

# VFPMS NEWLETTER

## Special points of Interest:

- New Report Format
- Regional News
- Practitioner Profile

## ATTENTION!

### New Report Format

VFPMS sought expert advice from judges and magistrates at the Children's Court of Victoria to improve VFPMS medical reports. Valuable suggestions resulted in modifications to the our suggested format for medical reports that should assist Children's Court magistrates in their decision making.

The recommended format for medical reports differs from the format for Police reports in that important information about a child's health, safety and psychosocial information is included in the body of the report and recommendations are made to guide the child's ongoing care.

The new Report format can be accessed via the "Guidelines and Proformas" section of the VFPMS website.

<http://www.vfpms.org.au/pages/MedicalReport.php>

The report format contains detailed and vital information that will demonstrate a professional and holistic assessment of the child, their circumstances and their medical and developmental needs.



#### Forensic Medical Reports

The most important section of the report and those which require most careful consideration are in the last two sections 'The Professional and Expert Opinion' and 'The Recommendations' made for ongoing treatment and care for the child.

Peer support is available from your locally based colleagues and those based in Melbourne.

Keep an eye on the website for some 'mock' reports to view as examples of good practice.

#### INSIDE THIS ISSUE:

New Report Format	1
Regional Development Gets a Boost	2
Regional Profile	2
Regional Referral Statistics	2
Practitioner Profile: Christine Sanderson	3
Shaken Baby Syndrome and Purple Crying	4

*"Paediatricians and forensic physicians can play a vitally important role in the future safety of the child."*

## Regional Development gets a Boost

**“Regional VFPMS configured according to regional requirements and workforce capacity”**

VFPMS welcomes Ruth Hardman to the role of Regional Development Officer. Ruth will be based at the Royal Children’s Hospital in Melbourne but has state wide responsibilities in assisting with the coordination and development of a forensic paediatric medical response for abused and neglected children in Regional Victoria.

Ruth hopes to capitalise on the excellent quality services already being delivered in the regions to begin to paint a picture of what a state wide service response will look like. Each region offers opportunities and challenges to providing and configuring services that are relevant for the children and families within their area, using the skills, expertise and knowledge of local health service providers, paediatricians and forensic physicians.

Liaison with regional Child Protection and Police will be high on Ruth’s priority list, ensuring that all are aware of the referral pathways to a forensic paediatric medical response in their region and what to expect following referral.



Ruth joins us from a background in Child Protection both in the UK and here in Victoria. She was recently employed by Southern Health as the “Vulnerable Children’s Project Officer” to implement the “Vulnerable Babies, Children and Young People at Risk of Harm: a Best Practice Framework for Acute Health Services”(DHS 2006). This post placed Ruth in an ideal position to understand the intentions and purpose behind the formation and development of VFPMS.

Contact Ruth at [ruth.hardman@rch.org.au](mailto:ruth.hardman@rch.org.au) or phone 9345 6004/ 0432 460363

### Regional Profile: Developments in the Grampians

Ballarat Health Service and the children of the region are well serviced again. There are now five paediatricians working within Ballarat Health Service and across the community. In addition there are two private paediatricians available at the popular Howitt Street Paediatric Clinic.

Dr Maurice Easton has been appointed Clinical Director for the Department of Paediatrics at Ballarat Base Hospital. He is joined by Visiting Medical Officers, Dr David Tickell, Dr Danni Bao, Dr Fiona Noble and Dr Louise Du Plessis. They also divide their work between the Ballarat Base Hospital and the Howitt Street Clinic. All the paediatricians are available for referrals for medical assessments of suspected abuse and neglect.

Accessing a service in Ballarat is as easy as contacting the Ballarat Base Hospital switchboard and asking for the paediatrician on call. Urgent and non-urgent appointments can be made with the most appropriate Medical Practitioner.

### Regional VFPMS Referrals July 2008— April 2009

The numbers of children able to be seen in the area where they live has steadily increased over the last eighteen months. This is a great achievement and one on which we can continue to build responsive regional network.

Region	Health Service Area	Number of Patients
Grampians	Ballarat	15
	Horsham	1
Barwon/South West	Geelong	13
	Warrnambool	9
	Hamilton	1
Lodden Mallee	Bendigo	18
	Mildura	7
Hume	Swan Hill	2
	Albury/Wodonga	2
	Shepparton	2
Gippsland	Wangaratta	4
	Sale	21
	Bairnsdale	3
<b>TOTAL</b>		<b>98</b>

## Regional Practitioner Profiles

The first of a series of profiles of colleagues working across Victoria aimed at linking the VFPMS regional network. So, beware! The *Roving Reporter* will be offering further invitations to regional practitioners for future editions.

Our first profile features Christine Sanderson. Christine works as a paediatrician for Barwon Health. Along with 7 other paediatricians, she is based both at the Geelong Hospital and at the Ryrie Street Clinic.

*How long have you been working with vulnerable children? What are some of your career highlights to date?*

I started my paediatric career in 1986 with a Winter term in the emergency department at RCH in Melbourne. That term got me thinking that

- 1) I was invincible (I survived one episode of gastro and 3 URTIs without a day off etc etc)
- 2) I liked most children
- 3) I liked most paediatricians.

While children are amazingly resilient they are also vulnerable. I've been working with vulnerable children since then.

I've had many highlights – certainly the parents and kids I have had the privilege to meet. It sounds clichéd but it is true and it keeps me humble.

