

Submission to the Second Action Plan: Resourcing clinical forensic medicine across health and judicial responses to domestic, family and sexual violence

Fidelis Forensics is an Australian team of senior medical specialists providing independent clinical forensic medicine consultancy, education and advisory services to health, legal and government organisations. Its experts bring extensive experience across forensic and emergency medicine, custodial and sexual health, clinical toxicology, injury interpretation, attempted strangulation, patient safety and clinical governance.

Fidelis Forensics provides independent medicolegal opinion and peer review, alongside education, mentoring and specialist advice for clinicians, lawyers and organisations. Its work connects frontline healthcare with forensic-standard practice and judicial expertise, underpinned by ethical, evidence-informed care and equitable access to specialist capability.

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brings particular expertise in injury interpretation, medical-record analysis, patient safety, clinical governance, quality and risk, and medical education. Her work bridges frontline healthcare, specialist forensic assessment and independent medicolegal opinion.	has extensive expertise in toxicological analysis, the clinical and behavioural effects of substances, injury interpretation and medical-record review. Her combined medical and legal expertise supports clinically informed, independent opinion across healthcare and judicial settings.

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The Second Action Plan must expand and embed a nationally connected, health-led clinical forensic medicine response across emergency and acute healthcare, with equitable access across metropolitan, regional, rural and remote Australia.

This specialist response should reduce the likelihood and impact of further domestic, family and sexual violence by improving early recognition of violence-related harm; identifying and treating immediate, hidden and enduring health effects; supporting informed safety and care planning; documenting patterns of injury and escalation; and strengthening coordinated responses to people using violence.

The response must preserve each person's dignity, autonomy, informed consent and choices, including access to forensic-standard assessment, documentation and evidence preservation without requiring immediate police reporting. Independent medicolegal opinion and expert evidence should remain available where a person later chooses a judicial pathway.

Executive Summary

Domestic, family and sexual violence (DFSV) is a major health, safety and justice issue. Health services are often a point of contact after violence, yet clinical care, forensic assessment and later medicolegal interpretation are commonly organised through separate pathways. This fragmentation can leave injuries unrecognised or insufficiently understood, limit access to specialist follow-up and reduce the future value of clinical documentation.

Clinical forensic physicians work across this divide. They assess and treat people who have experienced violent crime, including DFSV; identify injuries that may be subtle, delayed, internal or enduring; support forensic-standard documentation and evidence preservation; prepare independent medicolegal opinions; and provide impartial expert evidence in criminal, civil and other judicial settings. Their expertise is particularly important following non-fatal strangulation, where limited visible injury does not exclude airway or laryngeal injury, arterial dissection, hypoxic brain injury or other neurological harm.

This is a person-led healthcare model grounded in health, dignity, autonomy, informed consent and choice. People can receive specialist assessment and treatment without first deciding whether to report to police or participate in a legal process. Clinical forensic assessment considers immediate health needs and the potential for delayed and enduring effects, informing decisions about imaging, observation, treatment, specialist referral, safety-netting and follow-up. With consent, the person's history, symptoms, clinical findings, care and clinical reasoning can be documented to a forensic standard and relevant evidence preserved without being released to police. This addresses current health needs while preserving, rather than narrowing, the person's future choices.

Australia requires a nationally connected clinical forensic medicine workforce to embed this expertise within emergency and acute healthcare and make it accessible across metropolitan, regional, rural and remote communities. National coordination would support 24-hour specialist consultation, in-person assessment where required, workforce development aligned with the Faculty of Clinical Forensic Medicine of the Royal College of Pathologists of Australasia (RCPA), consistent clinical governance and continuity from healthcare through to independent medicolegal opinion and expert evidence where a person chooses to pursue a judicial pathway.¹

National coordination is also necessary to identify, evaluate and translate emerging research into Australian practice. International developments, including UK research examining whether components of post-sexual assault forensic examination can be completed more quickly and with less burden for the person, require careful assessment, co-design and safe implementation. A nationally resourced research and practice-development function would enable emerging approaches to be evaluated without compromising clinical care, informed consent or evidentiary integrity.

Clinical forensic medicine is delivered differently across states and territories and may sit within health or justice portfolios. Existing governance models include hospital-based care, multidisciplinary centre examinations, specialist forensic physician reviews, and nurse-led assessments. These variable health and justice models create inconsistencies and structural barriers. A national framework should be health led, with access, clinical assessment, treatment, follow-up and patient-reported outcomes governed through health. There is a strong case to be made for consistent support for forensic physician-led processes embedded in acute health services to ensure equitable and safe care for people who have experienced DFSV.

