assault is suspected)
- Medication (including contraception and immunization)
- Allergies

For adolescents use HEADSS structured questionnaire to enquire about psychosocial factors, alcohol and drug use, sexuality and other factors relevant to this age group

Specific questions related to alleged assault

Ask about symptoms that arose following the alleged assault

Ask about whether the child has (following the alleged assault):

- Cleaned wounds (how and when)
- Changed clothing
- Showered or bathed
- Used +/-menstrual hygiene products
- Voided Defecated (especially if genital injury is suspected)
- Eaten Drunk (especially if oro-facial injury is suspected)
- Taken analgesics or other medication
- Engaged in other sexual activity (if sexual assault is suspected)

Examination findings

- Appearance and demeanour, cooperation, affect, tiredness, tearfulness
- Orientation and mentation (mini mental state exam if required)
- Quality of interpersonal interactions and engagement

- Measure height, weight and head circumference, (plot on growth charts and document percentiles)
- Clothing, jewellery, tattoos, (in general terms)
- General exam findings – systems exams and ear, nose, throat, mouth (internal)
- Thorough examination of skin
- CNS
- Development
- Behaviour
- Relevant negative findings (e.g. no injury at site where trauma alleged to have occurred)
- Consider complications of trauma (eg strangulation, brain injury)

Photo documentation:

It is good practice to photograph visible injury.

- Indicate that photography occurred and whether there were any technical problems
- Photographs – how many? What sites? Under what conditions? What format?
- Special photographic equipment or techniques?
- Include information about where photo-documentation (images) is/are stored.

Specimen Collection for Forensic analysis

List of all specimens and document the chain of evidence. Keep a duplicate copy of the list of specimens given to police. Record when, and to whom, specimens were released (Chain of custody).

Consider whether you might collect:

- Debris
- Clothing (one item per bag)
- Wet and dry swabs for offender DNA (for example swab from bites for saliva tests)
- Buccal swab for reference (victim) DNA
- Other (finger-nail scrapings, hair etc)

Investigations

Depending on the context of the child's injury you might need to consider performing investigations for clotting disorders, metabolic disease, occult bone injury, intra-abdominal injury and medical conditions confused with abuse.

- Full blood examination
- Clotting studies
- Other blood tests (list)
- Radiology (list)

See VFPMS website for guidelines regarding investigations to perform when searching for specific types of occult injury or medical conditions that can be confused with abuse.

Medical Management

- Treatment
- Medications provided and prescribed
- Specialist referral (who, where? what opinion and treatment is sought?)
- Planned review and medical follow up

Information sharing

- Information provided to investigators (Who? When? What?)
- Information provided to health provider
- Information provided to patient

Limitations

List any omissions or limiting factors.

Opinion

This is the most important part of the report and must be very carefully worded! No new information should appear in this section.

This section should contain some, or all, of the following:

- Interpretation as to the nature of the story
- Interpretation as to the findings
- Interpretation of results of investigations
- Relationship between the story and the findings/results
- Likelihood of cause of injury/child's condition
- Time of injury
- Sequelae / complications - possible and anticipated
- Level of certainty of diagnosis / opinion
- Evidence base on which opinions are based
- Recommended treatment/intervention
- Limitations to opinion

Note that in a forensic report you should always include your opinion about the following:-

ALWAYS include opinion about:

- Mechanism of injury
- Forces
- Timing
- Consequences
- Alternative 'explanations"
- Overall likelihood = ASSAULT

A summary of the way you interpret the history and examination findings can be a sensible starting point.

You need to clearly display your reasoning (i.e. the logic used to reach your conclusion). If necessary proceed step by step to demonstrate the process used you have used, based on the evidence before you, to reach a logical conclusion. You need to comment on the relationship between the offered explanation for each injury (if there is one) and the examination findings and/or investigation results. In situations when a patient has multiple injuries it is usually appropriate to consider injury patterns in addition to considering the cause of individual injuries.

Comment in terms of likelihood. This could include phrases such as " it is not possible that …", "highly improbable", "highly unlikely", "unlikely", "I am not able to determine which of these possibilities is

more probable (or likely)", "more likely than not", "likely to have been caused by" "highly likely" "almost certainly" and "this is the only possible explanation that might account for …". At times phrases such as "possible but improbable" might be most appropriate.

