



DOCTORS FOR SEXUAL ABUSE CARE

PO BOX 90 723, 5/4 WARNOCK STREET, GREY LYNN, AUCKLAND
PHONE: (09) 376 1422 FAX: (09) 376 0790 email: dsac@ihug.co.nz website: www.dsac.org.nz

NATIONAL NEWSLETTER

EDITORS: SANDRA RHIND & CAROLINE CORKILL

ISSUE No. 72 OCTOBER 2007

Manager's Report - Hayley Samuel

1. National Sexual Abuse Assessment and Treatment Service

ACC are currently engaging with some District Health Boards with regards to the roll out of this service as an 18 month trial. If any of you are involved in this in your area, please contact the DSAC office for further information and support.

2. ACC Early Response Team

As you may be aware (refer to DSAC National Newsletter May 2007, Issue 70), there has been an ongoing concern expressed by the DSAC Executive Committee regarding the ACC Early Response Team both in terms of the function and purpose of the team and that this initiative had been promoted as being supported by DSAC. This team was originally described as a "team that will consist of experienced case managers to proactively contact victims of recent high profile sexual assaults, and where agreed and possible, meet face to face as soon as possible." Following correspondence between DSAC and the Sensitive Claims Unit Branch Manager, Alison Maloney, it has since been clarified that "ACC do not directly contact the claimant. Our approach is to the officer in charge, with whom the victim has already had contact, and asks that our contact details are passed on. If the victim doesn't

contact us we do not pursue this" also that "ACC would welcome DSAC doctors contacting us with cases where they considered an immediate approach from ACC would be appropriate."

3. ACC001 Request for Assistance

At the recent Sensitive Claims Advisory Group Meeting the ACC001 Request for Assistance was discussed. This is to be lodged by claimants and can be done via telephone (by phoning the Sensitive Claims Unit), or on completion of the form. The form lists the types of assistance available: medical treatment, elective surgery, return to work support, travel costs, lump sum for permanent impairment, independence allowance, home help, child care, personal care, weekly earnings compensation, equipment provision, home modifications, education support and training for independent living. Note – this will NOT cover replacement clothing but will, for example, cover taxi fares to and from medical appointments.

4. DSAC Ministry of Health Family Violence Intervention Contract

The DSAC Partner Abuse Intervention Trainers have continued to meet the Ministry of Health contractual requirements in terms of training delivery. Training figures over the period of the two contracts that DSAC has held are as per the table on page 2.

The contract has been renewed with an end date of 30th June 2010.

A Train the Trainers weekend had been scheduled to run in August but was postponed as a result of insufficient GPs and Practice Nurses applying to become trainers. Consequently we will run a second recruitment round with advertisements to be placed in NZ Doctor Magazine and Kai tiaki. We will aim to run the training early next year.

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5. The New Zealand Sexual Health 29th Annual Conference – 24th & 25th August 2007, Rotorua

A lunchtime session for sexual assault clinicians was facilitated by Christine Foley, Kristen Sorrenson and me. Twenty people attended. I provided a brief update on the sexual abuse assessment and treatment service. There was also some time spent discussing cases and identifying what sexual assault clinicians would like included in future NZ Sexual Health Conferences which respect to this area of work.

6. Meeting with Lauren Perry – Head of the Sexual Violence Taskforce Secretariat

Christine Foley and I met with Lauren Perry, Head of the Sexual Violence Taskforce Secretariat, and Kim McGregor, Director of Rape Prevention Education, on 16th August 2007. Kim was taking Lauren, who is Wellington-based,

around on a meet and greet tour of key sexual assault service providers in Auckland. Christine and I briefed Lauren on DSAC's role within the field of sexual violence.

Upcoming:

1. DSAC Annual General Meeting & Regional Liaison Doctors' Update – 2nd – 4th November 2007 – Wellington

This year's RLD Meeting/Peer Review format will run as per last year's meeting and will be held at WIPA, Wang House, Level 7, 195-201 Willis Street.

