RANZCOG 2016 ANNUAL SCIENTIFIC MEETING
'IMPROVING FRONT-LINE HEALTH CARE SERVICES FOR THE MOST VULNERABLE'
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GOVERNOR OF TASMANIA
HOTEL GRAND CHANCELLOR, LAUNCESTON
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Good morning everyone. Thank you for the invitation to speak at your conference.

I apologise in advance for my presentation not matching my abstract and for a rather liberal interpretation of the topic you asked me to address. I will begin with a case study which I will then place in the context of what we know about the prevalence of child abuse and neglect and family violence before discussing routine screening of pregnant women for family violence as well as what broader preventative strategies are needed to address the issues of family violence and child abuse.

My case study, the case of baby Bjay Johnstone is the subject of an on going coronial inquest investigating the death of a 45-day-old baby, a story which has received considerable media coverage in Tasmania over the last year.[1] The baby was born in the Mersey Community Hospital in October 2012 and died on 28th November 2012 after being taken to hospital with serious injuries to his skill, brain and legs. A specialist doctor, who gave evidence at the inquest, stated that the scans showed that Bjay had suffered multiple fractures to his skull, ribs and pelvis, as well as signs of spinal damage and multiple brain trauma. The medical evidence was that the injuries were inflicted on at least two separate occasions in the first three weeks of the baby's life. A paediatric nurse described Bjay's injuries as the worst case of child abuse she had seen.

After the baby's death, the baby's father, Simon Johnstone, pleaded guilty to one charge of ill-treating a child and three charges of assaulting the baby's mother, Fleur Atkin. He received a sentence of two and a half year's imprisonment in 2013. He was not charged in relation to Bjay's death because the police could not determine who inflicted the fatal injuries.

[1] The material which follows is taken from the numerous newspaper and online media accounts of the coronial proceedings.

Bjay's mother, Fleur Atkin, told the inquest in October that whilst they were still in hospital, she discovered the baby's father, Simon Johnstone, holding their new-born son by the throat around 30 centimetres off the bed. She said his abuse of the baby started when Bjay was just two days old and he would regularly smother, choke drop and punch his son. She graphically demonstrated some of this conduct to the court with a doll. She also told the inquest that she feared for her life and suffered daily beatings from Johnstone, who would also put knives against her throat. She said he told her he would throw her down a mineshaft if she left him. She alleged that Johnstone was enraged by the thought that he might not be the biological father.

It is difficult to uncover the precise chronology of events from the newspaper reports of the coroner's inquest which began in August 2015 and is on going. However, it is clear that nursing staff were aware of the risk when a midwife saw Simon Johnstone and Fleur Atkin when she was 29 weeks pregnant. The midwife reported the pair giggled inappropriately during the consultation, and admitted to using cannabis and having no place to live. They were staying with Simon Johnstone's mother at Railton but reported that this was not working out. Fleur Atkin had a bruise on her face and the midwife suspected she had been subjected to domestic violence. She logged an 'unborn baby alert' with child protection services by calling an after hours number. Her colleague logged a subsequent report in following weeks on the basis that the mother reported smoking two bongs a day in the 33rd week of pregnancy. It seems that the couple often attended appointments in dirty clothes and were so drug affected they slurred their words and were unsteady on their feet. A 'code black' – relating to violent behaviour – had been issued against Mr Johnstone during a hospital appointment when Bjay's mother was going into labour.[2]

Whilst midwives and social workers who dealt with Bjay's parents could not recall hearing back from child protection services,[3] it is clear that CPS began working with the parents after receiving the unborn baby alert and they visited the couple and baby very soon after they went home from hospital. However, they considered closing the case after an

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[2] Helen Kempton, 'Baby Bjay Johnstone had bruises at just 10 days old, Coroner Olivia McTaggart told' *Mercury*, 13th August 2015. http://www.themercury.com.au/news/scales-of-justice/baby-bjay-johnstone-had-bruises-at-just-10-days-old-coroner-olivia-mctaggart-told/news-story/82233bcb90e4a8e981466724d1e5da7a viewed 17 February 2016.

