"To Study Prosecution Of Sexual Assault And Violent Crime Offenders Without Victim Involvement."

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Index

1. Introduction

2. Executive Summary
   2.1 Address for Correspondence
   2.2 Project Title
   2.3 Fellowship Highlights
   2.4 Conclusions and Recommendations
   2.5 Dissemination and Implementation

Programme

3. Domestic Violence
   3.1 Illustrative Clinical Vignette
   3.2 Background
   3.3 Domestic Violence
   3.4 Disadvantaged Groups
   3.5 Human Rights and Public Policy

4. Evidence Based Prosecution

5. The Role of the Doctor and the Forensic Medical Examination
   5.1 Immediate Care
   5.2 Injury Documentation and Interpretation
   5.3 Collection of Samples
   5.4 Disease Prevention and Other Medical Treatment
   5.5 Follow Up
   5.6 Mandatory Reporting

6. Victim’s Wishes

7. Common Difficulties

8. Cultural Shifts in the Community and in the Profession

9. Recommendations and Conclusions
1. Introduction

Victims of sexual assault and violent crimes are sometimes reluctant to participate in criminal investigations and this seems to be more prevalent in disadvantaged groups such as new immigrants, those with a mental illness and prisoners. Although the disinclination to be part of prosecution is multi factorial, all too often it is not borne of free will. It is clear that often fear, coercion or duress plays a leading role as to why so many victims of crime are unable to participate in the judicial process.

In some cases these pressures originate from the alleged perpetrators of these crimes and victims are left confused and susceptible to further abuse in the future. These would appear to be particularly noticeable where violent abuse is in the domestic setting. Additionally, the current process places a substantial weight upon the shoulders of victims and this pressure may be too much when new to the system and already in a vulnerable state.

As a result, some overseas jurisdictions have started to prosecute these crimes without relying on testimony of the subject. Instead, a more intense focus is applied to evidence gathered around the assault from police testimony, medical records and expert opinion. This form of evidence based prosecution has of itself not been without some criticism. It is suggested that it can further disempower a victim of crime by removing yet another aspect of control from their lives, in favour of public policy.

It would seem that worldwide, legislators and prosecutors alike have felt that prosecution rates for sexual and violent assaults are particularly low in the domestic forum. In the home there is often a power play or reliance on one party that renders the reporting as well as any further action not a real possibility. Any relationship breakdown could have dire financial, emotional and indeed cultural ramifications. As a result victims are frequently subject to further abuse in an escalating pattern.

The Churchill Fellowship facilitated examination of direct evidence based prosecution of personal assaults in the United States and the United Kingdom. This was tempered by working with victims advocate groups in order to develop a better understanding of the effect on those subjected to this type of violence.
None of this would have been possible but for the tremendous support of the Winston Churchill Memorial Trust. The opportunity to travel abroad and take an active part in maintaining the rights of disadvantaged groups whilst developing a better understanding of common problems that multiple agencies on both sides of the planet face is irreplaceable. I must also express my sincere gratitude to my employers Dr Edward Ogden PSM, Head of the Custodial Medical Unit, Victoria Police and Ms Beth Wilson, Victorian Health Services Commissioner for their support and assistance during 2007 and 2008. I owe my sincerest gratitude to Professor David Wells OAM of the Victorian Institute of Forensic Medicine who has tirelessly mentored me with undying enthusiasm over the past decade and continues to provide me with an inspiration to strive for excellence. Special thanks should also be made to the departments and people that I visited overseas that all welcomed me with an openness that only comes with a common purpose.
2. Executive Summary

2.1 Address for Correspondence:

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2.2 Project Title

"To Study Prosecution Of Sexual Assault And Violent Crime Offenders Without Victim Involvement"

2.3 Fellowship Highlights

a) Working with the Attorney General's Department at Rhode Island, United States. Examining the prosecution of assaults prospectively and comprehensively, starting with initial police investigations, followed by medical examination and finally observing courtroom and trial dialogue and process. Special Assistant District Attorney Maureen Keough was invaluable in designing an itinerary that matched the needs of the project.

b) Meeting with the Metropolitan Police in London and discussing difficulties in prosecution and investigation of interpersonal crime. A/Commissioner John Yates was very helpful in this regard.

c) Visiting with Forensic doctors in Scotland and developing an understanding of future challenges in forensic medicine and evidence based prosecution.

