Domestic and family violence death of ‘Tricia’

Domestic and Family Violence
Death Review and Advisory Board

Queensland Government

Seek Help

If you, or someone you know, need help, then the following services are available to assist.

- **Lifeline** is a 24 hour telephone counselling and referral service, and can be contacted on 13 11 14 or www.lifeline.org.au
- **Kids Helpline** is a 24 hour free counselling service for young people aged between 5 and 25, and can be contacted on 1800 55 1800 or www.kidshelponline.com.au
- **Mensline Australia** is a 24 hour counselling service for men, and can be contacted on 1300 78 99 78 or www.menslineaus.org.au
- **DV Connect** is a 24 hour Crisis Support line for anyone affected by domestic or family violence, and can be contacted on 1800 811 811 or www.dvconnect.org.
- **Suicide Call Back Service** can be contacted on 1300 659 467 or www.suicidecallbackservice.org.au
- **Beyondblue** can be contacted on 1300 22 4636 or www.beyondblue.org.au

Guidelines in relation to safe reporting in relation to suicide and mental illness for journalists are available here: http://www.mindframe-media.info/for-media/media-resources

We honour the voices and journeys of those who have lost their lives to domestic and family violence, and extend our sympathies to the loved ones who are left behind, their lives forever changed by their loss.

Our efforts remain with ensuring that domestic and family violence deaths do not go unnoticed, unexamined or forgotten.

A report of the Domestic and Family Violence Death Review and Advisory Board pursuant to section 91Z of the *Coroners Act 2003*.

Published in Brisbane, Queensland by the Domestic and Family Violence Death Review and Advisory Board.

All enquiries regarding this document should be directed in the first instance to the Secretariat, PO Box 1649, Brisbane, QLD, 4000, or by email: Coroner.DFVDRU@justice.qld.gov.au

About this report

The Domestic and Family Violence Death Review and Advisory Board (the Board) is established by the *Coroners Act 2003* (the Act) to undertake systemic reviews of domestic and family violence deaths in Queensland. The Board is required 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 deaths.

This report has been prepared by the Board in accordance with section 91ZC of the Act, which authorises the Board to prepare a report about a matter arising from the Board's functions, including about its findings in relation to a case review carried out by the Board. To protect the identity of people involved in this case, names and other identifiers have been changed within this report.

The views expressed in this report are reflective of the consensus decision-making model of the Board, and therefore do not necessarily reflect the private or professional views of a member of the Board, or their individual organisations.

22 June 2017

The Honourable Yvette D'Ath
Attorney-General and Minister for Justice
Minister for Training and Skills
1 William Street
BRISBANE QLD 4000

Dear Attorney-General

In accordance with section 91Z of the *Coroners Act 2003,* I submit to you a systemic review report compiled by the Domestic and Family Violence Death Review and Advisory Board in relation to the domestic and family violence related death of 'Tricia'.

At their February 2017 meeting, the Board made a determination to release this case review report to inform current planning processes in relation to the development of an integrated service system response for domestic and family violence in Queensland.

As the primary purpose of the release of the report is to inform current planning processes, the Board recommends that this report not be tabled in the Queensland Parliament in accordance with section 91ZC (6) of the *Coroners Act 2003*.

Yours sincerely

Terry Ryan
State Coroner
Chairperson
Domestic and Family Violence Death Review and Advisory Board

Overview

This report outlines the deceased's prior history of domestic and family violence and the known history of service system contact leading up to the death. It considers the key issues identified within the report with respect to current activities being undertaken across Queensland to better prevent, and respond to, domestic and family violence.

In early 2014, police responded to a reported episode of domestic and family violence between Tricia and her partner, Peter. Subsequent to their investigations, officers made an application for a domestic violence protection order listing Tricia as the respondent and took her into police custody.

Three hours after being released from police custody, Tricia called a friend in distress. She was discovered deceased shortly afterwards by a resident at the hostel she was staying at, after taking her own life.

The Board has decided to release this report to inform current planning processes across Queensland, with a particular focus on the trial of 'high risk teams' and the development of an integrated services framework that aims to better support and protect victims of domestic and family violence.

Although this death occurred a number of years ago, preceding a range of reforms since implemented in Queensland, issues identified in the case review remain relevant today. There is an opportunity to use these learnings to consider ways to improve victim safety, particularly where they may have multiple and complex needs.

This report highlights the importance for all generalist and specialist services to have the capacity to recognise and respond to the cumulative impact of being a victim of domestic and family violence, and the need to provide support in relation to both presenting and underlying issues over the longer term.

A full overview of activities undertaken by the Board, inclusive of preventative recommendations made by the Board, will be provided to the Minister, and published on an annual basis, in accordance with the Board's statutory reporting requirements[1].

[1] As per section 91ZB of the *Coroners Act 2003*.

Prior history of domestic and family violence

Tricia was aged 32 years at the time of her death. Records indicate that she was a victim of domestic and family violence in multiple intimate partner relationships from a young age. Her first abusive intimate partner relationship commenced when she was just 14 years old and dating someone 13 years her senior

There is documented evidence of domestic and family violence occurring in five relationships spanning more than 15 years.

During such time, the violence Tricia was subjected to included:

- physical assault (e.g. hit in the face, dragged through the house and along the road, thrown into fences, assaulted while pregnant, had petrol poured on her, slashed with a knife, bitten)
- verbal abuse
- sexual assault
- destruction of property
- threats to kill her and her children
- attempts to take her children from her

One former intimate partner non-lethally strangled Tricia on at least five occasions to the point of losing consciousness. Tricia was also hospitalised on numerous occasions following these violent assaults.

