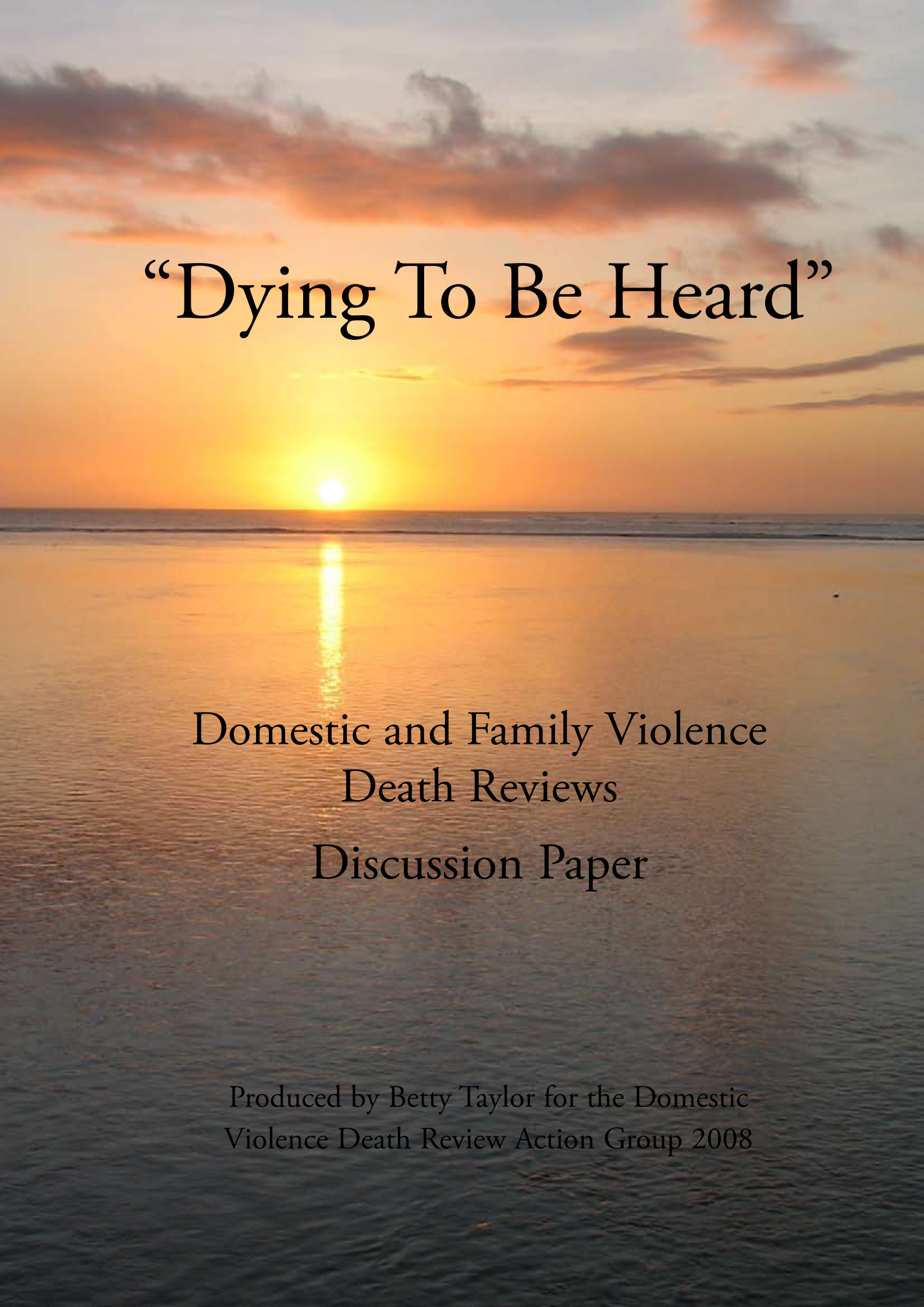

"Dying To Be Heard"

Domestic and Family Violence Death Reviews

Discussion Paper

Produced by Betty Taylor for the Domestic Violence Death Review Action Group 2008

"Dying To Be Heard"

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Acknowledgements

This discussion paper has been produced for the Domestic Violence Death Review Action Group members, who have worked tirelessly to see the establishment of a Domestic Violence Death Review Board in Queensland. Their efforts will ensure that domestic and family violence related deaths do not go unnoticed, unexamined or forgotten.