2.4 Conclusions and Recommendations

a) Many of the problems faced by those involved in prosecution of violent and sexual assault crimes are experienced globally.

b) People who are subject to domestic violence are often fearful of repeated and escalating violence should they report the matter.

c) Successful prosecution is possible without testimony of the victim.

d) As a rule, prosecutions brought without reliance on victim participation do not adversely affect the victim.

e) Allowing these crimes to go on without redress, speaks volumes as to the kind of behaviour that society tolerates or is within normal limits.

f) It is therefore imperative that serious interpersonal violence is properly investigated and prosecution sought to protect individuals and make for a healthier community.
2.5 Dissemination and Implementation
   a) Ongoing communication with research groups in London, Scotland and the United States.
   b) Presentation of findings to professional bodies and academic colleges in addition to police and forensic health workers, through current employers.
   c) Presentation of findings to community groups (eg Rotary) in order to raise awareness.
   d) Discussion with rural hospital and indigenous groups to further raise awareness and facilitate reporting of abuse.
   e) Involvement in future training seminars and workshops.
   f) Review article to be submitted for publication in an academic journal.
2.6 Programme

2.6.1 Chicago, Illinois, United States
Department of Surgery, Loyola University Medical Centre. Hosted by Professor Ravi Shankar. Discussions regarding domestic violence severe injuries with a special interest in burns. Examined difficulties in determining aetiology and understanding ageing of severe injuries. Also discussed cultural risk factors and stigmas of domestic violence and injury reporting.

2.6.2 Providence, Rhode Island, United States

2.6.3 Providence, Rhode Island, United States
Providence Police Department. Attached with detective unit and completed “police ride along” with community visits. Observation of criminal investigations and evidence gathering. Discussions surrounding firearms crimes and sexual assaults. Further discussions surround workplace issues and threats to police officer safety. Attended Medical Examiner’s Office and examined methods of specimen collection and injury interpretation.

2.6.4 Newport, Rhode Island, United States
Newport Police Department. Discussion regarding cultural and geographical differences in criminal and offence profiles.

2.6.5 London, United Kingdom
Hosted by Royal College of Physicians. Attended and completed forensic examiner’s course. Examined issues including recent legislative changes, police and community safety and evidence gathering.

2.6.6 London, United Kingdom
Hosted by Medico-legal Society of London. Attended sexual assault and expert witness seminar by Dr Robin Moffat, Incoming MLS President.

2.6.7 Camberwell, United Kingdom
Hosted by Haven sexual assault centre. Observed and discussed forensic medical evidence collection and victim support. Examined efficient, effective and yet sensitive provision of medical and forensic services to reporting witnesses.

2.6.8 London, United Kingdom
Discussions with Dr Tania Francis and Dr Neville Davis MBE of the London Medico legal Society. Secured reciprocal arrangements with Medico legal Society of Victoria.
2.6.9 London United, Kingdom

2.6.10 Glasgow and Edinburgh, Scotland
Hosted by Individual Forensic Specialists and Policing Agencies over a two week period. Contacts include DCI Raphael of Strathclyde Police, Dr Glen Sykes and Dr Dave Atchison. Further meetings with Dr Colin Barrett, Head of Integrated Health Consortium which manages forensic and custodial medical service delivery.
3. Domestic Violence

3.1 Illustrative Clinical Vignette

A 27 year old woman is brought to hospital by ambulance with severe injuries following an alleged beating by her husband of three months. Her injuries are life threatening and warrant an extended stay in hospital. During this admission it is noted that the patient recently immigrated to Australia, has almost no social supports and relies entirely on her husband and his family both economically and socially. She has recently developed an alcohol dependence and her supply is controlled by her husband. It is also discovered that she is pregnant. Over the past two months she has been brought to hospitals on three occasions (once by the police) with injuries following interpersonal violence at home. The assaults appear to be escalating in both frequency and degree and this has been noted by police and medical staff.

