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Professionals' Responses to Aggravated Intimate Partner Violence

A Study of the Norwegian Duty to Avert in Criminal Case Documents

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Abstract

How are professionals in Norway responding to the pervasive issue of intimate partner violence (IPV)? Under Norwegian law, the duty to avert (DTA) obliges all citizens, including professionals, to act against intimate partner violence, distinguishing it from legislation on mandatory reporting (MR) as it allows – and demands – averting by reporting to the police or by other means. There is a lack of insight into the usage of the duty to avert among professionals dealing with intimate partner violence.

This article examines the legal framework of the duty to avert intimate partner violence (DTA-IPV). It assesses the extent to which professionals comply with the duty to avert IPV, identifying who engages in such actions and what they do. Additionally, it investigates the impact of DTA and presents a typology derived from the research, outlining four typical scenarios observed in this study. Analysis of criminal case documents from 38 aggravated IPV cases reveals that while professionals attempt to avert IPV, considerable potential remains untapped. Professionals act in line with their respective

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fields, resulting in variations in the enforcement and nature of DTA actions across different professions. Moreover, there is a complete absence of references to the legal provision regarding the duty to avert as grounds for these DTA actions, suggesting a lack of legal awareness among professionals. These findings underscore the need for enhanced training and education on DTA and prompt whether DTA-IPV legislation should be simplified to ensure a better understanding of the legislation.

1. Introduction

1.1 Overview: The duty to advert

Intimate partner violence continues to be a pressing issue in Norway, demanding effective intervention and prevention. Under Norwegian law, *everyone* – ordinary citizens *and* professionals alike – has a duty to seek to avert intimate partner violence, regardless of any confidentiality obligations.[1] This duty, known as '*avvergingsplikten*', is established in section 196 of the penal code. While it constitutes a legal obligation, the duty to avert also offers an *opportunity* for professionals to act on qualified concerns. It allows them to intervene in cases of intimate partner violence (IPV) without being restrained by strict confidentiality obligations.[2]

The Norwegian duty to avert differs from similar duties in other legislations known as mandatory reporting, and I, therefore, introduce the 'duty to avert' (DTA) as a new typology. The duty to avert aims to reduce the incidence of IPV, with the underlying premise being that more averting leads to less IPV.[3] IPV is a subcategory of 'domestic violence' that refers specifically to abuse between qualified types of romantic partners. The duty to avert intimate partner violence (DTA-IPV) is recognised as a complex set of rules to interpret, a point acknowledged by the Norwegian legislative authority.[4]

1 'Everyone' refers to all citizens, and violations are punishable for those above the age of 15 years, which is the age of criminal responsibility in Norway; see section 20 in The Norwegian penal code 2005 (Lov om straff, LOV-2005-05-20-28). The duty to avert is regulated in penal code section 196.

2 This article highlights this opportunity to avert IPV rather than the threat of punishment outlined in section 196.

3 This is never expressed explicitly but appears as an underlying reason every time the legislator wants to include more offences to limit violence and abuse; see e.g. Prop. 66 L (2019–2020). Here, and in several other preparatory works, it is stated that this duty is an expression of a fundamental societal obligation; see p. 15.

4 'Several consultative bodies have pointed out that the duty to avert is formulated in a way that is difficult to understand. The Ministry of Justice and Public Security shares this viewpoint. However, it is not easy to delineate the duty to avert in a manner that provides better guidance.' Prop. 66 L (2019–2020) p. 34. All translations from preparatory works etc. are mine.

Norwegian professionals seem to have limited knowledge of their legal duty to avert intimate partner violence, despite the requirement to adhere to both their duty of confidentiality and duty to avert in their practice.[5]

Although the rules governing what professionals are required to do when encountering IPV vary from country to country, the tension between a professional's duty of confidentiality and duty to act remains the same. As these two duties often demand opposite activities, and the line between them might be challenging to ascertain, professionals commonly struggle to decide which duty to prioritise. Both the IPV victims and the perpetrators may be dependent on the assistance that the professionals can provide. This dilemma is further emphasised by research indicating that, in some cases, intimate partner violence escalates to intimate partner homicide.[6] In many of these cases, professionals were in contact with the couple and were often aware of the intimate partner violence prior to the murder. This highlights the critical need for effective intervention and support mechanisms in these situations. In addition, professionals tend to gain insight and access to private information through their work.

1.2 The scope of intimate partner violence in Norway

Norway is renowned for its gender equality and modern perspective on women and women's rights. However, intimate partner violence remains a persistent societal issue. Two recent reports examined the extent of IPV in Norway and found it to be high. In the first report, published in 2023, 11% of women and 3% of men reported exposure to severe IPV.[7] The second report estimated the socioeconomic cost of domestic abuse as almost NOK 92.7 billion in 2021.[8] Research has shown that IPV may affect victims in multiple ways, including direct victims and children who witness IPV. Exposure to IPV is associated with an increased risk of poor health and psychosomatic symptoms, suicide attempts, substance use/alcoholism, economic difficulties, reduced functional capacity, mental illness and psychological distress.[9] Therefore, a growing body of research suggests that identifying and addressing IPV as early as possible is crucial to mitigate its detrimental effects.[10]

5 For research examples, see Brevik, *et al.* (2024) and Stang and Aamodt (2013).

6 See for example Lövestad S, *et al.* (2024) and Vatnar S, Friestad C and Bjørkly S (2017).

7 This report does not use the legal threshold in its definitions of 'intimate partner' and 'violence', and it is based on self-reporting. However, it still provides an understanding of the magnitude of the problem, see Dale Aakvaag and Strøm (2023).

8 Pedersen (2023). Approximately EUR 9.1 billion or USD 10.7 billion.

9 Findings from several studies correspond regarding the influence of IPV, as demonstrated by for example Devries, *et al.* (2013) and Dodaj (2020).

10 Coker, *et al.* (2002) p. 266.

Norway's well-developed public support system, which includes a national insurance scheme that provides comprehensive health and social assistance for all citizens, offers a robust framework for addressing such challenges. Insight into how the duty to avert intimate partner violence is complied with in Norway's primarily well-functioning system may provide valuable inspiration and development opportunities for other legal systems as well as its own. Furthermore, the duty to avert intimate partner violence (DTA-IPV), as a new typology, might also be applicable to other countries in evaluating the effectiveness of similar systems.

1.3 Research questions, ethics and article structure

We know little about how and if professionals fulfil their duty to avert IPV in Norway. The case law concerning violations of the duty to avert in Section 196 of the Norwegian penal code is scarce.[11] There are no documented court proceedings concerning violations of DTA-IPV for professionals – or anyone, for that matter.[12] No previous studies have examined professionals' averting activities in criminal case documents in IPV cases in Norway. This absence of documentation and research implies that there is a lack of crucial insight into how compliance with DTA-IPV unfolds for professionals in their practice.

This article examines the following:

1. What is the legal framework for the Norwegian duty to avert in cases of IPV?
2. Do professionals seek to avert in cases of aggravated IPV?
3. If so, who averts, and how do they avert?
4. Do averting activities affect the presence of IPV in these cases?

To answer these questions, I will examine the Norwegian legal sources to establish the legal framework regarding DTA-IPV (chapter 2.3). Next, I will explore and analyse

11 The Ministry of Justice and Public Security has speculated that 'this may indicate that the provision has little effect, but it could also be due to the fact that the provision stipulates a behavioural rule that originates from a fundamental societal duty and that the rule is largely adhered to'. See Ot.prp. nr. 8 (2007-2008) p. 261.