A national program should also be provider-inclusive. Public health services, the RCPA Faculty of Clinical Forensic Medicine and appropriately credentialed independent specialist forensic organisations each bring different capabilities.¹ Organisations such as Fidelis Forensics can provide flexible clinical forensic medicine capacity across jurisdictions; support workforce training, supervision, peer review and quality assurance; translate emerging research into practice; and provide continuity through to independent medicolegal opinion and expert evidence.

Scope of this submission: This submission considers clinical forensic medicine primarily in relation to DFSV, including the assessment and interpretation of injuries, clinical toxicology and the potential effects of substances on health, cognition and behaviour. This focus reflects the purpose of the Second Action Plan and should not be understood as defining or limiting the discipline. Clinical forensic medicine has substantially broader applications, including traffic medicine and fitness to drive, custodial medicine, fitness for interview and judicial

¹ Royal College of Pathologists of Australasia, 2024.

proceedings, coronial review, clinical toxicology, injury interpretation and independent medical-record review across criminal, civil, regulatory and other medicolegal matters.

Fidelis Forensics recommendations for the Second Action Plan

1	Establish a national clinical forensic medicine program to embed specialist expertise within emergency and acute healthcare and connect clinical care, forensic-standard documentation, independent medicolegal opinion and expert evidence across health and judicial responses.
2	Resource specialist clinical forensic medicine capacity in priority health settings , supported by 24-hour statewide and national consultation pathways so that expertise is accessible across metropolitan, regional, rural and remote communities.
3	Build a sustainable clinical forensic medicine workforce through RCPA-aligned training and consultant positions, protected supervision, peer review, continuing professional development and equitable pathways to fellowship.
4	Ensure person-led access independently of police reporting , supported by informed consent and clear safeguards governing examination, treatment, documentation, evidence preservation, information sharing, record retention and later medicolegal review.
5	Establish national, health-led clinical governance, research translation and continuous practice-improvement functions , developed with the RCPA Faculty of Clinical Forensic Medicine, specialist DFSV services, Aboriginal community-controlled organisations, people with lived experience and other relevant communities and workforces.
6	Adopt a provider-inclusive commissioning framework that enables appropriately credentialed public, Aboriginal community-controlled and independent clinical forensic medicine organisations to contribute specialist service capacity, training, supervision, peer review, research translation, medicolegal opinion and expert evidence under common national standards.

Why Clinical Forensic Medicine Belongs in the Second Action Plan

Primary prevention, preventing violence before it first occurs, remains indispensable. The Second Action Plan should also strengthen responses after violence has occurred.² A crisis response cannot itself prevent all future DFSV, but it should reduce avoidable health harm, preserve the person's choices, identify patterns that may warrant a coordinated response, and connect people with the supports they choose, all the while increasing patient confidence in themselves and the service system.

The RCPA describes clinical forensic medicine as the branch of medicine concerned with forensic medical services primarily for living people and with the collection and interpretation of

² Rapid Review Expert Panel. (2024). *Unlocking the prevention potential: Accelerating action to end domestic, family and sexual violence*. Department of the Prime Minister and Cabinet.
<https://www.pmc.gov.au/sites/default/files/resource/download/unlocking-prevention-potential.pdf>

information for civil and criminal law, the judiciary and police. In practical terms, it deals with both the medical and legal dimensions of patient care.^{1,3}

Clinical forensic medicine is a recognised specialist discipline with a formal RCPA fellowship pathway.¹ In emergency settings, its work includes sexual-assault assessment, domestic and family violence examinations (including assaults, non-fatal strangulation etc), forensic specimen collection and injury interpretation, while balancing patient care with evidentiary integrity.³

The Current Gap: Healthcare Without Specialist Forensic Support

Health services are a critical point of contact for people experiencing DFSV. The 2021–22 Personal Safety Survey found that 17 per cent of Australian women, approximately 1.7 million women, had experienced physical or sexual violence by a cohabiting partner since the age of 15. Twenty-three per cent had experienced emotional abuse and 16 per cent economic abuse by a cohabiting partner.⁴ Police recorded 40,087 victims of sexual assault in 2024, the highest number in the national time series and 10 per cent more than in 2023.⁵ Police data capture only assaults that are reported and recorded.

DFSV can involve physical injury, non-fatal strangulation, acquired brain injury, chronic pain, disability, sexual and reproductive health consequences, psychological distress and cumulative health harm.⁶ These harms may be subtle, delayed, internally located or difficult to interpret. In a Victorian forensic-service cohort, 16% of eligible patients reported strangulation; among those with complete examinations, observable neck injury was recorded in 75%.⁷ A person may also attend healthcare several times with apparently disconnected concerns before an underlying pattern becomes visible.