Despite this, the young woman is initially reluctant and finally refuses to take any part in police enquiry. It is strongly suspected that she is fearful of retribution and has otherwise been coerced not to be involved in any prosecution efforts. Consequently, the patient returns to exactly the same environment which resulted in her original presentation and admission.

Without the patient's cooperation prosecution of the offender will be difficult and there is a sentiment that the authorities should not become further involved when, the victim does not want this.

The investigating police are concerned at the pattern of violence and predict further worsening physical abuse in the future. The medical team remains anxious for their patient's welfare as well as that of the unborn child. The issue as to what should happen next is posed.

3.2 Background

Unfortunately, the above fictitious example could very much represent an actual case file and in some instances the final chapter completes an already unpleasant tale. As a result the community will demand to know why these acts were tolerated and despite so many red flags, the ultimate outcome was not
prevented. The scenario draws upon social inequity, vulnerable patient groups and social awareness. It also links in with the kind of society that people wish to be a part of and drawing lines of what behaviours are to be considered socially acceptable.

Interestingly, the scenario above is not unique to the Australian jurisdiction. Other countries have turned their minds as how to best address these problems and several competing interests have been noted.

It is very well acknowledged that violent behaviour should not be tolerated especially in one's home and there is a vested public interest in ensuring the safety of one's citizens. Despite this, there is a concern that the interests of the individual must also be recognised. This is an even more sensitive issue in this population as further elements are removed from their control.

A further veil of uncertainty is added when one considers that the patient's decision not to be involved in the criminal process is not at all an independent one. Accordingly, a real conundrum is born. This project sought to draw upon the lessons gleaned from jurisdictions in the United States and the United Kingdom and propose applications in the Australian arena.

### 3.3 Domestic Violence

Domestic violence can take many different forms. It may be represented by controlling emotional behaviours or sometimes it may come in the form of violent physical abuse. The controlling and intimate relationship between the abuser and the subject is of key significance and in many cases the abuse is endured through fear of economic pressures, social isolation or repeated violence.
Moreover, domestic violence remains an all too often hidden issue and probably affects more people than initially suspected.\textsuperscript{1} In fact it has been reported that domestic violence is the leading cause of injury to women between the ages of 15 and 44 in the United States.\textsuperscript{2} Victims are not confined to any socio-economic group, age band or ethnicity.\textsuperscript{3}

3.4 Disadvantaged Groups

Some groups that pose a special vulnerability to intimate violence include the elderly, those with an intellectual impairment and prisoners.\textsuperscript{4} This is most likely due to an apparent or indeed actual disparity of power in the relationship.

Both anecdotal evidence as well as literature report that women are more frequently victims of domestic violence than men. This is also reflected in the number of cases in each group at the courts.\textsuperscript{5} Pregnant women are also at increased risk.\textsuperscript{6}

Australian communities have a long history of defending the rights of people who are sometimes unable to stand up for themselves. In one's humble opinion, providing support to those vulnerable or otherwise susceptible to inequity and injustice lies at the core of Australian values. As a result, further investigation as how to best manage serious domestic violence was necessary.

\textsuperscript{3} deLahunta, EA, Tulsky, AA. Personal exposure of faculty and medical students to family violence. JAMA 1996; 275:1903
3.5 Human Rights and Public policy

As alluded to above, the prosecution of serious assaults against the person is certainly in the public interest and is a matter of public policy. It is generally agreed that society worldwide finds interpersonal violence abhorrent and unacceptable. Despite this, less than 50 countries specifically protect women against domestic violence and many countries do not recognise rape as a crime if the offender and victim are married.⁷

4. **Evidence Based Prosecution**

Following on from the above, the author was able to spend two weeks at the Attorney General’s Office in the State of Rhode Island in the United States examining methods of evidence based prosecution.

Rhode Island has a population of just over one million people all housed in roughly four thousand square kilometres. The jurisdiction provided an excellent forum to examine evidence based prosecution and to develop a practical understanding of the Violence Against Women Act (VAWA) which was drafted by American Vice President Joe Biden and signed into Public Law by President Bill Clinton in 1994.