- The RLD Meeting will run over two days beginning at **10.00am on Friday, 2nd November**
- Peer Review will run over two days beginning at **1.30pm on Saturday, 3rd November**
- The Weekend Meeting will finish at **12.00pm on Sunday, 4th November**

With special thanks to
Image Centre,
34 Westmoreland Road West, Grey Lynn, Auckland
(09) 360 5700



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The AGM will be held on Friday, 2nd November at Carol Shand's House, 8 Braithwaite Street, Karori.

2. Next Visiting Speaker – Dr Marylene Cloitre

I am still working with Dr Cloitre to finalise possible dates for her to visit New Zealand as our guest speaker in 2008. Dr Cloitre comes highly recommended by John Briere.

Dr Cloitre is the founding director of the Institute for Trauma and Stress at the New York University Child Study Center, and the Cathy and Stephen Graham Professor of Child and Adolescent Psychiatry. Her book entitled "Treating Survivors of Childhood Abuse: Psychotherapy for the Interrupted Life" was published in 2006 and presents a "modular adult psychotherapy approach grounded in extensive clinical experience and research. Provided is a flexible, empirically supported framework for helping clients manage symptoms related to past physical or sexual abuse; build emotion regulation and interpersonal skills; and process traumatic memories and their associated feelings of fear, shame, and loss. Session-by-session guidelines include many suggestions for tailoring interventions to each person's needs in the context of a safe, supportive therapeutic environment."

Please contact the DSAC Office if you would like to be added to our mailing list in order to ensure that you receive further information about Dr Cloitre's seminars.

3. Initial Paediatric Training Course – Auckland 2008

In response to attendee feedback Dr Patrick Kelly has reviewed the programme and extended the course to run over four days instead of three. The programme content however will remain the same.

Dates – 1st – 4th April 2008.

Venue - Auckland Hospital, Auckland.

Please contact the DSAC Office if you are interested in receiving further information about this course, or to register your interest.

4. Advanced Paediatric Training Course – 1st – 3rd August 2008, Christchurch

The dates for the 2008 Advanced Paediatric Training Course have been confirmed for Friday 1st – Sunday 3rd August 2008. The Special Guest Speaker will be Lori Frasier MD – biography as follows:

Dr. Lori Frasier attended the University of Utah College of Medicine and completed a paediatric residency at the University of Washington. She was fellow at the Harborview Sexual Assault Center under Dr. Carole Jenny,

from 1988-90. Dr Frasier was on faculty of the Department of Paediatrics at the University of Iowa, from 1990-1995 establishing the sexual abuse evaluation clinic there, and participating in evaluations of physical abuse and neglect. From 1995-2002 she was on the faculty of the Department of Child Health at the University of Missouri-Columbia, Director of the Child Protection program there, and from 1994-2002 was the Medical Director of the Missouri SAFE-CARE Network a network of medical providers trained to provide medical evaluations to abused and neglected children. She is currently the Medical Director of the Medical Assessment Team at the Center for Safe and Healthy Families, Primary Children's Medical Center, Salt Lake City, Utah, and a Professor in the Department of Paediatrics at the University of Utah School of Medicine. She has published many articles and chapters in the field of child abuse and has lectured locally and nationally. She is the immediate past Chairman of the Executive Committee for the Section on Child Abuse and Neglect of the American Academy of Paediatrics and on the board of Directors of the American Professional Society on the Abuse of Children (APSAC). Dr. Frasier has been appointed to the American Board of Paediatrics, first sub board in Child Abuse Paediatrics.

Hayley Samuel
DSAC Manager



DSAC Accreditation News

New improved forms were finalised at a face-to-face meeting of the Accreditation Sub-committee meeting held in Christchurch on 29th July. It is hoped that they will be more user friendly and simplified so that all categories for adult, adolescent and child will use the same form. The committee is keen to encourage applicants and reduce barriers, so please make contact with us via the office if it all seems too hard. We will look at individual circumstances and are happy to be flexible in how the requirements are met.

