CENTRE FOR
Women's Safety
and Wellbeing

Preventing violence,
promoting health,
advancing gender equality

Centre for Women's Safety and Wellbeing

Submission to WA Auditor General performance audit on the Delivery of Forensic Medical Examinations

August 2026

Acknowledgement of Country

The Centre for Women's Safety and Wellbeing acknowledges the Whadjuk Nyoongar people as the Traditional Owners of the land on which we work. We acknowledge Aboriginal and Torres Strait Islander peoples of this nation, and we pay respect to Elders past and present. We acknowledge the continued deep spiritual attachment and relationship of Aboriginal and Torres Strait Islander peoples to this country and commit ourselves to the ongoing journey of reconciliation.

Recognition of Victims and Survivors

The Centre for Women's Safety and Wellbeing recognises the strength and resilience of adults, children, and young people who have experienced domestic, family and sexual violence and acknowledge that it is essential that responses are informed by their expert knowledge and advocacy.

We pay respect to those who did not survive and acknowledge friends and family members who have lost loved ones to the preventable and far-reaching issue of domestic, family, and sexual violence.

About the Centre for Women's Safety and Wellbeing

The Centre for Women's Safety and Wellbeing (CWSW) is the leading voice for women and children affected by gender-based violence in Western Australia and the peak body for domestic, family and sexual violence services and community-based women's health services in WA. CWSW works to prevent domestic, family and sexual violence against women and their children, promote women's health and wellbeing, and advance gender equity.

We work to ensure that the evidence base is taken up in policy and practice to further the safety, health and wellbeing of women and their children. We advocate for systems and structures that enable and support the safety, wellbeing and economic security of women.

CWSW also promotes non-violent and respectful attitudes and behaviours towards women and girls in the broader community, and community responsibility for violence prevention.

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Introduction

"Getting a forensic medical examination does not always mean that someone will get the justice they deserve. It is not a choice that everyone can or will make. Yet, for too many people, it is a choice that they cannot make, because these examinations are not accessible to everyone who may benefit. Even for those who can make that choice, the experience of an examination can sometimes be traumatic rather than therapeutic."[1]

The Centre for Women's Safety and Wellbeing (CWSW) welcomes the opportunity to provide this submission to inform the Office of the Auditor General's performance audit to assess if WA Health effectively delivers forensic medical examinations (FMEs) to victim-survivors of sexual assault.

For many years now CWSW has been raising significant concerns about access to and the delivery of forensic medical examinations to victim-survivors of sexual assault in Western Australia. Too many victim-survivors are currently experiencing excruciatingly long delays, not able to access a FME at all and/or are experiencing significant secondary victimisation due to the way that FMEs are delivered, particularly in regional and remote areas[2].

FMEs are often the first point of contact for a victim-survivor with the "response system". It is such an important opportunity at this point to intervene in a victim-survivors' journey for the better, to provide a response that provides immediate care and belief and starts to counter the insidious dynamics of sexual assault.

Despite this, fewer than 5% of people who report sexual assault undergo a forensic medical examination. In 2024 police received 5,791 reports of recent sexual assault, while only 284 sexual assault forensic medical examinations were recorded by the

[1] Victorian Law Reform Commission (2021, November 16). Forensic medical examinations. In Victorian Law Reform Commission (Ed.), Improving the Justice System Response to Sexual Offences: Report. https://www.lawreform.vic.gov.au/publication/improving-the-justicesystem-response-to-sexual-offences-report/16-forensic-medical-examinations/

[2] Centre for Women's Safety and Wellbeing, *Review of the Specialist Sexual Assault Support Services* (November 2024

Department of Health[3]. This figure clearly demonstrates the inaccessibility of the current FME delivery in WA.

As this submission will make clear, it is apparent that there is no immediate sexual violence crisis response system (and not one that includes forensics) in WA. Rather, we have a collection of piecemeal responses that lack true coordination and leadership. The absence of this system stewardship means that accountability is dispersed across agencies, access pathways are inconsistent (or non-existent), and victim-survivors are too often left to navigate complex health, forensic and justice responses on their own[4].

Sexual violence is a significant public health, welfare and human rights issue with profound and long-lasting consequences on victim-survivors, their families and communities.

The sheer prevalence and threat of sexual violence in particular shapes how all women and girls perceive their safety and in turn this affects their freedom to participate in all areas of life. The threat of sexual violence and harassment directly affects women and girls' sense of safety in everyday life. The sheer volume of sexual violence that they see, witness as a bystander and feel as an imminent possibility acts to limit their freedom. This prevalence and ongoing threat of sexual violence shapes how women and girls assess risk, navigate public and private spaces, and participate in work, community and social life.

Sexual violence encompasses a wide continuum of behaviours, ranging from sexualised jokes, harassment and coercion through to assault and rape. The concept of the "continuum of sexual violence" acknowledges that these behaviours are interconnected and cannot be easily separated into discrete categories. Importantly it is not a hierarchy of behaviours; rather it recognises that the harms across the continuum have significant consequences for victim-survivors. Many experiences occur in everyday environments, including workplaces and within relationships, including intimate partner and intra-familial contexts. These experiences are linked by underlying social norms and structural factors that enable and sustain violence.

At its core, sexual violence is an abuse of power, underpinned by gender inequality as a primary driver, and must be understood within its broader social context rather

[3] https://www.parliament.wa.gov.au/watch/chamber/docs/questalarminglyalarminglyions/8df93b52350f4b3f81addc4087f58a96/cq421036.pdf?

[4] Centre for Women's Safety and Wellbeing, *Review of the Specialist Sexual Assault Support Services* (November 2024)

than solely as a matter of individual offending. It is well recognised that social and cultural conditions (where we live, work, learn and socialise) can permit or prohibit sexual violence.

Victim-survivors experience significant psychological, physical, emotional and social consequences, highlighting the need for coordinated, specialist responses that support their health, recovery and access to justice[5]. For victim-survivors who experience a sexual assault, a FME is an important part of the immediate health and justice response. FMEs support the immediate health and wellbeing of victim-survivors by facilitating medical assessment and treatment while also enabling the collection and documentation of forensic evidence that may assist future criminal investigations or judicial proceedings.

This submission outlines the persistent issues with accessing FMEs which have been consistently raised by victim-survivors and frontline workers, and compares the current delivery of forensic medical examination services in Western Australia against recognised best practice, to demonstrate that the current crisis response to sexual violence is intolerable and change is urgently required.

[5] National Association of Services Against Sexual Violence, *National Standards of Practice Manual for Services Against Sexual Violence* (3rd ed., 2022)

Forensic Medical Examinations

A FME is a comprehensive physical examination undertaken following a recent sexual assault to collect evidence of the assault and determine whether any injuries or medical issues require assessment or treatment as a result of the assault. FMEs support both the immediate health and wellbeing of victim-survivors and the collection and documentation of forensic evidence that may assist future criminal investigations or justice proceedings[6].

In addition to collecting forensic evidence, FMEs provide an opportunity to undertake an initial medical assessment, identify and treat injuries, address immediate medical concerns, and facilitate ongoing medical care and specialist support where required[7]. While the examination itself is an important aspect of both healthcare and forensic evidence collection, it is most effective when delivered as part of an integrated service system that includes specialist counselling, advocacy, psychosocial support and coordinated health and justice responses[8].

Forensic evidence collection following a recent sexual assault may involve either an Early Evidence Kit (EEK) or a full forensic medical examination, depending on the circumstances of the assault, the time elapsed since the incident, the victim-survivor's needs and wishes, and the availability of appropriately trained clinicians. An EEK enables the collection of time-critical forensic specimens that may otherwise be lost if collection is delayed. Most samples are self-collected by the victim-survivor under the guidance of a health professional or police officer. Where there are delays in accessing a full FME, an EEK provides an opportunity to preserve early forensic evidence, allowing victim-survivors to change clothes, shower, use the bathroom and attend to their immediate needs while awaiting further assessment[9].

A full FME is a more comprehensive assessment that includes documentation of injuries and may involve the collection of multiple forms of forensic evidence,

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[6] Western Australian Department of Health, *Responding to a Recent Sexual Assault Procedure* (June 2025)
[7] Western Australian Department of Health, *Responding to a Recent Sexual Assault Procedure* (June 2025)
[8] National Association of Services Against Sexual Violence, *National Standards of Practice Manual for Services Against Sexual Violence* (3rd ed., 2022).
[9] Sexual Assault Resource Centre, *What is a Forensic Examination and Specimen Collection?* (2024); Western Australian Department of Health, *Responding to a Recent Sexual Assault Procedure* (June 2025).

including forensic swabs, blood and urine samples, clothing and photographic documentation where appropriate. Medical assessment and care are provided alongside the forensic examination to address the immediate health and wellbeing needs of the victim-survivor including, sexually transmitted disease testing, emergency contraception access and treating injuries[10]. The type of forensic evidence collection undertaken is determined by the individual circumstances of each presentation and should be guided by clinical assessment, the needs of the victim-survivor and relevant forensic requirements[11].

Features of best practice

Responses to sexual violence have evolved significantly as the evidence base has grown and now reflects an increasing understanding of the complex and long-lasting consequences of sexual violence on victim-survivors. Current evidence recognises that effective responses require coordinated, multi-and inter-disciplinary approaches that support victim-survivors' health, wellbeing, recovery and, where appropriate, access to justice pathways[12].

There is broad consistency in the evidence base regarding the principles and practice that underpin best practice responses to sexual violence. The National Association of Services Against Sexual Violence (NASASV) as the national peak body developed Practice Standards endorsed by the Commonwealth Government that provide a framework for specialist sexual assault service providers to deliver high-quality, victim-survivor-centred, and trauma-informed care.

The *National Standards of Practice Manual for Services Against Sexual Violence* (Practice Standards) purpose is to ensure that organisations operate ethically, effectively, and inclusively, with policies and practices that prioritise victim-survivor safety, dignity, and rights[13].

[10] Western Australian Department of Health, *Responding to a Recent Sexual Assault Procedure* (June 2025).
[11] Western Australian Department of Health, *Responding to a Recent Sexual Assault Procedure* (June 2025).
[12] National Association of Services Against Sexual Violence, *National Standards of Practice Manual for Services Against Sexual Violence* (3rd ed., 2022)
[13] https://www.nasasv.org.au/nationalstandards

These best practice principles apply broadly across specialist sexual violence services and are also directly relevant to the delivery of FME services. FMEs should be seen as just one part of a response that supports the immediate and ongoing needs of victim-survivors. As such, we briefly outline the key elements of best practice below to inform our analysis of current FME "system" in Western Australia to provide a benchmark against which the existing system can be assessed.