Domestic violence protection orders, listing Tricia as the aggrieved and her partner/s as the respondent, were issued in four of these violent relationships.

Additionally, Tricia was listed as a respondent in domestic violence protection orders for violent acts against two former partners. On both occasions, Tricia had responded to the violence being perpetrated against her by stabbing her violent partners with a pocket knife and a shard of glass respectively.

To escape the abusive relationship of one partner, Tricia relocated to another town with the assistance of a community service. Shortly after moving she met her last partner, Peter who she described as different from her other partners in that he was a good and kind person. Peter was proactive in supporting Tricia to seek help for substance abuse and mental health issues.

A few months into their relationship, Peter asked Tricia to move out of his house due to her argumentative and aggressive behaviours which resulted in Tricia self-harming. Upon engaging with a hospital Acute Care Team, Tricia revealed significant distress at '*messing up'* the relationship and expressed self-blame and suicidal thoughts at the perceived loss of her relationship with Peter.

There was no recorded domestic and family violence in the relationship with Peter prior to the episode the police responded to just before her death. Conflicting allegations were made by both parties, with it being alleged that Tricia had threatened Peter with a knife, and that she had smashed plates and cups after being assaulted and dragged by the hair following an argument; allegedly regarding her drug use.

Police subsequently determined that Peter was in need of protection, as Tricia appeared to be at risk of becoming aggressive towards him as a result of her experiencing drug withdrawal. They subsequently transported Tricia to the watch house and made an

application for a protection order listing her as the respondent, and Peter as the aggrieved. This was the night before Tricia's body was discovered.

Service system contact

In accordance with section 91E of the Act, this review considered the interaction with, and effectiveness of, any support services provided to Tricia; the general availability of these services; and any failures or missed opportunities that may have contributed to or prevented this death from occurring.

Available records demonstrate that Tricia had a long history of involvement with the police, courts and the health system, including contacts with mental health and drug treatment services, domestic violence service providers and paramedics, with relevant contacts that are proximate to the death, outlined below.

Queensland Ambulance Service (QAS)

Tricia had prolonged contact history with QAS for a range of presenting issues including suicide threats and attempts, non-fatal overdose, and, for assault related injuries.

There were eight instances where QAS responded following domestic violence episodes between 2006 and 2014. At each of these contacts, Tricia openly disclosed to responding officers the injuries were the result of domestic violence. However, Tricia generally refused treatment and transportation to hospital, even where injuries sustained during episodes of domestic abuse required follow up medical assessment and treatment.

The QPS was also in attendance at each of the domestic violence related contacts, indicating there were no incidents that QAS was aware of which escaped the attention of police.

The most recent contact with QAS occurred less than three months before Tricia died. On this occasion, Peter requested QAS attend as Tricia was emotional and expressed that she wanted to hurt herself, after they had a heated argument about their relationship problems. Tricia denied any suicidal thoughts or gestures and refused treatment.

Previously, the QAS was called to attend on two occasions where she had been strangled by one of her violent partners. On the first occasion, Tricia reported pain to the neck area, difficulties swallowing and redness to the throat area. The second occasion, Tricia's injuries were considered potentially life threatening and she was transported to hospital for assessment.

Alcohol, Tobacco and Other Drugs Service (ATODS)

Two weeks prior to her death, Tricia self-referred to Alcohol, Tobacco and Other Drugs Service (ATODS) seeking treatment for her morphine addiction. Tricia was scheduled to commence the opioid substitution program the week after she died.

In the initial intake record, ATODS recorded information on a range of high risk, social and behavioural factors impacting Tricia. However, domestic violence was not screened for as part of this process.

There is a significant relationship between substance use and trauma exposure among women, with up to 80% of treatment seeking women reporting a lifetime history of sexual or physical abuse[2]. As such, traumatised women often engage in substance abuse, or "*self-*

[2] Cited in Cohen, L.R., & Hien, D.A. (2006). Treatment outcomes for women with substance abuse and

medication", as a maladaptive coping mechanism.

Due to the strong association between substance abuse and domestic and family violence, it has been recommended that patients attending substance abuse treatment should be screened for intimate partner violence (victimisation and perpetration)[3]. There could also be potential benefits for substance abuse treatment programs/facilities to concurrently provide interventions to address domestic violence[4].

In 2013, the National Centre for Education and Training on Addiction (NCETA) released guidelines aimed at improving responses for victims of domestic and family violence presenting at drug treatment services[5]. These guidelines recommended strategies to address domestic and family violence within the substance treatment spectrum, including:

- Evidence-based policy and practice responses;
- Organisational awareness of domestic and family violence issues, with all alcohol and other drug workers requiring at least basic skills in addressing domestic and family violence;
- Routine screening regarding domestic and family violence experiences.
- Responding to disclosures, while prioritising safety;
- Coordination of services;
- Standardised response frameworks;
- Broad-based rather than single issue focused interventions;
- Access to highly skilled practitioners as required;
- Targeted workforce development; and
- Monitoring, accountability and evaluation.

While Tricia was proactively seeking to address her substance abuse problems, it is imperative that treatment is accompanied by the introduction of adaptive coping strategies and interventions to address a client's underlying trauma. Without new coping skills, a person recovering from substance dependency is prone to relapse when confronted by the stressors associated with prior trauma experiences.

