



SAFE-CHOICE

Sexual Assault & Forensic Examination — Collaborative Hybrid Oversight in Clinical Encounters

Enabling timely access to the right forensic medical response while strengthening sector capability

Submission to the consultation on the Second Action Plan

National Plan to End Violence against Women and Children 2022–2032

[REDACTED]
Senior Forensic Physician

[REDACTED]
Senior Forensic Physician

[REDACTED]
Australian Clinical Forensic Medicine Alliance

31 July 2026

Subject: Technology-assisted, specialist-supported forensic medical advice and examination

Executive summary

THE PROPOSAL

Commonwealth support for a Stage 1 pilot of SAFE-CHOICE, a hybrid synchronous model placing a specialist clinical forensic physician alongside the frontline practitioner, in real time, at the point of care.

This submission responds to Evidence to action: informing direction for the Second Action Plan (ANROWS and the Department of Social Services, May 2026). SAFE-CHOICE was designed by forensic physicians — the doctors responsible for conducting and overseeing forensic medical examinations and, where required, presenting their findings in court as expert witnesses.

The platform is supported by the Faculty of Clinical Forensic Medicine of the Royal College of Pathologists of Australasia, Forensic and Medical Sexual Assault Clinicians Australia, and the Department of Forensic Medicine at Monash University.

CENTRAL PROPOSITION

The problem is not simply access to an examination. It is access to the right forensic response: clinically safe, forensically sound, trauma-informed, proportionate and capable of withstanding later justice scrutiny.

Part A — Summary and recommendations

1. This submission addresses a specific and remediable failure of system integration — one named repeatedly across the consultation paper's evidence review but not yet the subject of a national action. Most Australians who disclose domestic, family or sexual violence outside a small number of metropolitan centres cannot access a specialist forensic medical response, or the medico-legal expert opinion that follows from it, within a forensically relevant timeframe. The specialist workforce is small, thinly distributed and concentrated in capital cities. There is no nationally consistent framework for minimum standards of clinical forensic practice, practitioner credentialling, evidence documentation, forensic photography and storage, specialist oversight or medico-legal reporting. The populations at greatest risk — rural and remote communities, and Aboriginal and Torres Strait Islander women in particular — are precisely those furthest from the existing services.
2. The central problem is not simply access to an examination. It is access to the *right* forensic response. A full forensic medical examination is not indicated in every presentation. Undertaking one without specialist triage may expose a victim-survivor to avoidable distress, create unrealistic expectations about evidentiary outcomes and risk further traumatisation. Conversely, a specimen collected without trained oversight, that is not processed, or for which no expert opinion is available downstream, is worse than no specimen: it consumes resources, raises false hope, and on the criminal standard of proof can be turned against the case it was meant to support. Access to examination is therefore the right entry point for national policy, but examination counts are not a useful outcome measure. The meaningful outcome is the right response, at the right time, with defensible forensic practice and the expert capacity to carry the case through the justice system.

3. The response proposed is SAFE-CHOICE: a purpose-designed, secure digital platform enabling hybrid synchronous clinical oversight. A trained frontline practitioner — a general practitioner, nurse, midwife, Aboriginal health practitioner, remote area nurse or emergency clinician, local to the patient — conducts the face-to-face encounter while a specialist clinical forensic medicine doctor participates in real time by secure video: triaging whether an examination is indicated, discussing risk, benefit and expected forensic yield with the patient directly, guiding history-taking and examination where one proceeds, assuring the quality of specimen collection, injury documentation and clinical photography as it occurs, and then assuming carriage of the medico-legal report, the expert opinion and any evidence in court. This is not standard telehealth: the remote expert is effectively in the room — the local practitioner provides the hands, guided by the specialist's eyes and expertise.

4. The supervisory architecture is established Australian practice. It is the working model of the Newborn and Paediatric Emergency Transport Service (NETS) in New South Wales, the Paediatric Infant Perinatal Emergency Retrieval (PIPER) service in Victoria and Adult Retrieval Victoria — mature, government-funded services in which a senior specialist, available around the clock, holds real-time clinical control of care delivered by frontline teams at the most remote sites in the country. SAFE-CHOICE applies the same architecture, on the same foundations — a continental geography, a thin specialist workforce, and a population that should not be disadvantaged by where it lives — to clinical forensic medicine.

A PROVEN AUSTRALIAN ARCHITECTURE

NETS, PIPER and Adult Retrieval Victoria already deliver specialist-supervised frontline care to the most remote sites in Australia. The Second Action Plan does not need to prove a new model. It needs to apply an accepted one to a discipline that has not yet received it.