The purpose of developing this discussion paper on domestic and family violence death reviews is to serve as a mechanism for further engagement with government on this important issue. Budget constraints have not allowed for extensive consultation and the need for this is recognised within the recommendations of this discussion paper. However, we were able to undertake targeted consultation with some key stakeholders.

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- DV Connect

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In introducing this discussion paper into the public arena for further consideration, I wish to thank all who have provided support and assistance in a variety of ways. As always, it is appreciated. To those who have lost beloved family members or friends as a result of intimate or family violence, your loss, pain and the courage with which you move through this, is what inspires us to continue to work towards building a safer and stronger community where such tragedies are not forgotten and are not tolerated.

Betty Taylor

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Disclaimer

This discussion paper has been written for the purpose of a law reform project and should not be used as legal advice. Any person with a legal question should obtain legal advice from a lawyer. Any references to the law are in general terms and we believe the information is correct as at the date of publication. The views expressed in this paper are those of the Domestic Violence Death Review Action Group (DVDRAG) and the author. The author, steering committee of DVDRAG and Women's Legal Service Inc. accepts no responsibility for any loss suffered by any person who uses or relies on the information contained in this paper, or for any loss, which may arise due to error or omission in the information.

INTRODUCTION

It is twenty years since the Queensland Domestic Violence Task Force produced its report "Beyond These Walls" which first brought the issue of domestic violence on to the public agenda in Queensland in a significant way.[1] The report highlighted the "catastrophic" effects of physical, emotional and sexual abuse which results in pain, suffering, permanent injury and tragically, in some cases, death.

In drawing attention to the deadly nature of domestic violence, one written submission to the Task Force stated:

> **" I thought he would kill us. He threw my son into the back of the van and dragged me into the front seat. He punched and punched me until I passed out. He bit my face like a ravenous animal. .....He said he would hunt us down and kill us both if I tried to leave again. It was no idle threat." (Beyond These Walls, p.17 1988)**

Many of the recommendations from Beyond These Walls, which built on the earlier work of feminist activists, have guided and shaped Queensland's response to domestic violence. In the ensuing twenty years, a large variety of domestic violence interventions and responses have been developed and implemented including the enactment of the Domestic & Family Violence Protection Act 1989. Policy and funding initiatives have seen the establishment of women's shelters, statewide domestic violence specific telephone services for both women and men, a network of specialist domestic violence services, counselling programs for women, children and men, a statewide research centre, a limited number of behaviour change programs for perpetrators, as well as enhanced responses from government agencies including, but not limited to, police, court and health services. There have been subsequent changes in legislation, policy direction and interagency cooperation.

The overall homicide data for the twenty year period since Beyond These Walls Report was launched is unavailable and the need for consistent and publicly available data is a recommendation of this discussion paper. However, from the current available data, indications are that overall homicide rates are decreasing but intimate and family homicide rates have maintained a yearly average of 20-25 deaths. This would suggest that over the past 20 years there have been an estimated 500 deaths classified as intimate partner or family relationship.

Homicide data is collected nationally by the National Homicide Monitoring Program (NHMP) within the Australian Institute of Criminology. Homicides are recorded into four categories: intimate partner, family relationship, friend / acquaintance and stranger. Most domestic and family violence killings would be categorised as intimate partner and family relationship. It is unknown how many homicides are included in friend / acquaintance and stranger categories which are domestic or family violence related.

The NHMP collects data on the following incidents:

- All cases resulting in a person or persons being charged with murder or manslaughter (including the charge of 'dangerous act causing death' which applies to the Northern Territory), but excluding other driving-related fatalities, except where these immediately follow a criminal event such as armed robbery or motor vehicle theft.

1 Responses to domestic violence did exist prior to 1988. However, such responses were primarily provided by women's shelters operating with limited funding.

- All murder-suicides classed as murder by the police.
- All other deaths classed by the police as homicides (including infanticides), even though no offender has been apprehended.

Attempted murder is excluded, as are violent deaths such as industrial accidents involving criminal negligence (unless a charge of manslaughter is laid). Lawful homicide, including incidents involving police in the course of their duties, is also excluded.