With the potential for improvements in treatment outcomes for clients presenting to services, there are opportunities to consider ways to improve the screening, assessment and response to domestic and family violence in these types of settings, particularly with the roll out of the Common Risk Assessment Framework in Queensland[6], and the implementation of training for domestic and family violence in hospital and health settings[7].

PTSD who have experienced complex trauma. *Psychiatric Services, 57*, 100-106.

[3] Kraanen, F.L., Vedel, E., Scholing, A., & Emmelkamp, P.M.G. (2013). Screening on perpetration and victimization of intimate partner violence (IPV): Two studies on the validity of an IPV screening instrument in patients in substance abuse treatment. *PLoS ONE, 8*, e63681, doi:10.1371/journal.pone.0063681 Accessed on 16 June 2016

[4] Capezza, N.M., Schumacher, E.C., & Brady, B.C. (2015). Trends in intimate partner violence services provided by substance abuse treatment facilities: Findings from a national sample. *Journal of Family Violence, 30*, 85-91.

[5] White, M., Roche, A.M., Long, C., Nicholas, R., Gruenert, S., & Battams, S. (2013). *Can I Ask…? An alcohol and other drug clinician's guide to addressing family and domestic violence*. National Centre for Education and Training on Addiction (NCETA), Flinders University: Adelaide, SA.

[6] Recommendation 77 of the Special Taskforce Final Report: *The Queensland Government designs a best practice common risk assessment framework to support service provision in an integrated response, and designed for use by generalist and specialist services (supported by relevant tools)*

[7] Recommendation 59 of the Special Taskforce Final Report: *The Queensland Government and DV Connect work in partnership to develop a model to provide immediate access to specialist domestic*

Mental health service providers

Tricia was engaged with multiple mental health service providers in the weeks and months preceding her death. Between 2008 and her death in 2013, Tricia had contact with public mental health services in three different towns, on eight separate occasions. In addition, her service system contact included a private psychologist and a psychiatrist.

Hospitals

Tricia self-presented to hospital Emergency Departments (ED) for suicidal thoughts or behaviours on four different occasions between 2004 and 2011, with staff routinely referring Tricia to the Acute Care Team (ACT) for assessment and intervention.

Prior to her death, a hospital ACT oversaw Tricia's mental health presentations from late 2012 when she presented to the ED in crisis. Current and historical "*dysfunctional relationships*" were identified by the ACT in their mental health consumer intakes with Tricia. The ACT appropriately referred Tricia to existing psychological supports to manage the ongoing issues after the crises that required presentation to the ED was resolved. The ACT continued to monitor Tricia and attempted to follow-up until late 2013. After multiple failed attempts to contact her, the ACT closed its file.

The importance of robust discharge and safety planning following a suicide attempt should not be underestimated. Regular contact in that crucial period after release from hospital is important to realise sustained therapeutic improvements[8]. However, the willingness of the patient to engage in such services is imperative.

For Tricia, her lack of engagement over the longer term impacted on the ability of services to provide meaningful support.

The *Special Taskforce on Domestic and Family Violence Final Report* (the Special Taskforce Report) made a number of recommendations in relation to improving responses to victims of domestic and family violence within hospital and health services.

Relevant recommendations to improve hospital responses to victims of domestic and family violence have subsequently been implemented with the release of a suite of training resources to support clinicians in November 2016. Queensland Health has now rolled out a training package for all health services employees, both clinical and non-clinical, in the public and private health sector to enhance their capacity to respond appropriately to disclosures of domestic and family violence. This publicly available online training package provides guidance on recognising and responding to domestic violence and encourages all health staff to refer to specialist support services[9].

Private practitioners

Tricia began seeing a psychologist through a Mental Health Care Plan referral in early 2013 for counselling regarding anxiety and depression associated with past trauma and ongoing concerns about legal matters. Tricia completed six sessions as part of the mental health plan over the next few months. A subsequent mental health care plan extension was organised, however, Tricia only attended one further session and cancelled all other appointments from that point on.

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and family support and referral services within public and private maternity hospitals and emergency departments.

[8] De Leo, D., & Heller, T.S. (2007). Intensive case management in suicide attempters following discharge from inpatient psychiatric care. *Australian Journal of Primary Health, 13*, 49-58

[9] See more here: https://www.health.qld.gov.au/clinical-practice/guidelines- procedures/patient-safety/duty-of-care/domestic-family-violence

The psychological intervention consisted of cognitive behavioural therapy, sleep hygiene, goal setting and stress management and relaxation. Through this intervention, Tricia reportedly realised improvements in her mood, however, her anxiety levels persisted. The primary concern for Tricia was the upcoming criminal charges she was facing in which she had been told that she was likely to face a period of incarceration.

During the counselling sessions, Tricia began the process of exploring her underlying traumatic issues, which she reported as "*including kidnap and sexual assault*", but she continued to be troubled by the memories of her past. There was no disclosure of any current domestic or family violence throughout these sessions, during her relationship with Peter.

Tricia attended a psychiatrist for a review in late 2013 who diagnosed her with a mental disorder and recommended a treatment plan consisting of pharmacological medication and ongoing psychological treatment to address the deceased's complex social stressors. Substance abuse, mental health and self- harm were discussed but there was no discussion of her extensive history of prior domestic violence victimisation, or the potential impact of these experiences.

