Suicides of victims of domestic and family violence

The Domestic and Family Violence Death Review and Advisory Board (the Board) is responsible for the systemic review of domestic and family violence deaths that have occurred in Queensland. The Board’s role and functions are outlined in the Coroners Act 2003 (the Act).

The purpose of the Board is to identify common systemic failures, gaps or issues and make recommendations to improve systems, practices and procedures that aim to prevent future domestic and family violence related deaths.

On Thursday, 2 February 2017, the third case review meeting of the Board was convened. The Board considered six apparent suicides of victims of domestic and family violence.

This Communiqué provides a brief summary of these discussions, and outlines key themes and issues identified at the meeting. Preventative recommendations made by the Board with respect to these deaths will be made to the Minister, and published on an annual basis, in accordance with the Board’s statutory reporting requirements.

Case Characteristics

The third case review meeting considered the context and circumstances of the apparent suicides of four women who had a prior history of victimisation in their intimate partner relationships, and two young people who had been exposed to domestic and family violence within their immediate familial network.

In all cases considered within this meeting, there was contact with formal services including police, the Courts, health care providers, specialist services, and/or child safety services in relation to domestic and family violence, including immediately prior to the death.

Current protection orders under the Domestic and Family Violence Protection Act 2012 (DFVP Act) were in place to protect the adult victims in two cases. In a third, police made an application listing the deceased as the respondent shortly before her death, after a long history of violent victimisation inflicted on her by multiple former partners.

All deceased had a prior history of suicidal behaviours or acts of self-harm, and all of the deaths occurred within a period of relationship conflict or separation, (for the young people this was in their immediate familial network).

All four adult victims had co-occurring mental health, and substance misuse, problems.
Key Themes and Issues

Identification of the person most in need of protection

All adult females in the cases reviewed had previously been identified as a respondent by services, even though some had a significant prior history of victimisation. This demonstrates the need for increased understanding of when, why and how victims may use violence, and highlights opportunities for enhancing the capacity of services to identify these underlying relationship dynamics.

Where a primary victim who uses violence as a reaction to prior abuse is listed as a respondent on protection orders, it can have wide-ranging and long-lasting ramifications, including in the way that services respond to that person. It can also impact on a victim’s willingness to seek help in the future, and may increase their risk of further victimisation as it can validate and perpetuate a perpetrator’s abusive actions.

Recent legislative amendments have been enacted as part of the Special Taskforce reforms to ensure that cross-applications for protection orders are heard at the same time to assist in the consideration of any underlying relationship dynamics, and the identification of the person most in need of protection.

Finding 1: There is substantial research suggesting that women use violence predominantly as a protective strategy, or as a reaction to abuse and not as a means to exert control over others. As such, it is important that consideration is given to identifying the person most in need of protection, at every point of contact with services.

Prior history of mental health problems, suicidal and self-harming behaviours

Mental health problems were prevalent among victims, as was a prior known history of suicidal and/or self-harming behaviour. Informal supports, such as family members or friends, may not always understand the significance when a loved one expresses suicidal ideation, or know how to respond, and there is an ongoing need for awareness in this area.

In cases subject to review by the Board, while help may have been sought regarding suicidal ideation or attempts, the service response appeared to be symptomatic, sporadic and lacked a coordinated approach. Little consideration was given to the ‘bigger picture’, particularly in the context of a victims’ prior history of domestic and family violence which should have indicated a heightened risk of harm in some cases.

There were also potential missed opportunities for more intensive support from services in the cases reviewed at this meeting. As identified in the Queensland Suicide Prevention Action Plan 2015-2017, there is a need to embed in clinical practice an approach that focuses on identifying and responding to a person’s need for support as opposed to one that seeks to eliminate the immediate risk of suicide. Given the rapid fluctuation in risk that many people experience, this approach moves away from treating the presenting symptoms, and promotes consideration of the underlying factors perpetuating this behaviour.

Greater recognition that domestic and family violence may be a factor which exacerbates future risk may also be required.

