Family Violence Death
Review Committee

Input for the report of the Independent Expert on the enjoyment of all human rights by older persons

This document is a response to the Independent Expert's call for inputs to inform a report on violence abuse and neglect against older persons from Aotearoa New Zealand's Family Violence Death Review Committee (the Committee).

Background

The Committee is based in the Health Quality & Safety Commission New Zealand and provides independent advice to its board on how to reduce the number of family violence deaths.

In the Committee's terms of reference,[1] family violence is defined as:

> any behaviour that coerces, controls or harms, an (ex) intimate partner and/or family member(s) by the means of deprivation, negligent treatment, isolation, intimidation, threats, violence, and/or causes them to fear for their own, or another family member's safety or well-being. It can include physical, sexual, psychological, emotional, and economic abuse, as well as neglect and exploitation… children's exposure to these forms of abuse and the effects of abusive behaviour. It is understood as a pattern of abusive behaviour and can also span multiple relationships and generations.

A family violence death is defined as:

> the unnatural death of a person (adult or child) where the suspected offender(s) is a family or extended family member, caregiver, intimate partner, previous partner of the victim, or previous partner of the victim's current partner, and where the death was an episode of family violence and/or there is an identifiable history of family violence.

The Committee conducts in-depth reviews into family violence death events. We take a life-course approach to understanding the victim, the offender and their wider family, as it has been our experience that responses to present-day offers of service or support are shaped by past actions of helping agencies.

The Committee's work is grounded in Te Tiriti o Waitangi (Treaty of Waitangi). Through this, the over-representation of Māori families in family violence homicides is understood as a reflection of multiple and repeated breaches of Te Tiriti. We use Te Pou, an Indigenous

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[1] www.hqsc.govt.nz/assets/Our-work/Mortality-review-committee/FVDRC/Publications-resources/FVDRC_Terms_of_Reference_FINAL_-_May_2021.pdf

framework for the interpretation of mortality data, to ensure the Committee's recommendations take account of, and do not reinforce, pre-existing inequities.[2,3]

The Committee takes a system perspective. Our reviews highlight that problematic practice by one agency will be built on by the behaviours of partner agencies. Mistakes (biased, punitive or minimising responses) beget mistakes.

Submission

In the descriptions below, we have chosen to characterise older persons as those aged 50 years and over, recognising the differing age structures of Māori, Pacific and European populations in Aotearoa. Using this definition, there were 67 older persons (21 percent of total) who died as a result of a family violence homicide between 2009 and 2020.

1. Manifestations of violence

Our data shows that, among older persons, 46 percent of family violence homicides were intrafamilial homicides (deaths that were **not** intimate partner violence or child abuse and neglect), while the remainder were intimate partner violence. Among intrafamilial homicides, there was an equal number of mothers and fathers who were killed by their children, approximately 71 percent of all intrafamilial homicides. In 35 percent of intrafamilial homicide events, the offender was found not guilty by reason of insanity, highlighting the importance of mental health services working closely with the families of those in need of their services.

Within intimate partner violence homicides, there was an over-representation of gun violence among older adults. In the general population of intimate partner homicides, 15 percent were the result of gun violence. Among older persons, 31 percent were the result of gun violence (for 75 percent of these cases, the offender attempted or completed suicide at the time). There was also a higher proportion of older persons whose homicide was **not** precluded by separation. Across the general population of intimate partner homicides, there was no reported history of separation in 44 percent of cases. For older persons, there was no reported history of separation in 56 percent of cases.

2. Intersectionalities

The Committee has highlighted the importance of understanding the whole family context, especially where additional needs are evident, such as where there is mental or physical disability within the family. Families will often step in where inadequate services exist. In-depth reviews of homicide events demonstrate how the voice of disabled people can be silenced, privileging the voice of others, including family members and services that have the capacity to do the most harm by withholding access to support. Indeed, the Committee's data set includes cases of grossly negligent behaviour in the care of older persons.

Equally, the Committee holds records of situations where families expressed significant concern about the mental wellbeing of those they were caring for, only for their voice to be minimised. As detailed above, 35 percent of intrafamilial violence offenders were found not

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[2] Roguski M, Grennell D, Dash S, et al. 2022. Te Pou: An Indigenous Framework to Evaluate the Inclusion of Family Voice in Family Violence Homicide Reviews. *Journal of Family Violence*. DOI: 10.1007/s10896-022-00459-6.

