A RIGHT TO SAFETY

NOT MY CORE BUSINESS

Domestic Violence Homicides:
Where does risk identification sit?
Why does risk assessment matter?

Government of South Australia
Office for Women

South Australian Agenda to reduce violence against women

The National Plan to Reduce Violence Against Women and Their Children. → **Outcome 5,Strategy 5.2.2** : sharing outcomes of reviews into deaths and homicides related to domestic violence.

The South Australian State Strategic Plan → **Target 18:** A significant and sustained reduction in violence against women through to 2022 (baseline 2005).

A Right To Safety: State reform agenda

Strategies

- **Violence Against Women Collaborations** address and monitor violence at community level
- **Family Safety Framework** to address high risk
- **Senior Research Officer (Domestic Violence)** to identify and examine systemic issues arising from DFV Deaths

Taking A Stand: Responding to Domestic Violence

Strategies

- **Improved Police responses**
- **Women's DV Court Assistance Service**
- **Early Warning System**
- **White Ribbon Accreditation across Government**
- **Legislative reform (strengthening penalties/name changes)**

Homicide in South Australia

Since 21 March 2010:

112 people have died through assault or violent means (this includes deaths across the following relationship type: No relationship, Acquaintance, Intimate and Family relationship)

Intimate / family relationship

37 people have died through external assault or violent means with the known offender (criminal matter finalised) or suspect (where cases are unresolved in the courts) being either a current or past intimate partner or a close family member

24 of these deaths were females: 19 adult females and 7 children

Broader impact of violent deaths

These deaths may not be included in the 'known offender' category because they were intervening in a violent situation (this can include new partners of DV victim), however they represent the impact of violence in the community, beyond the death of a victim. Suicide deaths are not recorded in the above information and of the **8 people to be killed in multiple fatalities, 6 were innocent third parties to the acts of violence and had no relationship to the offender.** In short, the effect of these deaths are wide reaching and involve many more families and communities than represented in the individual homicide statistics.

**There should also be a (conservative) 10% margin of error associated to these figures due to the manual collation of the statistics

“Three women are hospitalised each and every week in this country with a traumatic brain injury – the result of an assault by her partner or ex-partner”

Source: Brain Injury Australia

“Mental health issues are the strongest indicator for clinicians of an association with partner abuse for women attending general practice. However, in this study, multiple physical symptoms were also strongly associated with intimate partner abuse (in particular tiredness, diarrhoea, and chest pain).”

“… a combination of sociodemographic features, mental health issues and an increasing number of common psychosocial physical symptoms should alert clinicians to the possibility of partner abuse”

Source: Hegarty et al, Physical and Social predictors of partner abuse in women attending general practice: A cross sectional study, British Journal of General Practice, July 2008

“Prior non-fatal strangulation was associated with a six fold odds of becoming an attempted homicide, and over seven fold odds of becoming a completed homicide. These results show non-fatal strangulation as an important risk factor for homicide of women, underscoring the need to screen for non-fatal strangulation when assessing abused women in emergency department settings.”

Source: J Emberg, Non-fatal strangulation is an important risk factor for homicide of women, National Institute of health, 2008

“Studies indicate that women who are affected by intimate partner violence are more likely to have alcohol problems, to smoke (Loxton et al 2006) and to use non-prescription drugs (Quinlivan & Evans 2001) than women not affected”

“VicHealth (2004, p77) found that alcohol harm, illicit drug use and tobacco consumption were further contributors to the disease burden associated with domestic violence (5%, 2% and 14% respectively).”

