fvdrc | Family Violence Death Review Committee

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Tēnā koe

Discussion Paper, 22 March 2022, Response from the Family Violence Death Review Committee

This submission is written on behalf of the Family Violence Death Review Committee (FVDRC) and from a family violence homicide perspective. The FVDRC is a statutory committee that reviews family violence homicides and advises the Health Quality & Safety Commission on how to reduce the number of family violence deaths in Aotearoa New Zealand.

The discussion paper begins with the premise that, because it is not currently compulsory to report firearms injuries in Aotearoa, police may be missing vital information concerning fitness to access firearms, or crime involvement. Included in the discussion document are current provisions for reporting on firearms injuries, where "it is necessary to prevent or lessen a serious threat to public safety or the life or health of an individual" or where "if they believe a firearms licence holder should be limited or prohibited from using a firearm due to a physical or mental health condition", amongst other conditions. Within the paper, there is also a discussion about the definition of a firearm injury, and the data sources available for reporting on firearms injuries.

It is notable from the discussion on sources, that police overwhelmingly appear to record the majority of firearms related injuries. Whilst only a relatively small number to present at hospital. It doesn't appear that there is a record of firearms injuries that occur at shooting ranges and clubs. Of concern is that police record occurrences rather than offenders – it is anticipated that each of these occurrences will be associated with an offender, although this is not made clear in the discussion.

The shift in moving from recording the offender to the injured person is a significant one, and is highlighted in the example provided on mandatory reporting. The example, drawn from British Columbia, requires the collection of the name of the injured person. It is assumed that this person is subsequently questioned about who inflicted the injury. This places the responsibility for reporting on the injured person, irrespective of any consideration of their ongoing safety. There is no information about whether the injured person would be subject to prosecution if they chose not to disclose the name of the offender.

In section 2.4, there is an acknowledgement that police most likely receive reports of firearms injuries from medical practitioners. While data is available on the licence status of those who inflict the injuries, it does not appear that there has been any work undertaken to understand what is currently being missed. This leads to questions about whether the police have appropriately discussed with medical professionals why they would not report a firearms injury. Given the current legislative framework, it is difficult to understand where a firearm would be involved in an injury and there wasn't "a serious threat to public safety or the life or health of an individual". Is it because the injured person did not want it reported? Was the medical professional not aware of their responsibilities? Are there other systemic issues that we are currently unaware of?

In section 2.5, other reporting frameworks have been described, at least one of which specifically relates to family violence:

> "Reports of intimate partner violence concerns in DHB settings are underpinned by a non-legislative framework between the Ministry of Health and Police. Trialled in three DHBs and being rolled out nationally, reports of intimate partner violence to Police occur through a five tier 'graduated response' underpinned by effective interagency collaboration. This framework guides clinicians to complete a risk assessment, balance competing considerations, involve the patient's wishes if possible, and escalate concerns to Police in appropriate circumstances and ways. Reports of family violence in primary care settings are not legally mandatory but are enabled through the HIPC Code where it is necessary to prevent or lesson a serious threat to public safety or the life or health of an individual."

Assumptions concerning initiatives such as this is that all partners are effectively resourced to undertake their role and understand their responsibilities in a collective response to keeping people safe. It is the experience of the Committee that poorly resourced good intentions result in unrealistic expectations and unmet need. The Committee has a number of examples of women screening positive for intimate partner violence, yet this being met with limited, or ineffective response if any response occurs at all.

At the heart of the proposals being presented is the intention to place the responsibility to report unsafe firearms practice on those who have already been harmed by such practices, the victim. In the case of a self-inflicted injury (as was the index case for this proposal), there are no unintended consequences. Where a person is reluctant to report who inflicted the injury, there may be valid reasons for this reluctance, including a fear for their own safety. Where health professionals are not currently upholding a duty to report, the mechanisms for reporting might need to be reconsidered, or additional work could be undertaken to further understand why this is the case.

The Committee supports effective communication between health professionals and the police to enhance public safety. However, we note that the legislative framework for this to occur already exists. Therefore, we support option 4, where reporting is strongly encouraged through existing mechanisms. In supporting this option, we note that this document provides no discussion on what will happen to victims if they chose not to report who was responsible for inflicting the injury. It is our over-riding concern that victims will be placed in an untenable position as a result of seeking medical attention. While it may be appropriate for this to be considered an "exemption", this does not encourage the parties involved to fully consider the safety options available for the injured person.

Awareness raising within the health sector (section 3.2) requires that health professionals understand violence as a health issue rather than a social determinant of health. There has been a long-standing reluctance for violence to be fully considered a health issue, despite established relationships with long-term health physical and mental health consequences, drug and alcohol consumption, and suicidality. This further requires that health professionals understand their role in addressing wellbeing, rather than just the elimination of symptoms. This is a significant culture shift required for the medical profession, that can not necessarily simply be addressed through "consequences…when a health practitioner fails to meet a mandatory reporting standard" (question 22). Consideration needs to be given to the context in which medical professionals are operating, where there is currently significant unmet demand and restructure being undertaken. A culture shift such as that described will require an investment in medical education as well as an understanding how the current medical system supports or prohibits a wellbeing approach.

Finally, in section 4.4, consideration is given to the injured person. Given their centrality in this proposal, it is a surprise that they are considered almost as an after-thought. The safety of the injured person should be central to the proposed reporting standards. What are the health and social wellbeing considerations taken into account when approaching the injured person? Who holds the responsibility for eliciting information about the offender? What supports are put in place after the injured person has provided the information? Is there any consideration of the trauma inflicted on witnesses and their responses to the event? These considerations should not only apply to gun violence in a family context, but gun violence in general.

Yours sincerely

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