12 Additionally, there is a lack of evidence showing health professionals being subjected to penalties or loss of rights within the jurisdiction of the Norwegian Board of Health Supervision (*Statens helsetilsyn*) or the Board of Health Personnel (*Statens helsepersonellnemnd*). Following my request, the Norwegian Board of Health Supervision conducted a search on my behalf in January/February 2023. Its jurisdiction no longer includes breaches of the penal code, which are now solved by reporting to the police. There were no cases referring to DTA. Relevant violations were related to the 'duty provisions' in the Health Personnel Act (*Helsepersonelloven*). Of these provisions, section 31 is the most relevant and is similar to a breach of the duty to avert, since it gives health personnel a duty to notify the police and fire department if necessary to avert serious harm to individuals or property. Only two cases involved a breach of this section, neither of which included cases of IPV or equivalent.

criminal case documents in cases of aggravated IPV (chapter 4). These documents have been extracted from the Norwegian police's data system called 'BL', which stores all documents collected and produced by the police and prosecution within a criminal case.[13] This article reveals that while professionals take action to avert IPV, their efforts still have untapped potential. It also outlines what different professions do and introduces a typology of four typical case types.

Given my access to a considerable amount of sensitive data, I implemented measures to ensure anonymity and confidentiality throughout all stages of the data research process. Consequently, no individuals were identifiable in my working documents or can be identified in the research findings. Furthermore, I adhered to relevant ethical guidelines and frameworks for handling this sensitive information.[14]

Obtaining informed consent from the people involved in these criminal cases was impossible. Researchers have established this, and both the Director of Public Prosecutions and the Council for Confidentiality agreed that obtaining consent was impossible in the case of this article.[15] Ethical considerations are necessary due to the combination of a lack of consent and the highly sensitive nature of the information. Therefore, it is vital to emphasise the need for knowledge on how professionals deal with severe IPV to enable them to improve their handling of DTA in IPV cases. Insight into empirical data of this magnitude is crucial to preventing IPV.

This article continues by discussing and establishing the Norwegian legal framework for DTA-IPV. An account of the methods used and a presentation of the findings follow before the discussions and conclusion.

2. Legal framework

2.1 Terms and definitions

Before examining the legal framework regarding DTA-IPV, it is necessary to define the relevant terms and concepts in this article.

'*Professionals*' are the subjects of my examination, meaning employees in Norway's public service and welfare system. The term includes professionals working for the state or municipalities and private actors performing tasks on behalf of the state

13 BL is short for *basis løsning*, meaning basic solution.

14 The research ethics act (2017), NESH (2021).

15 Bjelland and Dahl (2017) p. 10.

or municipality. I have also included 'registered' religious communities.[16] These professions have in common that, due to the nature of their work, they all have a duty of confidentiality. All professions working within these entities are included in this study. The professions with identified DTA activities are divided into eight categories for ease of understanding: police, doctors, health workers, child protection services, priests, crisis shelters, judicial actors and social services.

'*The duty of confidentiality*' for the various professions is established by legislation associated with each profession.[17] Common to these rules are a *passive* duty not to share and an *active* duty to prevent access to confidential information. This includes all information that should not be shared without consent or legal exceptions, such as personal data, medical records, child welfare documents and other sensitive information.

'*Criminal case documents*' are documents produced and used by the police and prosecution during investigations and later in trials.[18] They often include filed police reports and other reports, pictures, interrogation transcripts, witness testimonies, medical and other journals and case documents from child protective services. In short, these documents form a collection of all relevant information gathered to obtain a conviction. They are extracted from the Norwegian police's criminal case register, BL. This register is a tool for working with criminal cases, in which the police assemble all the information they have collected and produced during investigations, as well as during criminal proceedings and following trials.

2.2 Positive human rights obligations

Since 1968, the European Court of Human Rights has developed the concept of positive obligations within certain human rights that is now generally accepted.[19] It is certain that it requires member states to actively take preventive operational measures to protect (potential) victims of domestic violence.[20] The Court has interpreted these

16 This is because priests and leaders in registered religious communities (*prester og forstandere i trossamfunn*) have a duty of confidentiality, see penal code section 211, have contact with people of different ages and situations and are often likely to receive (or observe) sensitive information. For instance, priests in the Church of Norway carry death notifications on behalf of the state/police. A proposal to remove their duty of confidentiality was submitted for public hearing in the autumn of 2024. This proposal received considerable opposition in the consultation responses.

17 See e.g. health personnel act chapter 5, child welfare act chapter 13 and police act Section 24.

18 Bjelland and Dahl (2017) p. 8, referred to as 'police case files'.

19 European Convention on Human Rights (1950).

20 Kurt v. Austria, para 157.

obligations with slightly different nuances within the right to life in Article 2, the prohibition of torture in Article 3 and the right to respect for private and family life in Article 8.[21]

Article 1 of the Istanbul Convention establishes that 'the purposes of this Convention are to (…) protect women against all forms of violence, and prevent, prosecute and eliminate violence against women and domestic violence'.[22] According to Articles 14 and 15, parties must educate and train their professionals. Such education and training are crucial and effective in ensuring DTA-IPV and, in turn, securing compliance with the purpose of the Istanbul Convention. Since Norway has ratified these conventions, the state has committed to ensuring compliance with its obligations, as (re)stated in Section 92 of the Norwegian Constitution.[23]

2.3 What is the legal framework for the Norwegian duty to avert in cases of IPV?

2.3.1 Mandatory reporting versus duty to avert

Several countries mandate that professionals report cases of IPV to the police, which is known as mandatory reporting (MR or MR-IPV).[24] The international research discourse on whether MR-IPV benefits or disadvantages victims often involves countries that have ratified the same human rights conventions and thus share a common legal framework.[25] However, national legislation often provides many defining framework conditions for the debate, intersecting social science and comparative law in this complex and multifaceted topic.

Norwegian law differs from that of other countries in several ways concerning MR-IPV. First, its definition of IPV is narrow. Second, its version of MR differs significantly from that of other countries since it does not solely require 'reporting' but also allows for fulfilling the duty 'by other means'. Thus, the international term MR does not accurately describe the Norwegian provision. In this article, I introduce

21 Harris, *et al.* (2023), Holmboe (2022) and Kjølbro (2023).

22 Council of Europe Convention on preventing and combating violence against women and domestic violence (2011).

23 The Constitution of the Kingdom of Norway.

24 Vatnar, Leer-Salvesen and Bjørkly (2021).

25 Internationally, MR-IPV is controversial. Critics argue that consent should be a condition for MR-IPV and that reporting without consent deprives victims of autonomy and leads to less help-seeking. Supporters argue that MR-IPV helps uncover IPV, relieves victims of the choice of whether to report and helps victims in a trapped situation In addition, the World Health Organization does not recommend MR-IPV for health personnel (World Health Organization 2013). For a presentation on this topic and references to both wings of opinions, see Vatnar, *et al.* (2024).

the term 'duty to avert' (DTA or DTA-IPV). Due to the particularities of Norwegian legislation regarding DTA, this article delves into the Norwegian law on DTA-IPV more thoroughly than typical empirical articles. Understanding the law is crucial for clarifying the subject of study and fostering a nuanced debate on DTA-IPV within the international research discourse.

Norwegian law determines the framework for DTA-IPV. I now introduce the Norwegian legal framework, including the content of the Norwegian penal code's provisions on DTA and what constitutes IPV.[26]

2.3.2 Duty to avert

As mentioned, the duty to avert (*avvergingsplikten*) in Section 196 of the Norwegian penal code requires *everyone* to seek to avert several offences listed in the provision.[27] Among the listed offences are sections 282 and 283 of the penal code, which relate to domestic violence and aggravated domestic violence, respectively.[28] The duty requires individuals to report or seek to avert, by other means, a criminal act or its consequences at a time when this is still possible and it appears certain or most likely that the act has been or will be committed. The duty to avert applies regardless of any duty of confidentiality. Breaches of both the duty of confidentiality and the DTA are punishable by a fine or imprisonment for a term not exceeding one year.