Foundational frameworks

The NASASV Practice Standards articulates eight foundational frameworks which guide all seven standards and their sub-standards to ensure a shared understanding of the drivers, impacts and effects of sexual violence and in doing so the best ways to help support victim-survivors. The foundational frameworks provide the principles, philosophical underpinnings and theory which are then translated into practice by the standards. The foundational frameworks are:

1. **Feminist understandings of sexual violence**: a gendered analysis is central to understanding gender inequality and the drivers of sexual violence. Sexual violence is a deeply gendered form of violence. It disproportionately affects women and girls and is overwhelmingly perpetrated by men and boys. As such, a gendered analysis is essential to understanding sexual violence and the underlying social and structural drivers that enable it.
2. **Intersectionality:** sexual violence is fundamentally gendered, but people's experiences of violence are also shaped by intersecting social, cultural, and structural factors such as race, disability, sexuality, age, socioeconomic status, and cultural background. An intersectional lens recognises that gender inequality interacts with other systems of oppression to create different experiences of violence, discrimination, and access to support..
3. **Trauma model of recovery**: understanding that each individual's response to traumatic events is unique and reflects a complex interplay of factors. Applying a trauma-informed lens looks at 'what has happened to a person' rather than 'what is wrong' with them.
4. **Social justice:** promoting principles of equity and fairness of opportunity and access. Experiences of sexual violence can be compounded by inequitable systems and services.
5. **Anti-oppressive practice**: critically reflective practice that seeks to address and challenge social inequality and systemic power imbalances affecting clients. Anti-oppressive practice seeks to return power to people who have experienced

violence by centring their voices, respecting their autonomy, and supporting informed choice and self-determination.

6. **Victims' rights:** the protection of the rights of victims of crime, such as the right to respectful responses, information and access, access to justice and criminal compensation.
7. **Person-centred care:** Victim-survivors are put at the centre of decision-making and professionals work alongside them to get the best outcomes.
8. **Responsibility and accountability for adults who choose to perpetrate sexual violence:** understanding that adults who choose to perpetrate sexual violence are responsible for their actions and victim-survivors of sexual assault are never responsible.

These foundational frameworks are the principles that must underpin and drive all specialist sexual violence delivery in Australia. All eight principles work together to provide the baseline for specialist sexual violence practice.

A note on secondary victimisation

Where support services are not delivered by specialist staff with strong foundational frameworks grounded in feminist and trauma-informed lens, there is a risk of secondary victimisation. Secondary victimisation occurs when practitioners 'unwittingly take on an abusive role when they fail to recognise that the power differential inherent in the relationship between patient and clinician can mirror past abusive relationships'[14].

Key features of best practice

The NASASV Practice Standards also draws upon an extensive review of national and international standards and guidelines. The Standards provide guidance on the provision of services to adults and children who have experienced sexual assault. The third edition of the Standards expands upon the second edition by including guidance on providing services to children and young people who have experienced child sexual abuse, and children and young people exhibiting harmful sexual behaviours.

[14] https://www.health.nsw.gov.au/parvan/sexualassault/Publications/responding-ascsa.pdf

The *National Plan to End Violence against Women and Children 2022-2032*[15] emphasises that victim-survivors need "survivor-centred, holistic responses involving multiple sectors that will meet their diverse needs". Responding to sexual assault requires addressing multiple needs of victim-survivors in a way that is timely, integrated, person-centred, trauma-informed, gender-informed and culturally safe.

In an extensive review of the literature and interviews with survivors and practitioners, found that survivors identified that recovery after sexual violence is "***an ongoing journey that encompasses gaining safety and a sense of personal stability, as well as relational and social repair***" [16]. Recovery is facilitated when survivors can gain redress, accountability and justice. This means that the service system must apply a broad view of recovery, going beyond the alleviation of individual psychological and physical trauma impacts.

Holistic

Victim-survivors have multiple and often complex needs in responding to and recovering from the consequences of sexual violence. The impact of sexual violence can ripple through all areas of a person's life, and all aspects of a victim-survivors life circumstances can impact response and recovery. Service support needs can include forensic and medical support, therapeutic support, safety planning, system navigation, advocacy, court and legal support, parenting/family support, substance use, housing and financial matters. Best practice adopts a holistic approach that recognises and responds to the full range of victim-survivors' health, social and practical support needs[17].

This means that the victim-survivor must be placed at the centre of service delivery and recognises that recovery is an individual and often non-linear process. While some victim-survivors may require immediate medical treatment or a forensic medical examination, others may prioritise counselling, advocacy, legal assistance, housing support or assistance to address other social determinants of health. Best practice therefore requires services to be sufficiently flexible to respond to each person's individual circumstances, preferences and changing needs over time.

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[15] https://www.dss.gov.au/national-plan-end-violence-against-women-and-children

[16] https://anrows.intersearch.com.au/anrowsjspui/handle/1/22712

[17] National Association of Services Against Sexual Violence, *National Standards of Practice Manual for Services Against Sexual Violence* (3rd ed., 2022).

Holistic responses should recognise the strengths and self-determination of victim-survivors, rather than focusing solely on the impacts of trauma, services should work collaboratively with victim-survivors to identify their priorities, support informed decision-making and promote long-term recovery and wellbeing. This strengths-based approach aligns with contemporary trauma-informed practice and contributes to improved health, social and justice outcomes[18].

Integrated Responses

Best practice responses to sexual violence are characterised by integrated and multi and inter-disciplinary service delivery. Victim-survivors often require support from multiple services following a sexual assault, including healthcare providers, specialist sexual assault services, police, legal services, counselling providers and community organisations. Effective service systems should be ensuring that these services work collaboratively to provide coordinated care that responds to the individual needs of victim-survivors[19].

Integrated service delivery aims to reduce fragmentation by improving communication and collaboration between these agencies. Rather than putting the onus on victim-survivors to independently navigate multiple services, integrated models facilitate coordinated care, which can also help to prevent victim-survivors falling through the gaps between service systems.

A key objective of integrated service delivery is to minimise the need for victim-survivors to repeatedly recount their experiences to different agencies. Repeated disclosures can contribute to secondary victimisation and increase the risk of disengagement from services. Best practice therefore seeks to streamline service delivery by ensuring that responses are coordinated around the needs and choices of the victim-survivor.

Flexible and Long-Term Choice

Recovery following sexual violence is not a linear process. Victim-survivors may seek support immediately after an assault, delay disclosure for months or years, or re-engage with services at different stages of their recovery. As such, responses to

[18] Centre for Women's Safety and Wellbeing, *Review of the Specialist Sexual Assault Support Services* (2024).
[19] National Association of Services Against Sexual Violence, *National Standards of Practice Manual for Services Against Sexual Violence* (3rd ed., 2022); Centre for Women's Safety and Wellbeing, *Jurisdictional Review of Specialist Sexual Violence Service Models* (2026).

sexual violence should provide flexible pathways that enable victim-survivors to access support when they need it and not limit assistance to a single point in time.

A fundamental principle of best practice is recognising the autonomy and self-determination of victim-survivors. Services and responses should support individuals to make informed decisions about their care, recognising that each person's needs, priorities and recovery journey are unique. The Reach Project found that across any form of service response survivors wanted tailored and flexible interventions over which they have control and choice[20], and other reviews have similarly found that victim-survivors of sexual violence want to be able to flexibly choose the support they require, given they often have distinct needs which may change over time. This is critically important and aligns to the Practice Standards that support practice that counteracts the dynamics and effects of sexual violence, by being given choices, flexibility, asked to give informed consent to any interventions and feels empowered by their engagement with the service.

Flexible service models also acknowledge that support needs evolve over time. While some victim-survivors may initially require crisis intervention, others may later seek therapeutic support, assistance with legal processes, advocacy, or referrals to housing, financial counselling or other community services. Best practice therefore requires services to facilitate re-engagement and provide ongoing access to specialist support as circumstances and priorities change. Flexible choices include[21]:

- a choice of one-to-one or group therapy
- option to access support over the phone or online
- open-ended rather than time-limited support
- available irrespective of whether a report is made to the police or not
- in a safe, professional but non-clinical setting
- accessible to accommodate victim- survivors who do not have English as their first language or those with learning disabilities
- variety of appointment times.

Trauma-Informed Practice

Trauma-informed practice is widely recognised as a fundamental principle of best practice responses to sexual violence. It acknowledges that victim-survivors may

[20] https://anrows.intersearch.com.au/anrowsjspui/handle/1/22712
[21] https://www.gov.uk/government/publications/formal-support-needs-of-adult-victim-survivors-of-sexual-violence

experience a range of physical, psychological, emotional and behavioural responses to trauma, and that these responses can influence how individuals seek support, engage with services and participate in healthcare and justice processes. Trauma-informed practice requires services to recognise the impacts of trauma and deliver care in ways that promote safety, minimise the risk of re-traumatisation and secondary victimisation, and support healing and recovery.

The National Practice Standards emphasise that, in the context of sexual violence, all services should operate according to the key principles of trauma-informed care[22]:

- Safety – ensuring physical and emotional safety
- Choice – individuals have choice and control
- Empowerment – prioritising enablement and skills building
- Trustworthiness – task clarity, consistency, interpersonal boundaries
- Collaboration – sharing decision-making and power

Trauma-informed services seek to create environments that are physically and emotionally safe for victim-survivors. This includes providing compassionate, respectful and transparent communication, ensuring victim-survivors understand the purpose of assessments and interventions, supporting informed decision-making, and recognising each individual's right to autonomy and choice. These approaches aim to build trust and reduce the likelihood of further harm through interactions with service systems.

Forensic medical examinations require particular attention to trauma-informed practices due to the intimate and potentially distressing nature of the examination. Best practice requires clinicians to communicate clearly, explain each stage of the examination, obtain informed consent throughout the process and respond sensitively to signs of distress. Where possible, examinations should be undertaken in environments that promote privacy, dignity and emotional safety, with access to specialist psychosocial support before, during and after the examination.

Trauma-informed practice also goes beyond individual interactions and should be embedded within organisational policies, workforce development and service design. Ongoing education, reflective practice, clinical supervision and interagency collaboration support the consistent delivery of trauma-informed care and contribute to improved outcomes for victim-survivors. Embedding trauma-informed

[22] https://www.nasasv.org.au/nationalstandards

principles across organisations helps reduce the risk of secondary victimisation and strengthens the quality and consistency of specialist sexual violence services.