Mental health practitioners who respond to presenting issues of mental illness and substance abuse are well placed to identify and respond to domestic and family violence. Unlike General Practitioners, however, mental health professionals do not have policies or guidelines reflecting best-practice principles regarding the identification and management of patients with domestic violence.

Recommendations 60[10], 61[11] and 62[12] of the Special Taskforce Final Report were referred to the Australian Health Practitioner Regulation Agency (AHPRA) which advised that it had consulted with accreditation agencies to identify how current accreditation standards address the issues of domestic violence. AHPRA have advised that they are currently providing information in communiques about continuing professional development registration standards being broad enough to encompass domestic and family violence, and to raise awareness of the importance of practitioners having skills in recognising, and appropriately intervening, where this relates to their practice.

Crisis Support Service

A domestic and family violence crisis support service was contacted on five occasions between 2011 and 2013. Each contact was made by other services on behalf of Tricia. On each occasion, the calls for assistance related to requests for crisis accommodation following an episode of domestic and family violence.

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[10] Recommendation 60 of the Special Taskforce Final Report: *The Minister for Health recommends to the Australian Health Workforce Ministerial Council that the Health Practitioner Regulation Boards of Australia require specific skill sets pertaining to recognition of and appropriate intervention for domestic and family violence and child harm be included in accreditation standards submitted by Accreditation Agencies under the National Law.*

[11] Recommendation 61 of the Special Taskforce Final Report: *The Minister for Health recommends to the Australian Health Workforce Ministerial Council that Health Practitioner Regulation Boards of Australia work with appropriate accreditation bodies and colleges to enable professional development on recognising and intervening appropriately in domestic and family violence to be considered suitable for Continuing Professional Development recognition*

[12] Recommendation 62 of the Special Taskforce Final Report: *The Minister for Health recommends to the Australian Health Workforce Ministerial Council that consideration also be given to including skill sets and professional development programs.*

At no time were staff able to complete a formal intake with Tricia.

Tricia checked out of crisis accommodation placements before the service was able to complete an intake. Alternatively, Tricia could not be provided with accommodation as she required medical clearance or needed to transfer her subutex medication to the residence.

As a crisis support service, on each engagement, the onus was placed on Tricia to recontact the service for further assistance. Continued engagement with this important service could have been enhanced through proactive follow-up by staff with vulnerable clients such as Tricia who request assistance multiple times. Consideration of the potential impost on the capabilities and resourcing of this service would be required for such an initiative to be implemented.

On one occasion after she had been beaten "*black and blue*", Tricia advised this service that the perpetrator possessed an unlicensed gun. This had not been disclosed previously when police had applied for a domestic violence protection order. As an intake was not completed, staff did not pursue this further and the information was not passed on to police at the time.

Given that this particular relationship was characterised by significant and severe episodes of violence, further consideration should be given as to what action domestic and family violence specialist support services should take in response to disclosures by aggrieved persons in relation to a perpetrator's access to firearms, particularly where there may be a heightened risk of harm.

The Special Taskforce prescribed an integrated service response as a way to improve responses to domestic and family violence. Crucial to an integrated approach is open and responsive sharing of information between service providers so that victims do not have to tell their stories repeatedly, and a timely response from providers is facilitated, especially in high-risk cases.

As such, in their final report, the Special Taskforce recommended the introduction of enabling legislation to allow information exchange between government and non-government agencies, with appropriate safeguards[13].

With amendments to the *Domestic and Family Violence Protection Act 2012*, this recommendation has now been delivered. The amendments provide a framework that enables certain government and non-government service providers to share victim and perpetrator information in specific circumstances for the purpose of assessing risk and managing cases where there is a serious threat to a person's life, health or safety because of domestic violence.

While sharing information with consent remains the preferred approach, the amendments prioritise the safety of victims and their families by enabling exchange without consent. Information sharing guidelines will be developed in consultation with the Privacy Commissioner that provide for the secure storage, retention and disposal of information, and guidance on when it should be shared.

When delivering findings in his Inquest into the death of Noelene Beutel, Coroner Hutton also recommended the establishment of an integrated team-based 'one- stop shop' pilot, where relevant agencies can co-locate and collaborate to meet the needs of domestic and family

[13] Recommendation 78, Special Taskforce on Domestic and Family Violence. (2015). *Not Now, Not Ever*.

violence victims as well as improvements in cross-agency information sharing to improve safety outcomes for victims[14].

Taking this into consideration, the Special Taskforce recommended that three integrated service centre trial sites be established. These sites have subsequently been announced as Mt Isa (regional city), Logan-Beenleigh (urban), and a discrete Indigenous community (Cherbourg)[15] .

These services are expected to provide holistic, safe and accountable responses to victims and perpetrators of domestic and family violence. Implementation at trial locations will be rolling, with all locations expected to be in operation in 2017.

These integrated service trials will require greater levels of information exchange about victims and perpetrators, which may require a significant practice and culture change for some services. Information sharing protocols to support the trials are expected in 2017, as are information technology solutions.

Issues for review

Tricia had substantial service contact over many years, including in the hours before her death, which represent multiple opportunities for intervention, and provides insight into the service system response to victims with multiple and complex needs. Reactionary, sporadic and isolated responses were evident by services in this case, which failed to take into account the cumulative patterns of harm and risk that can have a detrimental impact on a victim's life over time.

