Prevention and Response to Violence, Abuse and Neglect Serious Incident Review Sub-Committee

Lessons and learnings – March 2026

The Clinical Excellence Commission (CEC) Serious Incident Review Sub-Committees consist of multidisciplinary clinicians who review serious incidents to identify key learnings, emerging risks, and patient safety issues with broader implications. One of their key roles is to recommend actions to mitigate potential patient safety risks.

The following is a summary of lessons and learnings concerning violence, abuse and neglect (VAN)[1] developed by the CEC, Patient Safety and Clinical Governance Business Unit from Serious Incident Reviews. Consumer/ patient details have been changed.

Services should review this document to determine what further local action is required.

This document contains content that may be distressing. If the content raises concerns for you, speak to your manager, your Employee Assistance Program, or call 1800RESPECT the National Domestic, Family, and Sexual Violence Counselling information and support service.

Consideration of violence, abuse and neglect factors in comprehensive care planning

Key messages:

Comprehensive care and integrated planning: Clinicians should look beyond the immediate issue and assess broader psychosocial, medical and safety needs, especially for patients where VAN factors have or may be identified, and for patients with parenting responsibilities.

Engage specialist services: For patients with complex trauma and/or sexual assault history, include VAN services to improve safety planning and care response.

Safe discharge planning: Where domestic and family violence (DFV) or other VAN issues are identified, or if patients disclose feeling unsafe at home, discharge plans must consider risks and seek to support the safety of the victim-survivor. This may include considering accommodation and psychosocial support to prevent further harm.

[1] The term 'violence, abuse and neglect (VAN)' is used by NSW Health as an umbrella term to describe various forms of interpersonal violence. These include all forms of child abuse and neglect, sexual assault, domestic and family violence, and children and young people with problematic and/or harmful sexual behaviours, who often have their own experiences as victims of abuse and neglect.

Case 1

Background

A consumer who was receiving care from a Community Mental Health Team presented to the Emergency Department (ED) with erratic behaviour and concerns that they were a risk to themselves. They had multiple previous similar presentations to the ED. The consumer had sole parenting responsibilities for young children and multiple psychosocial stressors including a history of being a victim of domestic violence (DV) resulting in post-traumatic stress disorder. It was noted that on discharge from the ED there was no documented plan of treatment strategies or referral to community supports. Two weeks later the consumer was found in a serious condition following self-harm.

Discussion

This case highlights the need for comprehensive care and integrated care planning. It is important that clinicians and those providing care look beyond the presenting issue to assess what other supports or care may be required, particularly when consumers have parenting or carer responsibilities. Repeated presentations to the ED are often a red flag for safety concerns and the need for ongoing support. A psychosocial assessment that includes assessment for broader risks and harms should be facilitated. All disclosures, responses to VAN and subsequent actions are to be documented in the Health Care Record.

In this case although safety assessments were conducted from a mental health perspective, the consumer's broader psychosocial situation and necessary supports, or the care required, were not assessed. Clinicians should consider safety and risk from a VAN context in addition to a mental health context. Psychosocial factors and any history of interpersonal trauma must be considered to provide comprehensive care. It is also important to recognise that many Aboriginal people experience the impacts of personal and intergenerational trauma, including the effects of historical disconnection from culture, community and kinship networks.

Clinicians need to be aware of bias to avoid assuming that a consumer's behaviours or symptoms are solely mental health related, particularly when a history of trauma or abuse may be contributing to their presentation.

Case 2

Background

A consumer with mental health and alcohol and other drug use comorbidities was receiving care from a Community Mental Health Team. The consumer had a long history of trauma from harmful relationships, including DFV and sexual assault, and had been engaged with Sexual Assault Services (SAS). Following a pattern of multiple ED presentations, a formal ED management plan was put in place. The consumer was found at home two weeks later in a serious condition following an overdose.

Discussion

Although the Sexual Assault Service was consulted at the time of the sexual assault, this case highlights the importance of engaging SAS and other specialist VAN services in care planning processes, including formal ED management plans, when indicated. Consultation and discussion with VAN services to coordinate care may assist with safety planning and crisis response.

An ED management plan serves as an alert to clinicians and other care providers that increased engagement with the consumer is required. The inclusion of specialist SAS and/or other VAN services in care planning assists to provide more comprehensive care for consumers who have

experienced harm. Safety planning should be inclusive, multidisciplinary, reviewed regularly, and responsive to the needs of the consumer (and any children in their care).