1 Recommendation 99 of the Taskforce report, effective from 29 January 2016
In several cases, ongoing suicidal threats by the perpetrators were interwoven within the victims’ personal histories of suicidal ideation and attempts. Within this context, threats of suicide appeared to have been used as a technique to retain control over the victim in the relationship, particularly in the context of actual or pending separation.

There were elements of good practice from the health services noted, including proactive and supportive engagement provided by social workers within hospitals or other agencies. However, concerns relating to continuity of care were identified, with multiple staff transitioning in and out of support roles, meaning that some victims were continuously required to re-tell their story. This limited the capacity of services to develop effective rapport, reducing the likelihood of interventions being effective and potentially re-traumatising the victim.

In several cases the victim moved between hospital and health services frequently, which also impacted on the ability of the health care system to provide meaningful ongoing support.

**Maximising opportunities for intervention**

The varied reasons, and underlying motivations, for victim help-seeking was discussed by the Board. For example, in one case, while the victim sought assistance from police, by the time officers attended and the immediate conflict had de-escalated, the victim repeatedly refused to provide further statements considered necessary for the successful pursuit of criminal charges.

The reluctance by a victim to provide a statement or testify in court hinders the capacity of police to successfully charge an offender. Without the cooperation of the victim, which is supported by a statement, there may not be sufficient evidence to sustain prosecution, particularly where there are conflicting versions of events and no other witnesses.

To this extent, other avenues of providing evidence to the court were discussed, including the utilisation of video footage from body worn cameras. The use of expert witnesses, where a victim refuses to testify, has also been trialed internationally with an apparent improvement in successful prosecutions.

It was recognised that outside of ensuring the immediate safety of all parties and the enforcement of any relevant legislation, frontline officers are not necessarily best placed to address the complex dynamics of relationships characterised by domestic and family violence, with a need for more specialist and longer term responses. Recently, ‘co-responder’ models have been trialed in certain police districts in Queensland, in which a specialist domestic and family violence practitioner works alongside police to provide a more nuanced intervention, subsequent to the initial call for service.

The perceived ‘severity’ of sentencing was discussed with reference to perpetrators who had inflicted significant physical injuries on their partners receiving short or suspended sentences. It is salient to note recent legislative amendments, since these deaths occurred, including the introduction of new domestic violence aggravated offence categories, as well as a specified offence for non-lethal strangulation, which are designed to increase penalties for these types of offences.

In relation to these legislative amendments, the Board acknowledged recent training for police that has been rolled out statewide to ensure all officers are aware of their responsibilities under the new changes.
It was further identified that it may be important to roll-out comprehensive and appropriate training to other relevant stakeholders to ensure they are adequately equipped to identify the signs and risk associated with non-lethal strangulation, and ensure referral to appropriate medical treatment.

Further, while maximum penalties for specified offences have increased, legal practitioner training may also be required to improve the successful prosecution of such matters.

However, there are still barriers limiting the information available to the court in relation to domestic and family violence cases, as criminal and civil proceedings are heard separately in most courts\(^1\), and because summary offences are heard within the court district the offence occurred. As such, information pertaining to proceedings in other court districts across the state may not be readily accessible to a Magistrate to inform their decision-making for domestic and family violence related offences.

Further, while assistance is offered by specialist court support workers during the civil application process, these supports are not necessarily available during related criminal proceedings consistently across the state.

**Finding 2:** Evaluating the impact and effectiveness of recent legislative amendments that aim to strengthen the criminal justice system response to perpetrators of domestic and family violence, and improve outcomes for victims, is important.

**Finding 3:** Where criminal proceedings are ongoing, an exploration of current support models for victims of domestic and family violence as they negotiate the criminal justice system may be required; including opportunities to improve the provision of support in this area.

**Specialist support in crisis accommodation**

Two of the female victims whose deaths were reviewed by the Board were residing at women’s shelters at the time they died.