Trauma-informed services challenge traditional symptom-based models and may be better able to engage clients, avoiding retraumatising or pathologising them. Whilst much of the literature emphasises the need for trauma-informed practices, advocates for *trauma and violence informed practice* (TVI), bring into focus structural inequities, colonisation, intergenerational violence and the responsibility of organisations to change the systems that perpetuate harm[23].

Intersectionality

Whilst sexual violence is a gendered crime, it also disproportionately affects marginalised groups. Aboriginal and Torres Strait Islander women, women with a disability, women who are homeless and people who are sexuality and gender diverse experience sexual violence at higher rates than the general population. Victim-survivor experiences of sexual violence are experienced in combination with other forms of structural inequality, discrimination and disadvantage. Therefore, it is critically important to adopt an intersectional approach that recognises how multiple aspects of a person's identity and lived experience can interact to influence vulnerability, help-seeking behaviours and experiences of service systems.

Intersectionality acknowledges that victim-survivors may experience overlapping forms of discrimination, disadvantage or marginalisation. Recognising these intersecting factors enables services to identify and respond to barriers that may otherwise prevent victim-survivors from accessing appropriate care.

Cultural safety is an essential component of best practice and recognises the importance of self-determination, respect, partnership and reflective practice, and actively seeks to address power imbalances that may exist between service providers and victim-survivors. Services should be responsive to the diverse cultural experiences of individuals and communities; to help ensure care is delivered in ways that are respectful, inclusive and free from discrimination.

For Aboriginal and Torres Strait Islander peoples, culturally safe practice requires recognition of the ongoing impacts of colonisation, intergenerational trauma and systemic inequities that continue to influence their health and wellbeing. Best practice responses should be developed in partnership with Aboriginal communities

[23] https://pmc.ncbi.nlm.nih.gov/articles/PMC7328714/

and organisations, support self-determination, and recognise the importance of culturally appropriate models of care.

Intersectional approaches include not only being inclusive by incorporating diversity into existing service delivery models - but also acknowledging that fundamentally different approaches and models may be needed for different groups[24]. Queensland Sexual Assault Services includes specialist services for young women, people with intellectual and learning disabilities, Aboriginal and Torres Strait Islander women, migrant women, and men. An Aboriginal community-led sexual assault support service model is being developed in Victoria and will trial five Aboriginal sexual assault healing services. Australian research has found that there was a need for further work on developing and evaluating approaches for First Nations survivors and survivors from migrant and refugee backgrounds, as well as other disenfranchised communities[25].

Cultural safety

Cultural safety can be conceptualised "*more broadly as knowledge paired with constant critical reflection about the patient experience within the structures of power that health care is delivered*"[26]. However, cultural safety means different things to different people and also means something different when we think about acceptability and accessibility of a service. It is very important that any service or system thinks through all the different ways that cultural safety is defined by different groups of people to ensure the best service design. This can only be achieved by working in direct partnership with those groups.

We know that sexual violence was a tool deliberately used during settler colonisation to subjugate and dominate First Nations women and communities. The repercussions of this intergenerational trauma are still felt today. It is why responses to current day sexual violence for Aboriginal people must reflect and understand this history and acknowledge that colonisation is still an ongoing process. Cultural safety must be prioritised within this context. The evidence demonstrates that without culturally designed interventions, they are frequently unsafe and ineffectual for Aboriginal victim-survivors[27]. Providing specialist care

[24] https://www.ourwatch.org.au/about-us/key-documents/intersectional-approach.
[25] https://anrows.intersearch.com.au/anrowsjspui/handle/1/22712
[26] https://jaapl.org/content/early/2022/06/16/JAAPL.210139-21
[27] https://noviolence.org.au/wp-content/uploads/2019/07/2019-ATSI-SV-Paper-Digital.pdf

and culturally appropriate services can help avoid re-traumatisation and re-victimisation of victim-survivors[28].

These best practice principles described above have direct application to the delivery of FME services. In light of the evidence base, FMEs should provide integrated, timely access to crisis responses with appropriately trained clinicians who are skilled in both forensic evidence collection and trauma-informed care. Victim-survivors should be supported throughout the examination process with clear communication, informed decision-making, and with access to specialist psychosocial/accompaniment support throughout the whole process. FMEs should promote privacy, dignity and emotional safety while recognising the potential for the examination process itself to be distressing or retraumatising.

It is also important to integrate forensic medical examinations within the broader specialist sexual violence service response. Effective referral pathways between specialist sexual assault services, police, health and legal services should support continuity of care and ensure victim-survivors are able to access appropriate support beyond the initial examination. Coordinated service delivery should work to reduce fragmentation and minimise the need for repeated disclosures.

Equitable access is another important part of best practice responses. Victim-survivors should be able to access timely, high-quality forensic medical care regardless of where they live or whether they choose to engage with the criminal justice system.

WA sexual violence context

Despite the significant prevalence and serious impacts of sexual violence, WA has one of the least developed specialist sexual violence service systems in Australia when population, geography, workforce and funding are considered. WA currently has the lowest funding and lowest workforce **per capita in Australia**. **To further demonstrate this, there are just 12 FTE specialist sexual violence workers for the whole of regional WA**.

[28] https://msd.govt.nz/documents/about-msd-and-our-work/publications-resources/literature-reviews/literature-review-on-international-best-court-support-models-for-victim-survivors-of-sexual-violence.pdf

CWSW has previously completed jurisdictional analyses which found that the current system in WA is significantly under-resourced and unable to meet the needs of victim-survivors[29]. In some regions there are vast regional areas with no specialist sexual violence response at all including the Great Southern, Wheatbelt and Kimberly regions. The regional Sexual Assault Support Services experience even further funding disparities, have very limited workforce capacity, and operate across extremely large geographic areas with significant unmet need. Furthermore, the current service system is fragmented across government and non-government service streams, with limited integration between crisis, therapeutic, child sexual abuse and regional support pathways. The WA sexual violence sector is made up of:

1. One metropolitan-based Sexual Assault Resource Centre (SARC) (13 years and older) run as a government service under North Metropolitan Health Service (NMHS) and funded by the Mental Health Commission.
2. Five regional Sexual Assault Support Services (SASS) (13 years and older), delivered by non-government organisations, procured by North Metropolitan Health Service.
3. 15 Child Sexual Abuse Therapeutic Services (CSATs) and Indigenous Healing Services (IHS) for victim-survivors under 18 years and their families, delivered by non-government organisations, procured by the Department of Communities.

Metropolitan waitlists are more than 12 months long, and regional waitlists have more than 65 victim-survivors waiting for just one service (if there is even one to attend at all). Five of the six services cover regional WA – most of the landmass of state – and between them receive only $2 million a year[30]. There is a significant need to resource the regional services to ensure access to regional and remote victim-survivors, through properly funded in-reach, outreach and increased location availability.

There has been no meaningful investment in the specialist sexual violence sector in decades, despite lengthy waiting lists, an increase in the number of sexual violence incidences and the increasing presentations particularly due to technology-facilitated abuse and the impacts of violent mainstream pornography.

[29] Note: not currently publicly available
[30] Note: WA 2026-27 Budget included a short term 70% uplift which has yet to be rolled out.

Alongside the baseline sexual violence infrastructure currently being very limited and underfunded, access to FME also varies significantly according to a victim-survivor's geographic location. SARC is the primary provider of FMEs services in the metropolitan area, while victim-survivors in regional and remote areas are only able to access them through local hospital emergency departments and who may get telephone advice from SARC.

FME presentations may involve either an EEK or a full forensic medical examination, depending on the circumstances of the assault, the time since the assault occurred, the victim-survivor's needs and wishes, and the availability of appropriately trained clinicians. A full FME may be undertaken even if a victim-survivor is unsure whether they wish to report the assault to police. However, advice from SARC indicates in many regional and remote locations, there is limited or no capacity to store forensic evidence where police are not involved[31]. Consequently, a report to police can be required before a full forensic medical examination can be undertaken in these regional locations.

FME access - metropolitan area

In the Perth metropolitan area, SARC is the sole specialist sexual assault service (for over 13-year-olds). SARC provides crisis care, counselling and forensic medical examination services for people (aged 13 and older) who have experienced a recent sexual assault.

Metropolitan-based victim-survivors may present through several pathways, including referral from police, self-presentation to a hospital emergency department, or referral to SARC. Depending on the circumstances, SARC clinicians predominately conduct examinations at the SARC facility in Subiaco, however, can occasionally attend metropolitan hospitals to undertake the examination when required. Forensic evidence collection may involve either an EEK or a full FME. An EEK can enable time-critical forensic samples to be collected when immediate access to a full forensic medical examination is not possible. Where clinically indicated, a comprehensive forensic medical examination can subsequently be undertaken by a SARC doctor.

Victim-survivors are able to access a full forensic medical examination even if they have not decided whether to make a report to police. In these circumstances, forensic evidence may be collected and stored in accordance with applicable

[31] https://news.wapha.org.au/collection-of-forensic-evidence-after-a-disclosure-of-sexual-assault/

policies and procedures, allowing victim-survivors additional time to consider whether they wish to engage with the justice system. In addition to forensic evidence collection, SARC provides medical assessment, treatment, crisis support, counselling and referral to ongoing services. We note however, that the counselling waitlist at SARC is currently more than 12 months, and as such the availability of crisis counselling is limited to brief, crisis interventions. For children 12 years and younger, the only option is the Child Protection Unit (CPU) at Perth Children's Hospital. Where the victim-survivor is aged between 13-15 years, healthcare staff can contact either SARC or CPU.

The Peel region is considered metropolitan by the WA Department of Health – as a result the local hospital does not deliver FMEs and instead routinely refers victim-survivors to SARC in Subiaco – a 75 km one-way trip.

FME access - regional and remote areas

In regional and remote WA rather than being provided primarily by the SARC as a specialist service, FMEs can only be accessed through local hospital emergency departments. Depending on the location, a full FME may be undertaken by a medical practitioner or a SARC-trained nurse who has completed specialist forensic training. SARC provides 24-hour telephone advice and clinical support to regional clinicians to assist with forensic evidence collection and clinical decision-making where required.

The availability of trained forensic medical specialists, however, significantly varies across regional and remote locations. WACHS guidance requires clinicians responding to sexual assault presentations in public hospitals to consult SARC by telephone, and children under 13 are managed in consultation with the Child Protection Unit at Perth Children's Hospital. Full forensic examinations can only be performed by any doctor or a qualified person who has been gazetted following formal training under the *Criminal Investigation Act 2006*. Although there are a number of gazetted WACHS staff across the State, they are not available at every site or on every shift. Where an appropriately qualified clinician is not available, hospitals may seek telephone guidance from SARC, arrange transfer to another location where possible, or offer an Early Evidence Kit.