5. The model builds capability within existing services rather than creating a parallel system. Where an in-person specialist service is available within a forensically relevant timeframe, that service remains the default pathway; the hybrid model operates where the alternative is not an in-person specialist examination but no specialist examination at all, and existing jurisdictional forensic and sexual assault services can themselves use the platform to support their regional networks. Non-diversion from existing bricks-and-mortar services should be an explicit design condition of any national action.

6. The consultation paper reports that sexual violence has not declined nationally since 2005, that sexual violence responses remain siloed from the domestic violence service system, and that up to one third of Australians mistrust women's reports of sexual violence. Contemporaneous, specialist-supervised forensic documentation addresses each of these directly: it is the mechanism by which a complainant's account is corroborated by objective clinical evidence rather than tested against community attitudes. The same infrastructure serves the full spectrum of domestic, family and sexual violence — non-fatal strangulation, physical injury in intimate partner violence, and coercive control patterns evidenced through structured documentation over time — which is why a differentiated sexual violence strategy and an integrated service platform are complements, not alternatives.

7. Each encounter generates a structured, standardised, audit-locked clinical record. Aggregated under defined governance and explicit patient consent, this constitutes a national sentinel surveillance capability for domestic, family and sexual violence — directly responsive to the data and

measurement gaps identified throughout the consultation paper, and alignable with the AIHW Family, Domestic and Sexual Violence Integrated Data System now in development.

8. ACFMA seeks Commonwealth support for a Stage 1 pilot covering software customisation, security and usability testing, clinical governance development, stakeholder co-design and pilot readiness, with the pilot pathway — a state-based regional network, Commonwealth-supported Urgent Care Clinics, Primary Health Network and general practice sites, enhancement of existing jurisdictional forensic services, or a mixed priority-area cohort — selected during the design phase with Commonwealth, jurisdictional, clinical, DFSV, First Nations and justice partners.

Recommendations

Recommendation 1 Include, under Priority Area 5 (System Integration and Workforce), a national action on equitable access to specialist clinical forensic medicine, with the availability of the right forensic response — timely, proportionate, court-admissible examination where indicated, and downstream medico-legal expert opinion — rather than examination counts as the outcome measure.

Recommendation 2 Approve and co-fund a Stage 1 SAFE-CHOICE pilot covering software customisation and testing, clinical governance, co-design and pilot readiness, with the pilot pathway selected during the design phase, integration with existing jurisdictional forensic and sexual assault services under their clinical governance, and an explicit non-diversion condition.

Recommendation 3 Require that the medico-legal admissibility architecture — the respective evidentiary roles of the frontline and supervising practitioners, chain of custody for specimens and digital images, authentication of the electronic record, and qualification of the remote specialist as the expert witness — be settled in writing with the relevant Director of Public Prosecutions before first patient contact, as a precondition of deployment rather than a matter for post-hoc evaluation.

Recommendation 4 Develop a nationally consistent framework for minimum standards of clinical forensic practice, practitioner credentialling, evidence documentation, forensic photography and storage, specialist oversight and medico-legal reporting, on the model of existing specialty-college quality programmes.

Recommendation 5 Progress national standardisation of forensic medical examination data, aligned with the AIHW Family, Domestic and Sexual Violence Integrated Data System, so that examination records contribute to national measurement of strangulation, coercive control, weapon use and repeat victimisation under defined governance and consent.

Recommendation 6 Resource First Nations co-design of any hybrid forensic pathway as a separate, dedicated workstream under Our Ways – Strong Ways – Our Voices, led through Aboriginal Community Controlled Health Organisations, with data governance consistent with Indigenous data sovereignty principles.

Recommendation 7 Recognise and invest in the latent frontline forensic workforce — general practitioners, remote area nurses, midwives, Aboriginal health practitioners and emergency clinicians willing to undertake supervised forensic work — including

structured training, credentialling, remuneration, vicarious trauma support and routine debriefing, and preserve reporting pathways that do not require police involvement so that victim-survivors retain choice over if, and when, the justice system is engaged.

Recommendation 8 Commission an evaluation framework measuring access, equity, appropriateness, clinical safety, forensic quality, victim-survivor experience, workforce outcomes and justice readiness — including prospective research on admissibility, prosecution and court outcomes, which the international teleforensic literature identifies as its single largest evidence gap.

Part B — Response to the consultation

1. The service gap the Second Action Plan should name

9. Clinical forensic medicine — the examination of victim-survivors and alleged offenders, the documentation of injury, the collection of forensic specimens, the preparation of medico-legal reports and the giving of expert evidence — is among the smallest medical disciplines in Australia. The specialist workforce is concentrated in capital-city services, and service arrangements vary markedly by jurisdiction. Outside those centres, a person disclosing sexual violence may face a choice between travelling hundreds of kilometres within the forensic sampling window — often unaccompanied, without showering or changing clothes, immediately after an assault — or forgoing forensic examination altogether. Many forgo it. The consultation paper's own evidence review identifies rural and remote populations as a group for whom monitoring is inadequate and access barriers persistent; the forensic examination gap is one of the most concrete of those barriers, and one of the least discussed.