Source: In Braaf, R and Barret, I: Domestic violence and mental health, Australian Domestic Violence Clearinghouse May 2013

“In a review of 13 studies, Golding (1999, p 112) found suicidal tenancy rates of up to 77% among women who experienced Violence by a partner”

Source: In Braaf, R and Barret, I: Domestic violence and mental health, Australian Domestic Violence Clearinghouse May 2013

“90% of paramedics had attended a case of domestic violence in the last year, while four in five said they felt less than confident about managing the situation”

Source: Emergency Medicine Australasia journal

Of working women in Australia:

"nearly a third of respondents (30%) had personally experienced domestic violence, with 5% stating that the violence had occurred in the previous twelve months and 25% stating it had occurred more than a year ago" " A further 20% had not personally experienced domestic violence but knew someone in paid employment who had"

"Of those who had discussed the violence with someone at work, almost half (48%) had disclosed the violence to their manager/supervisor, though only 10% found their response helpful"

Source:The *Safe at home, safe at work: National domestic Violence and the Workplace survey (2011)*

Evidence is emerging that cases where both domestic violence and child abuse occur represent the greatest risk to children's safety (Stanley 1997; DePanfilis & Zuravin 1999; Miller, Fox & Garcia-Beckwith 1999) and that large numbers of cases in which children are killed have histories of domestic violence (Wilczynski 1996; Edleson 1999b; Fleck-Henderson 2000).

Source: Australian Domestic and Family Violence Clearinghouse Topic Paper:
Domestic Violence in the Context of Child Abuse and Neglect

The *Personal Safety Survey, Australia, 2005* also found that 59% of women who had experienced violence by a previous partner since the age of fifteen were pregnant at some time during the relationship. Of these women, 36% reported that **violence had occurred during a pregnancy** and 17% had **experienced violence for the first time when they were pregnant**

Source: Personal Safety Survey, ABS 2006, p. 11

“women who had experienced violence by a previous partner (57%) had **left and returned** at least once (Australian Bureau of Statistics 2007).

“…. **separation** was an especially significant risk factor for homicide. Just over one-third of murdered women (36.8%) were divorced or separated at the time, compared to 19.7% of women who experienced non-lethal violence.

The researchers identified jealousy, possessiveness and disputes over children as increasing **the risk of violence following separation**”

Women may also be concerned for the safety of their children and other loved ones. In Humphreys and Thiara’s (2003, p. 200) study of post-separation violence, 18% of women reported **threats to other family members**.

- On an average day in 2010-11, 59% of all new requests for immediate accommodation were unable to be met by Australian homelessness services funded under the Supported Acommodation Assistance Program (SAAP).i

63.2% of women who experienced physical violence at the hand of a male partner (current or previous), boyfriend or date in the previous twelve months **did not report the most recent incident to the police**

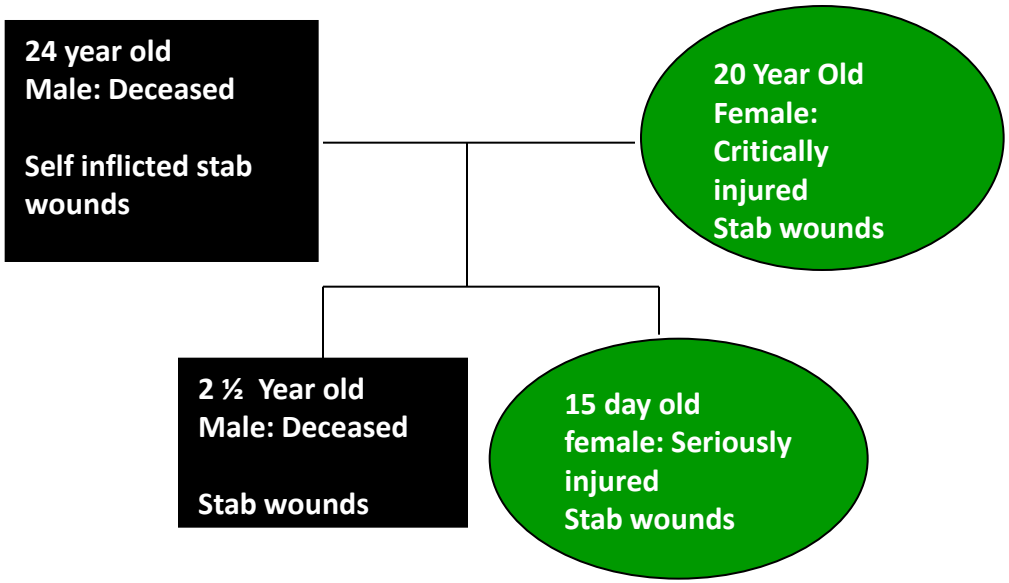
Source: Personal Safety Survey, ABS 2006, p. 21

Risk factors in IPH(Family Safety Framework)

- Victim is pregnant or there has been a recent birth
- There has been a recent separation or the victim wishes to separate
- There is an actual or perceived new partner
- in the victims life
- Offender has strangled or choked the victim during an assault
- Offender has used sexual violence or coerced victim into unwanted sexual practices
- Offender has stalked the victim
- Offender appears obsessed with the victim or children
- Offender appears jealous, bitter or hostile towards the victim or children
- Offender has recently been denied or restricted access or contact with children.