Case 3

Background

An older person with a history of mental health issues and multiple psychosocial stressors presented to an ED following a suspected suicide attempt. The injuries sustained required admission for surgical repair. During their admission, they reported difficulties with their living situation and feeling unsafe due to DFV. Despite this, they were discharged from the surgical ward to their existing accommodation and suffered further harm following a second suicide attempt two weeks later.

Discussion

It is the responsibility of all health workers to respond to DFV. This response at a minimum is to include: an assessment of risk and safety needs and referral to specialist services and workforces such as social work or VAN services. The outcomes of which are to be incorporated into the comprehensive care and integrated planning process. For further information, see NSW Health Policy Directive *Domestic Violence - Identifying and Responding* (PD2006_084). Additional supports may include the NSW Police. For further information see NSW Health Information Bulletin *Information sharing with NSW Police to reduce domestic and family violence threat* (IB2025_044).

In this case the older person stated on multiple occasions they felt unsafe in their present accommodation, however, were discharged home to their current address. In such situations, consideration should be given to housing and other psychosocial support requirements during the admission.

Safety planning prior to discharge is to include an exploration of the person's living arrangements, circumstances, and accommodation so that patients are discharged into a safe environment.

Reflective prompts

The following reflective prompts are designed to support Local Health Districts (LHD) and Speciality Health Networks (SHN) to consider whether their services fully address any of the issues raised within this document, or whether there are areas for improvement. The reflective prompts could be utilised to inform discussions during clinical governance meetings, Safety Huddles, Morbidity and Mortality meetings, and local quality improvement planning.

Do health workers in your Health service know the indicators of DFV and are they supported to ask about DFV?	It is important to be able to recognise and respond to a range of DFV indicators. Where DFV is suspected, and it is safe to ask the patient, all NSW Health workers are required to ask direct questions about violence. To support this direct enquiry, Health workers must have access to clear information about indicators of DFV and the importance of asking about violence sensitively in a safe and private environment.
When DFV is identified how are health workers supported to provide responses that prioritise victim-survivors and others safety?	Health workers responding to a disclosure of DFV should always: Acknowledge and validate the experience of the person Explore safety needs, including any fears about the immediate safety of the patient and their children Offer and facilitate access to specialist and family violence services Consider action to address immediate and/or serious threats to the patient's safety or the safety of others Establish arrangements for the patient's ongoing safe access to the health service.
Are health workers in your service supported to assess DFV risk, and respond to serious DFV threat?	DFV risk is dynamic, and the frequency and severity of violence can change over time. Health services should: Maintain up to date consultation and referral pathways for specialist NSW Health VAN services and Social Work services, to support risk assessment and safe responses Ensure all health workers are aware of consultation and referral pathways Ensure processes are in place to provide safe discharge and transfer of care, including where the patient may not be safe to return home.

Resources

Clinical Excellence Commission

- Lessons and learnings – Key themes arising from review of incidents involving violence, abuse and neglect

NSW Health

- DFV Sharepoint page - NSW Health Worker's Guide to Identifying and Responding to Domestic and Family Violence
- Healthworker Initial Responses to Domestic and Family Violence: A Trauma and Violence Informed Practice Guide
- Integrated Prevention and Response to Violence, Abuse and Neglect Framework
- PARVAN website

NSW Health Policy Directives

- Child Wellbeing and Child Protection Policies and Procedures for NSW Health (PD2013_007)
- Domestic Violence - Identifying and Responding (PD2006_084)
- Domestic Violence Routine Screening (PD2023_009)
- Health Care Records - Documentation and Management (PD2025_035)
- Information sharing with NSW Police to reduce domestic and family violence threat (IB2025_044)

Key statewide DFV support and referral pathways

1800 RESPECT - Support for people experiencing, or at the risk of experiencing, violence and abuse, their friends and family, and professionals – 1800 737 732 (available 24/7)

NSW Health Child Wellbeing Unit - Information on what action to take in response to any level of harm to a child or young person, including reporting of significant harm, and for information on relevant prior child protection concerns - 1300 480 420

NSW Domestic Violence Line - Counselling and referrals to women experiencing domestic and family violence - 1800 65 64 63 (available 24/7)

Men's Referral Service - For men who use violence, their families and friends and secondary consultation for professionals - 1300 766 491 (available 24/7)

Victims Access Line (NSW) - Support for victims of violent crime in NSW with information, referrals and support to access counselling, financial support (including for immediate needs), and recognition payments - 1800 633 063, and Aboriginal Contact Line - 1800 019 123

If you have any questions or comments about this document, email CEC-PatientSafety@health.nsw.gov.au.