10. Where examination does occur locally, it is frequently performed by a clinician who is not qualified or credentialled to provide expert opinion evidence downstream. The case is then transferred to a second clinician, asked to interpret an examination they did not conduct on a patient they never met. The evidentiary and ethical weaknesses of that arrangement are obvious, and the victim-survivor is rarely aware of them at the time of consent. For the frontline clinician, the prospect of being subpoenaed years later as an unsupported witness is a well-recognised deterrent to engaging in forensic work at all. That reluctance is rational under current arrangements, and it will not be resolved by exhortation; it requires a structural answer to the question of who carries the case.

11. Several jurisdictions have sought to close the access gap by training larger numbers of non-specialist clinicians through short courses. This may increase nominal access, but short-course training alone cannot create sustainable forensic capability, particularly in low-volume settings where a clinician may perform one examination a year. Forensic care requires more than sample collection: trauma-informed history-taking, assessment of whether an examination is indicated at all, knowledge of DNA and toxicology collection windows, recognition of injury patterns and non-fatal strangulation, secure forensic photography, structured documentation, peer review and expert interpretation. Without real-time specialist input, an isolated trained clinician may miss important forensic opportunities or undertake examinations unlikely to assist the patient or the justice process. Either outcome causes harm.

12. The justice-system consequences run in parallel. The consultation paper reports that up to one third of Australians mistrust women's reports of sexual violence, and that roughly one in four believe allegations are made from regret or retaliation. Whatever else is done to shift those attitudes, the practical protection for an individual complainant is contemporaneous, objective, specialist-quality clinical documentation. Non-fatal strangulation illustrates the point: in the largest Australian clinical series, external physical signs were absent in 49 per cent of strangulation cases, and strangulation was strongly associated with intimate partner violence. Findings of that kind are captured, or lost, at the first examination. There is no later opportunity.

13. In combination, these failures create five linked risks: an access risk (travel and delay discourage presentation); a quality risk (subtle but important findings are missed by clinicians with limited training, case exposure or support); an appropriateness risk (examinations proceed when not indicated, causing avoidable distress and false expectations); a justice risk (poor documentation, absent photography, incomplete sampling or a dislocated expert weaken later proceedings and compound trauma); and a workforce risk (infrequent providers feel exposed to medico-legal risk and psychological burden, contributing to attrition). A national response must address all five together. Improving access while degrading appropriateness or justice readiness is not progress.

2. The SAFE-CHOICE model

14. SAFE-CHOICE pairs two clinicians in a single encounter on a secure, purpose-designed platform. The frontline practitioner — local to the patient, face to face, the 'hands' — conducts the consultation. The specialist clinical forensic doctor — remote, connected by secure synchronous video, the 'eyes' — is effectively in the room: triaging, advising, participating directly in the consultation with the patient's consent, assuring quality in real time rather than retrospectively, and then assuming carriage of the case through the justice system. A specialist trauma counsellor can join the same encounter and remain the patient's counsellor through telehealth thereafter, wherever the patient moves — continuity that removes the retelling of the account to a succession of strangers.

15. The model supports assessment of whether a forensic medical examination is indicated; discussion of risk, benefit and expected forensic yield with the patient before anything proceeds; guided history-taking and live examination support where appropriate; targeted injury documentation, secure forensic photography and structured evidence collection; clinical risk identification, including direct questioning on non-fatal strangulation; and medico-legal reporting, downstream expert interpretation and warm referral to health, safety, counselling, legal and support services. The right response may be a full synchronous examination with downstream court carriage; targeted documentation or early evidence collection; medical care, safety assessment and referral; or no forensic examination at all, where the presentation is beyond the timeframe likely to yield benefit — in which case the patient receives trauma-informed health care and psychological support, and is spared an intrusive procedure that would have served no one. In every case the options are discussed between the patient, the local clinician and the forensic expert, in real time, at the point of care.

16. Three design conditions attach. First, non-diversion: the model extends the reach of existing services under their clinical governance and does not compete with them; existing jurisdictional forensic services can themselves operate the platform to support their regional networks and emergency departments. Second, victim choice is preserved at every point — police report, medical care only, or evidence collected and stored pending a later decision — because the decision to engage the justice system belongs to the victim-survivor and to no one else. Third, quality is assured structurally: credentialled node sites with private clinical space, approved imaging and secure connectivity; a credentialled local workforce; documentation, evidence-handling, photography, storage, review and reporting processes under written governance; and audit, case review, supervision and incident management built in.