Inquest: Jakob and David WYATT

Full findings delivered 20 February 2012 and available at www.courts.sa.gov.au/coroner



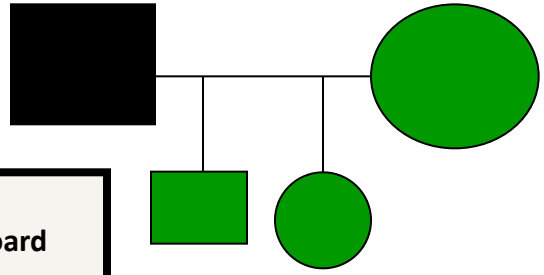
2005-2009

Mental health
- James Nash House
- Community Forensic team
- Community treatment orders
- MAC Team
- MH Triage

NEAMI – Non-Gov MH support

Justice
- Parole Board
- DPP
- District Court
- Prison & Community Corrections

SAPOL
- Arrests- Offensive weapon
- Breaches
- MH detention



Health
- ED
- Psychiatric Admissions

DASSA
- Counselling
- Urine Screening

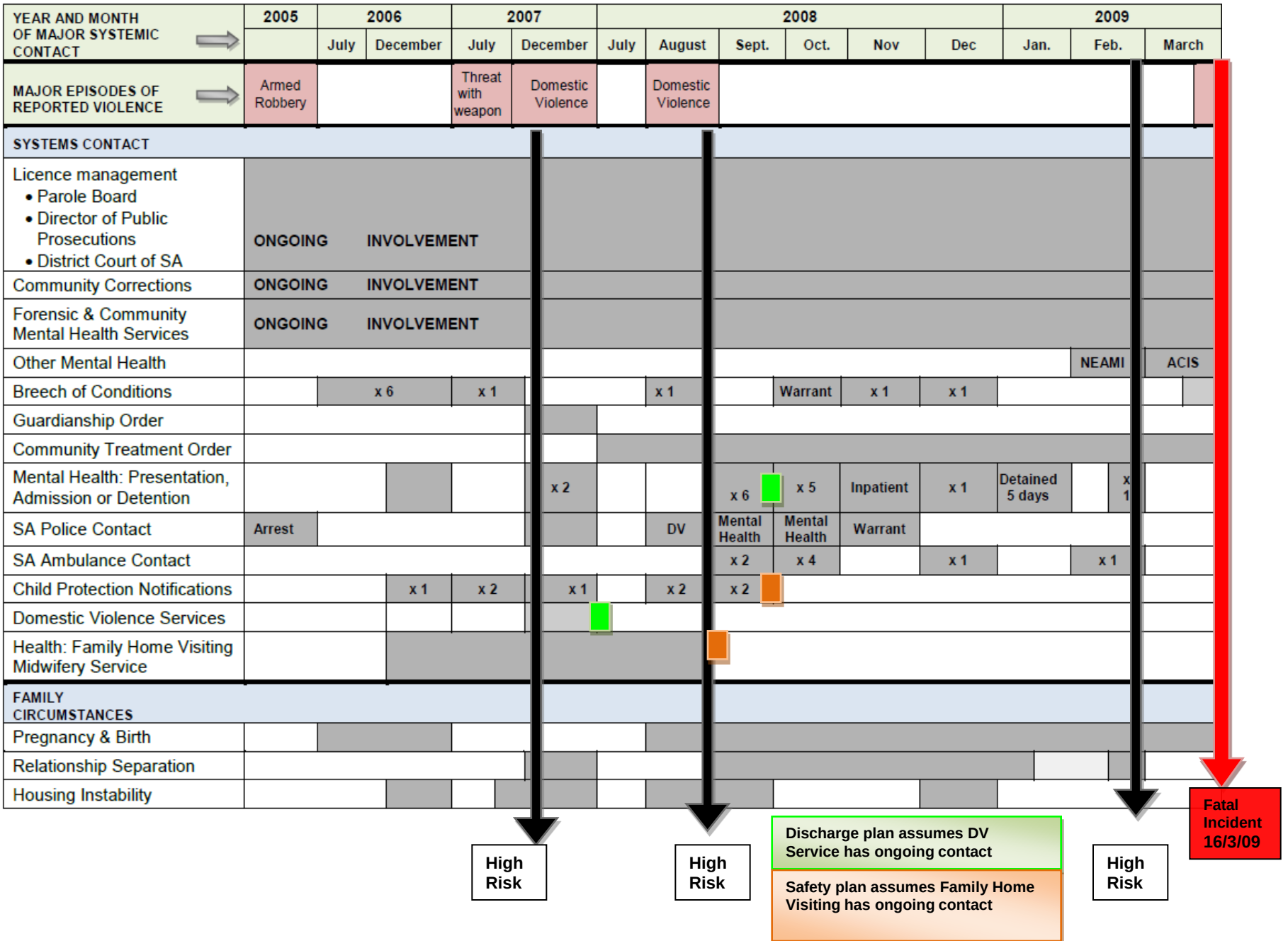
FamiliesSA
- 6+ Child protection notifications
- Numerous – financial support