Emergency clinicians are skilled in urgent assessment and treatment, but complex forensic assessment, documentation, injury interpretation and medicolegal obligations require specialist capability as well as frontline clinical care. A connected clinical forensic medicine

³ Cunningham, N., & Parkin, J. A. (2025). Forensic medicine in the emergency department: Principles, practices and challenges. *Emergency Medicine Australasia*, 37(6), e70175. <https://doi.org/10.1111/1742-6723.70175>

⁴ Australian Bureau of Statistics. (2023). Personal Safety, Australia, 2021–22. <https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release>

⁵ Australian Bureau of Statistics. (2025). Recorded Crime—Victims, 2024. <https://www.abs.gov.au/statistics/people/crime-and-justice/recorded-crime-victims/latest-release>

⁶ Australian Institute of Health and Welfare. (2022). Family, domestic and sexual violence data in Australia: Hospitalisations for family and domestic violence. Australian Government.

⁷ Sarkar, R., Moller, M., & Bugeja, L. (2025). A cross sectional study of case and injury characteristics in domestic and family violence patients reporting nonfatal strangulation to forensic practitioners in Victoria, Australia. *Forensic Science International*, 112533. <https://doi.org/10.1016/j.forsciint.2025.112533>

service can give treating teams timely access to that expertise while allowing the patient to remain within the health service.³

A Single Specialist Workforce Across Health and Justice

The distinctive strength of clinical forensic medicine is its capacity to apply specialist medical expertise across healthcare and judicial settings that are otherwise fragmented. Although this submission focuses on its application to DFSV, the specialty's broader practice sustains a diverse specialist workforce and enables expertise developed across injury interpretation, clinical toxicology, traffic medicine, custodial medicine and other medicolegal fields to inform complex violence-related matters.

- In healthcare, clinical forensic physicians assess and interpret injuries, advise on treatment and follow-up, support trauma-informed examination, and assist with evidence preservation and objective documentation.
- In medicolegal practice, they review clinical records, distinguish what findings can and cannot be established, and prepare independent opinions that assist investigators, legal practitioners and decision-makers.
- In court, they provide impartial expert evidence on the nature, timing, significance and limitations of clinical findings, including where no visible findings are present or several explanations are possible.

Although this submission focuses on DFSV, clinical forensic medicine is not confined to DFSV-related assessment. The specialty also encompasses all cause injury interpretation, clinical toxicology, the effects of substances on cognition and behaviour, traffic medicine and fitness to drive, custodial assessment, fitness for police interview or judicial proceedings, coronial review and the interpretation of complex medical records.

This breadth strengthens the specialist response to DFSV. Questions arising in DFSV-related matters often require expertise extending beyond the examination of an injury, including consideration of injury mechanisms and alternative explanations; the effects of prescribed medications, alcohol or other drugs; cognitive capacity and memory; pre-existing and enduring health conditions; and the significance and limitations of findings recorded across multiple healthcare presentations.

This continuity matters. Documentation created for immediate clinical care may later become important evidence of an incident or a broader pattern. The value is not that documentation determines an outcome; rather, accurate contemporaneous records and appropriately qualified interpretation can help later decision-makers understand both the significance and the limits of the clinical findings.

The role of a clinical forensic physician is not to advocate for a conviction, an acquittal or any other predetermined outcome. It is to provide independent, impartial medical opinion within the limits of the available evidence. That expertise may assist a person who has experienced

violence, a person alleged to have used violence, investigators, prosecution and defence practitioners, coronial processes, tribunals and courts.

Making appropriately qualified expert opinion more widely available supports procedural fairness and reduces the risk that complex medical evidence is inaccessible, overstated or interpreted without the relevant specialist expertise. The health response should not be measured solely by criminal case progression: its first purpose remains appropriate healthcare. Its additional value is preserving choices and enabling more informed and equitable judicial decision-making where proceedings occur.

Case study 1: Preserving healthcare and future choices

A person experiencing DFSV presents to a regional emergency department after being strangled by their partner. They report difficulty swallowing, dizziness and memory disruption but have few visible external injuries. They want healthcare but are not ready to speak with police because they are concerned about immediate safety, their children and retaliation from the person using DFSV. Through a national clinical forensic medicine pathway, the treating clinician obtains real-time specialist advice or arranges direct assessment by a clinical forensic physician.

The assessment considers the mechanism and duration of the strangulation; any loss or alteration of consciousness; and immediate, delayed and potentially enduring effects. This includes identifying symptoms or clinical findings that may indicate airway or laryngeal injury, carotid or vertebral artery dissection, hypoxic brain injury or other neurological harm, and determining whether imaging, observation, specialist referral or other treatment is required.