These arrangements create significant access barriers. Transfers for FMEs are not always possible, especially where distances are long, transport options are limited, or the victim-survivor is distressed and unsupported. While WA Police and other

agencies can possibly assist with transport in some cases, this is not a reliable nor a victim-survivor-centred access model.

The limitations of the current model are also evident at the metropolitan–regional interface. Peel Health Campus does not conduct FMEs and instead refers victim-survivors to SARC in Subiaco – as it is considered metropolitan by WA Department of Health. For some victim-survivors this requires a 150 kilometre round trip. CWSW has heard many instances of victim-survivors disengaging at this stage as it is all "too hard".

Despite their potential, access to EEKs can be inconsistent. EEKs are generally available through WA Health settings and selected mining sites, rather than as part of a broader, clearly communicated statewide response. This means that victim-survivors in remote communities may still have no practical way to preserve time-sensitive forensic evidence unless they can reach a hospital quickly. Any expansion of EEK access needs to be accompanied by specialist guidance, clear consent processes, safe storage and referral pathways, and follow-up with sexual assault support services. EEKs should be just one part of a broader regional and remote access strategy, not as a replacement for investment in broader specialist FME capacity and the necessary accompaniment and therapeutic support alongside it.

Current issues with the "system"

There are significant issues with the way that FMEs and WA's crisis response to sexual violence is delivered.

There is no "system"

There is currently no coordinated system response to crisis sexual violence presentations including FME provision in WA. Service delivery is piecemeal and inconsistent, with access highly dependent on where a victim-survivor lives. A lack of whole-of-government collaboration and system leadership contributes to significant variation and gaps across WA and significant inequitable access for victim-survivors in regional areas compared with metropolitan regions.

Regional FME delivery is currently reliant on individual staff members championing the issue and seeking SARC-accredited training. When those staff move on, the relationships, local knowledge and ways of working they have developed are often not sustained because the processes are not embedded. This model is not sustainable and limits long-term service provision and systemic change. Without ongoing governance structures, the consistency and quality of service provision will continue to be compromised, with direct impacts on victim-survivors.
This reflects the limitations of an ad hoc approach, where individual staff seek training in the absence of a broader strategy to build and sustain an FME specialist workforce.

For example, [redacted], a group of nurses have completed the SARC FME training largely through their own initiative and commitment to improving local access. However, because this capability has not been embedded within a sustainable and supported system, access has fluctuated. CWSW has received reports of victim-survivors being unable to access an FMEs [redacted], experiencing significant delays, including waits of more than 10 hours earlier this year ([redacted] 2026), and receiving examinations that were highly retraumatising. These experiences demonstrate how reliance on individual champions, rather than an integrated, resourced crisis response model, can result in inconsistent access and further harm to victim-survivors.

There is also limited system planning focused on what victim-survivors require. Current mechanisms for whole-of-government collaboration and leadership are

insufficient to support the development of policy and the design of a coordinated sexual violence service system for adult and child victim-survivors, including intersecting sectors such as justice and police. The lack of collaboration and coordination between the government-run SARC, SASSs and CSAT/IHS contributes to ongoing fragmented responses to sexual violence, making service gaps less visible to decision-makers and the public, while victim-survivors continue to wear the brunt of these consequences.

This is highlighted by the Department of Health's *Responding to a Recent Sexual Assault Policy*[32]. This policy requires Health Service Providers to report the number of referrals made to the SARC as part of annual compliance monitoring. However, the policy does not specifically require the collection or reporting of referrals made to Child Sexual Abuse Therapeutic Services (CSATs), or Sexual Assault Support Services (SASS). This limits the policy's capacity to provide a comprehensive picture of referral pathway and highlights the fragmentation in the sexual violence system.

Additionally, the associated *Responding to a Recent Sexual Assault Procedure*[33] applies specifically to individuals aged 13 years and older who have experienced a recent sexual assault. The documents identify the Child Protection Unit (CPU) at Perth Children's Hospital as the specialist service for children aged 12 years and younger (and, in some circumstances, up to 15 years). However, there does not appear to be a corresponding publicly available WA Health policy outlining minimum standards, roles, responsibilities, and care pathways for responding to recent sexual assault involving children under 13 years of age. This creates a gap in guidance for the management and coordination of responses for younger children.

[32] https://www.health.wa.gov.au/~/media/Corp/Policy-Frameworks/Clinical-Services-and-Planning/Responding-to-a-Recent-Sexual-Assault-Policy/Responding-to-a-Recent-Sexual-Assault-Policy.pdf
[33] https://www.health.wa.gov.au/~/media/Corp/Policy-Frameworks/Clinical-Services-and-Planning/Responding-to-a-Recent-Sexual-Assault-Policy/Supporting/Responding-to-a-Recent-Sexual-Assault-Procedure.pdf

Emergency department entry point

In late 2025 [redacted] a victim-survivor was admitted to [redacted] hospital. Despite the severity of the situation, the hospital attempted to discharge her either to a refuge or into homelessness. The refuge advised that it was unable to safely accept her until the following morning due to staffing limitations. Nevertheless, from approximately 3:00 pm until 11:00 pm, the hospital repeatedly refused to keep the victim-survivor overnight, despite having beds available for this purpose. Ultimately, it required significant advocacy from both the [redacted] and the [redacted] to secure the hospital's agreement to retain and support the victim-survivor until the following morning.

Requiring victim-survivors to attend hospital to access an FME creates a significant barrier to care. Only a small proportion of victim-survivors present to police stations or emergency departments following sexual violence. Many do not see their sexual assault as a medical issue as they do not see themselves as physically unwell, or may be unsure why they are being directed to a hospital setting[34]. For some, the hospital environment may also be associated with previous distressing experiences, including involuntary admission to a mental health ward, which can increase fear and contribute to a reluctance to attend.

Emergency departments are also not designed to provide a trauma-informed response to sexual assault. They are high pressure, very public and clinically focused environments, often with limited privacy, competing urgent presentations and staff who often do not have specialist sexual violence training. This can make it difficult to provide the calm, private and supported environment required for an FME. In other jurisdictions, FMEs are rarely conducted in emergency departments themselves and are usually undertaken in a separate, dedicated more private area of the hospital at a minimum.

[34] https://qsan.org.au/wp-content/uploads/2019/04/Right-to-choose-final-pdf-with-covers.pdf

In [redacted] 2026, a victim-survivor presented to the emergency department [redacted]. The local sexual assault support service was not contacted by the hospital until around 6.30am, and the forensic medical examination was not completed until approximately 4.00 pm, resulting in a wait of more than 11 hours. During the examination, a teleconsultation with Perth was undertaken in front of the victim-survivor, where the attending clinician lacked knowledge of how to take samples correctly, and asked very intimate questions about the procedure on the call in front of the victim-survivor, which was reported as highly retraumatising. After the examination, the hospital reportedly would not provide travel assistance, and the victim-survivor had to be driven home by police, [redacted].

Using emergency departments as the default entry point for FMEs also contributes to the significant waiting times experienced by victim-survivors in WA. Victim-survivors and services have provided substantial examples of victim-survivors being required to wait for extended periods in emergency departments before an FME can be undertaken[35].

> *"Largely the length of wait times would be similar in other regional hospitals due to lack of appropriate space and staff availability and sexual assaults are not prioritised. Emergency departments are not the place to be conducting these, it doesn't happen in other places"*

These delays are seriously harmful in the aftermath of a sexual assault. To preserve evidence victim-survivors may be asked to remain in the clothing they were wearing at the time of the assault and to avoid showering unless they are provided with an Early Evidence Kit in the interim. Waiting for long periods in these circumstances can be highly distressing and may compound the trauma of the assault. It also increases the likelihood that victim-survivors will leave before the examination occurs, meaning they may miss the opportunity to access forensic evidence collection, medical care and specialist therapeutic support.

[35] Rintoul, Kaitlyn (2023, October 24). WA woman says Karratha Health Campus left her humiliated & traumatised after alleged rape. The West Australian. https://thewest.com.au/news/pilbara-news/wa-alleged-rape-survivor-details-ongoing-horrorin-quest-for-justice-after-failed-investigation--c-11877043

The variation between hospital capacity is also a problem. Some regions do have major hospitals. For example, Bunbury Regional Hospital is the largest regional hospital, while Hedland Health Campus is significantly smaller with less infrastructure. The variation between regional hospitals means the workforce and facilities vary considerably. Some hospitals will have easy access to private rooms available to conduct the examination, while in others it is limited access due to the volume of presentations at any time.

> *"[hospital] told us that they don't have the appropriate room in facilities to do it so sexual assault will always be deprioritised, they only have one room, and it is in constant use- so highly likely if someone insists they want one would have to sit there for 8-12hrs"*

Victim-survivors being turned away or required to travel

CWSW has received many examples of victim-survivors being advised to travel to Perth or a larger regional hospital for an FME. In some examples, this was due to the availability of staff, other times the reason was less clear. In some cases, victim-survivors were told to travel to another location, often without support or travel assistance. Our previous Review heard a historical example of a victim-survivor in the Wheatbelt being sent to Perth in a taxi for an FME by police (250km one way)[36]. Peel Health Campus also does not perform FMEs and instead refers clients to SARC in Subiaco which is a 150km round trip. This is highly traumatising for victim-survivors, and many will choose to opt out at this point. This is a major concern for services who are sometimes unable to re-engage these victim-survivors with appropriate support.

> *"At least a 6 hour wait at Kalgoorlie hospital. There are only male detectives in Kalgoorlie - so will sit in hospital with 2 male detectives which victim-survivors hate, then there are often only male staff members available to do testing. [Our region is the] size of Victoria in area - anyone who is remote needs to travel to Kalgoorlie and I don't think they will."*

[36] https://cwsw.org.au/wp-content/uploads/2024/12/Sexual-Assault-Support-Services-Review.pdf

In [redacted] 2025, a victim-survivor attended hospital in [redacted] after she was raped. The hospital did not do a FME or offer an EEK. The victim-survivor reported she was essentially turned away from the hospital and reported that hospital staff told her the rape was her fault. She attended the local FDV refuge a week later in distress and was experiencing significant pelvic pain. The refuge paid for a local private GP to examine her, and she was referred to Perth for urgent medical intervention due to the nature and extent of her injuries.