Entering a refuge to escape a violent relationship represents a period of heightened risk. Being forced to flee a violent partner can be extremely distressing, and may leave a victim with a strong sense of hopelessness or loss associated with the separation. There can also be a range of specific stressors associated with entering a refuge such as a loss of immediate social connections, the need to obtain longer term accommodation, or financial hardship.

In this regard, suicide risk among female victims of domestic and family violence may increase in circumstances where a victim has sought crisis support, with research indicating that about one-third of women experience suicide ideation or attempts during this time.

The Board acknowledged that residing in a refuge can be very isolating, particularly as a victim is often moved away from their local community as a protective measure to reduce the likelihood of the perpetrator locating them.

\(^1\) The Southport Domestic Violence Specialist Court hears both civil and criminal proceedings.
However, while it is important for staff to be aware of this sense of isolation, it is critical that safety policies and procedures are adhered to. For example, one refuge allowed the victim’s adult children to visit her at the shelter which was a breach of safety protocols designed to ensure that the shelter remained private. This exposed the victim to additional pressures due to the enmeshed familial relationships between her family and the perpetrator’s, leading to an escalation in violence against her adult children as the perpetrator subsequently attempted to locate her.

As seeking refuge in crisis accommodation may be a period of heightened risk of harm for some victims, regular monitoring by staff should form part of standard procedure, including in ensuring that everyone is accounted for on a daily basis.

Demands on staff in refuges are significant, and they may not have received adequate training to be able to effectively consider or respond to the complexity of social issues that a client may experience. In this regard, it is important that services ensure that staff have appropriate training, and there are sustainable mechanisms to build capacity, including access to professional supervision, with a focus on continuous improvement in available support.

While it is recognised that refuge staff may not have the necessary qualifications or skills to intervene in relation to mental health problems and suicide risk, ‘gatekeeper training’ has proven efficacy and is available for those (non-specialist) agencies who are in a position to screen and refer people at risk of suicide to appropriate supports.

Limiting access to lethal means has also been shown to have a strong impact in the prevention of suicide. Significant success has been achieved through the implementation of suicide resistant rooms and cells in health and corrective settings, where ligature points have been reduced or removed.

Given that many women’s shelters are existing houses or other residences, it was considered by the Board that there may be few opportunities to introduce safer facilities at current refuges without a significant financial investment. However, consideration could be given to these factors when future infrastructure works are planned to build or modify accommodation. This must be balanced with the need for clients to reside within a comfortable environment which is as close to a home environment as possible.

Overdose of prescribed medication was the cause of death in the two cases reviewed by the Board at this meeting where the deceased were residing at women’s refuges. Based on the review of these deaths it became apparent that women’s shelters may not have policies and procedures that support safe medication management.

Individual care planning with a client who has been identified as at risk of suicide can extend to safety planning regarding access to medication, to assist in limiting their access to lethal means. In health settings where a person has been identified to be at risk of suicide, safety planning can be put in place to restrict that person’s access to medications that may be potentially lethal prior to discharge. This planning is mutually agreed upon between staff, the patient and their family.

Policies and procedures are in place in other types of residential facilities, who don’t have clinical staff, to ensure appropriate medication storage and management, with the client’s consent. These procedures could be adapted to crisis accommodation facilities for victims of domestic and family violence with their consent.
**High risk teams and an integrated service response**

The service system response in the cases reviewed appeared to be predominantly reactive and symptomatic. In some cases, information about the extent of the risk was identifiable, but responders were not able to recognise the underlying patterns or relationship dynamics. The Board discussed whether the cases under review would have met the criteria for referral to the high risk teams which are currently being implemented in trial sites across Queensland.

In many cases, it was considered that the incidents in isolation may not have met the threshold for referral.

Further, some victims may resist engagement or intervention with an integrated service response or high risk team, just as they do with individual agencies, if they feel that services are being intrusive. They may subsequently avoid contact with these agencies in the future which can lead to an increased risk of harm for victims.

In this regard, it is important to be mindful of the potential unintended consequences associated with information sharing. For example in one case a worker was alleged to have unintentionally provided information about the victim to the perpetrator that she was trying to separate from, which led to a noted escalation in harm for her.

