Royal Commission into Family Violence

WITNESS STATEMENT OF AMY MORGAN WATSON

I, Amy Morgan Watson, Registered Nurse and Midwife of 20 Flemington Road, Parkville, in the State of Victoria, say as follows:

1. I am authorised by The Royal Women's Hospital (**The Women's**) to make this statement on its behalf.

2. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Current role

3. I am currently the Associate Nurse Unit Manager of the Women's Emergency Care at The Women's. I have held this position since July 2014.

4. My position includes both a clinical and managerial role. I provide care to patients in the Emergency Care department and I am a team leader of nursing and midwifery staff.

Background and qualifications

5. I am a registered nurse and midwife. I completed my Bachelor of Nursing Science at the Royal Melbourne Institute of Technology in 2008 and commenced as a graduate nurse at The Women's in 2009. In 2010, I completed a Postgraduate Diploma in Midwifery Science and commenced a further graduate year as a midwife at The Women's in 2011.

6. In 2013, I completed a Diploma of Nursing Science in Child, Family and Community which means I am a qualified maternal and child health nurse. I continue to work casually as a maternal and child health nurse.

Training on family violence

University training for nurses and midwives

7. University training for nurses and midwives is primarily focussed on medical care. As part of my university training, I learnt about pregnancy, labour and birth, post-natal experience and how to look after a woman once she leaves hospital. I also learnt about high-risk groups of pregnant women, such as women who have a mental illness, are taking drugs or excessively consuming alcohol and who may suffer social isolation. There was no specific curriculum on family violence.

8. It was not until I undertook my Diploma of Nursing Science in Child, Family and Community that family violence was incorporated into the curriculum. As part of my course, nearly an entire subject was devoted to family violence and I was required to write a 2,500 word paper about the health impacts of family violence and whether mandatory screening was an appropriate approach to addressing family violence. Maternal and child health nurses care for women who are affected by family violence and have a more autonomous role in the referral process compared to a nurse or midwife in the hospital setting.

9. As part of my training to be a maternal and child health nurse, I also completed a mandatory half day training session on the Common Risk Assessment Framework, referred to as the 'CRAF'. This training included how to identify family violence, how to appropriately and sensitively ask about family violence, how to complete a risk assessment using the CRAF, and how to respond to a disclosure including relevant referral services.

Training at The Women's about family violence

10. I have participated in two different training sessions about family violence at The Women's – the Acting on the Warning Signs training and the Strengthening Hospital Responses to Family Violence training.

11. The Acting on the Warning Signs project is a partnership between The Women's and Inner Melbourne Community Legal to build capacity and willingness of health professionals to identify signs of family violence and to provide appropriate information and referral pathways.

12. I attended the Acting on the Warning Signs training in May 2015. It was a full day of training. The training focussed on identifying and responding to disclosures of family violence, including referral pathways within the hospital. An important part of the training for me was learning from Inner Melbourne Community Legal and Victoria Police about the services they provide and the options available to women. Prior to

this training, I didn't realize that Inner Melbourne Community Legal ran a drop-in legal service onsite at The Women's that women could attend without an appointment. As a clinician working in the Women's Emergency Centre, we don't know what happens to a lot of the women we care for as we may never see them again. I found it useful to learn about what the legal and police response is to family violence, as I don't normally see this side of things. It reinforced for me the multi-disciplinary approach to identifying and responding to family violence and keeping women and their children safe.

13. The Strengthening Hospital Responses to Family Violence project is a partnership between The Women's and Bendigo Health which is developing, implementing and evaluating training, protocols and resources to improve health care and social support for patients experiencing family violence. The project commenced in June 2014 and was funded by Department of Health and Human Services for 12 months, with an evaluation conducted by Our Watch.

14. There were two training sessions delivered as part of this project, and I attended both training sessions. The training was delivered during 'double staffing' time which is in between the morning and afternoon shift when more staff are able to participate. More than half of the staff in the Women's Emergency Care department attended the training. Each training session ran for an hour and a half. The first training session focussed on how to identify women at risk of family violence and how that may present clinically in the Women's Emergency Care department. For instance, it is not just about women who present with a black eye, it could be women presenting with a complaint which is not urgent from the hospital's perspective and could be managed by a general practitioner, or a woman who has multiple presentations of the same health complaint such as a recurrent urinary tract infection.

15. The second training session focussed on how to sensitively ask women whether they are experiencing violence and referral pathways so that the clinician knows who to call if a woman does want support from additional services. During the training, we explored creative ways of ensuring the patient was on her own when we asked whether she was experiencing violence, for example, waiting until a nurse could escort her to the bathroom to take a urine sample. We also learnt about different ways of framing the question depending on the circumstances of the case.

Impact of family violence training on my practice

16. Attending training about family violence has changed the way I practice as a nurse and midwife. It has increased my knowledge and awareness of how family violence impacts on a woman's health. Intimate partner violence is the major cause of preventable death and disease in women aged 15 to 44 years, greater than high blood pressure, obesity and smoking. In the Women's Emergency Care department, we are presented with many gynaecology, reproductive and sexual health complaints so we see the profound effects of family violence and how it contributes to these health complaints.