Lack of therapeutic support and continuity of care

Victim-survivors who access an FME through a regional hospital often receive no therapeutic support during the process. CWSW has consistently heard that post-FME follow-up and referrals to local SASSs are also inconsistent, with pathways varying between locations and not embedded as part of routine practice. Most of the SASSs are unable to provide staff to attend hospitals because doing so requires significant resourcing and is not supported by the current funding levels which have not changed in more than a decade[37]. This is a critical gap for victim-survivors. FMEs are invasive procedures that may occur during, or soon after, the immediate aftermath of sexual assault. Without psychosocial support and accompaniment from a professional with specialist sexual violence knowledge and trauma-informed training (which is what happens in the metropolitan area via SARC), victim-survivors in regional and remote areas can be left without essential care during a highly distressing point.

Services reported that they have previously attended hospitals to support victim-survivors during FMEs. However, many have been unable to continue providing this support because it requires substantial staff time and there is no dedicated funding to divert staff from other therapeutic and support work. As noted in previous sections above, the regional sexual assault support services only have 12 FTE to service all of WA. It is unbelievably difficult to service in reach to hospitals on a staffing level as low as this. As a result, many victim-survivors are proceeding through a distressing and invasive procedure without critical support. Additionally, this way of working has never been an embedded part of the system. An integrated sexual violence crisis response has largely been delivered on the

[37] Note: WA 2026-27 Budget included a short term two-year 70% uplift which has yet to be rolled out.

goodwill of services and individuals, and as a result it is inconsistent or non-existent in many places.

Accompaniment support would provide victim-survivors with practical and emotional support throughout the FME process, as well as ongoing assistance with, service navigation, advocacy and link ins with ongoing specialist therapeutic support. A victim-survivor-centred approach requires the deliberate redistribution of power so that autonomy is restored through informed choice, transparency and shared decision-making. In this context, accompaniment is not a minor insignificant role but is relational, practical and trauma-informed practice that helps ensure victim-survivors are not left to navigate our complex systems alone.

The WA SARC helpline does not appear to have been designed to provide a statewide crisis response to sexual assault. It is an appointment-based model that primarily connects victim-survivors who have recently experienced sexual assault with SARC's metropolitan crisis response (including forensic medical examinations) in one location in Perth. In practice, victim-survivors who contact the helpline after-hours may be booked into an appointment at SARC during business hours, unless there are immediate medical concerns. Although the helpline is promoted publicly, services reported that it does not consistently connect victim-survivors with their local SASS, particularly in regional areas. It is also unclear whether regional public hospitals that contact the SARC forensic consultation line are routinely provided with local SASS details so that victim-survivors can access support and accompaniment during the forensic process.

Access to forensic medical examinations should be clearly linked to specialist support. Other jurisdictions more consistently recognise the need to connect crisis responses, forensic medical examinations and police processes with counselling, advocacy and local follow-up. In WA, there is a need to establish consistent referral and accompaniment pathways so that victim-survivors are not left to navigate the aftermath of sexual assault alone, especially in regional and remote areas where it is currently lacking. Effective access to specialist advocacy and accompaniment and support during FMEs through SASSs would help reduce secondary victimisation, improve the response at the first point of contact and reduce pressure on other state services.

Communication about specimen destruction

Currently, PathWest stores forensic samples securely for up to 12 months. This storage period is intended to give a victim-survivor time to decide whether they wish to report the assault to police. When Early Evidence Kit or toxicology specimens are collected, the victim-survivor is provided with information and the date of collection is recorded on the back of the envelope by the worker assisting them. Specimens are then stored for 12 months from that date. If no report to police is made within the 12-month period, and the victim-survivor was 18 years or older at the time the specimens were collected, the forensic specimens are destroyed by the laboratory. **The victim-survivor is not contacted before this occurs.** Different arrangements apply where the victim-survivor was under 18 at the time of collection, as government records relating to children cannot be destroyed. In those circumstances, specimens are transferred to WA Police for indefinite storage.

The destruction of forensic evidence without any proactive attempt to contact the victim-survivor is highly concerning. It places all the responsibility on the victim-survivor to remember the collection date, understand the consequences of the 12-month timeframe, retain the information provided to them at a time of acute distress, and take action before the deadline. This is not consistent with a trauma-informed or person-centred response. Victim-survivors may have completed an FME shortly after an assault, while experiencing shock, fear, dissociation, injury, shame or confusion. In that context, it is completely unrealistic and unfair to assume that they will be able to keep track of bureaucratic timeframes or make a final decision about police reporting without any further support or a reminder.

A trauma-informed approach requires systems to actively support victim-survivors to retain choice and control wherever possible. Forensic evidence may represent an important option for a victim-survivor who is not ready to report immediately but may wish to do so later. Destroying that evidence without contact completely removes a future option without the victim-survivor's informed participation at the point the decision becomes final. This compounds the loss of control already experienced through sexual violence and is likely to be experienced as another secondary victimisation from a system decision made about the victim-survivor but without them. A more victim-survivor-centred process would include proactive follow-up before any destruction occurs, so that victim-survivors are given a genuine opportunity to make an informed decision. This would also provide a significant opportunity to connect a victim-survivor with appropriate recovery support if required.

This issue also highlights the broader absence of continuity of care following FMEs and points to the total lack of a crisis response to sexual violence. A victim-survivor who does not report immediately should not be treated as having disengaged from the system or as having forfeited their future options. Many victim-survivors delay reporting for complex and legitimate reasons, including safety concerns, fear of not being believed, uncertainty about the criminal justice process, cultural or family pressures, disability-related barriers, previous negative experiences with systems, or the need for time to stabilise before making major decisions. Proactive follow-up before specimen destruction would recognise these realities and provide an opportunity to reconnect victim-survivors with specialist advocacy, counselling and information about their options. WA must consider a consistent statewide process for safe contact and warm referrals to specialist sexual violence services before stored forensic specimens are destroyed.

Workforce capability, training and support

The availability of appropriately trained clinicians is a key factor influencing the delivery of forensic medical examination services across Western Australia. The metropolitan model is supported by specialist SARC doctors, while regional and remote hospitals generally rely on local general medical practitioners and SARC-trained nurses, with clinical advice provided by SARC when required. CWSW notes that while any doctor can do the FME training there is no requirement for them to do so before they undertake an FME, which does not apply to nursing staff.

The availability of trained and gazetted forensic staff is not guaranteed in regional areas, and this creates a significant barrier to consistent FME access. Regional health services experience higher workforce turnover than metropolitan services, which can result in the loss of local expertise, relationships and institutional knowledge. This makes it difficult to sustain FME capability over time, particularly where service delivery depends on a small number of individual clinicians. Training pathways are also limited. SARC-accredited training is only delivered in regional locations a few times a year, which restricts how quickly hospitals can develop a trained workforce and respond to changes in staffing.

There is also limited ongoing support, supervision or professional development for staff once they have completed training. Additionally, unless the Department of Health or the Health Service Provider (HSP) sponsors a place, the training is expensive, costing approximately $2,000 per place. This creates a further

disincentive for staff and services, particularly in regional areas where budgets and staffing capacity are already constrained.

CWSW notes that there is significant variation in the training of FME staff across Australia. SARC's FME training is a once off 3-day course. In contrast NSW's program is significant and has multiple offerings including a 12-week medico legal course, and a graduate certificate[38].

Despite the specialist nature of FME work, there appears to be limited formal recognition of the additional training and expertise required. Regional staff are expected to undertake FMEs as part of their ordinary role, rather than as a recognised specialist function requiring dedicated support, supervision and workload consideration. This stands in stark contrast to FME medical staff at SARC in the metropolitan area who are recognised for their specialism and subsequently remunerated at significant levels to reflect this[39][40].

This is a substantial issue because FMEs require a high level of clinical skill, forensic knowledge, trauma-informed practice and confidence. Infrequent exposure to this work in regional hospitals can undermine practitioner confidence, particularly where clinicians are generalist medical or nursing staff rather than dedicated forensic practitioners. Staff may also be required to provide evidence in court in relation to an examination they have conducted. For many clinicians, this can be a daunting responsibility, particularly where they have not received ongoing training, supervision or support for the legal aspects of the role. These factors make staff less willing to undertake the training or maintain FME capability, which further weakens the sustainability of the regional workforce.

A note about tele-consults

CWSW notes that WA Country Health Service has implemented a policy requiring staff performing FMEs in regional hospitals to contact SARC so that guidance is available when generalist clinicians undertake these examinations. While this requirement may appear on paper to be a good idea, it is not an adequate substitute for a trained and supported FME workforce.

[38] https://swecav.hss.health.nsw.gov.au/portal/courses/search/department-search?department=mf
[39] Senior Medical Practitioner, Consultant Year 1 has a minimum base salary of $234,798
[40] https://downloads.wairc.wa.gov.au/gazettes/volumes/101/parts/2/subparts/101-2-7.pdf#page=17

Teleconsultation cannot replace the clinical judgement, expertise and trauma-informed practice required to conduct an FME safely and sensitively. This is particularly concerning where the clinician undertaking the examination has limited FME experience and is relying on real-time advice during the procedure itself. CWSW has heard multiple examples of clinicians contacting SARC while in the middle of performing an FME and asking technical questions in front of the victim-survivor about how to collect specimens or undertake aspects of the examination. This practice seriously risks undermining the victim-survivor's sense of safety and confidence in the process and makes an already invasive and distressing procedure feel more confusing and unsafe. It is not consistent with a trauma-informed response.

> **What other procedure do we allow untrained and/or unconfident clinicians to talk through that procedure over the phone in front of a patient?**
>
> **How is this an acceptable way of providing what should be a trauma-responsive exam that is supposed to try to maintain dignity and safety of the patient?**

Specialist advice should of course be available to support clinicians, but it should sit within a broader model of workforce development and supervision, rather than being relied on as the primary mechanism for ensuring quality and safety in regional FME provision.

Lack of accessible information

While the North Metropolitan Health Service (where SARC is housed) has a generalist easy read information sheet for patients to use, it is not adapted specifically to the sexual violence or FME context[41]. There is generally a significant lack of accessible information about FMEs or sexual violence. Information about what an FME is, what it involves, where it can be accessed, what choices a victim-survivor has, and what happens to forensic samples is difficult to locate and is not consistently provided in formats that are accessible to people with disability and cultural and linguistically diverse backgrounds, including Easy Read materials and translates resources. The absence of this information creates an additional barrier

[41] https://www.kemh.health.wa.gov.au/~/media/HSPs/NMHS/Hospitals/WNHS/Documents/Patients-resources/SARC---About-Me-Form.pdf

for victim-survivors who may already face substantial barriers to disclosure and reporting.