Improving systemic responses to vulnerable victims of domestic and family violence within both general and specialist services requires improved screening, assessment and service provision. Greater awareness is also required regarding the interrelationship between domestic and family violence, problematic substance misuse and mental health problems among service providers, including police and health practitioners, to enhance current support options to aggrieved persons.

While acknowledging the significant reforms currently occurring in Queensland as outlined above, the following issues have been identified when reviewing relevant service records for Tricia in the period leading up to her death.

Victim vulnerability

Vulnerabilities and issues affecting individuals do not occur in isolation, and the complex nature of their interaction and relationship with each other has been increasingly recognised by governments, services and the community as they seek to respond to a range of concurrent issues.

As a recent and promising example of this shifting focus, the QPS has rolled out a state-wide training program for its officers called the '*Vulnerable Persons Training Package'*, a two day face-to-face session that equips police officers with the knowledge and skills to work within the new legislative frameworks for domestic violence and mental health.

[14] Coroner Hutton. (2014). Inquest into the death of Noelene Marie Beutel.
[15] Recommendation 74, Special Taskforce on Domestic and Family Violence.

Tricia's case demonstrates the compounding impact of a victim's individual vulnerabilities, and their concurrent experiences of domestic and family violence, and provides several insights into how the system responds in these circumstances.

Significantly, Tricia left school without completing Year 10 and commenced a relationship with a man who was 13 years her senior. It appears that this relationship (while she was still a minor) established a pattern of maladaptive coping strategies and anti- social behaviours that were pervasive throughout Tricia's subsequent relationships. Tricia's chaotic lifestyle was characterised by:

- Polysubstance misuse;
- Drug manufacturing, and other drug related offending;
- Prostitution;
- Repetitive victimisation across relationships;
- Homelessness;
- Offending behaviours (e.g. assault, armed robbery, property offences, drink driving);
- Mental health problems; and
- Enduring suicidality and episodes of deliberate self-harm.

The following issues were particularly prevalent for Tricia over her life course:

- Problematic substance use;
- Mental health problems;
- Suicidal ideation, attempts and self-harm; and
- Criminal offending.

Problematic substance use

Substance abuse is associated with both perpetration and victimisation of domestic and family violence. It is also the case that substance use is common among women with a history of trauma. Tricia was first introduced to drugs by her partner at the age of 15 when she would intravenously use amphetamines, progressing to daily intravenous heroin and amphetamine consumption. Tricia would also regularly smoke cannabis and occasionally take cocaine and ecstasy.

By 2005, Tricia reported prolonged heavy alcohol consumption, drinking 30 cans of full-strength beer on a daily basis, in addition to the polysubstance use referred to previously.

Tricia admitted to self-medicating her anxiety and depression over a long period of time with opioids and drugs. Tricia's substance use was her way to cope with her ongoing stressors, and following relationship conflict with her partner in 2013, she reported to hospital mental health services that she wanted to 'get high' as she couldn't cope with the situation.

Alcohol consumption appeared to be particularly problematic throughout the domestic violence episodes involving Tricia in one particularly violent relationship. Tricia had battled with her substance misuse problems and had sought assistance on multiple occasions including through detox programs in hospital, trying to go "*cold turkey*", taking symptomatic relief medication, and participating in opioid substitution programs with limited success.

In the year leading up to her death, Tricia had managed to cease her use of speed and heroin, but had relapsed into morphine use three months prior to her death following a reported relationship breakdown. She also reported reducing her alcohol intake to six to eight mid-strength beers in one sitting once per week at the time of her death.

Two weeks prior to her death, Tricia self-referred to ATODS as she wanted treatment for her morphine addiction as she was "*sick and tired of the lifestyle*". Tricia's last contact with ATODS was less than a week prior to her death. She was scheduled to commence the opioid substitution program the week after her death.

In addition to not being able to access the service immediately due to assessment and eligibility requirements; there are multiple identified barriers for women with substance abuse histories and experiences of abuse in seeking support, namely[16]:

- Abusers exploit the extra problems women experience as a form of abuse in its own right to control, humiliate, hurt or further disable them[17].
- The community, including criminal justice system and health professionals, are more likely to blame victims, question their credibility and take them less seriously.
- Service providers feel they lack the training in responding to the dual issues.
- Few services simultaneously tackle multiple issues a woman is coping with.
- Recovery from abuse is hard enough to deal with, but is made more difficult if a woman has to deal with multiple issues at once.
- Women with multiple barriers may have a more restricted ability to understand what is happening, as a function of their trauma.
- Women are dependent on others, reluctant to disclose problems and prone to self-blame because of their substance misuse.
- They have experiences of being excluded, rejected or treated badly.
- Women facing multiple barriers are less likely to be offered, and more likely to cancel or drop out of, follow-up appointments by health professionals.

Shaping reform to meet the needs of this vulnerable cohort must therefore account for these identified issues, and recognise the strong association between domestic and family violence victimisation and problematic substance use.

Mental health problems

Women who experience multiple forms of abuse and repeated abuse are at increased risk of mental illness. Women exposed to physical and psychological abuse report higher incidence and severity of depressive and anxiety symptoms, post-traumatic stress disorder (PTSD) and thoughts of suicide, compared with non-abused women[18].

Women with mental illnesses are also more likely to experience domestic violence at some point in their life, with domestic violence a common feature among women being treated for mental illness[19].