DESIGN CONDITION — NON-DIVERSION

Where an in-person specialist service is available within a forensically relevant timeframe, that service remains the default pathway. The hybrid model operates where the alternative is not an in-person specialist examination but no specialist examination at all.

3. Priority Area 1 — Victim-survivors

17. The consultation asks what would make the biggest difference to victim-survivors' safety and access to justice, and what barriers prevent people from seeking help. For the population this submission concerns, the barrier is not primarily attitudinal: the service does not exist where they are. A midwife at a regional hospital, a general practitioner at an Aboriginal Medical Service or a sexual health nurse receiving a disclosure currently has no forensic pathway to offer that does not involve long-distance travel at the worst moment of a person's life. Hybrid oversight converts the practitioner the patient has already chosen to trust into the point of specialist care — close to home, on Country, or within a trusted local health setting.

18. The model also materially widens choice for victim-survivors whose barriers are cultural or personal rather than geographic: examination by a known local practitioner, of a preferred gender, in a familiar setting, with a remote specialist rather than a second stranger in the room; medical care and stored evidence without any police involvement; and one counsellor across the entire episode of care. Each of these is repeatedly identified in the victim-survivor literature as determinative of whether help is sought at all. None requires the patient to compromise on the forensic quality of the response — and the triage function protects patients from the opposite failure, the low-yield examination undertaken because no one present had the expertise to advise against it.

19. On coercive control and technology-facilitated abuse, which the consultation paper nominates as emerging priorities, the contribution of forensic medicine is evidentiary. Coercive control is prosecuted, where it is prosecuted, on patterns — and patterns are built from structured, dated, well-documented clinical encounters. A standardised national examination record that captures strangulation, injury morphology, weapon involvement and the clinical features of controlling behaviour at every presentation, wherever it occurs, is infrastructure for the recognition of coercive control in exactly the sense the paper calls for.

4. Priority Area 2 — Prevention and early intervention

20. A forensic response model is not a primary prevention measure, and this submission does not present it as one. Its contribution to this priority area is narrower and real: more victim-survivors disclose to a health professional than to police or to a counselling line, which makes the universal health workforce the earliest formal identification surface the system has. A model that gives that workforce an immediate, twenty-four-hour connection to specialist forensic and family-violence expertise at the moment of disclosure — including specialist-supported questioning that surfaces high-risk features such as non-fatal strangulation, which patients rarely volunteer and generalists rarely ask about — strengthens early intervention at the point where the evidence says it is most likely to occur. It also relieves the frontline clinician of the choice between acting beyond their competence and not acting at all, which is the choice that currently suppresses engagement.

5. Priority Area 3 — Children and young people in their own right

21. Paediatric forensic medicine is a distinct sub-specialty with its own examination standards, consent complexities and workforce, and an initial deployment should be scoped to adults and older adolescents under existing jurisdictional protocols. Two interfaces nonetheless matter for this priority area. First, a structured examination record that routinely captures the presence and circumstances of children in the household converts every adult encounter into an identification opportunity for children experiencing violence — the consultation paper's finding that 377,000 adults experiencing partner violence had children in the home underlines what is currently invisible to the system. Second, the supervisory architecture is, in principle, extensible to paediatric forensic services facing the same geographic maldistribution, and should be evaluated with that extension in view, under paediatric specialist governance.

6. Priority Area 4 — People who use violence

22. Accountability for people who use violence rests, in the justice system, on the quality of evidence. The consultation paper reports positive trends in policing and prosecution of domestic and family violence; the constraint on that trend in regional Australia is increasingly evidentiary rather than attitudinal. Specialist-supervised examination raises the floor of evidence quality wherever the complainant presents, reduces the extent to which prosecutions depend on the complainant's testimony alone — a particular burden given documented community mistrust of women's reports — and supplies, from the outset, the expert witness the matter will eventually require. Clinical forensic medicine also carries responsibility for the examination of alleged offenders in custody; the same workforce shortage constrains that function, and the same supervisory architecture is applicable to it.

7. Priority Area 5 — System integration and workforce

23. This is the priority area to which the submission is principally addressed. On workforce, the arithmetic is the argument. The specialist clinical forensic workforce cannot be scaled to national geographic coverage within any realistic planning horizon; the training pipeline is long and the discipline small. What can be scaled is the reach of each specialist. Under hybrid oversight, one specialist on a roster supports encounters across an entire jurisdiction in a shift, while the face-to-face work is performed by a much larger latent workforce — general practitioners, remote area nurses, midwives, Aboriginal health practitioners, emergency clinicians — many of whom are willing to undertake forensic work if, and only if, they are trained, credentialled, supervised, remunerated and not left holding the medico-legal consequences alone. The transfer of downstream carriage to the specialist is the single design feature that unlocks that workforce, because it answers the deterrent identified at paragraph 10.