Explanatory notes and advice about how to fill in sections of the form are attached to the back of the forms, please read them first. For the cases the photocopier does most of the work! Don't forget to send some indication of management i.e. page 10 of the MEK or any letters or notes indicating if you have treated or referred the patient eg to counselling or to their GP.

A subsequent teleconference meeting on the 7th August processed six new applicants for accreditation, and two for provisional accreditation. Congratulations to all those who applied and I hope the written feedback was useful.

Jane Batchelor
Chair of DSAC Sub-committee



Expert Witness Intensive - Dr Min Lo

This was a one day training course for expert witnesses run by The Australian College of Legal Medicine. It was run by Dr Roy Beran, Neurologist and President of the ACLM and three New Zealand lawyers; Lester Chism, high court judge, Bruce Corkill, barrister and David Collins, Solicitor General. The course was well represented by DSAC including Min Lo, Kristen Sorrenson, Rosie Brhanovic, Clare Healy, Jane Batchelor, Lynda Gray and Joan Leighton. Other attendees included a handful of PMOs, paediatricians and forensic psychiatrists.

The first part of the day consisted of didactic lectures on report writing, preparation for court and delivering evidence in court. The following are some of the things that I noted:

1. Roy Beran noted with amusement that the majority of reports submitted by DSAC doctors came from a similar template.
2. Keep a log book of reports and court appearances. It is sometimes useful to be able to tell the court how many times you have appeared to give evidence.
3. The new Evidence Act 2006 came into effect on 1 August 2007. The new Act will not impact noticeably on us as doctors. Rules on the admissibility of evidence are now more "relaxed" based on whether evidence will be of "substantial helpfulness". The Act legally allows what judges have already been doing in the past.
4. State that you have read and are familiar with the Code of Conduct for Expert Witnesses. This means that your duty as an expert is to the court and not to the party that has hired you.
5. In the report, provide a short bullet point history of the alleged events. Use the 3rd person.
6. It is vital to state your qualifications, memberships and publications. A young recently qualified doctor is just as able to give expert opinion as someone more

senior. This is where being up to date and having good knowledge of the literature is very important.

7. Preparation of the report is extremely important. Presentation, spelling and grammar must be correct. Always provide an opinion or list of weighted possibilities and your reasons for what is more likely. The report is useless without a conclusion and opinion.

8. Simplicity is the key and spoon feed the judge and jury. You want them to accept your opinion and they need to understand what you are saying. Therefore, speak slowly, be measured in what you say, be factual and defensible, don't use technical jargon and use whatever visual aids will be helpful.

The moot court session was held in the second half of the day and was an extremely challenging and enlightening exercise. All participants were required to submit a report which was marked, and each doctor was put on the stand and challenged in cross examination.

It was more intimidating to be 'put on the stand' in front of colleagues than to actually go to court. The value of practising your court room skills with skilled lawyers and a roomful of your peers cannot be underestimated. David Collins was extremely skilled in his cross examination and it was worth the cost of the registration fee just to watch him lead someone through a cross examination like a lamb to the slaughter.

His advice in cross examination is to:

- Remain calm
- Speak slowly
- Do not be evasive
- Be well prepared i.e. know your stuff and be ready for the specifics of each case for example bruises, non specific genital injuries, normal genital examination etc.

Dr Min Lo
DSAC Executive



Azithromycin

Remember that supplies of Azithromycin (Zithromax) are available for STI prophylaxis for any patient who is at risk of infection as a result of a sexual assault. The regime is absolutely simple 1G. stat. (2 x 500mg tabs)

PHARMAC is fully subsidizing this drug through DSAC and supplies are available from:

DSAC National Office, PO Box 90723, AUCKLAND

To order your supplies for the next 6-12 months you can either write, email: dsac@ihug.co.nz or fax: 09 376 0790



Ministry of Health Launch of Elder Abuse & Neglect Guidelines - Dr Faye Clark

Launch of Elder Abuse & Neglect Guidelines – Ministry of Health, Wellington, August 1st 2007

For Hayley Samuel, Kalash Deva and myself, fog at Auckland Airport did not help our timeliness of arrival for this event, which also saw the launch of a little book commissioned by Ministry of Health, “An Ounce of Prevention” featuring our own Rita Middleton recounting the difference being trained in enquiry about Partner Abuse can make in a consultation.