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[16] Rose, D., Trevillion, K., Woodall, A., et al. (2011). Barriers and facilitators of disclosure of domestic violence by mental health service users: Qualitative study. *British Journal of Psychiatry, 198*, 189-194. – cited in Agnew-Davies, R. (2013). Identifying domestic violence experienced by mental health service users. In L. Howard, G, Feder, & R, Agnew-Davies (Eds). *Domestic Violence and Mental Health*. The Royal College of Psychiatrists: London. (pp 29-48).

[17] One partner would refuse to transport Tricia to hospital for her to receive her methadone (subutex) dosage on occasion, resulting in treatment non-compliance

[18] Pico-Alfonso, M.A., Garcia-Linares, M.I., Celda-Navarro, N., Blasco-Ros, C., Echeburu, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *Journal of Women's Health, 15*, 599-611.

[19] 45.8% of women with depressive disorders, 27.6% of women with anxiety disorders, and 61.0% of women with PTSD – Trevillion, K., Oram, S., Feder, G., et al., (2012). Experiences of domestic violence and mental disorders: A systematic review and meta-analysis. *PLoS ONE, 7*, e51740.

Interventions to address mental health problems are less likely to be of benefit without addressing the abuse experienced by an aggrieved party. Therapeutic gains are unlikely to be realised until the victim is free from violence[20], which highlights the need for services to be better equipped to concurrently consider, and address, the needs of clients presenting with multiple and complex needs.

Suicide ideation, attempts and self-harm

Tricia had a long history of suicide attempts and self-harming behaviour. As a result, Tricia had contacts with hospital emergency departments and mental health services on numerous occasions.

Between 2004 and 2014, there were 18 contacts with health services or police in relation to suicidal self-harm. This included 13 episodes of suicide threats or ideation, seven instances where she engaged in suicidal behaviours, and four instances of self-harm[21].

An Emergency Examination Order (EEO) was taken out for Tricia on more than one occasion. The first EEO was issued when police located Tricia in distress in late 2011. Tricia was admitted overnight, but no formal mental health assessment was conducted. There appeared to be some confusion about whether Tricia was under an EEO as Emergency Department staff recorded that she was free to leave, with a recommendation for her to see her general practitioner to arrange for a referral to counselling services.

A second EEO was completed by QAS in late 2012 after Tricia was located by police in an irate state and expressing suicidal thoughts. Tricia was noted as being extremely aggressive and was verbally and physically abusive towards police officers and nursing staff. As a result of her aggressive presentation she was unable to be fully assessed by mental health clinicians. Tricia was, however, reviewed by the Acute Care Team and was subsequently discharged the following morning after the EEO expired and she had refused consultation with the hospital social worker.

When Tricia was taken into police custody, the day prior to her death, a medical assessment was undertaken. This featured questions about substance use, mental health problems, and historic and/or current suicidality. Tricia reported a history of suicide attempts the previous year, but denied any suicide or self-harm thoughts within the past three months.

Victims of domestic violence are far more likely to be hospitalised for suicidal ideation or attempts[22] than other females, which indicates a need for routine screening of women who present or are admitted in crisis for both issues.

Criminal activity

Tricia had a history of engaging in criminal activities, largely in relation to property and drug offending.

As a juvenile, Tricia was cautioned for assault occasioning bodily harm. Further offences were generally committed in the company of her abusive partners of the time.

Tricia was sentenced to an Intensive Corrective Order in late 2012 for her involvement in a

[20] Howard, Feder, & Agnew-Davies. (2013). *Domestic Violence and Mental Health*. The Royal College of Psychiatrists: London.
[21] There were instances where contacts involved both threats/ideation and suicidal behaviours
[22] Kernic MA, Wolf ME, & Holt VL. (2000). Rates and relative risk of hospital admission among women in violent intimate partner relationships. *American Journal of Public Health, 90*, 1416-1420.

violent incident with another person. This was not domestic and family violence related and was reported by Tricia to be an act of self-defence.

At the time of her death, Tricia was facing court for armed robbery in which she was the alleged driver of the getaway car, and she reported being under the influence of substances at the time.

Tricia's solicitor reportedly advised her that he expected a custodial sentence for this offence, with the court proceedings scheduled to sit just two days after Tricia died. The expectation of likely imprisonment was a significant stressor for Tricia.

Identification of the person most in need of protection

Research indicates that there are significant differences between women's and men's use of violence in intimate partner relationships in terms of frequency, type and motivation[23]. Women's use of violence tends to occur in the context of the violence being perpetrated against them by their male partner, with the vast majority of female perpetrators also being victims[24].

While men may use violence to maintain control over a partner[25], women are more likely to use violence as a form of self-defence, with up to three-quarters of women stating they used violence to defend themselves[26]. Protection of children against violence, and retaliation for emotional and/or physical abuse are also cited as motivations for the use of violence by women[27].

On three separate occasions, police applied for protection for Tricia's partners, as aggrieved persons, following episodes of violence between both parties[28]. In the two domestic violence contacts where Tricia was listed as the respondent (prior to the events preceding her death), Tricia had inflicted superficial stab wounds to her partners during a violent episode in a bid to get the violence perpetrated against her to cease.

This was the case even in circumstances where there was a known prior history of her being a victim in the relationship, and on one occasion, she was served with the application while she was in hospital receiving treatment for assault related injuries from that partner.

Notably, legislative amendments have occurred subsequent to many of these occasions that were designed to improve criminal justice system responses to victims of domestic and family violence, through ensuring that consideration must be given to the identification of the person most in need of protection.