Health –
- CYWHS – Family Home Visiting

Domestic Violence Crisis Services

SAPOL
DV responses

Timeline of system contact and circumstances



Coronial Findings

That proximate to the deaths, there were lost opportunities for assessment of risk for the family and comprehensive safety planning / support to be enabled, across **all** of the agencies involved.

> "A number of organisations had reason to be concerned. It is plain that there was a significant lack of communication between the various agencies"

Domestic Violence was not attended to as an element of the family safety.

> "..the element of domestic violence that was apparent to many agencies involved, including DCS, James Nash House, all of the health services and Familes SA. The only intervention which focussed upon the case from a domestic violence viewpoint was that of SAPOL after the assault in 2007"

Full Findings at: www.courts.sa.gov.au/coroner

Coronial Findings

"Information Sharing between agencies and the mobilisation of resources to effect the Family Safety Meeting outcomes is paramount to minimising the risk of future harm and potentially preventing deaths in the context of ongoing and escalating domestic violence.

The Family Safety Framework is a **formal systemic response to addressing risk and promoting safety**. Therefore it should be noted by agencies that **their implementation of the framework will be examined in future Inquests where there is a context of domestic violence.**"

Coronial Recommendations

Family Safety Framework

4) That the relevant Ministers of Agencies party to the FSF, note their responsibility to have **operational capacity** to utilise the FSF mechanisms from **all parts** of their Agency and **across all disciplines** within the agency. This is particularly relevant in large Agencies which have a broad portfolio of multi-disciplinary services ranging from community based support services to emergency and/or tertiary services.

Coronial Recommendations

Family Safety Framework

5) That the Agencies party to the FSF should ensure that their staff have appropriate **knowledge and training** to **identify and assess** cases to determine risk under the FSF. Where 'high' risk of future violence is determined each Agency should have **clear referral and feedback pathways**, through nominated representatives, to Family safety Meetings as well as **clear feedback mechanisms** to inform case and safety planning for interventions specific to that Agency.