17. Further, the training I have received has widened my lens on how I care for patients. Prior to completing my maternal and child health training in 2013, there would have been only a handful of times when I had identified and asked a patient about family violence. I would only have asked if it was blatantly in front of me, such as if a woman presented with cigarette burns on her pregnant belly or a black eye. I had more of a 'tunnel vision' approach to treating the physical presentation in front me, rather than considering the woman's broader health and wellbeing.

18. Now I know that it's not just about the physical health complaints, but about delving deeper into what might be happening for a patient who attends the Emergency Care department with a less 'obvious' presentation. It could be that there are indicators which don't fit the clinical presentation or her partner may be present and he is aggressive, talking over her and refusing an interpreter for the medical consultation.

19. For example, a woman may present to the Emergency Care department at 2am with pelvic pain. She is advised that the doctor is busy and that she may have to wait a while. She is offered pain relief but refuses, which is unusual. The nurse gives her a blanket, she falls asleep and does not further question staff about when the doctor will be coming to see her. Before completing training about family violence, I would have considered this an odd presentation, but not delved deeper into the reasons why the woman might be attending the hospital at 2am. Now, I recognise that the woman might be attending the Emergency Care department because she is seeking safety and respite. A woman is the best assessor of her own risk. She may know that her partner has gone out drinking that night, which escalates the violence when he gets home. She may have identified that the hospital is the safest place for her that night.

20. We don't routinely screen every woman for family violence, rather we adopt a sensitive inquiry by case approach. If the situation presents identifying risk factors (such as the example I outline above), then staff will ask the question. If you ask regularly enough, then it becomes embedded in your practice. We always ask the question when the woman is by herself, we never ask in front of family members, friends or children over the age of two. As I mention above, during the training we discuss creative ways to ensure that a woman is alone when we ask her whether she feels safe, such as waiting for her partner to move his car or get a coffee.

21. I estimate that we have about one woman per week in the Emergency Care department who discloses family violence to a staff member.

22. Women are more likely to disclose to a health professional than to family members or friends. The training I have received has made me more confident to ask the question because I now know the referral pathways that are available. I think a lot of health professionals are hesitant to ask a woman if she is experiencing violence because they don't know what to do if the woman answers 'yes'. It is daunting having someone disclose violence to you.

23. If a patient discloses violence to me, I ask about her immediate safety. The majority of our patients in the Emergency Care department will be discharged home. I ask the patient "if you were to be discharged, are you safe to go home?" It is important that the woman is at the centre of the decision making process. I let her know about the services we have available at The Women's such as the women's social support service (run by the social work department) and the legal service. A woman might not want a referral, but it is important that she knows that the hospital is a safe place to come if and when she is ready to leave the relationship. Having the social support service and legal service available at The Women's makes me a more confident care-giver because I have direct access to internal referral pathways; I can give the woman information about the service, or direct her to the social work department to speak to one of our social workers or a lawyer.

24. One of the benefits of the Acting on the Warning Signs training was that we discussed how managers can support their staff when identifying and responding to disclosures of family violence. As Associate Nurse Unit Manager, I supervise graduate nurses and midwives who complete three month rotations in different departments within the hospitals. Junior nurses and midwifes might have a patient disclose violence to them for the first time, and they might not feel confident responding or be familiar with the

referral pathways. Part of my role is to support junior staff to respond to disclosures of family violence.

Documenting family violence disclosures

25. The Women's has physical, not electronic, patient files. If a patient disclosed family violence to me, I would record this in her file. I would also record that I had enquired about the woman's immediate safety and offered her a referral to the women's social support service or legal service. I would record whether the woman accepted or declined the referral, and if she declined, I would write that I had informed her about the services available and that she could come back in.

26. The only way of checking if a woman has previously presented to the hospital because of family violence is to read the history in the patient's physical file. There is an 'alert' page at the front of the file, but this is used to record things such as allergic reactions rather than family violence.

27. In the Emergency Care department, we have an electronic system called Emergency Data Information System which displays all the patients currently in the department on a screen. There is nowhere in this system to highlight that a woman has presented for family violence. The screen displays information such as the name of the treating practitioner, time of presentation, the specific presentation, investigation and diagnosis. With respect to the presentation, there are 15 set fields which can be selected within the broad headings of gynaecology, oncology and obstetrics. For example, if a woman presented with pelvic pain, we would select 'gynaecology' and then 'pelvic pain'. This record is printed out and filed in the patient's physical file. There is no set field for 'family violence' or other way of recording a presentation due to family violence on this system.

Recommendations for improvement

28. I have completed more training on family violence than a midwife would normally receive because I have an additional qualification as a maternal and child health nurse. I believe that the full day Acting on the Warning Signs training is sufficient to assist health professionals identify and respond to family violence, but I think it would be beneficial to have refresher training every year.

29. In my view, it would assist to have a field to record family violence presentations in the Emergency Care department on the Emergency Data Information System (EDIS).

(EDIS). This would enable family violence presentations to be recorded and statistics collated on the number of family violence presentations received by The Women's. It would enable subsequent practitioners to immediately know that family violence may be an issue, which can then be taken into account in the way the woman is cared for.

Amy Morgan Watson

Dated: 6 August 2015