The guiding principles of the *Domestic and Family Violence Protection Act 2012* require that "*in circumstances in which there are conflicting allegations of domestic violence or an indication that both persons in a relationship are committing acts of violence, including for*

[23] Swan, S.C., Gambone, L.J., Caldwell, J.E., Sullivan, T.P, & Snow, D.L. (2008). A review of research on women's use of violence with male intimate partners. *Violence and Victims, 23,* 301-314.
[24] Up to 92% of women who used violence were also victims – Swan et al (2008).
[25] DeKeseredy, W.S., & Dragiewicz, M. (2007). Understanding the complexities of feminist perspective on woman abuse: A commentary on Patrick G. Dutton's Rethinking domestic violence. *Violence Against Women, 13,* 874-884.
[26] Swan, S.C. & Snow, D.L. (2003). Behavioral and psychological differences among abused women who use violence in intimate relationships. *Violence Against Women, 9*, 75-109 – cited in Swan et al., 2008.
[27] Ibid.
[28] Two of these partners had a known history of violence perpetration against her (excluding Peter).

their self-protection, the person who is most in need of protection should be identified"[29].

This distinction is necessary to ensure that provisions of the *Domestic and Family Violence Protection Act 2012* are correctly utilised to protect individuals from harm and to minimise the misuse of cross-protection orders by perpetrators of domestic and family violence as a further means to control and intimidate their partners.

In their investigations, responding police officers are now required to consider the broader context of any reported acts of violence through the identification of controlling behaviours or the presence of fear in either party. To determine the person most in need of protection, consideration may be given to the nature and severity of injuries by each party; the history of domestic and family violence between the couple; and which party has the potential to seriously injure the other party[30]:

In this regard, responding police officers require a working understanding of the strategies that victims use to be able to appropriately detect these underlying patterns of violence perpetration, and other coercive controlling behaviours, beyond the presence of physical evidence (e.g. injuries, property damage).

The implications of agencies not correctly identifying the person most in need of protection can be significant, and increase the risks to the victim. The primary perpetrator may feel that their behaviour has been validated which may in turn reinforce further perpetration of domestic and family violence. Victims may also feel let down by the system and may be reluctant to contact police in the future.

It is clear that this decision-making by police is not always easy, particularly in circumstances in which there are conflicting events or allegations. Further, while these amendments have been made to the *Domestic and Family Violence Protection Act 2012*, this does not supersede the responsibilities of officers to investigate any offences that are alleged to have occurred in accordance with the *Criminal Code Act 1899*.

As such where there is evidence that an offence has occurred, then police must investigate the offence with a view to pursuing criminal charges where appropriate to do so, irrespective of whether that person may also be considered to be a person most in need of protection under the *Domestic and Family Violence Protection Act 2012*.

With respect to the reported domestic violence episode the night prior to Tricia's death, the actions of responding police officers were in accordance with the QPS Operational Procedures Manual (OPM).

Responding police officers conducted a protective assessment, which involves utilising a defined set of risk factors to identify the presence of risk of increased severity or frequency of domestic violence[31]. This assessment identified Peter, as the aggrieved, to be fearful and at high risk of violence. The subsequent decision by officers to take Tricia into custody aligns with the OPM's.

[29] Section 4(2)(d) of the *Domestic and Family Violence Protection Act 2012*.
[30] Stop Violence Against Women. (2010). *Determining the Predominant Aggressor*. http://www.stopvaw.org/determining_the_predominant_aggressor Accessed on 21 June 2016
[31] Officers used their Protective Assessment Framework. Which identified risk factors to the aggrieved (Peter) as being the use of weapons and alcohol/drug misuse. Peter was assessed to have a fear level of fearful and officers determined there was a high risk of further violence.

It is apparent however that responding officers may not have adequately articulated how the reported episode of violence reflected the complex dynamics of behaviours that constitute domestic and family violence.

For example, they cited the fact that Tricia had her hair up, as a reason to discount her statement that she had been dragged by the hair. Further, a reason provided by police for making the protection order application listing Tricia as the respondent was because they believed her to be experiencing drug withdrawals (and at risk of behaving aggressively in the future as a result of these withdrawals)[32].

While police did adhere to their operational policies, this does highlight the importance of ensuring that there is a clear recording of police decision-making as it pertains to the relevant provisions of the *Domestic and Family Violence Protection Act 2012*.

Holding domestic and family violence perpetrators to account

An increased focus on holding perpetrators to account for their actions is a key component of the Special Taskforce on Domestic and Family Violence Final Report (2015).

The Queensland Government has responded by:

- Introducing harsher penalties for breaches of domestic and family violence protection orders as well as police protection notices and release conditions;
- Providing for recording domestic violence related convictions which will provide insight into the pattern of offending; and
- Including domestic and family violence as an aggravating factor on sentence for criminal offences.

This case, unfortunately, provided a multitude of examples in which the deceased's former abusive partners were not held to account for the violence perpetrated against Tricia; and further demonstrated how this lack of accountability may serve to elevate the risk of violence when perpetrators are not dealt with in a manner commensurate with their acts.

For instance, after multiple previous reports of violence, one of her partners was finally arrested for inflicting knife wounds and facial injuries to Tricia and sentenced to 24 months in prison. However, he served only eight months behind bars. The day after his release, he assaulted Tricia by again (non-lethally) strangling her and causing "life threatening" injuries that doctors identified that Tricia could have died from "due to swelling of the throat and restriction of the windpipe". He also destroyed Tricia's property. The offender struggled with police during his arrest and kicked out (but did not connect) at an arresting officer and attempted to spit on officers (without making contact).