This is particularly concerning given the seriously significant prevalence of sexual violence experienced by people with disability. People with disability may also experience sexual violence in contexts that are less visible to mainstream systems, including institutional, residential, care, health, disability support or service settings. They may be reliant on perpetrators or others for communication, transport, personal care, decision-making support or access to services. Accessible information is a necessary part of ensuring victim-survivors can understand their options, make informed decisions, seek help safely and exercise autonomy after sexual violence.

More broadly, there is limited clear public information for victim-survivors about FMEs. While metropolitan pathways through SARC are more visible, information for regional and remote victim-survivors is far less clear. A victim-survivor in a regional area may not know whether an FME is available locally, whether they need to attend an emergency department, whether they must report to police first, whether they can access an Early Evidence Kit, or if they can have a support person present, or if there is a local specialist sexual assault support service that can assist them. This uncertainty can delay help-seeking or lead victim-survivors to disengage altogether.

There is also a lack of clear information for service providers, including SASSs, community organisations, disability services, family and domestic violence services, Aboriginal Community Controlled Organisations, youth services and other services where victim-survivors may present. These services need accurate, region-specific information about FME availability, referral pathways, timeframes, transport options, support and accompaniment arrangements, and the steps required to preserve forensic evidence. Without this information, providers may be unable to give timely and accurate advice, may refer victim-survivors to the wrong entry point, or can unintentionally reinforce the confusion and fragmentation already experienced by victim-survivors.

Improving accessible information should be considered a priority to improve access to FMEs. WA sorely needs consistent statewide information that explains FME options in plain language, clearly distinguishes metropolitan and regional pathways, and is available in formats that meet diverse communication needs. Even

if we improve FME provision and pathways, without clear and accessible information this will not translate into increased access for victim-survivors.

Limits of the current metropolitan model

Metropolitan access to specialist sexual assault services in WA is also constrained by the reliance on a single specialist service in Perth. While regional and remote barriers are acute, metropolitan access cannot be assumed to be adequate because SARC is located in the CBD. A single metropolitan access point does not provide any real choice for victim-survivors across a significant population density and geographically dispersed metropolitan area. It requires many people to travel significant distances, navigate transport, parking and attend a service that may not be close to their home, work or support networks. For some victim-survivors, particularly those experiencing family and domestic violence, coercive control, disability-related barriers, mental health concerns, homelessness, alcohol and other drug issues, or caring responsibilities, distance and travel can be enough to prevent access altogether.

The current situation limits the ability of victim-survivors to choose the setting and service that feels safest to them. Choice is a core element of trauma-informed and victim-survivor-centred practice. After sexual violence, victim-survivors should have options about where they attend, who supports them, whether they access a hospital-based or community-based response, and whether the service is culturally safe, disability-accessible or connected to their existing supports. When all metropolitan forensic and crisis pathways are concentrated through one service, these choices are essentially non-existent. This can be particularly difficult for victim-survivors who have previously had a negative experience with the service, who know staff or other clients connected to the service, who are concerned about confidentiality, or who simply do not feel safe travelling to or attending that location.

Concentrating access through one metropolitan service also creates system vulnerability. If that service is at capacity, operating on an appointment-based model, has limited after-hours availability, no drop in option, or is not the preferred option for a particular victim-survivor, there are no alternative specialist pathways within the metropolitan area. This reflects the current situation with crisis responses to sexual violence in the metropolitan area.

CWSW received an example from [redacted] where they had to transport a victim-survivor from [redacted] to SARC in Subiaco due to no ability to access an FME in [redacted] region. They reported that despite this victim-survivor never attending SARC previously, SARC initially refused to take her for the FME as she had been flagged as "aggressive" in the WA Health records at some point in the past. It was only due to the advocacy of [redacted] that they managed to negotiate around this with SARC to enable this victim-survivor to have an FME undertaken.

As seen in the example above, what other options are there for victim-survivors who are turned away from SARC for reasons like being "red flagged" in the public health system? Concerningly the SARC referral guidelines also limit who is appropriate to refer to them for care[42]. Noting that people with acute psychiatric presentations and people with acute drug/alcohol dependencies are not suitable for SARC where can these victim-survivors go in the metropolitan area to receive a specialist sexual violence response?

Additionally, the exclusion of people with any history of sexual perpetration creates a significant gap for those who have both perpetrated sexual violence and who have also been a victim of sexual violence. It is also unclear how young people who may have displayed harmful sexual behaviours towards other children in this guideline.

The current system is not responsive to the varied circumstances in which sexual violence occurs. A model with multiple access points across metropolitan Perth and regional WA with clear links to specialist and multidisciplinary support would allow services to be provided closer to where victim-survivors live and would reduce pressure on a single service. It would also support better referral pathways, earlier engagement and greater continuity of care.

Other jurisdictions demonstrate the value of having multiple specialist sexual violence services across metropolitan and regional communities, rather than concentrating access through one location. WA should consider metropolitan service planning in the same way that we recommended improving regional access-

[42] https://www.kemh.health.wa.gov.au/~/media/HSPs/NMHS/Hospitals/WNHS/Documents/Professionals/SARC/SARC-Referral-Guidelines.pdf

that is victim-survivors are more likely to engage when support is local and connected to their community.

Access for children and young people

Children and young people do not have consistent access to forensic medical examinations after sexual abuse. In the metropolitan area, these assessments are provided through the Perth Children's Hospital Child Protection Unit. Outside of Perth, access is less clear, which creates a significant equity gap, as a result, children and young people who have experienced sexual abuse may miss timely access to specialist assessment, early treatment, safety planning, therapeutic referral and forensic evidence collection when it is most useful.

An FME is an opportunity to provide reassurance to the child and their non-offending parent or carer. It can answer questions, address fear or confusion, and explain that the absence of physical findings does not mean sexual abuse did not occur. This helps reduce harmful myths and can support recovery[43]. For assessments to be safe and effective, they must be child-centred and trauma-informed. Children should receive clear, developmentally appropriate information, have their worries taken seriously, and be able to consent to some parts of the assessment and decline others. When delivered by trained clinicians, the process can restore a sense of control, validate the child's experience and avoid further harm[44].

Research with children, young people and parents after forensic medical examinations highlights several common concerns. Children can find it distressing to repeat their story to multiple professionals, particularly when they feel unheard or disbelieved. The way clinicians communicate and provide care is extremely important - kindness, clear explanations and emotional support can reduce distress, while rushed or insensitive responses can increase shame, fear and trauma[45]. Sterile, hidden or unwelcoming examination spaces can make children feel less safe. Parents and carers also need information and practical support, as they are often managing their own distress while trying to support the child.

[43] https://www.csacentre.org.uk/blog/reflections-on-the-benefits-of-the-medical-assessment-for-children-and-young-people-who-have-been-sexually-abused/
[44] https://journals.sagepub.com/doi/10.1177/08862605251324962
[45] https://journals.sagepub.com/doi/10.1177/08862605251324962

WA needs a clear pathway for children and young people to access forensic medical assessment as both an evidentiary process and a therapeutic and safeguarding intervention. This pathway should include specialist paediatric expertise, culturally safe and developmentally appropriate communication, supported referrals, regional access arrangements and clear links to child sexual abuse therapeutic services.

Long term issues

The persistence of these issues is particularly striking when considered alongside findings from a WA study conducted in 2011 examining health professionals' perceptions of sexual assault management[46]. The study identified many of the same challenges that have been raised in this submission. There was unanimous agreement among participants that WA faced significant gaps in regional service availability, a shortage of culturally appropriate services, and inadequate responses to victim-survivors within the legal system. Participants also highlighted lengthy waits in emergency departments due to a lack of specialist expertise and workforce capacity, uncertainty among health staff regarding forensic evidence collection and storage procedures, inadequate training in forensic, medical and psychological responses to sexual assault, limited follow-up care for victim-survivors, and experiences of disempowerment during assessment and management processes.

Importantly, many of the solutions recommended in 2011 mirror those being proposed today. These included clear statewide guidelines and protocols, improved forensic evidence collection procedures, strengthened sexual assault support services, increased workforce training and capability, better follow-up care, culturally responsive services, and a coordinated multi-sector approach involving health, forensic, psychosocial and justice systems.

The study also identified Sexual Assault Nurse Examiner models as a promising solution, noting their ability to provide specialist, consistent, trauma-informed care, improve follow-up support, and respond more effectively to the emotional needs of victim-survivors. More than a decade later, CWSW and other advocates are still calling for these same reforms.

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[46] https://www.researchgate.net/profile/Jonine-Jancey/publication/241648710_Health_professionals%27_perceptions_of_sexual_assault_management_A_Delphi_Study/links/00b7d5305696566e05000000/Health-professionals-perceptions-of-sexual-assault-management-A-Delphi-Study.pdf

The challenges currently facing forensic medical examination services and crisis sexual violence responses are not the result of a lack of evidence. They reflect a longstanding failure to implement the reforms that have repeatedly been recommended by researchers, advocates and victim-survivors themselves. The findings from this 2011 study serve as a reminder that WA has been aware of the problems and many of the solutions for well over a decade. The urgency now is not to undertake further analysis, but to act on the evidence that already exists. As the authors concluded, sexual assault requires "*a comprehensive, expert, standardised and sensitive management approach*" that integrates health, forensic, psychosocial and justice responses. Fifteen years on this conclusion remains as relevant as ever.

Other Jurisdictions

In terms of sexual violence sectors across Australia, CWSW previously prepared this high-level comparison for the Department of Health.

2025-26 data[47]

Jurisdiction	Service	Population	FTE	FTE per captia (ratio)	Funding	Funding per capita
WA	1 Govt, 5 NGOs	3,076,500	38.67	**0.13**	$8,163,090.00	**$2.65**
WA	5 NGOs only	3,076,500	12	**0.04**	$2,281,828.00	**$0.74**
[redacted]						

*please note green indicates estimate.

2026-27 data

Jurisdiction	Service	Population	FTE	FTE per captia (ratio)	Funding	Funding per capita
WA	5NGOs only w 2026-27 uplift	3,076,500	12	**0.04**	$3,562,555.00	**$1.16**
WA*	1 Govt, 5 NGOs w 2026-27 upli	3,076,500	38.6	**0.13**	$10,138,519.00	**$3.30**

We have included 2026-27 data for the WA sexual assault services to show the calculations including the recent funding uplift. Even when the 2026-27 & 2027-28 short-term uplift funding is accounted for, WA has the lowest funding and lowest number of FTE per capita in the whole of Australia. We caution interpretation and comparability of SARC funding information, as this includes funding for medical staff who deliver forensic medical examinations and are paid at significantly higher rates than the therapeutic counselling staff.