Plausibility relates to your capacity to believe something. The term "plausible" is best avoided. Words should be carefully chosen to accurately reflect your perception of the strength of the association between the postulated cause of injury and what you consider to be the likely cause of injury. You should also convey to the reader of your report a sense of your level of confidence. This should give the reader information about the evidence on which you base your opinion. The term "consistent with" may be valid but is often an imprecise rather sloppy turn-of-phrase. The phrase "in keeping with" has similar properties. These phrases imply that the explanation and the observed findings/results could possibly be causally related. The problems with using these phrases are that there might be other possible (unmentioned or not considered) causes for the findings and the terms might be interpreted by others (for example jurors) to imply a strong causal association. If you choose to use the term "consistent with" then I recommend that you feel compelled to provide details about all possible causes and indicate, if possible, how your "consistent with" suggested cause sits in relation to the alternative explanations.

Avoid terms such as "concerning for" "generates suspicion about" "is suspicious for" and similar phrases. The lawyers need us to convey information about FACTS. Whether or not we are "concerned" or "suspicious" is of no relevance to lawyers and jurors. We must phrase our opinions in terms of probability

and likelihood.

When referring to the timing of injury it might be appropriate to offer a comment such as "the features of this wound indicate that it could have occurred around the time suggested by ….." or " it is possible that the wound might have occurred at the time stated by …" or " the wound has features that are in keeping with it having occurred within the timeframe …". On many occasions it is sensible to offer only an imprecise estimate of the time of injury in terms of hours, hours to days, days to weeks, weeks to months, or months to years (prior to the time of examination/investigation). When injuries potentially have serious consequences it is reasonable to mention them. This is particularly important for life threatening injuries or assaults (such as strangulation or head injury) when a fatal outcome could have occurred (or still might occur).

Limitations to your opinion could include reference to missing information that might have probative value, your reliance on others (for their information, interpretations or opinions) and any factors that have restricted or hindered your assessment in any way. If you are missing important information then this should be stated. You should name the professionals and include their reports when you are reliant on these opinions for your opinion (ie their opinion forms the basis for your opinion). You could also offer to reconsider your opinion should addition information become available.

Recommendations

This section of a report is also extremely 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 Police
- Intervention from health services (include all healthcare recommendations here – including preventive health care, screening tests and surveillance
- Intervention from community-based agencies
- Parenting assessments, psychological evaluation of parent (s)
- Services/ for parents / carers
- Other (including psychological interventions / counselling)

Signature

· Typed name and title
· Contact details of author
· Date signed
+/- Jurat

Controversies and dilemmas upon which to ponder

Many forensic practitioners choose to selectively omit details of the history or examination for what they perceive to be reasons related to serving "the best interests" of their patient. For example, doctors might omit information related to a past termination of pregnancy, a mental illness or a social indiscretion.

Description of a tattoo of a particularly offensive or antisocial nature might be omitted in the belief that a jury might be prejudiced against the person (victim) should the jury become aware of the presence or content of the tattoo.

The practice of selectively "doctoring" a medical report is a very risky practice. This is a controversial area and opinions vary about the relative pros and cons. Caution should be exercised whenever you opt to selectively leave information out. How do doctors get around this issue? Some doctors remind patients that the documented information will be accessed by others (allowing a termination of the conversation about the sensitive topic at this point). Some doctors warn patients that if the conversation continues the doctor will be morally and legally bound to act on the disclosed information. Some doctors chose to selectively fail to document information in a patient's medical record with the patient's knowledge and consent. Many doctors choose to selectively omit information written in the work notes from a final medical report, aware that work-notes are legally discoverable and conscious of the inherent risks incurred.
Numbering pages is "a must". Numbering lines on each page is preferred in some jurisdictions. Some doctors choose to number paragraphs in the opinion section or throughout the entire report.

All limitations to your opinion should be acknowledged. This includes acknowledging any "missing" information or sources of information, (and to reiterate) your reliance on information obtained by others and your reliance on other professionals' expert opinions. This is particularly important when the opinions of professionals such as ophthalmologists and radiologists form the basis for the forensic opinion that you form.