24. Workforce sustainability cuts both ways, and the consultation paper is right to name vicarious trauma. A structured model creates the occasion for what ad-hoc arrangements omit: routine post-encounter debriefing of the frontline practitioner by the specialist, peer review of documentation, and a supervisory relationship in which the frontline clinician is never the most senior person responsible for a traumatic case. These are retention measures as much as quality measures. The absence of any nationally consistent credentialling framework for this work is itself a Second Action Plan opportunity: a national standard, developed with the specialty colleges and jurisdictions on the

model of existing college quality programmes, would give the latent workforce a recognised pathway and give governments a common quality floor.

25. On integration and data, every encounter under the model produces a structured, standardised, audit-locked record — the same fields, the same definitions, the same quality assurance, whether the encounter occurs in a capital-city service or a remote clinic. The consultation paper devotes sustained attention to the weakness of national measurement: inconsistent capture of strangulation and coercive control, poor visibility of repeat victimisation, and administrative data that cannot be integrated. A standardised national examination record, contributed under defined governance and explicit patient consent to the AIHW Family, Domestic and Sexual Violence Integrated Data System, addresses this at the point of origin rather than by later reconciliation. It would permit, for the first time, characterisation of clinically presenting violence by what is observed across all doors at once rather than what is brought through one door — a sentinel surveillance capability for emerging patterns, targeted resourcing, and the evaluation of the National Plan itself. Fifteen years of Western Australian experience with a structured, clinician-entered forensic examination database, and the internationally cited research programme built on it, demonstrate both the feasibility and the yield of this approach.

8. Aboriginal and Torres Strait Islander communities

26. Aboriginal and Torres Strait Islander women are hospitalised for assault-related injury at thirty-two times the rate of non-Indigenous women, and the consultation paper documents both the inadequacy of policing responses and the rational reluctance of many Aboriginal women to engage systems associated with child removal and victim misidentification. A forensic pathway delivered on Country, through the health service and practitioners a community already knows — an Aboriginal Medical Service general practitioner, nurse or Aboriginal health practitioner, supported remotely — with the explicit option of medical care and stored evidence without police involvement, is responsive to precisely the failures the paper documents. It must not, however, be designed for communities and delivered to them. Any First Nations implementation should be a separately resourced co-design workstream under Our Ways – Strong Ways – Our Voices, led through Aboriginal Community Controlled Health Organisations, with community-controlled decisions on participation and data governance consistent with Indigenous data sovereignty principles, including the Maïam nayri Wingara principles. That workstream should be funded as such, not absorbed as an implementation detail of a mainstream pilot.

9. The Stage 1 pilot — pathways, sequencing and the Commonwealth role

27. ACFMA proposes a Stage 1 pilot to finalise the service model, governance, technology, workforce and justice pathways required for safe implementation, covering software customisation, security and usability testing, clinical governance development, documentation and reporting templates, stakeholder co-design and pilot readiness. Costings should be settled during the design phase once the pathway and site cohort are agreed. Five delivery pathways are open, singly or in combination, and the choice should follow a short design phase with Commonwealth, jurisdictional, clinical, DFSV, First Nations and justice partners:

Pathway	Model	Best suited to
State-based pilot	Single-jurisdiction pilot across defined regional and remote sites (Western Australia proposed), under the governance of the existing state forensic and sexual assault service	Testing jurisdiction-wide integration across a large geography with clear clinical governance and controlled evaluation
Urgent Care Clinic pilot	Selected Commonwealth-supported Urgent Care Clinics in priority regions	Acute, unscheduled presentations; builds on existing Commonwealth investment as a rapid health-led pathway
Primary care / PHN pilot	Selected general practices or Primary Health Network-supported sites	Early disclosure in trusted local settings; scalable; supports non-police-dependent access
Forensic service enhancement	Platform operated by existing state and territory forensic services to support their regional clinicians and emergency departments	Strengthening current forensic networks; avoids duplication; supports low-volume providers and may reduce transfers
Hybrid priority-area model	Mixed cohort of urgent care, general practice, regional hospital, ACCHO and forensic service sites	Areas of highest unmet need; targets rurality, cultural safety and workforce gaps under a common evaluation framework

ACCHO = Aboriginal Community Controlled Health Organisation; PHN = Primary Health Network