It is important to note that the DTA is personal; that is, a*n individual* must consider it certain or most likely that new abuse will occur in the future based on their *own* assessment. The possibility of corporate responsibility in the penal code is essential but not addressed in this article.[29] Only the information at hand must be evaluated to ascertain whether this information activates DTA-IPV.

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26 See also Ferreira and Jacobsen (2024), Holmboe (2017), Holmboe, Leer-Salvesen and Vatnar (2019a), Holmboe Leer-Salvesen and Vatnar (2019b) and Sæther (2016).

27 There exists an unofficial translation of the penal code, including section 196. While the English translation lacks the latest amendments of this provision, it covers the essential aspects.

28 Section 283 is not a separate offence but provides a higher maximum penalty in severe cases of domestic violence.

29 In some cases, the lack of DTA performed or a lack of training etc. might be directed at the institution, making it subject of a corporate responsibility, see penal code sections 27 and 28. The Norwegian Bureau for the Investigation of Police Affairs (*Spesialenheten for straffesaker*) recently imposed corporate penalty on a police district of 300 000 NOK in a case of intimate partner homicide. The police failed to log contact with the couple correctly, mislabelling the criminal behaviour, leading to inadequate understanding of the seriousness of the situation. Thus, the police failed to secure the victims human rights, see The Norwegian Constitution section 92. The police's actions were considered grossly negligent professional misconduct in accordance with sections 171 and 172. It is unclear whether the couple were intimate partners in accordance with section 282. See also HR-2013-881-A para. 46 (regarding breach of the duty to secure the victims human rights. The case is regarding a couple not included in section 282).

As stated in the legal wording, the DTA applies when one person believes that it is *most likely* that future acts of IPV will take place.[30] According to the phrase 'at a time when it is still possible' to avert, this duty is directed solely towards future acts.[31] Although the DTA applies to *future* acts, acts of IPV that have *already* occurred may influence one's assessment of the likelihood of new acts of abuse. The DTA will then apply only to the parts of acts or consequences that have not yet occurred. In the landscape of IPV, one might argue that 'consequences' is a broad term encompassing long-term impacts, as mentioned in the introduction.

The law allows the person averting to decide how to best comply with the DTA, as reflected in the wording 'report or seek to avert by other means'. The preparatory works state:

> 'The law does not impose an absolute requirement that the prevention must occur through reporting [to the police]. Any attempt to avert the crime or its consequences leads to immunity from prosecution as long as the person obligated to prevent the crime or the consequence does what they believe is sufficient.'[32]

Thus, 'there could only be a duty to report if there is a risk of recurrence and there are no other ways to stop continued abuse'.[33]

In the preparatory works of the penal code, the Norwegian legislative authority states that 'the most important and practical action to avert would be to report the matter [to the police]. However, depending on the circumstances, there may be a duty to attempt to prevent the act and/or its consequences in another way'.[34] Later, in the preparatory works of changes in section 196, the nature of the duty is described as follows:

> 'The duty to avert imposes, depending on the circumstances, a rather intrusive obligation to act on the individual. It should be sufficient to make a reasonable assessment of whether the conditions are met. Central to the assessment should be whether the situation was such that it would be natural for an ordinary citizen, based on an ethical judgment, to attempt to avert it.'[35]

30 Regarding *future* acts, one might ask how far into future acts the DTA reaches. There is no need for the risk to be acute. The threshold is met when a person finds it 'most likely' that such acts will occur. See Ørum, Vatnar and Holmboe (2023).

31 Norwegian law does not impose a general obligation to report criminal offences that have already been committed.

32 Ot.prp. nr. 79 (1988–1989) p. 38.

33 NOU 1988: 29 p. 15.

34 Ot.prp. nr. 8 (2007-2008) p. 364.

35 Prop. 66 L (2019–2020) p. 157.

Except for these clarifications, the legislative authority provides few guidelines regarding the meaning and limitations of 'other means'. In other words, a wide variety of DTA actions are included in the scope of 'other means' as long as the person averting finds it sufficient to prevent IPV or at least reduce the probability of IPV to 'least likely'.

Impunity does not require exposing oneself (or one's next-of-kin) to life, health or welfare risks.[36] Note, however, that this exception does not apply when the victim is a minor, and the person failing to avert is the child's parent, stepparent, foster parent or someone else who has daily care of the child.[37]

2.3.3 Intimate partner violence

IPV is a subcategory of the broader term domestic violence, criminalised under sections 282 and 283 of the penal code. The provision covers intimate partners; the direct line of descent and ascent of oneself and one's intimate partner; members of one's household; and persons under one's care. To determine whether a case qualifies as 'domestic violence', two variables are crucial: which relationships are 'domestic' and which actions are 'abusive'. Under IPV, this consists of two elements, intimate partner and violence: who are included in the intimate partner scope and what actions are included in the violence scope?

Letter a of section 282 defines and criminalises IPV as involving 'his or her *current or former spouse or cohabitant*'. In some cases, the alternative in letter d is applied in cases of IPV, referring to members of one's household. This is a confusing way of applying section 282, and I will argue that the threshold remains the same in cases of intimate partners; only couples who have cohabited or been married are included in this definition of intimate partner.[38] Excluded are dating couples and even those who 'only' have a joint child. This makes the Norwegian legal definition of intimate partner much narrower than those of other countries. In other Norwegian state documents, they use a more common limitation that includes more informal couples. This difference in definitions of intimate partners in Norwegian sources might be confusing to professionals, adding to the challenges of DTA-IPV.

36 Section 196, third paragraph, letter b.

37 See section 196, fourth paragraph, added in 2020 (not included in the English translation). If read literally, this rule demands that such caregivers put their own lives at risk. It is assumed that this part of the exception must be interpreted restrictively, and that the legislator is aiming to impose a general duty to avert on parents and similar caregivers, but this has not been established in the preparatory works or in case law. See Holmboe (2025).

38 This does not necessarily meet with the obligations in the Istanbul Convention, see Ørum (2023).

Establishing a lower threshold for cohabitation can be particularly challenging, as this threshold remains unclear. Cohabitation is defined in section 9 of the penal code as 'two persons living together permanently in a marriage-like relationship'. This means that they must live together, and their relationship must be both intimate/romantic and stable, having lasted for a certain period of time.[39] The difficult part often lies in assessing whether they have been a cohabiting intimate couple for a sufficient duration, which must be determined individually in each case.[40] For example, there is no clear threshold for what is considered a sufficient duration. Furthermore, there are no clear guidelines regarding where they must live, such as whether there is a requirement for an apartment rather than a hotel or if they may live together in someone else's home. Couples in the grey area between dating and cohabitation often face complex living arrangements that do not align with the legal definitions.

Research indicates that the enforcement of the 'cohabitation' threshold has been somewhat inconsistent in jurisprudence.[41] This is also apparent in the researched cases in this article, based on my observations. One might ask if the severity of the abuse affects the assessment of cohabitation in each case – the more severe the violence, the more likely the court is to describe the couple as cohabiting and thus include them in section 282.

To be considered IPV, the acts in question must meet three criteria: (1) involve *threats, force, deprivation of liberty, violence or other degrading treatment*, (2) be *serious or repeated,* and (3) qualify as '*abuse*', based on their extent or severity.[42] The provision encompasses a wide range of acts and adopts a broad understanding of violence. This includes, among others, physical and psychological violence, controlling behaviour and sexual violence. Section 282 allows for collating all parts of the abuse and prosecuting them together.[43] There is no requirement for the presence of physical violence. Interpreting these criteria is demanding, and even trained lawyers may disagree on whether the threshold for applying section 282 is met in a given situation.[44]

39 'This is something more than just any cohabitation. An individual assessment must be made. Key factors will be the stability and duration of the relationship. On the other hand, the fact that the cohabitation is formalised through a cohabitation agreement will not be decisive. [...] Furthermore, it will be a significant factor whether the cohabiting couple have joint children', see Ot.prp. nr. 8 (1998-1999).