In most jurisdictions documentation of investigations about critical incidents (and in some jurisdictions peer review meetings and quality improvement meetings such as mortality and morbidity meetings) have a level of protection and doctors are not compelled to disclose the content of discussions that occurred during these meetings.
Ordinary patient-related discussions with peers do not have immunity from disclosure.
Controversy exists about the relative pros and cons of including in reports the degree of consensus amongst peers around interpretation of genital examination findings. It is this author's opinion that there is merit in open disclosure, particularly when there is a lack of consensus about a particular finding. It must be acknowledged, however, that the process of asking a peer or colleague for a second opinion could be interpreted in court to suggest a lack of confidence in one's own opinion. Perhaps the practice of routinely subjecting all photo-documentation of injury to review by at least one experienced peer could obviate need to subject this issue to scrutiny in court. It could then be argued that review by an experienced peer is a matter of maintaining quality standards and that it is "routine practice" rather than an indication of operator inexperience or lack of confidence. The same could be argued for routine review of all medico-legal reports.

Extra tips for words to use (and avoid) when writing reports

Examination findings and forensic procedures

1. **Describe the body** with reference to the standard anatomical position. Refer to landmarks on the body. A ridiculously sensible discussion on (wait for it...) Wikipedia – is worth a look http://en.wikipedia.org/wiki/Anatomical_terminology
2. **Examination conditions**
   e.g. "The subject was examined using room lighting and in the absence of magnification." Or "XXX was examined with fluorescent overhead lighting and no magnification."
3. **Cooperation**
   e.g. "XX cooperated well with all aspects of the examination."
   - Or "YYY cooperated with some aspects of the examination but would not permit measurements to be made of his height or head circumference."
   - Or "ZZZ would not permit examination of any areas of the body other than her arms and legs below her knees."
4. **Areas examined**
   e.g. "An inspection was conducted of the entire body." Or "The skin under her underwear was not examined." Or "An incomplete inspection of his skin occurred because strapping, splints and plasters were not removed" – or words to this effect.
5. **FMEK**
   Please **include the kit number**.
   State what went into the FMEK and what did not. Clothing bags usually do NOT get sealed in the FMEK.
   The 2 buccal swabs should be on the outside of the FMEK.
   e.g. "The following samples were collected, packaged, sealed, labelled and were replaced in the FMEK ..." "The FMEK was resealed with tamper-indicative tapes." "Clothing bags (3) and the sample of urine for toxicological analysis was also handed the DSC XXX at ZZZZ (24 hour clock) on (date)."

Medical jargon, grammar and syntax

Doctors use the English language in ways that are not universal. Plain English works best.
Please spell out full names of acronyms and aim to avoid all medical jargon that might not be easily understood by non-medically trained readers. The following "tips" aim to standardise VFPMS reports and improve the readability, clarity of expression and overall utility of VFPMS medico-legal reports.

1. **Acute.**
   The word "acute" is often used by doctors and nurses to mean "recent" but can be interpreted by non-medical people such as lawyers, child protection workers and police to mean "sharp" (as in an acute angle not an obtuse angle) or to mean "severe", "important" or "urgent" as in "Acute Health Care" which is a term used to refer to Emergency Medical Care in Departments of Emergency Medicine (Accident and Emergency Departments). I recommend that the word "acute" is avoided in medico-legal reports unless it is part of a title or you are quoting someone such as a radiologist (e.g. interpretation = an acute fracture which means there is no evidence of bone healing. Another

example is an interpretation of a subacute SDH which as we know could mean a number of possible causes/timing.) Using the word "recent" instead of "acute" will minimise the risk of confusing lay readers. I also recommend that when you use the word "recent" that you give readers a sense of what this means in terms of hours, days or weeks.

2. **As**

   The word "as" can legitimately be used as a comparison, as indicated, and as is reasonable in each and every report. e.g. "as big as a horse" or "as annoying as a mosquito". What is poor use of the word "as" is as a replacement for the word because. e.g. "She could not attend as she was ill." The word should be "because". e.g. "She could not attend because she was ill".

3. **Like**

   "Like" can be used incorrectly when the author should use the words "such as". e.g. "The tram track patterned bruising could have been caused by an object like a stick." The correct way to express this is "... could have been caused by an object such as a stick."