The offender was sentenced to 12 months imprisonment for the charge of Assault Police on this occasion. For the injuries sustained by Tricia he was charged with Common Assault (not the more serious offences of Grievous Bodily Harm or Attempted Murder) and was convicted

[32] Behaviours noted in the *Domestic and Family Violence Prevention Act 2012* include: Causing personal injury to a person or threatening to do so; Coercing a person to engage in sexual activity or attempting to do so; Damaging a person's property or threatening to do so; Depriving a person of the person's liberty or threatening to do so; Threatening a person with the death or injury of the person, a child of the person or someone else; Threatening to commit suicide or self-harm so as to torment, intimidate or frighten the person to whom the behaviour is directed; Causing or threatening to cause the death of, or injury to, an animal, whether or not the animal belongs to the person to whom the behaviour is directed, so as to control, dominate or coerce the person; Unauthorised surveillance of a person; Unlawful stalking of a person.

without punishment and forced to pay restitution for the property damage.

Notably, police identified that Tricia refused to make a statement out of fear of further retribution, leading to perceived difficulties in a successful prosecution. Given that this assault occurred just one day after the offender's release to parole for a previous brutal assault against the deceased, her fear on this occasion, and her concern that the system was not able to protect her, seems reasonably justifiable.

For earlier offences, the same offender had been given suspended sentences which did not deter the perpetration of violence by him against Tricia. After he poured petrol on Tricia during one assault, he was sentenced to four months imprisonment, suspended for two years for a breach of the protection order. He was not charged with any more serious offences arising from this incident. Weeks later, he physically assaulted Tricia in public. While police had sufficient evidence to conclude that the assault took place, they did not believe there was sufficient evidence to sustain a prosecution. Charges were not laid.

Within the same four month period in which he did not spend time in prison after his sentence was suspended, the offender perpetrated domestic violence against Tricia on six occasions that were reported to police. This included incidents of non-lethal strangulation leading to loss of consciousness. Given the severity and frequency of abuse in this relationship, it is likely that there were multiple other occasions which were unreported to police during this time.

Ultimately, he did serve time[33] in prison after being convicted of assault occasioning bodily harm when he attacked Tricia with a knife. Unfortunately, Tricia was subject to significant further harm and victimisation before he was incarcerated.

Recent research findings from New South Wales suggest that there is no difference in re-offending rates for domestic violence perpetrators who are sentenced to short-term (under 12 months) custodial sentences than those who are not incarcerated (i.e. given suspended sentences)[34]. However, there are limitations to this research. Significantly, the vast majority of domestic violence offenders are not given custodial sentences, and it is generally only those convicted of particularly serious offences (e.g. assault occasioning actual bodily harm) that end up incarcerated[35].

Imprisonment alone may not be sufficient to break the cycle of domestic violence perpetration. However, it does remove the offender for a fixed period of time allowing the victim to access relevant supports and services that they may be unable to access when they are subjected to intense and pervasive acts of coercive control by an abusive perpetrator. Furthermore, for incarceration to be effective it must be accompanied by intensive evidence-based behavioural change interventions delivered by professionals.

Queensland Corrective Services (QCS) recently removed the sentence length requirement for prisoners to be offered therapeutic or criminogenic programs, following a recommendation from the Special Taskforce on Domestic and Family Violence.

[33] This included the 4 month sentence which was enforced when the suspension period was revoked following further serious offending.
[34] Trevena, J. & Poynton, S. (2016). Does a prison sentence affect future domestic violence reoffending? Contemporary Issues in Criminal Justice, No 190. New South Wales Bureau of Crime Statistics and Research: Sydney.
[35] Ringland, C. & Fitzgerald, J. (2010). Factors which influence the sentencing of domestic violence orders. (Bureau Brief No. 48). NSW Bureau of Crime Statistics and Research: Sydney – as cited in Trevana & Poynton (2016).

In another relationship, police attended a series of domestic and family violence episodes between Tricia and one of her partners where a protection order was in place listing her as the aggrieved. The respondent was not routinely charged with breaches of this protection order. Proactive enforcement of protection orders is critical in reducing the likelihood of future abusive acts from occurring in relationships characterised by domestic and family violence.

In one specific episode of note it was identified that Tricia had stabbed her partner with a shard of glass, after he had punched her in the head repeatedly. Police made an application for his protection following the wounding listing Tricia as the respondent, despite a known history of domestic violence between the couple that identified him as the primary perpetrator in the relationship. Tricia's partner was not charged for the assault on her that resulted in her being hospitalised; nor was he charged with a breach of the protection order in place that listed him as the respondent.

Tricia was served with the application listing her as the respondent while she was in hospital, being treated for the injuries sustained during this assault. To escape this relationship, and ensure her own safety she was forced to flee her home and community.

This case strongly demonstrates the importance of responsive, holistic and proactive system responses which address immediate safety concerns, but also underlying issues, that may contribute to an elevation of risk over the life-course.

Addressing vulnerabilities and identifiable risk factors (such as childhood abuse, substance misuse, other offending behaviour, social isolation and mental health concerns), as well as building resilience and strengthening the influence of protective factors, may improve outcomes for victims with multiple and complex needs.