Since 2005 I've been travelling to Cambodia each year for 2 weeks, teaching APLS at the Angkor Hospital for Children, and this has been an inspiring and rewarding experience.

*Do you have an area of specialism or expertise? Why?*

I hope my area of expertise is what I do everyday - general paediatrics. I do more of the child abuse work than my colleagues and more paediatric gynaecology but that is only because they are referred to me as a woman paediatrician.

I have enjoyed being involved in teaching – I'm not sure if I'm good at it or I'm just the sucker that gets asked! I'm convening the children's health working group for Deakin Uni to put together a paediatric curriculum for the Deakin medical students who arrive in paediatrics next year.

*Is there a person, discovery or experience that has been a significant influence on your professional career?*

I was fortunate to work for Don Robertson, Max Robinson and Lionel Lubitz - they each taught me paediatrics but also so much more about the art of paediatrics and values that remain important to me.

*Can you tell us a bit about the region where you currently practice?*

Geelong is a great place to live and work. We have a great group of seven paediatricians who get along well. We work hard and one of us is always on call and within 10 min of the hospitals to provide an incredible level of service for the region. We cover about 200 000 population and we're always busy.

*In your experience, what are some of the challenges that face the doctors and paediatricians in your region?*

It is a real challenge to provide a 'best practice' service for kids with diabetes. It is also really difficult juggling the management of our busy practice and hospital roles and still having time to fight battles, teach and plan ahead!

*Do you have any tips or 'words of wisdom' for others?*

If you do forensic paediatric work you will need to debrief and your partner is not always the right person to do this with. Use a colleague if you can who will understand the personal impact of the emotional and physical hurt that we take on in transferrence, as well as the professionalism needed to manage children and families in crisis.

*If you were able to visit anywhere in the world for a relaxing two week holiday where would you go, who or what would you take and why?*

There are several places I'd love to visit that I haven't been before. Generally my holidays are reasonably active (sea kayaking, tramping, sailing) so I'd like to stay somewhere special for a really relaxing holiday and still be able to explore .... I'm intrigued by Zanzibar and I'd love to go and explore there - it would be totally new to me!

I'd take a friend who is great company to share the experience. I don't mind travelling alone but it's much more fun to share eating out in restaurants and going out at night.

There are 3 things I take wherever I go that have proved their usefulness over and over.

- my head light torch (just in case)
- my very small penknife (always handy to cut up fruit from the market, open bottles of wine, cut broken nails etc).
- a sarong – so useful – to wear over bathers or as a skirt, use as a towel, sleep on or under, wrap up my camera when you don't want it to look like a camera..... the list is only limited by your imagination!

Oh ... and a good book



*How did you first become involved with VFPMS and forensic work?*

**My answer is simple – child abuse is part of general paediatrics.**

## Shaken Baby Syndrome & Purple Crying

### VFPMS recently hosted

### Dr Ronald Barr & Marilyn Barr

On Thursday 5th March, a packed Ella Latham Theatre heard about the epidemiology, consequences and prevention strategies relating to Shaken Baby Syndrome. Dr Ronald Barr and Marilyn Barr enthralled the audience with research evidence alongside personal and anecdotal insights into the causes and effects of inconsolable crying in young babies.

“Parents who would never consider hitting their baby become frustrated with the continual crying to the point that they shake him or her”, explains Barr. “If the shaking is mild, there may be no external signs of harm. However the shaking may stun and quiet the baby temporarily. This makes the parent think the shaking stopped the crying and that no harm was done”.



Barr reports that the age when babies begin to increase their crying (two weeks) is the same age infants begin to be hospitalized for SBS, and the increase and then the decrease in crying amounts are reflected in increases and decreases of hospitalizations for SBS. The peak age of SBS hospitalizations is slightly later than the peak age of crying, probably because many cases are the result of repeated shaking.

Dr. Ronald Barr and Marilyn Barr discussed the period of PURPLE Crying and Shaken Baby Syndrome prevention

Further information is available on the website [www.don'tshake.org.au](http://www.don'tshake.org.au)

### Dr Ronald Barr

Ronald Barr is Director of the Centre for Community Child Health Research at the Child and Family Research Institute in Vancouver. He is also a Professor of Paediatrics at the University of British Columbia, a Canada Research Chair in Community Child Health

Research, an Associate with the Groupe de Recherche sur L'adaptation Psychosociale chez L'enfant (GRIP) at the University of Montreal, and Adjunct Professor of Paediatrics at McGill University.

### Marilyn Barr

Marilyn Barr currently serves as the Founder and Executive Director for the National Centre on Shaken Baby Syndrome in the US. She is also the Director of the British Columbia Shaken Baby Syndrome (AHT) Prevention Program in Vancouver, B.C.

She also serves as the works as a Management Consultant to the Intentional Injury Prevention Program, Children's and Women's Health Centre of British Columbia, Vancouver, B.C., Canada.

## The Period of Purple Crying

**P for Peak of Crying**—Crying peaks during the second month, decreasing after that;

**U for Unexpected**—Crying comes and goes unexpectedly, for no apparent reason;

**R for Resists Soothing**—Crying continues despite all soothing efforts by caregivers;

**P for Pain-like Face**—Infants look like they are in pain, even when they are not;

**L for Long Lasting**—Crying can go on for 30-40 minutes, and longer;

**E for Evening Crying**—Crying occurs more in the late afternoon and evening.



A new way to understand your baby's crying.

“Crying, especially inconsolable crying, is the most common trigger for shaking and physical abuse of infants”