28. Among these pathways, Commonwealth-supported Urgent Care Clinics warrant particular attention. They operate extended hours, accept walk-in presentations, and see precisely the acute, unscheduled injuries through which domestic, family and sexual violence first surfaces in the health system — making them a key setting in which presentations that would otherwise pass unrecognised and unrecorded could be captured. Their episodic, time-constrained model of care will not accommodate a full forensic medical examination in every case, and it need not: under specialist triage, Urgent Care Clinic sites could be developed to deliver a modified, targeted forensic examination — injury documentation, secure forensic photography and time-critical early evidence collection — with escalation or warm referral to a full examination pathway where indicated. This is the proportionate-response principle applied to the setting where acute presentations already arrive.

29. Western Australia presents the strongest first-mover case for a state-based pathway: the largest geographic maldistribution burden in the country, an established state-wide specialist sexual assault service, a mature emergency telehealth service into which the model can integrate, and a fifteen-year academic record in structured forensic examination data. The observations in this submission, however, do not depend on the choice of jurisdiction or pathway.

30. One sequencing condition warrants emphasis because it is easily deferred and ruinous if deferred. The admissibility architecture — the respective evidentiary roles of the frontline and supervising practitioners, chain of custody for specimens and digital images, authentication of the electronic record, and the qualification of the remote specialist as the expert witness — must be settled in writing with the relevant Director of Public Prosecutions before the first patient is

examined. The international teleforensic literature, spanning two decades of teleSANE programmes in North America, consistently reports improved evidence-collection quality and frontline clinician confidence under remote specialist supervision, but identifies the absence of legal-outcome data as its most serious gap. An Australian implementation that resolves admissibility prospectively, and then measures prosecution and court outcomes, would make a contribution of international significance while protecting the first patients from bearing that uncertainty.

HARD PREREQUISITE — MEDICO-LEGAL ADMISSIBILITY

The admissibility architecture must be settled in writing with the relevant Director of Public Prosecutions before the first patient is examined. This is a precondition of deployment, not a matter for post-hoc evaluation.

31. Evaluation should not be measured by examination numbers alone. The pilot must test whether victim-survivors receive the right response, at the right time, with safe care and defensible forensic practice: access and equity (time to specialist advice, travel avoided, regional and cultural reach, police and non-police entry); appropriateness (the distribution of full examinations, targeted responses, referrals and decisions not to examine, with reasons recorded); clinical safety, including strangulation identification and escalation; forensic quality (documentation completeness, photography, sampling, chain-of-custody compliance, specialist review); victim-survivor experience, assessed by trauma-informed methods; workforce confidence, supervision and retention; system integration; and justice readiness — timeliness and quality of medico-legal reporting and expert carriage, not conviction rates alone.

EVALUATION PRINCIPLE

Success should not be measured by examination numbers. The pilot must test whether victim-survivors receive the right response, at the right time, with safe care and defensible forensic practice.

32. The Commonwealth's role is the one it already occupies: national entry-point infrastructure, with 1800RESPECT the natural front door through which a frontline clinician anywhere in the country reaches the service; co-funding of the Stage 1 pilot alongside the lead jurisdiction; support for integration with Primary Health Networks, Urgent Care Clinics, state and territory forensic and sexual assault services, and police and justice stakeholders; custodianship of the national data standard in partnership with the AIHW; and evaluation. The states hold clinical governance and service delivery, as they should. The Second Action Plan is the instrument through which those roles can be aligned, and its five-year horizon is sufficient to take the model from Stage 1 pilot to an evaluated national capability.

33. ACFMA would welcome the opportunity to brief the Department on any aspect of this submission, including a live demonstration of the platform and the supporting evidence review of the international teleforensic literature. A worked illustration of the model against current-state pathways is at Appendix A.