Other members of DSAC that attended included Kathy Lowe (ADHB), Russell Wills and Rita Middleton.



L - R Lyn Fairs (Social Worker, Te Puaruru), Dr Kalash Deva, Dr Faye Clark, Hayley Samuel

Being present for only the second half of the program meant we missed some good presentations including the Elder Abuse Guidelines official launch, but did see the results of research on Violence and New Zealand Young People presented following a population survey done in secondary schools by Terry Fleming, Dr Peter Watson et al in 2000 - which showed that one in five students had experienced unwanted sexual contact (26% of female students, 14% of male



Dr Kalash Deva and Dr Faye Clark - DSAC Partner Abuse Intervention Trainers (students), one in five did not feel safe at school, and one in six had seen a parent hurt their children in their home. Six percent witnessed adults being physically assaulted at home and reported this as particularly disturbing. This group had significantly increased rates of depression, suicidality and anxiety, and showed higher incidences of problem behaviour, substance abuse and relationship difficulties compared to those not witnessing violence between adults. Not surprising, but excellent to see this researched and published.

The document is worth reading at www.youth2000.ac.nz
The presentation by Kay Hyman, General Manager for Clinical Services at ADHB demonstrated what determined leadership can do for implementing positive attitudes and getting screening in place in an institutional setting.

Finally, it was a pleasure to see the more than 10 years of dedicated effort that Jo Elvidge has put into partner abuse recognition and intervention in the health sector recognised, despite her protestations at being honoured.

Faye Clark
DSAC Partner Abuse Intervention Trainer



David Wells' Comments on Injury Interpretation - Dr Min Lo

Use of the term “consistent with”

E.g. findings being consistent with rape or sexual assault.

This is a pet beef of mine. Many doctors feel that they are obliged to solve the case as a result of their examination; this is the role of the judge or jury.

Typically, practitioners conclude a report by saying “my findings are consistent with the allegations”. Now it might be that the findings could be the result of the allegations by the subject. Alternatively, however, there may be other explanations. It has been my experience that it is very rare for there to be only one possible explanation. By stating that “it is consistent with the allegations” one does not allude to the possibility of other explanations. Not infrequently this process is not tested adequately in the court process and investigators

and lawyers may be left with the sense that this was the one and only explanation.

Further, there is evidence to suggest that the words “consistent with” may be interpreted in a very different fashion by other parties. Results of a survey of jurors (from South Australia I think) suggested that their perception was that when a doctor said “consistent with” they interpreted this as “caused by”. This is clearly not what has been meant by the author.

As a solution to this, could I suggest that if you are keen to continue using “consistent with” that you at least record other possibilities that your findings could be “consistent with”. This might require you to weight these other possibilities (e.g., possible/highly unlikely/etc.). Alternatively you could conclude that (say a series of bruises) are “consistent with blunt trauma” but if

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that is the case why not just say that they are the result of blunt trauma.

One further flaw with this process is that usually you are only hearing one version of events, i.e., that of the complainant. We know that a large number of complainants modify their account largely because of their state of distress, intoxication, or because of some underlying cognitive dysfunction. Hence, in court, a slightly different version may be put forward and yet you have nailed your flag to the post by saying it is consistent with the version you were provided with.

As I mentioned, this is a personal crusade!

Putting aside the issue of “consistent with”, I would feel a little uncomfortable with the concept that a medical practitioner is in a position where they can decide where someone has been sexually assaulted or raped.

A significant component of an adult sexual assault or rape is the absence of consent. This is a crucial element in the proof of such a charge. As medical practitioners we are not in a position to be able to say that consent was absent and, hence, cannot conclude that a sexual assault occurred. Rape is not a medical diagnosis.