“Rapport is key, I didn’t want to ruin that”

“There are privacy and confidentiality considerations”

“I don’t want to compromise safety”

“It’s the patients choice, they didn’t want to do anything”

“If it is an issue its up to the person to disclose that”

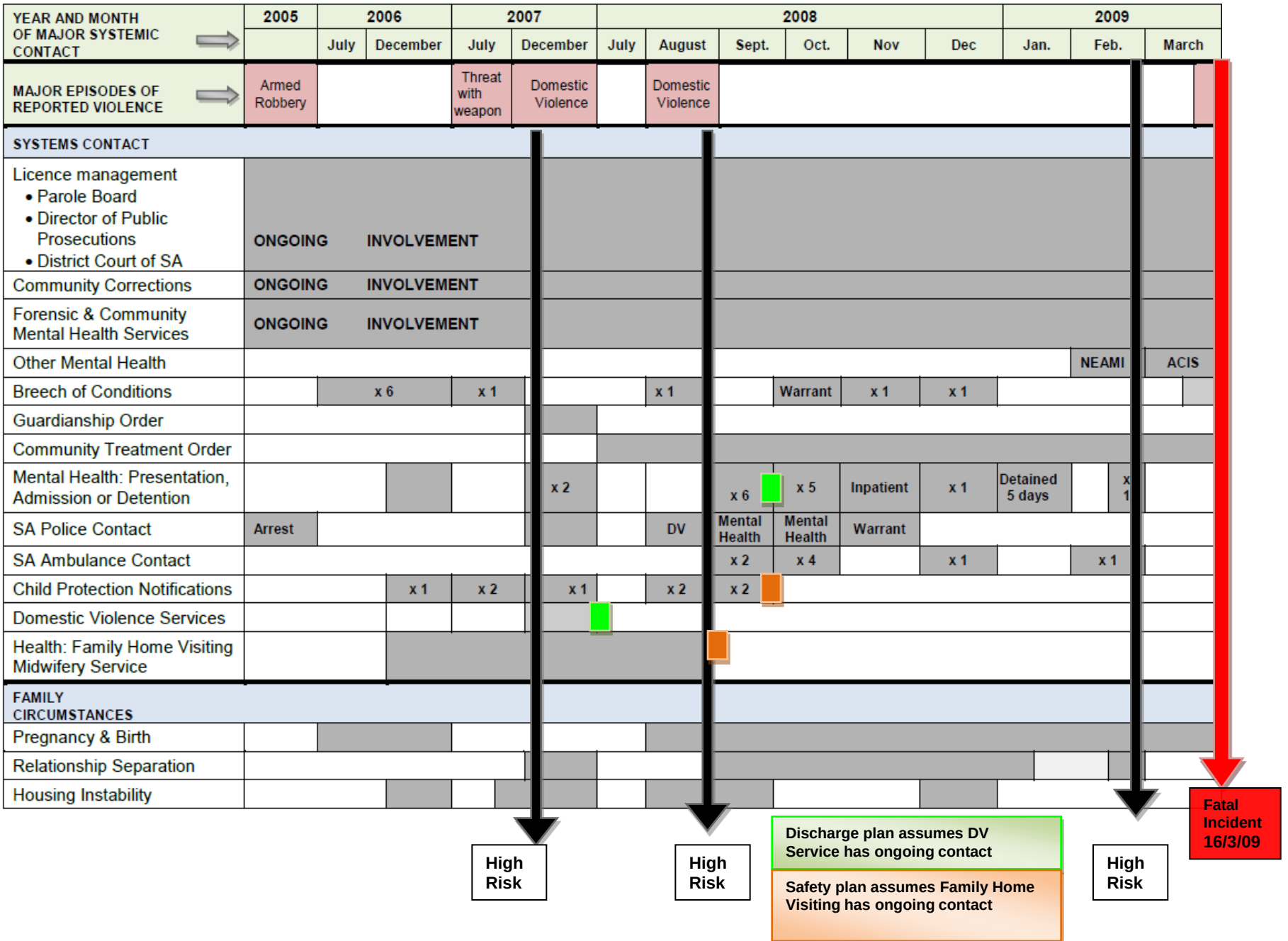
“I need to speak directly with the person, I can’t operate on hearsay [third party disclosures]”

“I’m not an expert, it’s not my field”

“There are specialist agencies to deal with that”

“It’s not my core business”

Timeline of system contact and circumstances



Do you understand the impact of domestic violence?

A. There was certainly, on the referral there were concerns with the history of [name excluded]and David, and they were just concerns that we were made aware of, and that was the intellectual disability and the mental health issues.