40 Husabø (2023).

41 See Skyberg (2023) and Ørum (2023).

42 This is often referred to as a 'regime characterized by permanent anxiety and fear of violence'. It was first defined by the Norwegian Supreme Court in 2010 and has subsequently been frequently referred to. See case Rt-2010-129.

43 For more on the concept of psychological violence in IPV, see Jacobsen (2024).

44 An example is HR-2019-621-A.

The cases that comprise this study's data material all concern aggravated IPV under section 283. This level of abuse far exceeds the threshold for section 282, which criminalises domestic violence. The lower threshold of section 282 triggers DTA, and the abuse in the selected cases is far above the threshold of DTA-IPV.

2.3.4 Overlapping profession-specific rules

All occupations have profession-specific legal rules and codes of conduct in addition to the DTA. Often, these rules require activities similar to DTA, and by complying with profession-specific regulations, one also complies with DTA. The rules might require one to obtain an overview of the available information that may affect the probability assessment in a specific case. Under these profession-specific rules, it may be sufficient for one joint unit, such as a combined medical records system, to possess sufficient knowledge of abuse to call for action. However, this is *not* the case for DTA. Profession-specific rules might also require *more* than DTA, as they can impose more extensive obligations, such as information retrieval, on the unit and each professional. However, this article focuses only on DTA-IPV, and this duty does *not* require information retrieval. Actions coded as DTA-IPV in this article might thus be considered as a professional 'only doing their job' under this overlapping set of occupational rules; this is perhaps especially relevant for emergency services. Nevertheless, it fulfils the DTA-IPV obligations.

3. Methods

3.1 Criminal case documents from BL

3.1.1 About the data

The material in this research comprises criminal case documents from the police's database, BL, a type of data rarely made available to researchers.[45] Bjelland and Dahl emphasised that since criminal case documents are created for purposes other than research, data from BL will most likely contain less misinformation compared to interviews and the like.[46] This, they argue, will improve the validity of the study. These criminal case documents are rich in detailed information about the individuals involved, the dynamics of their relationship(s) and their contact with professionals. However, they vary in content due to four variables. First, the documents were collected by police/prosecutors during investigations and trials, and factors regarding cases and the people involved in this work will inevitably influence what and how the documents were produced/collected. Second, all documents and statements made

45 Bjelland and Dahl (2017).

46 Bjelland and Dahl (2017) p. 9.

by the various contributors will differ, for example, based on the contributor, how the medical record was written, and the witness informing the case. Third, these documents were collected for a purpose different from that of this research. Finally, the organisation of these documents varies, which impacts the types of documents and the details I have received within each case. Because of this, it is not possible to comment on the significance of the absent information.

I was given access *only* to the documents and not to the 'living' part of the BL database, where police investigators communicate and explain, log and document choices, limitations and priorities. This delimitation resulted in a lack of insight into the decision-making process during the investigation and, therefore, provides less opportunity to understand what and why decisions were made. To some degree, this might make the police's work appear less thorough and deliberate, as this absence of contextual explanations limits outsiders' understanding of the rationale behind investigative decisions.

3.1.2 Accessing and sorting data

Access to criminal case documents requires consent from the Director of Public Prosecutions (*Riksadvokaten*) and the Council for Confidentiality (*Rådet for taushetsplikt og forskning*), which was provided. The National Criminal Investigation Service (*Kripos*) conducted an extraction of case numbers from its criminal case registry, STRASAK.[47] This was carried out on October 1, 2022, and included cases dating back to 2010. Cases conclusively decided after the extraction date were excluded from the material. Eleven of the 12 police districts in Norway had cases registered as aggravated IPV. They provided all cases except for five.[48] I reviewed all the cases and included cases using three inclusion criteria: (1) a final conviction for (2) aggravated (3) IPV.[49] Documents from 193 cases involving 194 perpetrators and 202 victims met the inclusion criteria. This first systematisation was based on an objective yes/no evaluation. The subsequent coding was a subjective assessment, inevitably 'influenced by [this] researcher's individual judgment'.[50]

47 *Kripos* extracted cases using four different codes: statt BL.

48 In these five cases, the police considered the ongoing threat level for the victim as too high, referred to as 'code red'. Based on this assessment, the documents were not issued. Finnmark Police District had no cases.

49 To assess the findings of DTA-IPV and their effects, I conducted a document analysis. The existing literature on this method does not perfectly align with documents of this scope and type, see e.g. Bratberg (2021) and Skilbrei (2023).

50 Bjelland and Dahl (2017) p. 10.

I was also granted access to all cases related to DTA in section 196 through the same application used for the dataset in this research, covering the period from 1999 to 2022.[51] The DTA cases included everything from police reports to convictions, totalling 65 cases, of which three resulted in convictions. I examined them all in the same manner as the other data in this research. *None* of these cases involved IPV or DTA-IPV. Also, only one case regarding a breach of DTA in section 196 has been heard by the Norwegian Supreme Court. This case involved a person who had failed to notify the police of a stabbing while it was still possible to save the victim's life; thus, it is not relevant to this article.[52]

Criminal case documents are classified and can only be accessed through rigorous application processes, due to the highly sensitive information they contain. Consequently, data beyond what is provided in this article is unavailable to the reader.

DTA-IPV was registered when it was evident *to me* – based on the criminal case documents and the above description of DTA-IPV – that (1) a professional has (2) received information triggering DTA, (3) leading to averting activities. I included reporting to the police and child protective services. Under 'other means', I included actions whereby it was apparent *to me* that the professional sought to remedy an ongoing IPV situation or avert future IPV.

I utilised a mixed-methods approach, initially building a dataset of all 193 cases with convictions of aggravated IPV and subsequently delving deeper into a strategic selection of cases.[53] I strategically selected cases to ensure representation from both urban and rural areas, as well as from all parts of Norway. The selected data included all cases from the police districts of Agder (southeastern Norway), Møre and Romsdal (western Norway), Innlandet (eastern Norway), and Nordland (northern Norway). In addition, I included cases from 2015 to 2022 from Oslo, Norway's capital. This selection consisted of 36 cases involving 36 perpetrators and 38 victims and constituted a representative sample.[54] These 36 cases amounted to 38,502 pages, ranging from 204 to 5390 document pages provided within each case.[55] In this selection, I systematically went through various searches, which ensured a consistent review of the following elements: table of contents, conviction, reference to the DTA,

51 The codes used by Kripos were 0699, 0684 (victim) and 0684 (convicted).

52 See HR-2017-824-A.

53 In the quantitative dataset, I coded for the gender and age of the victim and perpetrator as well as their marital status, whether they had children, the duration of the convicted IPV and year of conviction.

54 This selection was representative in terms of the couple's gender, age, duration of abuse, whether they had children and marital status.

55 For all averting actions, I coded the following categories: who averted, who in the family was in contact with the helper, the type of help given and the types of DTA actions.

police report(s), search in the police log, child protection documents, application of SARA, medical journals, witness interviews, interviews with the victim, perpetrator and children and statements from professionals.[56] When observing whether the registered preventive actions had influenced the cases, I assessed whether this had triggered a criminal case, whether the victim had been removed from the perpetrator or whether the relationship had ended - in other words, whether the preventive action made the new IPV less likely or impossible.