A solution might be that when dealing with genital injuries that you conclude by saying “there is objective evidence of blunt trauma to the (vaginal wall/hymen/inner aspect of the labia). This indicates that there has been penetration of the genitalia with a blunt implement that might include a penis, a finger or some inanimate object.”

Weighting

When you are assessing a series of possibilities in a report, it is reasonable that they should be weighted. Simply listing a series of symptoms or consequences does not leave the lay reader with any sense of likelihood. In these circumstances it would be quite reasonable to state that the following symptoms, (outcomes, causes etc) are likely, unlikely, improbable, highly improbable etc.

Remember that it is not your job to solve the case. I suspect this arises out of misplaced desire to help as we may all be guilty of as doctors. It might also be aggravated by watching a little too much crime television.

In many situations if all we can do is talk about issues around the application of blunt or sharp forces, then so

be it. There is no necessity to have to explain the exact cause of every single injury. It would be extraordinarily rare to be able to do this with any degree of confidence. In this case study, you could confidently state that there was evidence of multiple applications of blunt forces which were manifest by the presence of bruises and abrasions. One did not need to dissect each injury and say that (for instance) this was definitely a fingernail; this was definitely a hard object such as a stick etc.

Remember that in preparing these responses you need to be absolutely impartial. Many of the responses appeared to take the view that because you were being engaged by the Office of Public Prosecutions, then you should push the barrow of the prosecution case. This is not so. Your report should be exactly the same no matter who requests the advice; either prosecution or defence. When you have completed your draft report put yourself in the role of the “other side”. Would you see this report as being balanced, objective and lacking any evidence of bias?

Language

It is important that the reports you prepare can be understood by a lay audience. Whilst it may be reviewed by a fellow medical practitioner the bulk of the audience will be police, lawyers and other non-medical individuals. If you use medical terminology either explain the term in brackets following its use or alternatively in a glossary attached to the report, for example: scapula (shoulder blade), conjunctivae (white of the eye) etc.

Presentation of the report:

- * Presentation - clear documentation and bullet points etc.
- * Case background - this might include information about who requested the advice and what was requested, a summary of the history that was provided and the sources of that information.
- * Examination findings, the quality of the commentary, extent, appropriateness, pertinent negative and identification of material that may be missing.
- * Opinion. This will include:
 - a) Impartiality - the absence of any bias.
 - b) Objectivity - that is that the comments are based on the findings.
 - c) Scope - that all of the issues have been identified and addressed.

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- d) Limitations that is an acknowledgement of any limitations to the opinion.
- e) Weighting - that is a consideration of other explanation for the findings.

before washing as the blood may not necessarily belong to the owner of the hand.)

Internal Injuries

Caution is required when commenting about the possibility of internal injuries from photographs.

Describing injuries from photographs

Always be prepared to comment on the quality of photographs in any case in which you are involved.

Wound Depth

It is generally not possible to comment on the depth of a wound in a clinical setting let alone from a photograph.

Blood

Be cautious in describing injuries that are obscured by blood. There may be no underlying injury or there may be other significant injuries that are covered by blood staining. The ideal would be that a photograph is taken before and after blood staining is cleaned although this is not always practicable. (Remember to swab the hand

Measurements

Unless a scale is provided, you can only speculate about the size of an injury.

*Collated by Dr Min Lo
DSAC Executive*



THE MEDICAL MANAGEMENT OF SEXUAL ABUSE SIXTH EDITION 2006

The DSAC training manual is a resource for medical health professionals who provide medical care for victims of sexual assault. It is a supplement to the DSAC training courses in medical management of sexual assault and represents a collation of current thinking in this field of medicine, from both local and international sources.

The 6th edition is significantly different from the 5th edition and has been reorganised into 3 main sections. Not all subsections have been fully updated for this edition and these will be added to the online manual as they emerge. Until all sections have been updated, some cross referencing will be inaccurate.