The health response extends beyond identifying acute injury. It considers changes in voice or swallowing, breathing difficulties, headache, dizziness, memory disruption, impaired concentration, neurological symptoms and the potential for acquired brain injury, alongside psychological and other health impacts. The person receives appropriate safety-netting and follow-up because significant symptoms and injuries may emerge or become apparent after the initial presentation. With the person's informed consent, the history, symptoms, examination findings, clinical reasoning and care provided are documented to a forensic standard. Relevant evidence can be preserved without being released to police. This is particularly important because serious internal injury can occur without extensive visible external injury. If the person later chooses to pursue a judicial pathway, a clinical forensic physician can interpret the contemporaneous findings and explain both their significance and their limitations.

Several months later, the person chooses to pursue a judicial pathway. A clinical forensic physician reviews the/their contemporaneous record and provides an independent opinion explaining the significance and limitations of the findings, including why an absence of extensive visible injury would not exclude strangulation

Strengthening Recognition of Repeated DFSV and Accountability

DFSV is frequently patterned and repeated rather than confined to a single incident. Australian research has found that a history of domestic violence, particularly more frequent prior incidents, and breaches of violence orders are associated with further recorded violence, with risk increasing cumulatively across subsequent incidents.^{8,9}

Clinical forensic medicine cannot independently change the behaviour of a person using violence or overcome attrition across police, prosecution and courts. It can, however, make harm more visible, clinically interpretable and actionable within a broader coordinated response.

Where a person chooses a judicial pathway, forensic-standard documentation may preserve material for later consideration and help an investigator or court interpret clinical findings in context. International sexual-assault service evidence is not directly interchangeable with an Australian, doctor-led clinical forensic model; however, it shows why evaluation should separate health care, evidence collection and police release. In one Canadian emergency-department program, 63.9% of eligible patients completed an evidence kit, but only 29.7% released it to police.¹⁰ Access to care and documentation should therefore never be contingent on immediate or future reporting.

Building A Sustainable National Workforce

The RCPA Faculty of Clinical Forensic Medicine was established in 2014 as the representative and training body for doctors working in clinical forensic medicine. It sets professional standards and offers a training and assessment pathway to fellowship for suitably experienced medical practitioners.¹ A national response should build service capacity and the workforce pipeline together, rather than fund isolated consultations without regulation, supervision, governance or succession planning.

The Commonwealth Government should invest in funded training and consultant positions, protected supervision, continuing professional development, peer review, clinical governance, and networks that allow smaller services to access expertise. This is consistent with the Faculty's stated role in setting professional standards, education and training, and cooperation with legal and health-system partners.¹

⁸ Morgan, A., Boxall, H., & Brown, R. (2018). Targeting repeat domestic violence: Assessing short-term risk of reoffending. *Trends & Issues in Crime and Criminal Justice*, 552. Australian Institute of Criminology.

⁹ Hulme, S., Morgan, A., & Boxall, H. (2019). Domestic violence offenders, prior offending and reoffending in Australia. Australian Institute of Criminology.

¹⁰ Muldoon, K., Drumm, A., Leach, T., Heimerl, M., & Sampsel, K. (2018). Achieving just outcomes: Forensic evidence collection in emergency department sexual assault cases. *Emergency Medicine Journal*, 35, 746–752.

National Research Translation and Continuous Practice Improvement

Australia currently lacks a nationally resourced clinical forensic medicine system with clear responsibility and capacity for horizon scanning, research translation, coordinated evaluation and implementation of emerging practice. As a result, developments that could reduce the burden of examination may be identified or adopted inconsistently across jurisdictions.

A national research and practice-development function would enable emerging approaches to be critically assessed, co-designed with people with lived experience, piloted safely and translated into consistent clinical guidance. It would also create the infrastructure required to generate Australian evidence, compare outcomes across jurisdictions and continuously improve the accessibility and quality of care.

Health-Led Governance and a Provider-Inclusive National Model

The location of governance materially shapes the purpose and accessibility of clinical forensic medicine. A health-led framework places assessment, treatment, informed consent, confidentiality, follow-up and longer-term health outcomes at the centre of service design. Forensic integrity remains essential and should be supported through clear standards for documentation, specimen handling, chain of custody and independent opinion. However, access to clinical care should not be contingent on police reporting, and evidentiary requirements should not displace the person's health needs or choices.

Health-led governance should be multidisciplinary and connected to judicial systems without becoming justice-led. Appropriately credentialed clinical forensic physicians should lead clinical standards and oversight, working with emergency and acute healthcare, specialist DFSV services, Aboriginal community-controlled organisations, people with lived experience, disability and culturally specific organisations, police, courts and legal practitioners. This structure supports both person-led healthcare and reliable forensic practice.