4. **Reflects**

   e.g. "The bruise reflects blunt force trauma." This is a confusing use of this term. Usually a reflection is the mirror image of something. Perhaps the author means that what is seen is merely an image or an apparition (I am not really sure what I am seeing here?) that might be caused by blunt force trauma (or might not). The term suggests to me, as a reader, that the author doesn't know for certain what they are seeing. I suggest that a better word should be used. Save the word "reflects" for when you "reflect on an idea" by turning it over in your mind or are talking about an image that bends light back to you from a shiny surface.

5. **Would be consistent**

   e.g. "would be consistent". This is a conditional phrase. The burn would be consistent with a splash from hot oil. I immediately ask "when?" and "why?" Why is the term "would be" used? Under what conditions would the burn be consistent, and why didn't the author tell me about these conditions if there were some conditions under which the burn would be consistent and some conditions under which it would NOT be consistent? Surely the term that is required here is the word "is". i.e. "the burn IS consistent ..."

   Note that in general the term "consistent" needs to be qualified each time it is used. ALL (yes absolutely all) the differential diagnoses need to be mentioned and their likelihoods discussed. It is absolutely NOT OK to simply mention one possibility, offer an opinion that goes something along the lines of "the findings are consistent with the stated cause" and leave it at that. This is called "confirmatory bias" and it is not recommended for use in forensic medico-legal reports.

6. **Issues and Input**

   Some medical professionals use the word "issues" in relation to problems such as "she has mental health issues" and "he has behavioural issues" as a way of hiding information (perhaps in an attempt to protect privacy). This word is an extremely imprecise way of providing information in the child protection field. Please avoid the word "issues" at all costs. If you are given information by someone who uses this word then you must ask that person what they mean.

   Input e.g. "She needs medical input." This is an imprecise "jargonish" way to say ... what exactly? What will Child Protection and the courts make of this? It is unhelpful. I recommend being precise about what you recommend and the word "input" doesn't tell me what you think this child needs.

(Not much thought goes into the word "input".)

7. **Linked in**

   e.g. "She is linked in with CAMHS." Surely it is informative to say who sees her (or others in her family) over what period of time, where, and for what reason. This is another "lazy" medical jargon word that conveys next to zero information.

8. **Some, Many, Lots, A few**

   It can be frustratingly challenging to obtain detailed factual information from "difficult historians". Vague references to "many notifications to Child Protection over the years" or "lots of concerns about this family" are not sufficiently detailed for a good quality VFPMS report.

   These phrases convey woefully little information. They also convey negative messages to the reader about the diligence and intelligence of the author. Attention to detail appears to be sacrificed and, with this sacrifice there is an increased risk of an erroneous conclusion. Do try to obtain information that you can use in a meaningful way as the basis for your forensic opinion and recommendations.

9. **Family**

   Some paediatricians use the word "family" when they actually mean "mother" and sometimes "father", or rarely "couple". Names are always a reasonable way to refer to someone. The word "family" can be used when grammatically correct but please try to avoid it when you would be wiser to use a more precise term. e.g. "I spoke to the family" should be "I spoke with XXX". The sloppy use of the word "family" can sometimes make it really difficult to identify precisely who is responsible – to the detriment of the child.

10. **<u>The</u> mother, <u>the</u> grandmother**

    These individuals are not everyone's mother or grandmother. The term describes a relationship. The words therefore need to refer to the subject e.g. "her mother", "XX's grandmother", "the children's mother". The term "the mother" is frequently used in medical circles but is neither courteous/respectful nor is it "good English". It has no place in high quality VFPMS reports. Even worse is the extremely disrespectful use of the word "Mother" instead of the person's name.

    Please don't ever do this in a VFPMS report or when discussing children with others.

11. **Time**

    Please consistently use either a 24 hour clock or a 12 hour clock accompanied by am or pm. Please do not swap or mix up your choice midway through a report.

12. **Dates**

    Please use one way of referring to dates consistently throughout a report. It doesn't matter how you do this (e.g. 24/2/14 or 24.02.14 or 24th February 2014 or 24 Feb 2014 or whatever you prefer) but it looks like you cannot focus well and it reflects badly on the author when things such as references to dates "go all over the shop" throughout a report. Be consistent. It goes against your credibility when you are not.