I categorised both professionals and DTA-IPV actions into eight distinct groups: police, doctors, health workers, child protection services, priests, crisis shelters, judicial actors and social services. In terms of DTA-IPV actions, the groups were categorised as child protection, legal measures and risk assessment, medical and emergency care, police: protective measures, practical and psychological support, report to child protection services, report to police and impossible DTA: hidden IPV. I included the latter group because the professional did what was possible with the information available, and this was a reasonably common case type (see Section 5.4.4). Only instances in which professionals made an effort to seek to avert possible IPV were included, but this was effectively hindered due to the withdrawal of information.

The most obvious was that I was solely responsible for assessing the actions of others. Additionally, as previously mentioned, the scope of information varied from case to case, and there was inherent subjectivity in how the documents were produced and presented in the data.

4. Findings

4.1 Structure of the findings

I now present the findings and address the remaining three research questions:

2. Do professionals seek to avert in cases of aggravated IPV?
3. If so, who averts, and how do they avert?
4. Do averting activities affect the presence of IPV in these cases?

I begin by presenting the characteristics of the selected cases and offering insights into the studied material, including the characteristics of the partners and the types of abuse for which the perpetrators were convicted. I then present the findings, which are organised and presented according to each research question. Finally, I introduce a typology derived from the data in this study, which identifies four typical case scenarios observed.

56 SARA is short for Spousal Assault Risk Assessment; see Kropp and Hart (2015).

4.2 Characteristics of the 38 cases

All cases consisted of a female victim and a male perpetrator.[57] The ages at the time of judgment varied from 22 to 64 years for the victims and from 24 to 66 years for the perpetrators. The duration of IPV proven in court ranged from 0–3 months to 25 years, with an average of 6.5 years. IPV thus accounted for one-fifth of the victims' lifetimes, on average, with half a lifetime being the longest. Of the 38 families, 36 had children living at home.

Many of the vulnerability factors known from previous research on IPV were present in the data material.[58] Generally, low levels of education, low incomes, a high prevalence of disability pensions and the presence of substance and alcohol abuse and psychiatric challenges were involved. In several cases, it appeared that the victim had become disabled as a result of long-term IPV. A few cases stood out in that one or both partners had a higher level of education and organised living conditions and few other vulnerability factors.

In these cases, the IPV encompassed a wide range of acts. Of these, the level of physical and sexual violence, in addition to controlling behaviour, was especially prominent. Severe physical trauma was common, including head injuries; broken bones; internal damage; reproductive violence endangering the unborn and newborn child; being beaten up, strangled or burned; having a tooth knocked out; being pushed down the stairs; using various weapons; and being forced to take drugs or unfitting medication, such as insulin. Most women were subjected to gross sexual misconduct, although this seldom led to a rape conviction.[59]

4.3 Do professionals seek to avert in cases of aggravated intimate partner violence?

The analysis of the criminal case documents revealed that all the examined professional groups engaged in various DTA activities. A total of 108 individual professionals were identified as having conducted DTA-IPV actions. Of the 38 cases, averting actions were observed in 34, while no averting actions were identified in the remaining four cases. In the 34 cases with DTA-IPV actions, one professional averted in two cases, two professionals averted in 11 cases and three or more professionals averted in 21 cases. Of these 108 professionals, 56 carried out one averting action, 31 carried out two and 21 carried out three, resulting in 181 identified DTA actions.

57 Among all the 201 IPV-cases, only one couple had a reverse gender distribution, whereby the woman was the perpetrator, and the man was the victim.

58 Kropp and Hart (2015), Matias *et al.* (2020) and Oram (2022).

59 Rape/sexual assault is criminalised under penal code section 291, and can be used alongside section 282 in an indictment. The same applies to other sexual offences and homicide in section 275 and attempted murder in sections 275 and 15. This is done to a far too limited extent in the studied cases.

When identifying these activities, I applied the delimitation in section 196, which establishes the duty to avert. Professionals averted in 181 events; however, I found only three instances in which section 196 was referenced in the selected cases. The first referred to two doctors allegedly breaching this duty (see Section 4.5.4). The second concerned a doctor mentioning her obligations from this duty to her patient, but no DTA actions were evident. The third was a mention of legal duty in a pretrial court decision. None of these references to DTA-IPV led to any averting activities. Thus, all identified DTA-IPV occurred without reference to the statutory provision.

The analysis revealed no evidence that the duration of IPV had an impact on the number of DTA-IPV actions, as it neither predicted nor explained variability across DTA categories. Similarly, there were no indications that children witnessing IPV influenced DTA. Nevertheless, in five cases, only one child was in contact with the professional who averted. Of these, three were middle school students, one was in elementary school, and one was in kindergarten. The professionals' DTAs in these cases aimed to hinder ongoing IPV, not (only) violence towards the child.

4.4 If so, who averts, and how do they avert?

4.4.1 Data presentation

Having established that professionals conduct DTA actions, I now examined the data on the identified DTAs and who performed them, including the professional groups and the DTA actions they were most likely to undertake. Both professionals and DTA-IPV actions were categorised into eight distinct groups, as explained previously (see Section 4.2.2).

Table 1
DTA-IPV actions performed by each profession

Police	**99**
Police: Protective measures	33
Report to police	24
Legal measures and risk assessment	17
Report to child protection services	10
Medical and emergency care	9
Practical and psychological support	6
Child protection services	**28**
Child protection	12
Report to police	9
Practical and psychological support	5
Report to child protection services	2
Doctors	**24**
Report to police	9
Practical and psychological support	5
Report to child protection services	4
Medical and emergency care	3
Impossible DTA: Hidden IPV	2
Legal measures and risk assessment	1
Health workers	**16**
Practical and psychological support	9
Report to police	4
Report to child protection services	2
Impossible DTA: Hidden IPV	1
Judicial actors	**4**
Legal measures and risk assessment	4
Social services	**4**
Report to child protection services	2
Medical and emergency care	1
Practical and psychological support	1
Crisis shelters	**4**
Legal measures and risk assessment	1
Practical and psychological support	1
Report to child protection services	1
Report to police	1
Priests in church	**2**
Practical and psychological support	1
Report to child protection services	1
Total	**181**

Table 2
DTA-IPV actions and who performed them

Report to police	**47**
Police	24
Child protection services	9
Doctors	9
Health workers	4
Crisis shelters	1
Police: Protective measures	**33**
Police	33
Practical and psychological support	**28**
Health workers	9
Police	6
Doctors	5
Child protection services	5
Crisis shelters	1
Social services	1
Priests in church	1
Legal measures and risk assessment	**23**
Police	17
Judicial actors	4
Crisis shelters	1
Doctors	1
Report to child protection services	**22**
Police	10
Doctors	4
Social Services	2
Child protection services	2
Health workers	2
Crisis shelters	1
Priests in church	1
Medical and emergency care	**13**
Police	9
Doctors	3
Social services	1
Child protection	**12**
Child protection services	12
Impossible DTA: Hidden IPV	**3**
Doctors	2
Health workers	1
Total	**181**

Table 1 shows what DTA actions the different profession groups performed. Table 2 shows the same numbers, but sorted under the different DTA actions, showing who performed the actions.

4.4.2 Who averts: The professions

All professional groups performed actions identified as DTA-IPV. There were, however, considerable differences in the number of DTA-IPV actions identified for the various occupational groups (see Table 1). The numbers presented in this and the following subsection refer to the number of DTA actions, not individuals.

Among the professional groups, the *police* stood out with a notably higher number of identified DTA actions, totalling 99. This was followed by *child protection services*, with 28 actions. *Doctors* collectively accounted for 24 actions, and health workers accounted for 16. *Social services*, *judicial actors* and *crisis shelters* performed four actions each. *Priests* were last, with two actions.[60]

There were differences in the types of DTA actions that the various professional groups performed. This can be best seen when studying Tables 1 and 2 simultaneously. The two tables contain the same values; however, the first is sorted by professional group, while DTA actions categorise the second.