[3] 'Dead baby was deemed at risk: inquest', Geelong Advertiser, 12 August 2015.

unannounced visit on 18th October to Simon Johnston's mother's Railton house where the couple were living because there was nothing sinister about the appearance of the baby, the parents engaged appropriately and did not seem drug affected and the matter had been referred to Gateway. It seems that there appeared to be no reason to unwrap and examine the baby. However, bruising to the baby's thigh was observed by a health employee during a home visit six days later (when the baby was just ten days old) and a report was made to Child Protection Services. CPS went to the house and were told that the baby suffered extensive bruises to the thigh when the father, Simon Johnstone, walked into a door in the dark. The CPS workers said they did not unwrap the baby because the explanation was consistent with the bruising reported by the nurse. The inquest heard that the CPS workers received a hostile reception from Mr Johnstone's mother and were told "kids were dying whilst they were wasting their time in this house." The court heard that the mother, Fleur Atkin, denied being the victim of family violence when asked by the CPS worker, and said that her relationship with the baby's father was the best she had had.[4]

The child's parents were assessed by child protection workers but it seems that whilst the case was passed on in mid-October 2012 to Gateway, the family support organisation, the final risk assessment, which weighed risk factors (in this cases drug and mental health issues) against strength factors, failed to be handed over to Gateway.[5] Once a case was passed on to Gateway, further involvement from CPS depended on concerns being raised by Gateway workers. In any event, CPS workers had visited the home on 18th October, the 24th October and again on 30th October. At twenty days old the baby was admitted to the Mersey Hospital at Latrobe and then transferred to the Royal Hobart Hospital.

Days before he was admitted to hospital, police were also alerted to the case by an unusual source. Posts made on social media by the baby's grandmother about injuries to Bjay sparked concern from a British woman and other members of an online mental health support group who called Tasmania Police on their behalf. The call was logged on an internal police system but the information was not passed on to child protection workers. The sergeant who took the call checked the police system for any alerts about the grandmother and called the local Devonport station for any recent reports involving the baby. He found nothing and filed a

[4] Adam Langenberg, Mother of 45-day-old Bjay Johnstone cries out during inquest' 15 August 2015.
[5] Jenny Awford, Lucy Thackray and Freya Noble, 'Baby Bjay's parents' drug ..' Daily Mail, 19 February 2016

report.[6] This passed through the hands of a number of officers and ended up on the desk of a detective constable in Devonport who told the court that he was unable to investigate the call because he had multiple cases to cover that week which were of higher priority and he did not follow it up because it was third hand information. So none of the four officers who knew of the report referred it on.

This is undoubtedly an extreme case but unfortunately a similar case has just has hit the news this week in Launceston.[7] The Baby Bjay case demonstrates how a case can fall between the cracks with fatal results. Despite midwives and social workers identifying the parents as at risk and notifying CPS a number of times, despite CPS accepting the case, a child health nurse alerting CPS to bruising, a follow-up CPS visit and then a report to the police about the case, the baby was so badly beaten it died. Both the baby's grandmother and uncle were present during the CPS visits and could have reported any concerns. Instead they were hostile to the CPS workers. At the inquest, the grandmother initially said that reporting the matter was up to Fleur, it was neither her baby nor her responsibility. And it was Fleur's fault that the baby had died as she could have left the violent relationship. She was asked to explain her motivation for posting the material on Facebook and responded:[8]

> I don't have any family. My family dumped me. The only place I have to talk is Facebook. I don't have friends either.