Evidence Based Prosecution seeks to facilitate prosecution without relying on the testimony of the reporting witness or victim. Hence, a comprehensive and methodical process of evidence collection is necessary as well as co-operation between many agencies.

In order to develop a keen awareness of the system, a duration was spent ‘on the road’ with investigating police officers followed by a period with detectives. This was then
complemented with a prolonged attachment to the prosecutors’ offices and associated evidence gathering at hospitals and with medical staff. Finally, two days were devoted to observing court room hearing and discussion with both prosecution and defence attorneys.

From the very moment that an emergency 911 call is placed from a person in distress evidence may be gathered and as a result adequate training of all staff involved is imperative. This means that emergency call operators as well as police and other emergency workers who arrive at the scene first should receive appropriate training to hone evidence collection skills.

Treating medical staff whether they are doctors, nurses or other professionals should also receive training as how to best document and interpret injuries for further action. They should also be acutely aware that the testimony of the examined subject might not be readily available at the time of prosecution.

Initial reluctance of medical staff to attend court or give evidence can often be overcome with appropriate training and reducing fear of the unknown. Additionally, sometimes staff are initially hesitant to attend court due to lost time at the hospital. This can be overcome with forward
planning and highlighting specific questions for address.

In liaison with victims' advocate groups as well as victims' groups it was clear that sometimes subjects who are not able to take an active role in the prosecutory process remain hopeful that 'something will be done' on their behalf.
5. The Role Of The Doctor And The Forensic Medical Examination

Increasingly forensic medical examinations are being performed by specialist trained forensic nurses. The international experience of this practice has largely been a positive one. It has been noted that nursing staff are considerably better (by and large) at following a pro-forma specifically and comprehensively. This is contrast to medical forensic doctors who will sometimes deviate from a set algorithm depending on the situation. In addition, patients are more often women than men and as a general rule would prefer to be examined by another woman rather than a male doctor.

Nevertheless, whether conducted by a doctor or a nurse the functions of the forensic medical examination remain largely unchanged. This was process was examined at Rhode Island and in considerable detail in London.

The examination may be divided into broad parts.

5.1 Immediate Care

Some injuries might require immediate medical attention and these must be attended to right away. Ultimately the welfare of the patient is of utmost concern.

5.2 Injury Documentation and Interpretation

All injuries should be clearly identified and these may be photographed to help with subsequent injury description. This is especially useful where injuries might change with time or disappear completely. Approaches as to photography vary worldwide and between examiners. Some feel that identifying
photographs or photography of sensitive parts of the body should rarely (if ever) be taken; whereas other groups feel that these photographs are especially useful for prosecution purposes.

5.3 Collection of Samples

Collection of samples, especially in cases of drugging or where sexual assault is thought to have occurred is imperative. Interestingly, this process again appears similar in all the jurisdictions visited.

The Haven in Camberwell in the United Kingdom, had a 'clean room' for collection of these specimens. In order to avoid DNA contamination, specimens were collected by medical staff who would routinely get changed into surgical scrubs and collect samples in the purpose built clean room.

5.4 Disease Prevention and Other Medical Treatment

Disease prophylaxis varies from jurisdiction and is largely dependent on risk stratification. It is also worthy of mention that prophylaxis can often be expensive. Perhaps of variation is the use of emergency contraception. Here ethical and religious considerations are at play. There are questions as to whether emergency contraception should be routinely provided or whether it is actively forbidden by the treatment facility. In some areas, examiners have felt that they have been unable to advise patients adequately about the use of emergency contraception as it has been discouraged by hospital management.

5.5 Follow Up

Follow up of patients after examination is favourable but jurisdictions differ as to who is best placed to perform this follow up. It would seem that specialist forensic nurse or general practitioner follow up is the world standard.
5.6 Mandatory Reporting

There has been much discussion regarding mandatory reporting of abuse, especially in the United States. This is in direct response to community expectations surrounding domestic violence. Indeed a common finding in the histories of those who have suffered intimate personal violence is repeated presentation to medical services. In Australia several types of mandatory reporting exist, most notably the mandatory reporting of suspected abuse or neglect of children.