4.4.3 What did they do: Avertive activities

The most evident DTA act was *report to police*, which included formal reports under Section 223 of the criminal procedure act and notifications via emergency phone numbers or other contact methods.[61] Similarly evident was *report to child protective services*, whereby one can submit a concern report (*bekymringsmelding*), which is a formal action to ensure proper handling of the issue, as outlined in Section 2-1 of the child protection services act. This category also included informal notifications,

60 *Professions per DTA act in each group: Police* includes officers (79) and lawyer/prosecutors (20). *Doctors* include working in hospitals (9), general practitioners (3), working in emergency clinics (*legevakt)* (6) and psychiatrists (6). *Health workers* include nurses working in hospitals (3), emergency clinics (*legevakt)* (2) and schools (1); the category also includes community mental health centre employees (DPS) (4), emergency call centre operators (3), pharmacy employees (1) and psychologists in public service (2). *Child protection services* (21), including their emergency services (*barnevernvakta*) (7). *Priests* in the Norwegian church (2). *Crisis shelter* employees (4). *Judicial actors* in court (4). *Social Services* include the Norwegian Labour and Welfare Administration (NAV) (1), the Municipal Refugee Service (4) and kindergartens (employees/ managers) (1).

61 Criminal Procedure Act (1981).

but these might not be as easily identified. These *formal* forms of DTA were easily detectable if everything was documented correctly within the various logging systems and if they were included in the criminal case documents received.[62]

With 47 DTA actions recorded, *report to police* was the most common DTA activity across all professions. It included providing formal reports to the police (29) and informal notifications to the police (19). The profession that most often filed a police report was the police itself (24), followed by doctors and child protective services (9 each). Health workers (4) and crisis shelters (1) were also identified as having filed reports to the police, reflecting this type of DTA as a somewhat multidisciplinary activity.

Only the police were represented in *protective measures*, as they are the only professionals authorised to carry out such actions. The overlap between DTA actions and a professional 'only doing their job' was thus particularly relevant for this type of DTA. *Protective measures* was the second most frequently identified DTA action, amounting to 33, and included the following police activities: home visits (1), detain/arrest (22), policing activity (38) and place on secret address (1).

Practical and psychological support was the third most common category, with 28 actions identified. It included accompanying victims to crisis centres (7), supporting/assisting victims to seek help (9), collaborating with the police (2) and providing practical help (10). This DTA category was performed by seven distinct professional groups, making it as prominent as *report to child protective services*. Together, these were the two categories executed by the most diverse range of professional groups. Health workers most frequently provided *practical and psychological support* (9), followed by police (6), doctors (5), child protection services (5) and crisis shelters, social services and priests (1 each).

62 *DTA-IPV actions per group: Child protection* includes the following activities performed by child protection services: initiating an investigation (*undersøkelsessak*), etc. (4), placing children in emergency care (1), requesting information from the police or other authorities (2), home visits (2) and collaborating with the police (4). *Legal measures and risk assessment* includes police issuing restraining orders (14), police issuing restraining orders with electronic monitoring (2), judge in court upholding restraining orders (3), judge in court upholding pretrial detention, etc. (1) and SARA risk assessment (3). *Medical and emergency care* includes call for ambulance (3), referral to a psychologist/DPS, etc. (3) and accompany to health care (7). *Police: Protective measures* includes home visits (1), detaining/arresting (22), policing activities (38) and placing at a secret address (1). *Practical and psychological support* includes accompanying the victim to a crisis centre (7), supporting/assisting the victim to seek help (9), collaborating with the police (2) and practical help (10). *Report to child protection services* includes both formal and informal notifications to child protection services (17) and child protection emergency services (5). *Report to police* includes providing formal reports to the police (29) and informal notifications to the police (19). *Impossible DTA: Hidden IPV* refers to when the professional explicitly asks about the IPV when the victim is alone but is given false answers (lying, making excuses) (3).

Legal measures and risk assessment was the fourth most common category, with 23 actions identified. It included police issuing restraining orders (14), police issuing restraining orders with electronic monitoring (2), judges in court upholding restraining orders (3), judges in court upholding pretrial detentions, etc. (1) and SARA risk assessment (3). Due to the nature of this category, the police were registered with the majority of these actions (17), followed by judicial actors (4), crisis shelters (1) and doctors (1).

Closely following this was *report to child protection services*, with 22 actions identified. These included formal and informal notifications to child protection services (17) and child protection emergency services (5). These DTAs were also most often carried out by the police (10), followed by doctors (4), social services (2), child protection services (2), health workers (2), crisis shelters (1) and priests (1).

Medical and emergency care were conducted 13 times and included calls for an ambulance (3), referrals to a psychologist/DPS, etc. (3) and accompanying victims for healthcare (7). These DTAs were performed by police (9), doctors (3) and social services (1).

Child protection included activities performed by child protection services (12)—namely, initiating an investigation (*undersøkelsessak*) (4), placing children in emergency care (1), requesting information from the police or other authorities (2), home visits (2) and collaborating with the police (4).

Impossible DTA: Hidden IPV refers to situations in which a doctor (2) or health worker (1) explicitly asked the victim if she was experiencing IPV when the victim was intentionally alone with them. Despite these inquiries, the victim provided false answers (lied, made excuses) (3). The DTAs registered in these instances indicated that the professionals took all possible actions within their limited scope.

4.5 Did averting activities affect the presence of intimate partner violence in these cases? A presentation of four types

4.5.1 Introduction to the typology

Based on these findings, I developed a typology categorising outcomes related to DTA-IPV actions into four types. These types are divided into two main groups, distinguished by the availability of information about IPV. Within the group for which information is available, the first three types vary in both the identification of DTA-IPV actions and their outcomes. The fourth type pertains to cases with no available IPV information:

1. DTA actions lead to 'success', meaning that IPV ceases due to DTA actions.

2. DTA actions are lacking or consist of measures that are too mild and thereby appear insufficient.

3. No DTA leads to 'failure' (?), which refers to cases in which the absence of DTA actions appears as a potential breach of duty.

4. The victim keeps the IPV hidden, thereby hindering professionals from intervening to avert abuse.

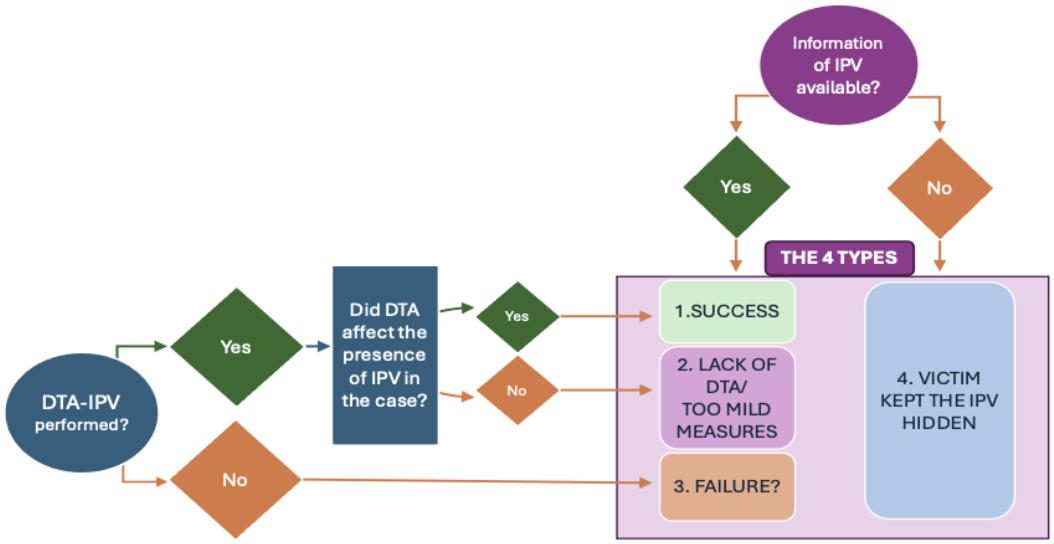

Figure 2
The four types of cases

Figure 2 shows the four types within the dataset: (1) DTA-IPV is a 'success', (2) DTA-IPV is missing or present but too mild, (3) 'failure' (?) due to the absence of DTA-IPV and (4) the IPV is hidden from the professionals.