Q. An intellectual disability, that concerns her does it.

A. Yes, that's right.

Q. When you say intellectual disability do you actually know whether she had an intellectual disability or not.

A. Not diagnosed, no.

Q. Did you perceive her as having an intellectual disability.

A. I perceived her as having some level of intellectual disability.

Q. How did that manifest itself to you. How did that present.

A. That she was probably a little bit slower to grasp information and I would need to have reiterated information, and then to make sure that she had the information I would ask her and get a reply whereas with a normal sort of intellect I wouldn't have to go into it as much detail.

Are you mindful of your own values? Do you understand risk elements?

Q. At the discharge meeting at James Nash House, you realised that the partner was pregnant.

A. Yes.

Q. You realised that the introducing of a new baby into a household would be stressful.

A. That was one of the things that just did not occur to me. I mean I have three children, I don't know why it didn't occur to me, I just kind of thought it was a joyous event and it would be nice. For some God forsaken reason, I just kind of overlooked the magnitude of that.

Are you able to talk to victims? What framework/understandings/assumptions are you making?

A. We specifically interviewed her - a social worker has documented there - did specifically interview her and David together to ascertain whether in fact she was keen to have to have him back or not, whether there was any ambivalence on her part - because if there was we would have looked at alternative accommodation, which we had been exploring, but on the basis of that interview she was fairly clear that she wanted him back and, more importantly because of the birth of the child, for help. And given the fact that they were fairly co-dependent we felt that that would be the best course of action, providing that there were supports.

Q. And when you say the social worker interviewed them together, does that mean that she was not spoken to alone.

A. Whether she was spoken to alone as well, I can't be sure.

Q. In circumstances where there has been a history of domestic violence and what might be seen as a physical power imbalance between the two parties, do you think it would be appropriate to have discussed the matter with her alone.

A. Yes.

Q. And would you expect social workers at James Nash House to be alive to that.

How are you defining domestic violence. What assumptions are being made?

Q. Well, perhaps putting that to one side, and given what you do know about David and his condition and his history and if we just look at the issue of there being a baby due any day now, what is your view with respect to David's likely reaction to there being a new baby brought into the house.

A. My experience with David was that he was very committed to - although is actions didn't always demonstrate that, but verbally he was committed to maintaining the family unit. He was very keen on present to assist her, and in fact from what I know in the past he did assist her in a great way in terms of shopping and helping her out with the baby, but then of course this was then obstructed by their disputes from time-to-time in which, on occasion, they'd separate. But he was very keen to always be reunited with her. She would wax and wain or change her mind about that from time- to-time - and that's to be expected given the circumstances, but before he was discharged on that occasion she had indicated that she wanted him back. And If I, you know, having knowledge of the fact that the baby was due, it would be important to try and maintain the family unit - providing, of course, they had adequate supports. So, we tried to make sure that they had adequate supports from the agencies who actually help with parenting, caring for the baby, as well as the safety plan that I talked about - whilst at the same time ensuring that his mental state was stable. It's always a balancing between, I guess, trying to manage him in the least restrictive environment whilst at the same time protecting the community, himself and his family - or bringing him into hospital and perhaps diffusing something temporarily, but that may then actually disturb the dynamic further. So, it's sort of weighing that up

Are you assessing risk based on all the available information? Is risk assessment and safety a shared responsibility?

Q. If we go to p.48, this might help you out a little. Now, this is Dr Furst's admission note, and toward the bottom of the page, we have got 'A fight with a partner over money. She slapped him then grabbed him around throat, he grabbed her back by the throat and threw her over the bed then left the house'. Were you aware of that offence which had occurred, precursor to him going into James Nash on that occasion.

Q. If you had have read the admission note of Dr Furst, you would have seen that he has assaulted her, and then going on to p.50, you would have seen that he has overdosed on olanzapine and has ideas of reference, he has auditory hallucinations, paranoid and guarded.

A. That information wasn't shared with me at a ward round.

Q. So your knowledge then and what you think now is that he was brought in because he had breached his licence, that's it.

A. Carrying an offensive weapon was my understanding at that time, yes.

Not your ‘core’ business but is it still your business?

Q. Is there any way that you could have found out some more information than what you did have at the time of this meeting with her and discussing with her, her alleged safety.