The issue of mandatory reporting was discussed at length in Scotland. Here it was noted that mandatory reporting may breach notions of patient autonomy and medical confidentiality. As a result this could make it even more difficult for victims to seek medical care as they might have to contend with complex legal ramifications should their treating doctor report the matter. It was therefore suggested that maybe reporting should be made where the violence or injury was serious in nature, but then the difficulty of defining and demarcating serious and non-serious injury becomes troublesome.

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6. Victim’s Wishes

Certainly there would appear to be a global shift to the mandatory prosecution of domestic violence cases. Although there is little doubt that this is in the best interests of the community, the same cannot be readily as said for the individual. This issue is only further complicated when considering that the victim might not be able to state what they want due to fear or coercion.

The criminal process can be daunting and has been at times accused of “placing the victim on trial”. As a result, some victims' advocates have counselled victims to carefully consider pursuing the matter with the police.

On the other hand, sometimes it has been made clear that the victim wants for active prosecution but does not wish to be involved lest they be subjected to violent retribution or isolation. After all, it is unlikely that any victim of violence is keen for the hostility to continue.

7. Common Difficulties

It is with an apprehensive comfort that many of the difficulties in prosecuting domestic violence offenders are common globally. Many of these have been touched upon already and include fear of further violence, appropriate evidence collection, admissibility of evidence and patient rights.

Domestic and interpersonal violence is often

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multi factorial and the violent act cannot be readily separated from other aspects of the patient’s life. There is often emotional and financial dependence on the abuser, a lack of other social supports and underlying depression, substance abuse or decreased self worth. When this is coupled with the involvement of children, initial victim co-operation is often withdrawn.¹¹

8. Cultural Shift in the Community and in the profession

Having regard to the above there has been a profound shift in culture over the past 50 years. Where once domestic violence was regarded as a private matter behind the seclusion of the family home door, society has now acknowledged that this behaviour is unacceptable.

Similarly there has been an evident cultural shift in the legal and criminal professions that has seen the advent of ‘no drop’ policies in some jurisdictions. That is to say that in some areas prosecutors will not drop the case subsequent to the reporting witness refusing to be involved in the furtherance of securing a prosecution. This has been referred to as the criminalisation of domestic violence.¹²

Whilst in Scotland discussions with treating forensic physicians focused on a more proactive role for doctors in the future. It was suggested that the responsibility of reporting the crime and indeed further questioning should involve the doctor. There was a feeling that as a public health issue domestic violence could be compared to other causes of ill health and it has been noted that successful prosecution of offenders paves the way for decreased incidence of assault.

9. Recommendations and Conclusions

So, what are the ramifications for the patient in the clinical scenario? It is clear that the law regards assaults as an offence against the community and as a matter of public policy. This must be reconciled with the fact that the course of prosecution relies heavily on the abused party. The victim in the example is entirely under the control of her husband and is trapped in the relationship. She is afraid of retribution violence should she testify and may be now habituated to the abuse. ¹³

Certainly it is in the patient's best health interests to allow health professionals and the law to help break this cycle of violence. To this end, it might be best to have the responsibility of these decisions managed by the treating team and the police. Should this be the case, caution must be exercised to pursue only those cases which appropriate; lest future victims be dissuaded from attending hospitals for medical attention.

In this case the decision to prosecute despite the victim's inability to be involved is the proper one. Failure to prosecute is most likely to result in further violence and probable serious injury or death.

Cases where there is a lower severity of injury represent a greater difficulty in this decision making process and perhaps education and awareness programs could play a greater role.

There has been some discussion as to whether prosecution without the victim's testimony nevertheless places the victim at increased risk of continued violence. The international experience is quite the opposite. It is apparent that this type of prosecution raises community awareness and reduces incidence of violence. This is more understandable when one considers that although an abuser might be able to exert some control over the victim, law enforcement and the courts fall well outside their web of power.

¹³ Shepherd J. Should doctors be more proactive as advocates for victims of violence? BMJ 1995;311:1617-21