The following outlines these four types.

4.5.2 Type 1: DTA-IPV leads to success

The legal provision of DTA-IPV aims to avert future acts of IPV. It is a necessity for such prevention that there is information available that makes future IPV appear 'certain or most likely'. Described as 'successes', there were cases in which such information was

available, and the professional's actions of DTA-IPV led to IPV ceasing or not taking place. It was a prerequisite that there was a clear connection between the preventive action of a professional and the cessation of IPV.

In several cases, DTA-IPV led to success. There was great variation in the professions involved in executing these DTA activities, as well as the types of DTA performed in the successful cases.

The police were identified with many DTA actions crucial to success. Given the nature of their work, this might seem obvious, but based on the researched data, it was not always the case. As shown in Table 2, the police performed DTA actions consisting of efficient measures that provided safety and protection from IPV. This suggests that once the police implement DTA actions, they are often effective. The police's understanding of abusive situations and safety issues seemed to affect victims' willingness and courage to cooperate with them.

Doctors achieved successful DTA-IPV in some cases, such as when a doctor reported an IPV-exposed hospitalised patient to the police. On occasion, they can detect a false explanation, such as, 'the surgical department reported this because the injuries were inconsistent with what the victim and the accused explained had happened'. Based on this report, the police immediately investigated, detained the perpetrator in custody and eventually obtained a conviction. Victims often appeared to be skilful at explaining away the injuries they had suffered, making it difficult for health personnel to reveal the abuse.

In one case, child welfare services notified the police that they wanted to take custody of a child and reported that they were also concerned about the mother. They believed the police should accompany her to ensure she received medical treatment, which they did. The police reported the case, which led to an investigation and conviction. In another case, child protective services asked the police to help evacuate a mother and her child, which they completed.

I included judicial actors because some demonstrated a strong understanding of the dynamics and risk factors of IPV, which enabled them to avert IPV. Judges have statutory room for discretion, allowing them to take into account DTA-IPV and, at the same time, comply with criminal law and criminal procedural rules. In one case, a victim wanted to withdraw the report she had filed, as well as the application for a restraining order—that is, the entire criminal case. The presiding judge did not allow

this, finding it 'a fairly common reaction in family violence cases where the victim is afraid that the consequences of her actions could lead to even worse conditions for herself'.[63] Such understanding was not common in this data material, and there were several examples of the opposite.

Sometimes, simple things made a big difference to a victim's safety, such as when a nurse moved a patient to a new hospital room so that the perpetrator would not find her. Some professionals offered additional support to their patients/clients to ensure their safety, such as assisting outside work hours and sharing their private phone numbers with frightened victims. These actions appear to have had a significant positive impact on the victims and enhanced the efficiency of criminal case proceedings.

4.5.3 Type 2: DTA-IPV is lacking or consists of too mild measures

In Type 2 cases, the information available is similar to that in Type 1, making future IPV appear 'certain or most likely'. What distinguishes Type 2 cases from Type 1 is that the DTA actions are lacking or too mild and, therefore, unsuccessful in averting future IPV. The most common reason seems to be an inadequate understanding of the IPV phenomenon or the situation.

In some cases, the police dropped the case or did not initiate an investigation without the data revealing why. For example, there was a case in which child protection services took custody of the children, and the police received several reports of IPV. They dropped all cases and resumed the investigation only after two orders from the public prosecutor (*Statsadvokaten*). Although this example applies to the police as a group, it is clear from the case that information was available to individuals within the police.

In one case, the police released the perpetrator from custody *before* electronic monitoring arrived, thereby endangering the victim as the perpetrator broke the restraining order repeatedly. In another case, a psychologist knew about ongoing IPV for more than a year and only offered support. In hindsight, this proved to be too mild a measure.

4.5.4 Type 3: No DTA equals failure?

As with Type 1 and 2 cases, Type 3 cases also have information available, making future IPV appear 'certain or most likely'. However, in these cases, no actions of DTA-IPV are identified despite knowledge of ongoing IPV, which makes the absence of DTA particularly striking.

63 This is in accordance with Section 222a of the Criminal Procedure Act.

There seems to be excessive 'respect' for the victim's wishes not to notify the police. In the studied data, this was most evident in medical journals due to the level of documentation, and doctors were, therefore, more visible than other occupational groups. In some cases, it was evident that the doctor had been aware of ongoing IPV from a current partner for *years* without taking any DTA actions. In one of these cases, the police declared that two doctors had breached the DTA. However, because the statute of limitations had expired, one doctor was found only to have violated the DTA and, consequently, the duties sanctioned in Section 31 of the Health Personnel Act.[64] He did not lose any professional rights. The victim had had more than 220 consultations with the general practitioner over the course of 15 years. In other cases, it appeared that the doctor had *considered* whether the case should be reported to the police but had not done so.

Some women asked the police to remove restraining orders because this would allow them to know the whereabouts of their partners or because the orders hindered the mothers in accompanying their children during visitations with fathers in prison. The deciding judge responded to these requests very differently. This diversity seemed to be due to a divergent understanding of the phenomenon of IPV.

4.5.5 Type 4: Hidden IPV

This fourth type differs from the other three in that no information about IPV is available to professionals in these cases, which makes probability assessment difficult. Thus, the absence of DTA-IPV is not considered reprehensible.

Many victims go to great lengths to hide ongoing IPV and become skilled at delivering plausible explanations, making it difficult for professionals to detect IPV. There were several cases in which the victims gave false answers. In one case, the perpetrator pushed his pregnant partner down the stairs. When receiving hospital care, she gave a different explanation. In another case, the police were summoned three times, but the victim denied that any violence had occurred each time. In a third case, the victim explained that she had never sought help or told anyone about the abuse. Once, she had a regular doctor's appointment, which she cancelled after her partner hit her, leaving her with visible injuries. She said she did not want to burden others or be a nuisance by asking for help.

64 The county governor (*Fylkesmannen*; now *Statsforvalteren*) found this to be a breach (*påpekte pliktbrudd*). This is a statement without automatic legal consequences. In this case, it is apparent that the police would have prosecuted the breach of DTA if the statute of limitations had not expired. This is the closest the police came to prosecuting a professional's violation of section 196 in all the studied material.

5. Discussion

5.1 Professionals' utilisation of duty to avert

The legal provision of DTA-IPV has a premise: DTA-IPV provides professionals the opportunity to avert IPV. Although 181 identified actions of DTA might appear plentiful, examining them against the backdrop of extensive abuse offers a more nuanced perspective. The 38 cases studied encompassed a cumulative violation duration of 248.5 years, equal to 0.73 averting actions per year of abuse. Similarly, the 108 individuals who carried out DTA actions amounted to 0.43 individuals performing DTA actions per year of abuse. Considering that 36 of the 38 women subjected to severe IPV had children living at home, this underscores the critical need for measures to protect both the women and their children.