A national model should also draw upon capability beyond any single institution or jurisdiction. Independent specialist organisations can provide flexible capacity where public services cannot sustain an onsite workforce; support training, supervision, peer review and quality assurance across sites; translate emerging research into practice; and maintain continuity where later medicolegal opinion or expert evidence is required. Provider diversity can strengthen reach, innovation and resilience, provided all commissioned organisations operate within common credentialing, clinical governance, transparency and evaluation requirements.

Fidelis Forensics is an example of this capability. Its clinical forensic physicians bring specialist medical, forensic and legal qualifications; experience across hospital, community and judicial settings; peer-reviewed independent medicolegal practice; and expertise in clinical education, service design and expert evidence. Fidelis Forensics does not propose an exclusive role.

Rather, its experience demonstrates why a national framework should be capable of commissioning appropriately credentialed independent specialist forensic medicine expertise alongside public health services, Aboriginal community-controlled organisations and professional bodies.

Equity, Clinical Toxicology and Safe Access

DFSV does not occur separately from colonisation, racism, ableism, poverty, criminalisation, migration status, geographic isolation, or discrimination associated with sexuality, gender identity and substance use.¹¹ These conditions shape exposure to violence, health outcomes, how a person is perceived by services and whether seeking assistance is safe or accessible.¹²

Clinical toxicology is an important component of clinical forensic medicine and has particular relevance to DFSV. Specialist interpretation may be required to understand intoxication, withdrawal, toxicity, overdose risk, medication interactions, altered cognition or memory, and the possible contribution of substances to a person's symptoms, injuries or behaviour. This expertise may be relevant when assessing a person who has experienced violence and when providing independent opinion concerning a person alleged to have used violence.

Toxicological evidence must be interpreted within the broader clinical and relational context. Substance use does not establish that violence occurred, determine a person's credibility or provide a complete explanation for another person's use of violence. Equally, fragmented memory or altered consciousness does not negate a person's knowledge of fear, injury and harm. Appropriately qualified clinical forensic physicians can explain both the significance and the limitations of toxicological findings, reducing the risk that substance use is overlooked, overstated or used to discredit a person within healthcare or judicial setting

A national clinical forensic medicine response must strengthen, rather than displace, existing services. Access must not depend on police reporting, participation in a criminal investigation, travel to a metropolitan centre or repeated demonstrations of credibility. The national response must preserve informed consent and control over examination, treatment, documentation, evidence preservation and information sharing; provide interpreting, communication and disability access; support access to practitioners of a preferred gender and, wherever possible, cultural background; and incorporate clear safeguards for privacy, data sovereignty, record retention and disclosure.

¹¹ Victorian Alcohol & Drug Association (VAADA). (2026). Submission to the 2nd Action Plan to Eliminate DFSV Against Women and Children

¹² Victorian Alcohol & Drug Association (VAADA). (2024). *Submission to the Inquiry into Women's Pain*.

Case study 2: Access to specialist expertise outside of a metropolitan service:

A person experiencing DFSV presents to a remote health service following sexual violence. The local clinician can provide urgent healthcare but does not routinely undertake forensic examination and cannot access an onsite clinical forensic physician. Travelling to a metropolitan service would require the person to leave Country, arrange transport and accommodation, and repeat their account to another service.

The clinician accesses a 24-hour clinical forensic medicine pathway. A specialist supports the local clinician to discuss available options, identify time-sensitive healthcare needs, determine which components of examination and evidence collection are relevant, and document the person's choices and clinical findings. An in-person examination is coordinated only if clinically or forensically required.

The person remains connected with their chosen local and community supports. Specialist access strengthens local care rather than displacing it or transferring responsibility for navigating fragmented systems onto the person who experienced violence.

Conclusion

Clinical forensic physicians are among the few specialists whose work connects the effects of DFSV across healthcare and judicial settings. Their role is to support appropriate assessment and treatment, accurate documentation, preservation of future choices, and, where legal proceedings occur, objective medical opinion.

The Second Action Plan should recognise this dual role and fund the faculty and the specialised workforce capability needed to deliver it. Investment should begin with a national workforce strategy developed with the RCPA Faculty of Clinical Forensic Medicine and communities most affected by structural exclusion.¹

This proposal does not claim that forensic medicine alone prevents repeated violence or secures accountability. It proposes a combination of practical health and evidentiary infrastructure so that harm is more likely to be assessed, treated and documented, while each person retains control over whether and when they pursue a justice pathway.