Note following assumptions and data caveats:

[47] https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/dec-2025#states-and-territories

- Unable to make any assumptions about NSW due to significant information gaps and inability to gather information during this review process.
- Data sets vary across jurisdictions; some datasets include forensic medical staff (e.g. SA, NT and WA SARC data), some count only sexual assault service staff (e.g. VIC, TAS, WA SASS) and some include FTE for crisis lines (e.g. WA, VIC, TAS) while others exclude this information (e.g. QLD) and VIC workforce and funding data does not include ACCO services.
- Note that most services are located near major metropolitan centres. Victoria, Queensland, and New South Wales each have multiple metro-based services, reflecting population distribution, city size, and the need for diversity in responses for victim-survivors.
- Based on available data, Western Australia has the lowest FTE and funding levels per capita.
- Note regarding age range of services for children under 13 years: WA data does not include services for under 13 years, neither does Queensland or South Australia. Victoria, Tasmania and NT core services include access to victim-survivors of most ages.

Forensic access in other jurisdictions

Issues with accessing forensic medical examinations are not isolated to WA. Other states have been grappling with addressing access to this critical service. However, WA is lagging behind in terms of taking steps towards rectifying this access issue. CWSW recently completed a jurisdictional review of sexual violence services[48] on behalf of the Department of Health WA. It is clear from that work that Australian jurisdictions have adopted a range of approaches to delivering FME services following sexual violence.

Several jurisdictions utilise Sexual Assault Nurse Examiners or equivalent models, in which nurses undertake specialised education perform FMEs within clearly defined clinical governance frameworks. Importantly, these models in other jurisdictions are generally supported by ongoing education and recognition of their specialist role.

[48] Note: not currently publicly available.

Recent investments

Other jurisdictions across Australia have made significant investments into their FME service delivery:

Queensland:

- $4.8million for the development of integrated response models for sexual assault services
- $56million for forensic medical examinations for sexual assault ($12million of this has been committed to enhance paediatric FME services)

South Australia:

- 2026-27 Budget included $36.2million to improve access to forensic medical examinations[49]
- In 2025 Yarrow Place was approved as medical specialist service under Patient Assistance Transport Scheme (PATS). Regional South Australians travelling to Adelaide to access forensic medical care at Yarrow Place may now be eligible for PATS travel and accommodation subsidies[50]
- 2023 Yarrow Place received $110,000 to expand regional counselling outreach and workforce support into five key region regional centres through the training and support for nurses[51]
- 2020 -$1.3 million over 3 years was allocated to Yarrow Place from the Victims of Crime Fund for: regional counselling expansion, Country Response Program and forensic medical workforce support[52].

New South Wales:

- In 2023, the NSW Government announced $53million in funding for an additional 48 full-time equivalent (FTE) permanent medical and forensic positions[53]

Service delivery and policy contexts

Our jurisdictional review also found variation in the way FMEs and sexual violence response systems are delivered and governed strategically.

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[49] https://www.statebudget.sa.gov.au/our-budget/womens-statement

[50] https://www.pats.sa.gov.au/pats-subsidies-extended-to-support-regional-victim-survivors-of-sexual-assault/

[51] https://www.dss.gov.au/national-plan-end-violence-against-women-and-children/progress/first-action-plan-progress/first-action-plan-activities-addendum/forensic-medical-services-and-counselling

[52] https://www.miragenews.com/13-million-to-support-victims-of-rape-and-sexual-assault/

[53] https://www.health.nsw.gov.au/news/Pages/20230918_00.aspx

Queensland:

- 2018-19 and 2024-25 Auditor General inquiry into forensics in Queensland has created significant change. The 2024-25 audit specifically focused on the delivery of forensic medical examinations for sexual assault victim-survivors[54]
- A 2023 Ministerial Direction sets a 10-minute target in emergency departments for the clinical care for sexual assault presentations
- Queensland Government Interagency Guidelines for responding to children, young people and adults who have experienced sexual assault or child sexual abuse[55]
- Health Service Directive - Caring for people disclosing sexual assault[56]
- In Townsville the Sexual Assault Response Team (SART) operates as a genuinely collaborative multidisciplinary model. Townsville SART is a partnership between support workers and counsellors from Townsville Sexual Assault Support Service, Townsville, Hospital and Health Services (including forensic examiners), investigators from Queensland Police Service, and lawyers from the Office of the Director of Public Prosecutions. SART supports all people (14 years and older) who have experienced sexual assault, recently or in the past. Consent rates for forensic examinations increased significantly (by 300 per cent), while the proportion of reports progressing to charges rose from 18 per cent to 21 per cent. At the same time, the rate of complaint withdrawals decreased from 17 per cent to 15 per cent. A critical difference with the SART model to other multidisciplinary models (like in Victoria and Tasmania) is it is built on independent coordination with collective governance and no lead government agency. Its governance structure is shared across partners, with an independently funded coordinator accountable to the governance group as a whole.

New South Wales:

[54] https://www.qao.qld.gov.au/reports-resources/reports-parliament/delivering-forensic-medical-examinations-follow-audit

[55] https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/924faa15-d282-48f0-a8e8-739521e2b0b1/interagency-guidelines-responding-sexual-assault-child-sexual-abuse.pdf?ETag=8273e87f1f8e6a4cc860ecdf3e556030

[56] https://www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/caring-for-people-disclosing-sexual-assault

- Integrated Prevention and Response to Violence, Abuse and Neglect (IPARVAN) Framework and the NSW Health Strategy for Preventing and Responding to Domestic and Family Violence Strategy 2021–2026[57]
- Emergency Care Institute – Clinical Tools – Sexual Assault[58]
- Early Evidence Collection Guidelines[59]
- Research on the NSW Health sexual assault medical and forensic workforce[60]
- Responding to Sexual Assault (adult and child) Policy and Procedures[61] this outlines that SAS counsellor will commence a crisis response, ideally within an hour of an individual who has experienced a recent sexual assault (within the past seven days), presenting to a NSW Health facility[62]. The crisis response by the counsellor includes co-ordinating a medical response if required and a forensic response if the individual wants one. Medical and forensic services are delivered in partnership with the SAS counsellor and should commence within two hours of a request. Under NSW Health policy, every district must have a minimum of one 24/7 integrated psychosocial, medical and forensic service.
- NSW training for sexual assault nurse examiners includes three years relevant clinical experience and a requirement to undertake a Graduate Certificate, such as the Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault offered through the NSW Health Education Centre Against Violence (ECAV)[63]

Victoria:

- Victoria has a coordinated 24/7 crisis response system. This involves an immediate response with a Counsellor Advocate from the local specialist sexual violence service. During business hours, calls to the Sexual Assault Crisis Line are diverted to a local specialist service.

[57] https://www.health.nsw.gov.au/parvan/Publications/iparvan-framework.pdf
[58] https://aci.health.nsw.gov.au/networks/eci/clinical/tools/sexual-assault
[59] https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2025_011.pdf
[60] https://www.health.nsw.gov.au/parvan/sexualassault/Pages/medical-workforce-research.aspx
[61] https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_006.pdf
[62] https://www.health.nsw.gov.au/parvan/sexualassault/Publications/medical-workforce-research.pdf
[63] https://www.ecav.health.nsw.gov.au/

- Victoria has also invested in multidisciplinary service models, including seven multidisciplinary centres (MDCs) that co-locate specialist sexual assault services with Victoria Police SOCITs, Child Protection, forensic medical services, legal services, family violence programs and victim assistance programs. These centres were first developed in 2007, to reduce the burden on victim-survivors by bringing key services together, improving coordination and reducing the need to retell traumatic experiences. Many MDCs include forensic suites and facilities for recording statements, enabling wrap-around supported reporting pathways[64].
- In Victoria, crisis care responses are founded on respect for victim-survivors' choices and are guided by Crisis Intervention Theory, which emphasises actions that increase long-term recovery prospects. Crisis responses support victim-survivors to make informed decisions about medical care, forensic options and legal pathways. Empowerment of the victim-survivor through the return of control is central to crisis intervention[65].

[64] https://www.police.vic.gov.au/options-guide-victim-survivors-victoria-police-perpetrated-family-violence-or-sexual-offences/reporting-in-person-at-mdcs
[65] https://workdrive.zohopublic.com.au/external/34c529bf9d42f256022e4e69d75cbd2edd567291adde0f53cfbf98f97ffd0dcf

Recommendations for reform

1. System leadership and coordination

The Department of Health must take a clear system leadership role in the delivery of forensic medical examinations (FMEs) and crisis sexual violence responses across Western Australia. Responsibility for the provision and coordination of FMEs cannot rest with individual Health Service Providers (HSPs) alone. The findings and themes emerging from our long term and ongoing consultation with frontline services and victim-survivors reinforces that a statewide approach is required to address longstanding inadequacies in service delivery and access to specialist care. Without leadership the system will continue to remain fragmented.

A whole-of-system approach is required to design and implement a more effective and sustainable forensic medical examination system. This includes establishing a clear statewide model of care, defining and clarifying roles and responsibilities, ensuring consistent clinical governance, and monitoring service performance. The Department of Health is uniquely positioned, as the WA health system manager, to provide the oversight and coordination necessary to drive reform and support continuous improvement across the system to the benefit of victim-survivors of sexual violence.

The Department must take responsibility for leading and coordinating the statewide response rather than delegating this responsibility to individual HSPs. While HSPs play a critical role in delivering services locally, they do not have the authority nor capacity to resolve the systemic issues that affect the forensic medical examination system as a whole. Leadership is required to create consistent accountability mechanisms and coordination to ensure that hospitals, police, forensic medical services, and specialist sexual assault services are working within an integrated and victim-centred framework.

Central leadership is also essential to address workforce challenges identified across the system. A coordinated approach is needed to develop a sustainable forensic workforce, particularly in regional and remote areas where service gaps are extremely pronounced. Without statewide workforce planning (and critically, investment in this workforce), access to timely and appropriately skilled forensic practitioners will continue to be inconsistent, compromising both victim-survivor care and the collection of forensic evidence.

Importantly, the effectiveness of any FME service and crisis sexual violence response is dependent on the existence of an ongoing sexual violence service system. FMEs cannot operate or be delivered effectively in isolation. Victim-survivors require immediate crisis support, advocacy, counselling, case coordination, and ongoing therapeutic care before, during, and after a forensic examination.