Appendix A — Example in practice: Sarah's forensic medical response

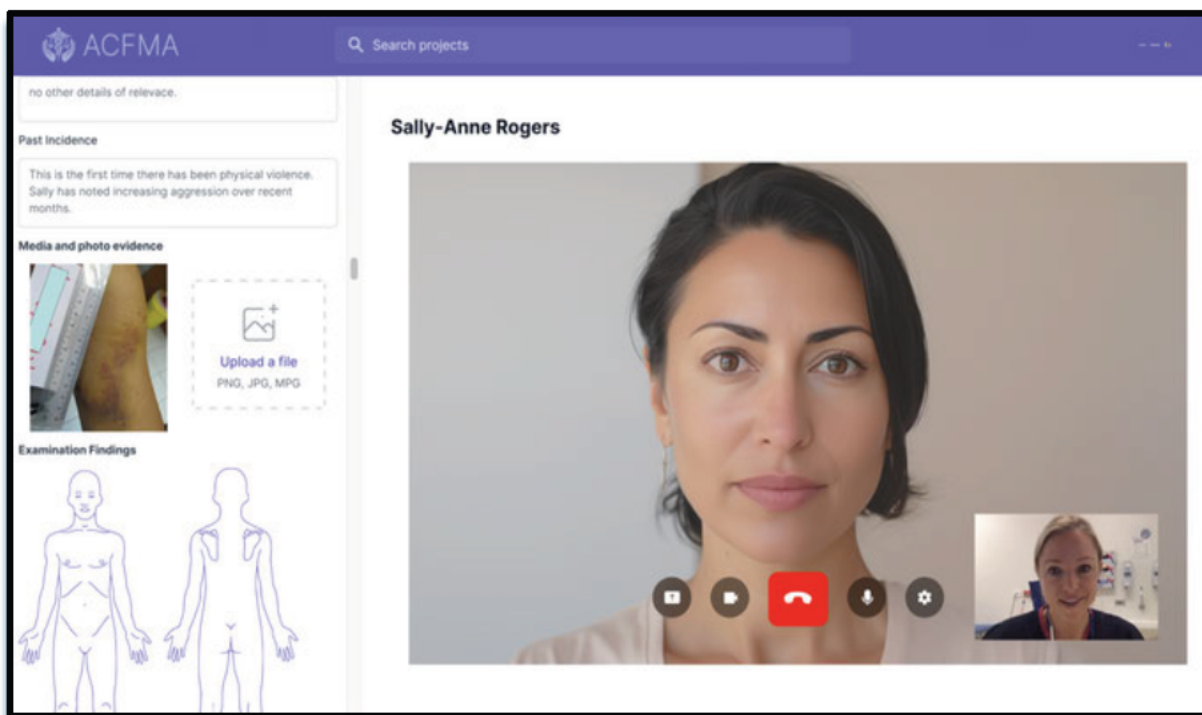
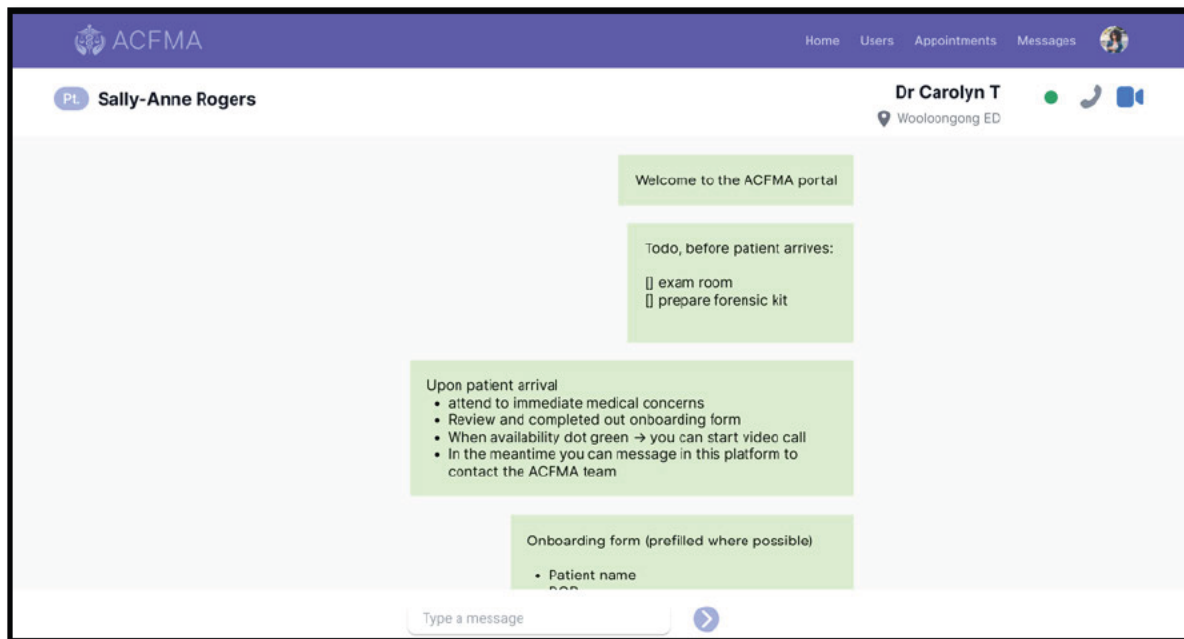
Sarah, 38, attends a rural urgent care clinic near her farm. Earlier that morning, her former husband punched her, struck her repeatedly across the back with a garden hose and sexually assaulted her. She has facial and back bruising. One week earlier he strangled her, but she does not realise this is relevant and is not directly asked. Her children are at preschool and she must collect them before 3 pm.