Section A contains practical guidelines for forensic examination and medical care of adult victims of sexual assault. For ease of use, references have been kept to a minimum. Forms and templates that can be used in your clinical situation are marked with a printer icon.

Section B contains guidelines for children and adolescents.

Section C contains important reference material.

Note that previous appendices are now included in the main body of each individual section.

The technology of the Web will allow DSAC to regularly up-date sections in response to new knowledge. Users can browse and download in print individual chapters as they wish.

Visit **www.dsac.org.nz**

Access to it is by purchasing an individual user name and number through the DSAC office.

Annual access fees include GST.

	Online	Hardcopy
Individual paid-up DSAC Members	\$40.00	\$80.00
Individual non DSAC Members	\$100.00	\$140.00
Medical Institution	Price on Request	\$140.00
Non-Medical Institution	Price on Request	\$140.00

Contact Details: DSAC, 5/4 Warnock Street, Grey Lynn, PO Box 90723, Auckland Ph: (09) 376 1422
Fax: (09) 376 0790 email: dsac@ihug.co.nz Website: www.dsac.org.nz

DSAC Diary of Events 2007/2008

DSAC is a RNZCGP CME Registered Special Interest Group

For all events apply to: DSAC National Office PO Box 90723, AUCKLAND, 5/4 Warnock St, Grey Lynn, AUCKLAND Tel: (09) 376 1422 Fax (09) 376 0790 email: dsac@ihug.co.nz website: www.dsac.org.nz

DSAC AGM - 2007

Venue:

Carol Shand's House, 8 Braithwaite St, Karori, Wellington

Time & Date:

6.30pm - Friday 2nd November 2007

DSAC INITIAL PAEDIATRIC TRAINING COURSE 2008

in the

MEDICAL ASSESSMENT OF SEXUALLY ABUSED CHILDREN AND ADOLESCENTS

Dates: 1-4 April 2008

Venue: Auckland Hospital
Auckland



ADVANCE NOTICE!

PUT THESE DATES IN YOUR DIARY FOR 2008!

Advanced Paediatric Training Course

Christchurch

1st - 3rd August 2008

Venue: To Be Advised

Special Guest Speaker

Lori Frasier MD

Dr. Lori Frasier attended the University Of Utah College Of Medicine and completed a pediatric residency at the University of Washington. She was fellow at the Harborview Sexual Assault Center under Dr. Carole Jenny, from 1988-90. Dr Frasier was on faculty of the Department of Pediatrics at the University of Iowa, from 1990-1995 establishing the sexual abuse evaluation clinic there, and participating in evaluations of physical abuse and neglect. From 1995-2002 she was on the faculty of the Department of Child Health at the University of Missouri-Columbia, Director of the Child Protection program there, and from 1994-2002 was the Medical Director of the Missouri SAFE-CARE Network a network of medical providers trained to provide medical evaluations to abused and neglected children. She is currently the Medical Director of the Medical Assessment Team at the Center for Safe and Healthy Families, Primary Children's Medical Center, Salt Lake City, Utah, and a Professor in the Dept. of Pediatrics at the University Of Utah School Of Medicine. She has published many articles and chapters in the field of child abuse and has lectured locally and nationally. She is the immediate past Chairman of the Executive Committee for the Section on Child Abuse and Neglect of the American Academy of Pediatrics and on the board of Directors of the American Professional Society on the Abuse of Children (APSAC). Dr. Frasier has been appointed to the American Board of Pediatrics, first sub board in Child Abuse Pediatrics.

LETTERS TO THE EDITORS

Letters to the Editors can be submitted, although publication, editing and abbreviation are at the Editors' discretion. While the principle of 'right of reply' to articles and letters published in the Newsletter is accepted, this right is not automatically granted and is subject to Editorial discretion and the limitations of space - DSAC news and information have priority. All letters submitted must include appropriate contact details and email submissions are preferable so as to reduce the possibility of error in transcription.

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