A. Given that David was the primary client, I didn't have a lot of information regarding any Families SA involvement, any previous state of her in a shelter. I had no information from apparent domestic violence crisis service workers that was shared with me. I'd never been contacted by any of her workers. A majority of my work was simply ensuring that he was discharged smoothly with supports in place with the occasional counselling. Should he feel the need to speak to a social worker, I was always available for him to speak with.

Q. Wasn't it the fact that you said in your evidence that you were at this discharge and round this period, you were at a loss of where to place him in the community. So therefore with David as your primary client you have looked at the easy option and that was Ms X.

A. We wanted to maintain the family unit. David wanted to return home. Naomi was happy to have him. That is sometimes the easier option, yes, looking at immediate family first before placing him in a boarding house.

Q. An easier option but you hadn't informed yourself about the history of the family that you were about to put back together again.

What are you recording? What does it mean? How will others interpret this?

Mental Health Nurse case note:

David is very unsettled today. He has tried to call [partner] 14 times and he is quite upset.

Do you recognise risk? How can you feel confident to have this conversation? Who needs to assist you?

Financial Counsellor:

[Partner] attends for financial assistance and the reason for needing to leave the home is noted as ‘ last night David broke into the house with a scissors and tried to strangle her”.

Why record anything? What is your assessment? Who will interpret it?

Midwife case note:

1st visit: *Male not wanting Female to breastfeed*

2nd visit: Male *verbally aggressive and controlling. He is trying hard to be a good father.*

Q.	Could you read that out to the court please.
A.	'Male not happy with female's decision to try breastfeeding'.
Q.	In terms of that entry, does that raise any concerns for the potential risks to this family.
A.	That's controlling behaviour.
Q.	In July of 2011 had you come across such a indication by a father to a mother not to breastfeed their child.
A.	Yes.
Q.	Is that ever a positive indication.
A.	If it's said in light of the mother's mental health or coping ability and they're trying to help, they've got the idea that - if the fathers have got the idea that bottle feeding is easier, that they can help more. So we do sometimes, yes, hear it in that context.
Q.	I see but it can also raise issues in other context, can't it.
A.	Yes.

How do you attend to separation – as a safety factor or as a heightened risk?

Q. So that if someone might start off at high risk if they didn't address things like the security of where they were living and so on and if they still had contact with the other party they might remain at high risk.

A. If they were still in contact then yes, they were high risk.

Q. If safe accommodation had been found for them and there was no longer contact with the other party, then they might fall down the list of priorities.

A. Correct.

How are you 'defining' the problem? Are you assisting the victim to minimise the violence?

Q. But is it correct to say that the lowest priority was -it was a relatively low priority, because you were dealing with victims, to actually go out and apprehend perpetrators.