She said she was not responsible because she had been through domestic violence her whole life. Later in her evidence she admitted knowing of the abuse to the mother and baby, gave details of it and said she regretted not talking to the authorities. The mother, Fleur Atkin, appears to also have had a troubled life. The inquest heard she had been subjected to childhood trauma and had suffered six miscarriages before she gave birth to Bjay. The evidence from Johnstone's mother suggested Fleur was terrified of Johnstone. The vulnerability of this family is tragic. No doubt the coroner will have some suggestions for how this particular baby's death could have been avoided and for a better information flow between police and CPS.

Child abuse in Australia

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[6] Awford, n 5.
[7] Mercury front-page headline, 24 February 2016: 'Dad on Baby Bash charge', and David Killick, 'Dad faces counts of assault on baby', p 4.
[8] ' "It's not my baby": Bjay inquest' *The Examiner*, 28 October 2105.

Prevalence estimates for physical abuse of children have been found in the majority of studies to have rates between 5% and 10%.[9] The latest child protection data indicates that around 143,000 children received child protection services in 2013-14, a rate of 1 in 37 children.[10]

At an individual level we know the risk factors associated with child abuse and neglect: poverty, lack of education; serious marital problems; frequent changes of address; violence between family members; lack of support from the extended family; loneliness and social isolation; unemployment and inadequate housing.[11]

Family violence and pregnancy

In 2015, Rosie Batty's selection as Australian of the Year highlighted the issue of family violence. The fact that one in four Australian women will experience domestic violence during their lifetime and that across Australia, at least one woman is killed every week by a current or former partner became well known facts. One Australian study has found Intimate Partner Violence to be the leading contributor to death, disability and illness for women aged 15-44.[12] But perhaps what is less well known is that women are especially vulnerable to domestic violence when pregnant. They are less likely to leave a relationship because they are financially dependent or have so much invested in raising the child with their partner. And because it is more difficult to leave, men who choose to use violence, take advantage of that.[13] Unsurprisingly, a history of violence before pregnancy is one of the strongest predictors of pregnancy violence. For these women, the frequency and intensity of violence can often increase during pregnancy. Pregnancy can also be a trigger for domestic violence. A quarter of Australian women, who have experienced partner violence, experienced it for the first time during

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[9] Australian Institute of Family Studies, 'The prevalence of child abuse and neglect, July 2013; https://aifs.gov.au/cfca/publications/prevalence-child-abuse-and-neglect

[10] Australian Institute of Health and Welfare, *Child protection,* *http://www.aihw.gov.au/child-protection* accessed 19 February 2016.

[11] Department of Human Services Victoria, 'What are the causes of child abuse' http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection/about-child-abuse/what-is-child-abuse/what-are-the-causes-of-child-abuse; accessed 19 February 2016.

[12] VicHealth, 2004.

[13] Fiona McCormack, Victorian Domestic Violence Chief Executive quoted by Rachel Kleinman, 'Pregnant Women not immune to domestic violence' Sydney Morning Herald, 3 January 2016.

pregnancy.[14] The period following birth is also a time of increased risk of domestic violence for women, as parental stress increases while caring for a newborn infant.

Domestic violence at any stage of life results in poorer health, reduced quality of life and higher use of health services. During pregnancy, violence can also contribute to miscarriage, premature labour, low birth weight and a higher incidence of infant death.[15] Moreover, studies have shown that there is a strong relationship between a mother's prenatal abuse by a male partner and postnatal trauma symptoms in her child.[16] Pregnant mothers may erroneously believe that abuse will not affect or harm a child until they are aware of it.

In Australia more than 300,000 women seek antenatal care each year, suggesting that those who care for them, midwives, obstetricians and gynaecologists, are well placed to identify women experiencing violence and to provide immediate support and referrals to other agencies for emotional, financial and practical support.