14. **A long time ago / a while ago**

    This could mean anything from a few hours ago to a few years ago, depending on context. Please aim to be as precise as possible when obtaining information. Ask questions to clarify exactly what is meant.

More Tips for Better Grammar

1. That

The word "that" needs to be used correctly in order to accurately convey meaning. e.g. "she said yesterday that he hit her" has different meaning to "she said that yesterday he hit her". To spell it out for those who might remain confused, in the first example the talking occurred yesterday and the hitting occurred at an unspecified time prior to this, whereas in the second example the hitting occurred yesterday and the talking occurred more recently than this.

Please also note that "that" and "which" are not interchangeable terms. "That" indicates a *defining* clause, while "which" indicates a *non-defining* clause. This means that when you use "that", you are indicating that the information following is essential to the meaning of the sentence. e.g. "XX is wearing a shirt that her mother bought her" – in this example, it is important that XX's mother bought her the shirt. Compare with "XX is wearing a shirt, which was bought by her mother" – in this example, the emphasis is on the fact that XX is wearing a shirt. That the shirt was bought by her mother is additional information that is not essential to the meaning of the sentence.

2. She said ...

Similarly, the position in the sentence of the reference to the person who told you this information can significantly alter the meaning depending on where in the sentence this information is located. e.g. "on the way to the zoo he said that his father hit his mother" has different meaning to "he said that on the way to the zoo his father hit his mother". In the first example the talking occurred on the way to the zoo (but not the hitting) and in the second example the hitting occurred on the way to the zoo and the talking to you occurred at a later time.

3. Prepositions

"In" or "over" the holidays – might be better termed "during" the holidays.

4. Where and when

- Where refers to a place
- When refers to a time

It is appropriate to refer to situations "when" (when you mean at a certain time) and "where" (when you mean in a certain place or places). e.g. "He always does this when (not where) I annoy him." Or "when indicated by the circumstances".

5. A

"A" can sometimes be incorrectly used instead of "each". e.g. "she attends once a term". "She attends once each term" or "... once per term" is grammatically correct.

6. Her and her partner... Herself and him

Every good student of grammar knows that it is correct to say "she and her partner went ..." and there is no situation that I can think of that would make "her and her partner ..." (as the subjective part of the sentence) grammatically correct.

7. Homophones

Be careful when using homophones – words that sound the same but have different spellings and/or meanings.

- **Bare** (unclothed/unadorned) / **bear** (black, brown or grizzly/to hold up – weight bearing/ "bear with me")

- **To** (a preposition and adverb) / **too** (also/in addition to)
- **There** (indicating a place) / **their** (indicating possession) / **they're** (contraction of 'they are')
- **Your** (belonging to you) / **you're** (contraction of you are)
- **Breech** (hind end, bottom presentation at birth) **/ breach** (broken, ruptured or torn, a violation)Not quite a homophone, but – **brought** (past tense of 'bring') / **bought** (past tense of 'buy')

8. Fewer/less

People often confuse the use of "less" and "fewer". "Fewer" is a *count noun* and should be used when the object to which it refers can be counted. e.g. "ten items or fewer", "AA has fewer bruises on his left arm than on his right".

"Less" is a *mass noun* – use it in sentences where you cannot count the object to which it refers.

e.g. "There is less sunshine today than yesterday." Because you can't have one sunshine, or two sunshines, "less" is appropriate. The same applies to "greater" and "more".

9. Might and May

- "Might" is possible
- "May" is permission

For example, you could say "he *might* have autism" because this is a diagnostic possibility. As a consultant paediatrician you *may* officially make this diagnosis and complete forms for Centrelink re the Carer's Allowance (i.e. you have permission).

10. Potential child abuse

"Potential child abuse" means that child abuse might occur in the future. This means that the subject is deemed to be at risk of child abuse. This child has the potential to be abused. The circumstances under which this child lives create the potential for abuse.

"Potential diagnosis of child abuse" means that the diagnosis of child abuse might be made at some time in the future.

"Possible child abuse" means that child abuse could (possibly) occur but might not. "Possible diagnosis of child abuse" means that the diagnosis of child abuse is possible.