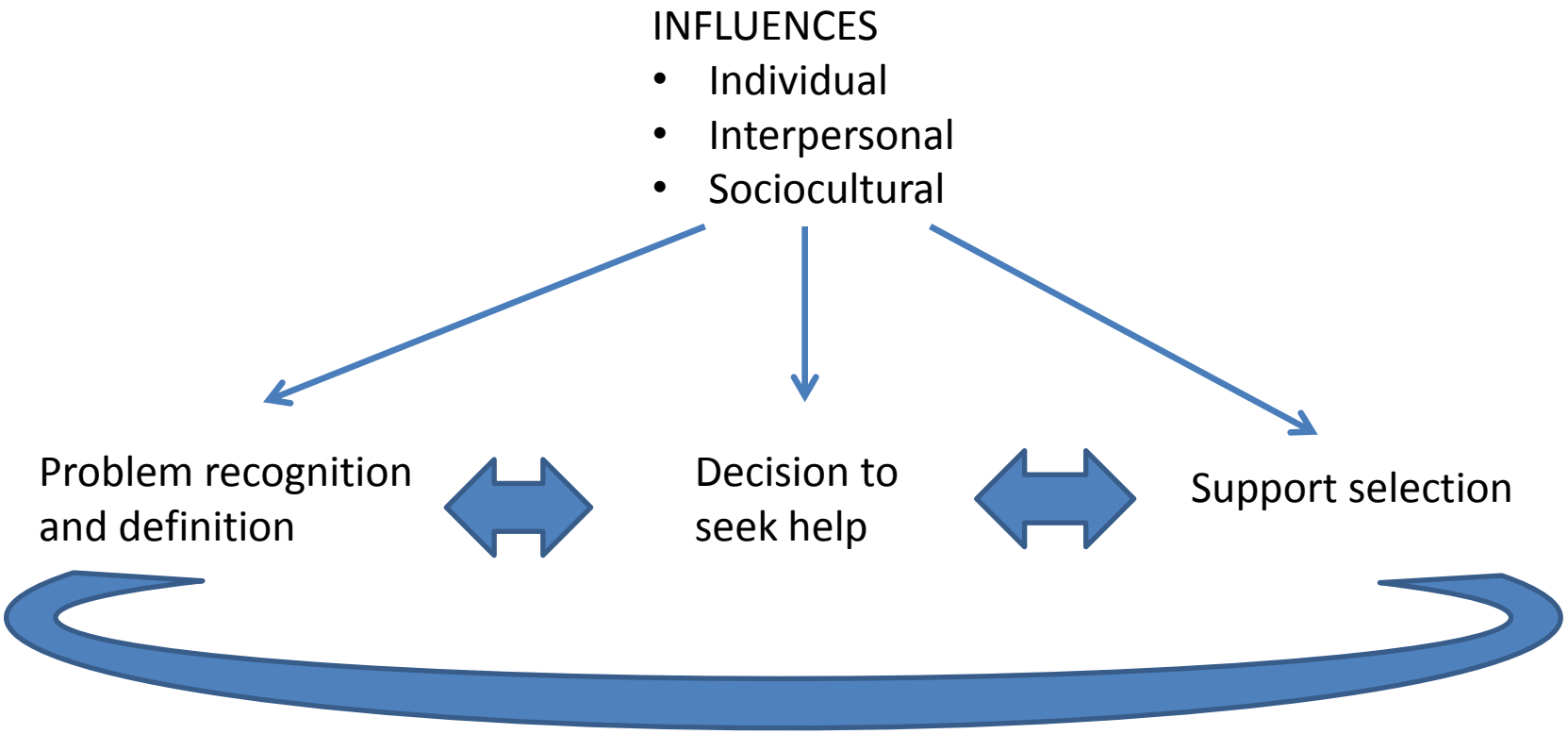
A. It came down to what the offence was and this PIR, it was a kick and a slap and that's still - it's still an offence, that's still horrible that a family has to go through that, but that's -

Q. But if you looked at it more closely you would see that it wasn't just a kick and a slap though, wouldn't you.

A. But in relation to the other matters that were happening in the area at the time, that there were more dangerous offenders at that time that posed greater risk to the families in the area.

Q. So I mean this man actually threatened to burn down the house with his family in it. So are you saying that the situation was so chaotic that you had many, many other offenders who were guilty of more serious crimes than the threatening of the life of four people.

A model of help seeking and change



Source: Liang et al, A theoretical Framework for Understanding Help-Seeking Processes Among Survivors of Intimate Partner Violence, *American Journal of Community Psychology*, Vol 36, Nos. ½, September 2005

Systemic issues being identified

- Evidence of information sharing beyond the FSF/MAPS i.e. between agency staff who are concerned but the matter doesn't reach the high risk threshold
- Evidence of the identification of medium risk i.e. to reach high risk threshold there must be a risk assessment – where are the medium risk assessment in case files and what is done about them
- Help seeking and disclosure – front line or first responses. How are they being improved i.e. identifying risk/referral/escalation processes? The credibility of third party reporting, again how is this attended to?

Innovation?

Professional practice implications: Information Sharing and risk assessment and risk management

- Where does this fit?
- What does information sharing mean to your practice?
- Do you see it as your role/business? Why not?
- Are **YOU** defining the individuals context of domestic violence
- Are you comfortable talking to people about risk and their experience
- Can you identify risk?
- Are you supported? Do you know what to do with risk?
- Can you afford to ignore it?

Domestic violence might not be YOUR ‘core’ business but is it ‘core’ to your PRACTICE?