At present, there is not a sufficient baseline level of sexual violence service infrastructure across Western Australia to support a consistently crisis response to sexual violence. Significant service gaps, particularly outside metropolitan areas, mean that many victim-survivors are unable to access the specialist support necessary to complement FME care. As a result, efforts to strengthen FMEs must occur alongside investment in specialist sexual assault support services. Strengthening one element of the system without the other will not deliver the integrated, trauma-informed response that victim-survivors need.

For these reasons, the Department of Health must provide strong statewide leadership of both the forensic medical examination system and its interfaces with the broader sexual violence service system. Sustainable reform requires a commitment to building the foundational service infrastructure needed to ensure that all victim-survivors, regardless of where they live, can access timely, high-quality, and trauma-informed care.

2. Invest in a crisis sexual violence response

WA urgently needs investment in a properly resourced, statewide crisis response system for people who have experienced sexual violence. While timely access to forensic medical examinations (FMEs) is an essential component of this response, reform efforts must go beyond FME access. A comprehensive crisis response must recognise that victim-survivors present with a range of immediate medical, psychological, emotional, practical and safety needs that cannot be addressed through forensic evidence collection alone. The primary focus of any response should be the health, safety and wellbeing of the victim-survivor, with forensic processes embedded within a broader framework of trauma- and violence-informed care.

Critical components to include as part of this are:

- Strengthening referral pathways between hospitals and their local sexual assault support services to ensure continuity of care before, during and after a forensic medical examination.
- Funding outreach/in reach models that enable sexual assault support services to attend hospitals and other relevant settings to accompany and support victim-survivors throughout the forensic medical examination process and link them into ongoing support and care
- Funding the co-locating of FME workers in non-hospital settings, including specialist sexual assault support services, Aboriginal community-controlled health services, women's community health centres and other trusted community-based locations
- Investment in the baseline specialist sexual violence services across WA as part of the DOH Women's Community Health Commissioning Program.

Access to forensic medical examinations must be more equitable across the regions of WA. Currently access remains inconsistent, with significant gaps in service availability across regional areas and in locations such as Peel, where the local hospital does not currently undertake FMEs. As a result, some victim-survivors face lengthy travel, delays in care, or challenges in accessing forensic services at all. These barriers are contributing to increased distressed, reduce engagement with support services, and affecting the collection of forensic evidence. There must be a clear commitment to statewide access to support victim-survivors across WA.

However, improving access to FMEs alone will not deliver the evidence-based response that victim-survivors require. Consistent with findings from interstate reviews and best-practice service models, FMEs must operate as part of an integrated crisis response system that addresses the full range of victim-survivor needs. This requires investment in specialist sexual violence services that can provide immediate crisis intervention, advocacy, emotional support, safety planning, information about options and rights, referrals to other services, and ongoing follow-up support. These services are critical in helping victim-survivors navigate complex health, justice and social service systems while supporting recovery and informed decision-making.

An integrated crisis response model should bring together specialist sexual assault counsellors and forensic medical practitioners as part of a coordinated service. As highlighted in models of practice operating in other jurisdictions, including New South Wales, the effective responses are those in which specialist counsellors and forensic examiners work in partnership to address the immediate psychosocial,

emotional, medical and forensic needs of victim-survivors. In these models, forensic examinations are not delivered in isolation but are embedded within a holistic crisis response that prioritises the person's wellbeing and sense of control throughout the process.

This approach recognises that victim-survivors often require support before, during and after a forensic examination. Prior to an examination, specialist advocates and counsellors can provide information, emotional support and assistance to help victim-survivors understand their options and make informed choices. During the examination, they can provide therapeutic support and help reduce the risk of re-traumatisation. Following the examination, they play a critical role in supporting safety planning, facilitating access to ongoing counselling and health services, and assisting victim-survivors as they navigate decisions about reporting and recovery.

A person-centred and trauma-informed response requires continuity of care rather than an episodic focus on forensic evidence collection. Victim-survivors consistently identify the importance of being listened to, believed, supported and provided with options throughout their engagement with services. An integrated crisis response system should ensure that FMEs occur within a framework of care that promotes recovery, safety and wellbeing while preserving access to justice options if and when victim-survivors choose to pursue them.

Consideration must also be given to co-locating FME practitioners within community-based settings, including specialist sexual assault support services, Aboriginal Community Controlled Health Services, women's community health centres and other trusted locations outside of emergency departments. As outlined in this submission, there are significant issues with the only access to FMEs being via emergency departments in hospitals. Some individuals will feel more comfortable accessing care within community settings that are culturally safe, familiar and less clinical in nature. Co-location can reduce barriers to access, improve engagement with services and create opportunities for more holistic responses that integrate FMEs, health, and psychosocial support.

An integrated crisis response should also include a proactive contact and referral process linked to the management of forensic specimens. Prior to the destruction of forensic samples, victim-survivors must be contacted through a sensitive, trauma-informed process that provides information about available options and facilitates connection to specialist support services where desired. Providing an opportunity

for re-engagement before specimen destruction acknowledges that recovery is not linear and that needs can emerge or change over time.

Importantly, this approach represents a preventative and proactive public health response, ensuring that victim-survivors are not only supported in the immediate aftermath of sexual violence but are also offered pathways to care and support at key decision points throughout their recovery journey. By building this mechanism into the system, WA can strengthen victim-survivor wellbeing outcomes through long-term engagement with support services.

3. Develop the forensic medical workforce

There is a clear opportunity to draw on the expertise of local specialist sexual assault support services and the nursing workforce to strengthen this critical part of the sexual violence response. Many jurisdictions are implementing Sexual Assault Nurse Examiners (SANE) to improve access to trauma- and violence-informed, person-centred care following sexual assault. Recognising and strengthening this workforce presents an important opportunity to address longstanding access issues, particularly in regional, remote and after-hours settings, while supporting a more sustainable forensic medical examination (FME) system

Opportunities for reform include:

- Ensuring dedicated Sexual Assault Nurse Examiners are available across public hospitals, with particular attention to regional and after-hours access.
- Formally recognising the expertise and specialisation of Sexual Assault Nurse Examiners through appropriate role descriptions, remuneration, entitlements and conditions. This recognition should reflect the seriousness of the role, the additional responsibilities involved, the need for ongoing specialist training, and the likelihood that practitioners may be required to provide evidence in court.
- Embedding court attendance and forensic responsibilities clearly within role descriptions, while also placing responsibility on the Department of Health to provide the training, supervision, support and capability-building required for staff to undertake these duties safely and confidently.
- Embedding SANEs into the model of care as part of the DOH's recommissioning of the Sexual Assault Support Services.

The role of SANEs should be formally recognised as an area of specialised practice within the nursing profession. SANEs undertake complex clinical, forensic and trauma-informed responsibilities that extend well beyond the scope of general nursing roles. Appropriate recognition should be reflected through dedicated role classifications, remuneration structures, conditions of employment, and professional development pathways. This recognition should acknowledge the expertise required to undertake forensic examinations, the emotional and psychological demands of the work, and the significant responsibilities associated with providing evidence that may be relied upon in court proceedings.

Formal recognition would also strengthen recruitment and retention efforts by creating a clear and valued career pathway for nurses seeking to specialise in sexual assault and forensic care. These workforce responsibilities must be matched by a commitment from the Department of Health to provide the necessary infrastructure and support for practitioners. This includes investment in training programs, ongoing professional development, clinical supervision, peer support networks, mentoring opportunities and mechanisms for maintaining clinical competency.

4. Develop innovative responses

A deliberate focus must be placed on addressing the persistent access barriers experienced by priority cohorts who face additional and often compounded barriers to support. While the establishment of a minimum statewide service response is a critical step, a one-size-fits-all model will not meet the diverse needs of victim-survivors. If reform is not deliberately co-designed with the communities most likely to be excluded, the system will continue to reproduce the same inequities, and the experiences of these victim-survivors will remain invisible.

For many victim-survivors, an FME should be a gateway into integrated multidisciplinary care, including immediate health care, crisis support, advocacy, safety planning, therapeutic referrals and justice options. If priority cohorts cannot access this in ways that are culturally safe, disability accessible, geographically close, they will continue to bear the cost of this ongoing harm. Priority cohorts experience many additional barriers to disclosure and help-seeking and require tailored responses that reflect their specific circumstances. The development of specialist resources, accessible information and tailored service models for different cohorts will be critically important. These must be co-designed including with

victim-survivors with lived experience, so that they reflect how people actually seek help, address the barriers they identify, and are trusted by those they are intended to support. For Aboriginal victim-survivors, this means these models must be genuinely Aboriginal-led and self-determined. Without this the system will continue to exclude the very people who require the most deliberate access to care.

Conclusion

Access to forensic medical examinations has been an issue for many years. Lived experience advocates, frontline sexual assault services and others have consistently been raising the inadequate responses that too many victim-survivors are receiving, and that are too frequently causing secondary victimisation.

These concerns are not limited to FME access exclusively but reflect broader systemic failures that leave victim-survivors without timely, coordinated and trauma-informed care at one of the most vulnerable times in their lives. Too often, these failures are contributing to secondary victimisation, where the systems intended to provide support instead create further harm, distress and isolation.

WA lacks a comprehensive, statewide crisis sexual violence response that ensures all victim-survivors can access immediate specialised support following sexual assault. Access to a FMEs is a critically important but only one part of the response that victim-survivors require. People affected by sexual violence also need access to crisis counselling, advocacy, information, safety planning, emotional support, healthcare, referrals and ongoing recovery services. Without this broader infrastructure, even the best FME service model will fall short of meeting victim-survivors' needs. Reform efforts must therefore recognise that FMEs must be delivered as part of an integrated crisis sexual violence responses that centres the health, safety and wellbeing of victim-survivors.

It is deeply hurtful to read reports from more than two decades ago that make many of the same recommendations that we do in this submission. There is a wealth of evidence informed by lived and living experiences of victim-survivors and frontline workers.

CWSW believes in change. We know it is possible. It is time now for us to act to create safe, dignified responses to people who have experienced sexual assault.

We are beyond thankful to the Auditor General of WA and the audit team who have taken the time to interrogate this issue. We are hopeful that it will lead to meaningful long-term change.

We finish this submission with a quote from a 2005 Australian Institute of Criminology study of women's help-seeking decisions and service responses to sexual assault, which still feels relevant more than two decades later[66]:

> "***Many research participants were disillusioned with the criminal justice system, but their participation in this study was motivated by the belief that system change is possible and by the hope that they will be heard and their words acted on. They are no longer willing to be silent. Are we, as a society, willing to listen, learn and act?***"

[66] https://www.aic.gov.au/sites/default/files/2020-05/no-longer-silent-a-womens-help-seeking-decisions-and-service-responses-to-sexual-assult.pdf