[3] Cram F, Cannell H, Gulliver P. 2022. Getting the Story Right: Reflecting on an Indigenous Rubric to Guide the Interpretation of Mortality Data. *Journal of Interpersonal Violence* 37(21–22): NP19599–NP19623. DOI: 10.1177/08862605211042565.

guilty by reason of insanity, often in the context where other family members had expressed concern about their wellbeing. The mother or father of the offender was killed in all except for one of these cases.

3. Access to justice

As part of the legislative framework of Aotearoa, a person can appoint an Enduring Power of Attorney (EPoA). The stated purpose of this provision is to protect individuals who lose the capacity to make decisions about their own personal care and welfare.[4] However, the appointment of an EPoA 'involves putting explicit trust in another individual to act on your behalf in an unforeseen situation where one is extremely vulnerable'.[5] While they are established when an individual has full capacity, it is rare for anyone to review and oversee an EPoA once the individual had reduced capacity.[6] The risks of abuse of an EPoA increase when the person granted that responsibility is also named in the individual's will,[7] is the beneficiary of a family trust or holds other legal powers.

Because of the potential for exploitation when an intimate partner or other family members have financial control, services need to understand a person's life beyond their immediate caregiver. While there is the potential to add safety mechanisms (such as the addition of more than one attorney or the addition of safeguards), the onus is on lawyers to advise about these measures where they are not in place. Introducing such mechanisms also requires a detailed understanding of points of vulnerability including housing and day-to-day care, as well as of the social, cultural and emotional coping mechanisms available to a disabled person and their family.[8]

Age is a prohibited ground for discrimination, according to Aotearoa Human Rights Legislation.[9] Equally, the Family Violence Act 2018[10] has provisions directed towards older persons. Neither of these provisions have been sufficiently activated, in part because of insufficient access to support and resources for older persons.

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[4] Protection of Personal and Property Rights Act 1988, ss 93A–108AAB.
[5] Murphy D. 2016. Enduring Powers of Attorney for personal care and welfare in New Zealand: an uncertain proposal. Graduate Certificate in Law thesis, University of Victoria, Wellington, p 8.
[6] Wuth N. 2013. Enduring powers of attorney: with limited remedies – it's time to face the facts! *Elder Law Review* 7.
[7] Caxton Legal Centre Inc. 2007. Submission 112 to the inquiry into older people and the law, Parliament of Australia, House of Representatives Committees. URL: www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=/laca/olderpeople/subs.htm.
[8] Willacy H. 2021. Safeguarding adults. Patient. URL: https://patient.info/doctor/safeguarding-adults-pro.
[9] Human Rights Act 1993, s21(1)(i).
[10] Family Violence Act 2018 s11(1)(f).

4. Examples of good practice to address violence and abuse against older persons

In our *Seventh report: A duty to care | Pūrongo tuawhitu: Me manaaki te tangata*,[11] the Committee drew on solutions from kaupapa Māori organisations and the disability sector to underscore an effective duty to care in response to violence experience. Such solutions are likely to be effective in responding to violence against older persons. Lessons learned from these approaches include the following:

- Responses to an individual need should occur in relation to the wider family – those who are supporting the family need to focus on the needs of the family rather than on service delivery or contracting priorities.
- Holistic world views acknowledge the impact of intergenerational trauma and intergenerational behaviour patterns – many who use violence against older persons have also been victims of violence in the past, but not seen as victims in their own right. Where ineffective or inadequate responses are provided, intergenerational trauma can be further embedded.
- Organisations need to develop trusting and supportive relationships with families – 'we want to provide help whatever the problem… at the earliest opportunity'. 'The things that people struggle to get early intervention support with, that could be the drivers of the more serious problems.'[12]

Te Kāwanatanga o Aotearoa
New Zealand Government

[11] Family Violence Death Review Committee. 2022. *Seventh report: A duty to care | Pūrongo tuawhitu: Me manaaki te tangata*. Wellington. Health Quality & Safety Commission. www.hqsc.govt.nz/resources/resource-library/fvdrc-seventh-report/.
[12] *Ibid.*, p 84.