Baird and Creedy from Griffith University suggest that maternity services that offer care by the same midwife allow women to form a trusting relationship with their midwife throughout the pregnancy, labour and after the child is born. Such a relationship allows midwives to *routinely* inquire about the nature of a woman's relationship, her sense of safety, available support and health education needs. However, their research found that midwives were not equipped to talk to their clients about domestic violence. Two thirds did not know about the risks and signs of domestic violence. One third did not know that younger women were more at risk. And around 25% incorrectly believed that perpetrators were violent because of alcohol or drug use. Most felt unprepared and unsupported to conduct routine screening. Baird and Creedy cite a Bristol study which showed that training and supporting midwives to use sensitive questioning can lead to a willingness to screen for domestic violence and to increased disclosure. They approve of the Queensland Domestic Violence Task Force's recommendation to routinely ask women who attend ante-natal clinics about their exposure to family and domestic violence. Some hospitals, such as Perth's King Edward Memorial Hospital have clinical guidelines indicating that screening for

[14] Kathleen Baird and Debra Creedy, 'Midwives can help detect domestic violence – here's how' *The Conversation*, March 10, 2015.
[15] Baird and Creedy, n 14.
[16] Daily Mail Australia online, 18 December 2014 quoting a Michigan State University study by Levendosky.

family and domestic violence occurs for all ante-natal women and that all medical officers and midwives administering screening are trained to implement it.[17]

What is the evidence about the effectiveness of routine screening for intimate partner violence? Does it lead to greater disclosure and importantly does it lead to reduced abuse? Routine screening for Intimate Partner Violence began in the United States following a recommendation of the American Medical Association in 1992 that all women entering the primary care setting be routinely asked about recent experiences of violence regardless of the reason for presentation.[18] Since then it has been adopted in other countries in various settings, including in a pilot project in New South Wales and in a Maori health provider clinic in New Zealand.[19] There is considerable debate about whether enough is known about the benefits and risks of screening for IPV to recommend its routine introduction. Some argue that the solution is only to ask symptomatic patients, whereas others have argued that the prevalence of IPV and the subsequent health effects warrant universal screening despite the absence of conclusive evidence. The reviews of effectiveness have been inconclusive and there are methodological difficulties in assessing the effect of routine screening independently of the intervention or treatment provided.[20] The assessment and referral may possibly itself have a positive effect on abuse victims by altering the way patients view their situation and they may obtain validation and support from the health care provider. But testing this, e.g. by a randomised control trial, is difficult.

I consider there is a danger in being overcautious here. Perhaps we should proceed without conclusive proof that routine screening is in itself effective? The studies, which have been attempted, show that it unlikely to be harmful.

One thing that comes out of the Baby Bjay case is that whilst the parents did seem open to help, no one in the family felt comfortable or trusting

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[17] See Screening for Family Violence .pdf and http://kemh.health.wa.gov.au/health_professionals/WHCSP/fdv_toolbox.php#Screening

[18] Jo Spangaro, Anthony B Zwi and Roslyn Poulos, 'The Elusive Search for Definitive Evidence on Routine Screening for Intimate Partner Violence' (2009) 10 *Trauma, Violence & Abuse* 55-68, 56.

[19] Spangaro et al, n 18, 56.

[20] Spangaro et al, n 18, 59.

enough to disclose either the violence to the mother or to the baby, despite evidence of bruising to both. May be it is true that, as Baird and Creedy argue, we need to develop better training, screening tools and practice tools to assist midwives and other health providers to raise the issue sensitively and offer support.[21]

By starting with the story of Baby Bjay, I don't mean to suggest that perpetrators of family violence are necessarily lower-class, uneducated, and/or possible users of illicit drugs. Nor are the victims necessarily poor or lacking in education. It is by no means socio-economically disadvantaged families that are vulnerable to abuse. As Rosie Batty says,

> Family violence happens to everybody. No matter how nice your house is, how intelligent you are. It can happen to anyone, and everyone.