11. Alleged the allegation of alleged abuse

When the word "alleged" (or "stated" or "said" or "told me that") is/are used then the word "alleged" is not required as an adjective or adverb. e.g., "she alleged that he allegedly touched her thigh" should become "she alleged that he touched her thigh". One "alleged" word per sentence is enough.

12. Further and additional

When you see additional bruises or hear additional statements to those already mentioned in your report, they are additional bruises and statements. The word "further" is rarely the best word to use in this context. Furthermore, it can be confused with the word "farther" which refers to distance.

13. Another, but not similar

Sometimes the words "another adult" are used when the subject is merely a child and the person is actually the first adult about whom a reference is made. The words "another adult" when used in relation to the first mention of an adult makes it seem as though you are not paying attention.

14. Last, past and passed.

Last is the end of an absolute span of time "the last ten minutes of a 24 hour period".

Past is the most recent event in relation a time or event already mentioned. e.g., The forensic collection times mention "the past 12 hours" which refers to the 12 hours prior to sample collection time. The word "last" is incorrect in this context.
Another correct use of the word "past" is as an adverb, e.g. "he flew past the window".

Passed is a different word altogether e.g. "he passed me the candy-cane" which is the past tense of "pass".

15. From a fall, due to a fall

The word "from" is perhaps not the best word to use when ascribing cause. "I received a gift from Wendy" is a legitimate use of the word "from" whereas "the abrasion came from a fall" might be better termed "the abrasion is the result of a fall" or better yet, word things as active sentences, e.g., "the fall resulted in an abrasion" or "the fall caused an abrasion". If you must use passive sentences than perhaps you could say, "the abrasion was caused during the fall", "the abrasion occurred as a result of the fall" or "the abrasion occurred during the fall".

Words to use with caution

1. Disclosures, rape, assault, victims and perpetrators/offenders or alleged perpetrators/offenders
   Forensic doctors must stay away from the ultimate issue (i.e. deciding whether someone is guilty). Words that imply, or worse clearly state that a crime has been committed must be avoided. Please be careful how you use these words. If the words are quotes then use quotation marks. If in doubt about how words could and should be used then ask senior doctors who understand how medical information must be presented. In NSW they identify possible suspects as "persons of interest" so you might come across this term but it is not widely used by Victorian police. Victorian police use terms such as "suspects", "possible suspects" and "the accused". In court reference is usually made to "the defendant". The use of people's names is usually an easy way for medical professionals to avoid an accusation of prejudice against an accused person.
2. Family violence
   Also known as "domestic violence". In the forensic world, in the injury prevention world, and in the WHO field etc., the preferred terms are "interpersonal violence" or "intimate partner violence". "Exposure to violence in the home" or "in their home" might be a useful phrase to use in relation to children. Many "domestic violence workers" refer to gender based violence directed towards adult women and other non-violent gender-based behaviour aimed to control adult women as "family violence" so please be cautious about how you use this term in relation to abused children. As a pediatrician it seems inappropriate to refer to violence directed towards women and their children (children are not their mother's chattels).
3. VARE
   SOCIT Police in Victoria video record the formal police interviews with children. VARE is always capitalised because it stands for "visual and audio recorded evidence". Words such as "VARE interview" can be used. http://www.dhs.vic.gov.au/cpmanual/investigation-and-

assessment/overview-of-investigation-and-assessment-phase/1178-vate-video-audio-taped-evidence/3

4. "In care" replaced the term "Out of home care"
   This is the current official and preferred term, rather than "foster care". "In care" and "out of home care" includes kith and kin placements, family group homes and residential unit placements.
5. Contact visits is preferred to "access"
   The Family Court of Australia orders are called Contact Orders, so it is probably better to term the contacts as "contact visits" rather than "access visits".
6. Children's Court of Victoria Orders
   The Child Protection website (and the *Children Youth and Families Act 2005*) lists the names of all the orders. Please ensure that information about orders is accurate – or indicate in the report that you are uncertain. You might wish to quote the words used if you are unable to verify the accuracy of information provided to you about orders. Note that in early 2016 the orders that can be granted by the Family Division of the Children's Court of Victoria changed. These orders include Interim Accommodation Orders, Protection Orders and Permanent Care Orders. These Court orders can be viewed at:-
   http://www.childrenscourt.vic.gov.au/jurisdictions/child-protection/court-orders