Although it is challenging to ascertain why professionals perform or refrain from DTA activities, two key factors seem apparent. First, the professional must have access to sufficient and adequate information. Second, the professional must consider performing DTA activities, including knowledge of the law on DTA. The data did not clarify how professionals' knowledge of DTA-IPV law affects their assessment of the information and action options. Nevertheless, one might argue that this knowledge appears insufficient in light of the following.

Section 196 establishes a threshold for professionals, enabling and requiring them to seek to avert abuse when IPV meets the criteria outlined in section 282. However, the findings suggest that the threshold for taking avertive actions is often set too high, as the law permits (and demands) more DTA-IPV than is currently observed. This results in many cases of ongoing incidents of new IPV, indicating an untapped potential for more DTA. If professionals acted on DTA-IPV as soon as the threshold for abuse according to section 282 (not aggravated abuse) was met, we would likely see a substantial increase in all types of averting actions.

None of the 181 avertive actions referenced the legal provision imposing this duty. The opportunity to use this legal foundation as a statutory justification for performing DTA-IPV remained entirely unused. Possible explanations are that the professionals either relied on other legal frameworks or were unaware of this duty's existence. The data did not explain this absence of legal citation. However, the lack of legal authority as a justification may indicate the latter. This lack of awareness aligns with previous research highlighting a knowledge deficit among professionals regarding DTA-IPV.[65] If professionals were aware of the DTA law, it is reasonable to assume they would be inclined to use it as the basis of or justification for their actions; yet, this did not occur in a single case.

65 Brevik, *et al.* (2024).

The unused DTA-IPV potential, combined with the prevalence of IPV in Norway, provides a compelling basis for arguing for an increase in DTA-IPV actions by professionals. The data did not identify specific factors that ensured compliance with DTA-IPV. Nevertheless, it is safe to say that *knowledge* of the legal provisions in section 196 is an advantage, as is the *accessibility* of the legal provisions. Simplifying the legal rules could be advantageous, making the provisions in sections 196 and 282–283 more accessible and manageable.[66] On the other hand, it can be argued that simplifying legislation regarding the duties of confidentiality and DTA might fail to address the nuanced complexities essential for navigating these situations effectively. Nonetheless, the current level of legal awareness among professionals in Norway appears unsatisfactory.

5.2 Differences in the duty to avert between professional groups

A wide range of DTA actions were identified, and various occupations performed these actions within the DTA categories. Nonetheless, there were apparent differences in the actions taken by the various professional groups in terms of how effective these actions had the potential to be. Professionals tended to conduct DTA activities based on their strengths and in alignment with their regular work tasks and methods.

The *police* performed primarily legal-based measures but drew on help from other entities and other aspects of their repertoire. *Child protective services* performed the most obvious DTA actions within their occupational domain, similar to the police. However, this group was less collaborative with other entities compared to the police. *Doctors* appeared to be versatile in their DTA activities. They were identified as having as many DTAs as child protective services and were the professional group that reported to child protective services second-most frequently. This may be due to their superior role in health and safety, as well as the hierarchy among employees in healthcare institutions. *Health workers* mainly provided practical and psychological support. They also reported to the police and child protection services. These professions were less visible in the material due to the police's enquiries after receiving doctors' statements. In response to this, doctors' medical records were usually provided, but this was not the case for medical records from other healthcare professionals. *Judicial actors* exclusively engaged in legal measures and risk assessments. *Social services* contacted other entities by reporting to child protective services and securing emergency care.

These findings illustrate that each professional group is inclined to remain consistent with its professional patterns. The diversity in actions among professionals underscores the importance of a collaborative approach to addressing DTA-IPV. The law gives this leeway under section 196, in addition to other occupational legislation.

66 Dullum and Bakketeig (2017).

Professionals have different approaches and opportunities to support victims and perpetrators based on their occupations and positions. The various professional roles often determine the types of help the professional can provide, which will vary in duration. These differences create completely different conditions for how best to avert IPV. First responders often address acute issues, and their contact with intimate partners is usually brief. Health providers, such as therapists, general practitioners and nurses in hospitals, can more often provide longitudinal follow-up for their patients. This continuity of care allows for a better opportunity to explore different approaches and to begin with less intrusive and more autonomy-preserving alternatives.

Certain occupational groups were not identified as performing DTAs. Alternative to violence (*alternativ til vold*), a non-profit organisation providing voluntary treatment and expertise on domestic violence, and thus interacting with families within the data, was not identified with averting activities. Similarly, crisis shelter employees were identified with few DTAs. While the data did not explain this absence, one might consider whether the continuous exposure to IPV for these positions and the core purpose of their work, which in ways constitutes DTA itself, becomes decisive to the outcome.

5.3 The four types and their implications

The four types raise different questions and implications.

For successful DTA in Type 1, one might ask whether this success could have been achieved earlier. It is essential to gain insight into what makes these DTAs successful and to identify the contributing factors.

In a typical Type 2 case, the professional settles on a too mild DTA, such as encouraging the victim to seek help elsewhere without offering additional support. This most often leads nowhere. However, when the professional makes appointments, drives, accompanies, and provides practical support, this is more likely to lead to successful DTA. Regarding cases with too mild or too little IPV, we need insight into how insufficient DTA-IPV affects victims, such as if it endangers them. Sometimes, the most dangerous scenario is trying to end a relationship but failing to do so.[67] The various parts of the system must contribute so that the case does not come to a halt.

In the Type 3 cases where no DTA-IPV leads to failure, something must change, such as attitudes, knowledge and handling of the cases. These cases emphasise the importance of all professionals understanding IPV and their duty to avert it. The impact of a collective understanding is amplified by the system's structure, in which the various professional roles are interdependent. The data material suggested that

67 Vatnar (2015).

this interdependency was a key factor in whether the DTA was successful. If the system does not protect the victim in the pretrial phase, it is no wonder that victims are reluctant to report IPV.

In type 4 cases with hidden IPV, it is essential to ensure that victims trust the system and ask for help. In these cases, victims normally deny IPV by withholding information, lying or rationalising injuries and may seek to withdraw police reports and lift restraining orders. The outcomes depend on the professionals' responses to these requests, both in terms of words and actions. It is a considerable challenge to assist an individual who is resistant to receiving help. Although the partners, including the victim, deny the occurrence of IPV, depriving them of the opportunity to receive help, it also significantly reduces the probability of DTA. Withholding information will inevitably impact a professional's assessment of the likelihood of new acts of IPV, thereby reducing the chances of receiving help.

6. Conclusion

This article explored the legal framework of DTA-IPV, whether professionals avert in cases of IPV, identified who engages in DTAs and the nature of their activities and assessed the impact of these averting activities on the cases. This study involved examining criminal cases of aggravated IPV. My main findings indicate that professionals performed DTAs in these cases, yet not to a sufficient extent. I identified 181 DTA-IPV actions carried out by 108 different individuals, amounting to 0.73 averting actions per *year* of abuse. Despite professionals performing DTAs and many of these actions impacting the outcome of the cases, many cases lacked substantial DTA-IPV, revealing untapped preventive potential in cases of aggravated IPV. Professionals tended to avert in ways closely aligned with their practices. There was considerable variation in the extent of DTA across different occupational groups.

There was a complete lack of legal reference in connection with DTA actions and a lack of knowledge about DTA-IPV among professionals. The findings suggest that professionals are unaware that their activities constitute compliance with DTA. Thus, there is a need for an increase in education, training and facilitation to ensure compliance with DTA-IPV. This would also ensure essential human rights compliance by providing education, training and facilitation.

Professionals must fully understand the legal frameworks within which they operate. This knowledge is vital to ensure compliance with laws and regulations, protect IPV victims and advocate effectively on their behalf. With this understanding, professionals can navigate complex situations, make informed decisions and recognise when to seek legal advice.

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