This is perhaps a good argument for routine screening for intimate partner violence. What is clear, however, is that there is an overlap between intimate partner violence and child abuse. If a woman is abused by her husband, this increases the likelihood of child abuse but the two kinds of abuse often exist separately. In relation child abuse it has been shown that parental socio-economic status is a risk factor for substantiated cases of child abuse, together with other factors such as hospital admissions for mental health, substance abuse and assault.[22]

As legal and medical professionals we tend to focus on responding to issues like family violence and child abuse after the event rather than dealing with the underlying causes. To finish, I would like to dwell for a few moments on the underlying causes. Of course medical professionals know a lot about 'primary prevention', stopping health problems before they occur and primary prevention has been successfully applied to areas such as smoking, HIV/AIDS and road safety in recent decades. We know that we must address the underlying causes or drivers of a problem, not just its direct antecedents or effects. And violence against women and children is a more complex and socially entrenched problem than smoking or road safety.

So what are the underlying causes of men's violence, and men's violence against women in particular? We know that the key driver of men's

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[21] Baird and Creedy, n 14.

[22] Melissa O'Donnell et al, 'Characteristics of non-Aboriginal and Aboriginal children and families with substantiated child maltreatment: a population based study' (2010) 39 *International Journal of Epidemiology* 921-928.

violence against women is gender inequality – both structural and normative expressions of gender inequality in public and private life. Other factors, such as alcohol or drug abuse and childhood exposure to violence, are found to contribute only when interacting with gender inequality.[23]

At the population level, we know that in societies and communities with greater structural gender inequality, there are higher levels of men's violence against women. This is the most statistically significant predictor of a higher incidence of such violence, above other social political and economic factors.[24]

At the individual level, men who hold violence-supportive attitudes and beliefs, such as those relating to male dominance in relationships and sexual entitlement, are more likely to make the choice to be violent against women – and this is the single most significant predictor for individual perpetration.[25]

At an individual level we know the risk factors associated with child abuse and neglect: poverty, lack of education, serious marital problems and so on, which I listed earlier. Certain community attitudes and cultural norms are likely to encourage child abuse. These include: acceptance of the use of violence and force; acceptance of the use of physical punishment of children; acceptance of parents' 'ownership of children' and their right to treat children as they see fit and inequality between men and women.[26]

So prevention must address gender inequality across its structural and normative dimensions and it cannot be done in isolation to social justice, human rights and public health endeavours in other areas to address economic disadvantage.

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[23] This discussion is based on: *Getting serious about change: the building blocks for effective primary prevention of men's violence against women in Victoria*, May 2015.
[24] WHO (2010) *Preventing intimate partner and sexual violence against women: Taking action and generating evidence*.
[25] VicHealth (2014) *Australians attitudes to violence against women, Findings from NCAS 2013.*
[26] Department of Human Services Victoria, 'What are the causes of child abuse' http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection/about-child-abuse/what-is-child-abuse/what-are-the-causes-of-child-abuse; accessed 19 February 2016, see also Donna Wynd, *Child abuse: what role does poverty play?* Child Poverty Action Group, New Zealand 2013, *https://www.google.com.au/?gws_rd=ssl#q=child+abuse+and+poverty+in+nz* accessed 19 February 2016.

I think that what I am trying to say here is that we can't change family violence (partner violence and child abuse) at the individual level alone - we need to change the social conditions that excuse, justify and even promote violence in the family. So as well as intervening at the individual level with mechanisms such as routine screening and the provision of referral and support for victims, we also have, as citizens, a duty to assist in addressing the underlying causes, gender inequality and cultural attitudes which support both it and physical violence toward children, as well as socio-economic disadvantage. And the link between poverty and child abuse needs to be acknowledged. Low educational attainment, poor mental or physical health can set up a cycle of poverty and stress which puts children at risk. Socially disadvantaged populations need improved access to affordable and stable housing, better access to primary health care, early childhood child care and education to help establish a protective environment for women and children. At the same time we need to acknowledge that it is not just socially disadvantaged families that are at risk of family violence.