While information sharing can improve victim safety, it is important to be cognisant of the purpose and intent associated with cross-agency information exchange. A balance must be maintained regarding an individual’s right to privacy, and in ensuring safe information sharing to enhance protective outcomes for a victim.

The Board also discussed the need for high risk teams to detect underlying issues that may increase harms or vulnerabilities for both a victim and a perpetrator (e.g. housing, unemployment, substance misuse, and mental health problems) and be adequately equipped to respond or refer as required.

In the cases subject to review by the Board, it was evident that these vulnerabilities were often present from a very young age and do not appear to have been adequately identified and addressed in a holistic manner over time.

**Finding 4:** There is a need for the high risk teams to have the capacity to identify and respond to cumulative patterns of harm and risk, as well as to a crisis episode that comes to their attention because of the severity of the incident.

**History of disadvantage, trauma and the role of early intervention**

In all cases subject to review by the Board there was a demonstrated vulnerability over the life course, for both the victims and perpetrators, with a noted accumulation of risk factors and a lack of identifiable protective supports. There also appeared to be limited intervention to address these underlying vulnerabilities, or to enhance the impact of protective factors within the deceased’s life.

The majority of the adult deceased had an extensive history of prior victimisation spanning multiple relationships, and it would appear that there was a sense that the violence was ‘normalised’ for some of these victims.

In cases where agencies became involved during periods of crisis shortly prior to the death, the adult victims had complex comorbidities that were difficult for services to effectively address with short-term
interventions, including problematic substance misuse, mental health problems, unemployment and homelessness.

These issues cannot be addressed in isolation from each other. For example, victims may use alcohol and/or other drugs as a coping strategy to manage their experiences of violence and trauma, an association which is well established within current literature. However problematic substance misuse may make a victim of violence more vulnerable as it can increase their risk of future harm, or their dependency on the perpetrator, particularly in circumstances where both partners are dependent on alcohol or drugs.

**Finding 5:** Reactionary, sporadic and isolated responses were evident by some services, which failed to take into account the cumulative patterns of harm and risk that can have a detrimental impact on a victim’s life. Addressing a victim’s underlying vulnerabilities and enhancing the influence of protective factors, is a crucial means through which to prevent repetitive victimisation across relationships.

In two of the deaths reviewed by the Board the victims identified as being Aboriginal or Torres Strait Islander. The normalisation of violence within Indigenous communities was recognised to present a challenge to addressing this type of violence. Further, it is also important to ensure that a person’s cultural background is taken into account when making a determination about the suitability of a service or agency, and their capacity to meet that individual client’s needs.

In recognition of the significant impact of family violence within Aboriginal and Torres Strait Islander families and communities, the Board has made a determination to consider, and report on, issues identified applicable to these cases in further detail in the next meeting.

**Finding 6:** The Board identified a need for culturally relevant services to provide an individualised approach commensurate with the cultural identity of the individual, and to match the positioning of the individual on their cultural journey.

Two cases reviewed by the Board involved young people who were exposed to domestic violence between their parents and caregivers, and who also experienced violence perpetrated against them within the family unit.

Despite the identification of vulnerabilities within these families by services as a result of reported acts of violence, there was limited ongoing intervention, even when the family continually came to the attention of these agencies throughout the young person’s life.

Agency responses did not appear to sufficiently take into account the previous abuse history, or the impact of cumulative harm, which represented a series of missed opportunities for earlier intervention.

The young people had also experienced bullying and peer group pressures. As such, the Board considered the role of schools in terms of their capacity to detect and respond to domestic and family violence issues, as well as suicide risk and mental health problems. Schools were identified as able to potentially play a crucial role in implementing a range of early intervention activities.

While schools may have dedicated support staff, the roll-out of mental health and suicide prevention
programs is not mandatory and there is substantial diversity as to what support is offered across the state.

**Finding 7:** Embedding health promotion and prevention principles into the school curriculum is important for early intervention, and to build resilience, which can enhance a child or young person’s capacity to cope with current or future stressors.

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