Stage	Current state	With SAFE-CHOICE
Presentation and disclosure	The GP confirms Sarah is not acutely unwell but has limited experience in this area. Sarah feels awkward because the GP previously played football with her former husband, and is reluctant to disclose detail.	The GP responds supportively. Sarah chooses to speak with Maddie, the female practice nurse, who has completed accredited training and can be supported synchronously.
Access and choice	Pathway A: Sarah is encouraged to contact police and travel approximately four hours each way to the capital for an examination, without showering or changing clothes. She has nobody to collect her children and cannot proceed. Pathway B: she is referred to a regional hospital two hours away, where the on-call examiner has completed a short course but has never performed a live speculum examination.	Maddie activates SAFE-CHOICE from the local clinic. The remote forensic doctor joins in real time, explains options and likely forensic value, and supports Sarah to make an informed choice without requiring police involvement or metropolitan travel.
Risk recognition	In both current-state pathways, strangulation is not directly explored. Sarah's elevated risk of serious harm or death remains unrecognised and unaddressed.	The specialist asks directly about strangulation. Sarah learns why it matters, recognises the seriousness of her situation, and receives assessment, safety information and appropriate escalation for ongoing symptoms.
Examination and evidence	In Pathway B, the inexperienced examiner is advised to collect a blind high vaginal swab without speculum examination. Vaginal bruising and discharge are not seen or documented. Facial and back bruising are described but not photographed — there is no approved camera or secure image storage. The tramline pattern is not recognised.	Under specialist guidance, Maddie completes a synchronous forensic medical examination using the clinic's kit. Injuries are documented and securely photographed. A small genital abrasion is identified and appropriate DNA samples are collected. The specialist supports interpretation and quality in real time.
Support and follow-up	Sarah leaves without a practical local forensic pathway. The barriers and poor experience reduce the likelihood that she will return after further violence.	Maddie provides warm referrals through the platform. Sarah chooses to make a police statement the next day. She can shower, collect her children and remain connected with local health, counselling and safety supports.
One year later	Where no examination occurred, evidentiary opportunities were lost. Where the limited examination occurred, injury	The forensic doctor provides expert evidence. The documented 'tramline' wraparound bruising is consistent with

Stage	Current state	With SAFE-CHOICE
	interpretation, genital findings and photographic evidence are unavailable, and the later expert never met or examined Sarah.	impact from a flexible hose. The vaginal DNA profile matches Sarah's former husband. The findings are presented with appropriate limitations and clinical context.

Illustrative composite scenario prepared by ACFMA. The name and circumstances are fictional and are included to demonstrate system pathways, not to identify any person.

Appendix B - SAFE-CHOICE platform and operating model



References

- ANROWS & Department of Social Services (2026). Evidence to action: informing direction for the Second Action Plan. Consultation Paper in support of the National Plan to End Violence against Women and Children 2022–2032. Canberra: Commonwealth of Australia.
- Australian Bureau of Statistics (2023). Personal Safety, Australia, 2021–22. Canberra: ABS.
- Australian Institute of Health and Welfare. The Family, Domestic and Sexual Violence Integrated Data System (FDSV IDS). Canberra: AIHW.
- Cripps, K. (2023). Indigenous women and intimate partner homicide in Australia: confronting the impunity of policing failures. *Current Issues in Criminal Justice*, 35(3), 293–311.
- Domestic, Family and Sexual Violence Commission (2025). Yearly Report to Parliament. Canberra: Commonwealth of Australia.
- Minter, K., Carlisle, E., & Coumarelos, C. (2021). 'Chuck her on a lie detector' — investigating Australians' mistrust in women's reports of sexual assault (Research report, 04/2021). Sydney: ANROWS.
- Zilkens, R.R., Phillips, M.A., Kelly, M.C., Mukhtar, S.A., Semmens, J.B., & Smith, D.A. (2016). Non-fatal strangulation in sexual assault: a study of clinical and assault characteristics highlighting the role of intimate partner violence. *Journal of Forensic and Legal Medicine*, 43, 1–7.
- Zilkens, R.R., Smith, D.A., Phillips, M.A., Mukhtar, S.A., Semmens, J.B., & Kelly, M.C. (2017). Genital and anal injuries: a cross-sectional Australian study of 1266 women alleging recent sexual assault. *Forensic Science International*, 275, 195–202.
- Australian Clinical Forensic Medicine Alliance (2026). Telehealth in forensic medicine for domestic, family and sexual violence: a scoping review of the international literature, 2005–2026. (Available on request.)