The National Homicide Monitoring Program has two specific data sources which are:

- Offence records provided by each Australian state and territory police service, supplemented where necessary with information provided directly by investigating police officers, and/or associated staff.
- Coronial records such as toxicology and post-mortem reports, as the law in each state and territory requires that all violent and unnatural deaths be reported to the Coroner. Since 1 July 2001, the National Coroners Information System has assisted in maintaning coronial records.

The data is further supplemented by press clippings, which are sorted according to the incident and filed with the offence report.

Current data on domestic and family violence homicides does not account for others killed in domestic/family violence related incidents including new partners, friends, work colleagues or bystanders. Consideration also needs to be given to those who suicide as a result of domestic or family violence or who die in other domestic violence related circumstances e.g. traffic accidents, falls, drug overdoses. This discussion paper will further examine the broader context of domestic and family violence deaths

DOMESTIC AND FAMILY VIOLENCE IN QUEENSLAND

During 2005/06[2] , there were 56 homicide incidents in Queensland involving the death of 60 persons. Of these deaths:

- 29% were classified as intimate relationships and 23% family relationships. The 29% of victim/ offender relationships recorded as intimate, is high compared with the national average of 21%.
- 27 (45%) of all Queensland homicide victims were women and of these, 11% were Indigenous women. 'Domestic [3]' was the alleged motive for the death of 63% of all female victims and 18% of male victims.
- Women were far more likely to be killed by someone they knew within an intimate or family relationship (63%).
- Males were more likely to be killed by a friend or acquaintance (37%) or stranger (33%).
- 89% of offenders were male and 11% female with no stranger homicides involving females as the offender.
- 71% of all Queensland homicides occurred in a residential setting.

Other data for the period 2005 -2006 indicates:

- 20,284 protection order applications were made to the Magistrates Court under the Domestic & Family Violence Protection Act 1989[4] . Of these, 12,667 were applications brought before the court by the Queensland Police Service.
- 29,605 new client matters were recorded in the data summaries from the Queensland Centre for Domestic and Family Violence Research. These statistics only relate to the 29 participating services across the state[5] that provide data to the centre.

During the 2006/2007 year there were a total of 53,101 calls to dvconnect[6] , the statewide domestic violence telephone service. National SAAP[7] data for 2006 -2007 shows that 96.4% of Queensland women whether single or with accompanying children accessing emergency accommodation were homeless as a result of domestic violence.

The above statistics do not encompass all acts of domestic violence as many incidents of domestic abuse go un-reported. However, they are indicative that domestic violence in Queensland remains a serious issue and it is within this context that lethal domestic and family violence occurs.

Domestic Violence is described as the use of violence by one person to control another and is used to describe any abuse that occurs in intimate relationships.

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2 National Homicide Monitoring Program Data Base
3 'Domestic' includes jealousy, termination of a relationship and other domestic altercations
4 Department of Communities http://www.communities.qld.gov.au/department/ig/shared/comsup/
5 Queensland Centre for Domestic & Family Violence Research: http://www.noviolence.com.au/
6 Data provide by dvconnect, the statewide domestic violence telephone service
7 Supported Assisted Accommodation Program data @ http://www.aihw.gov.au/publications/hou/ hpissndcar06-07qld/hpissndcar06-07qld.pdf

The abuse may take the form of physical, emotional, sexual, spiritual, social, and financial abuse. Abusive behaviours may range from intimidation, stand over tactics and threats to serious assaults, rape, strangulation and death. The abuse may continue long after the relationship has ended and it is well recognised that many women have either left the relationship or are in the process of leaving when they are killed. [8] Often the threats made to victims are not idle threats and each year a significant number of adults and children continue to die as a result of domestic / family violence.

Society still has a perception that violence in the public arena poses the greatest risk and it is often reported by the media accordingly. However, data from the Australian Institute of Criminology Homicide[9] indicates that people are most likely to be killed in the home by someone they know. Male intimate partners pose the greatest risk to females, whereas males are more likely to meet their death at the hands of a male friend or acquaintance. The National Personal Safety Survey 2005 found that during the previous twelve months, 160,118 women experienced violence by a current partner and 1,127,853 women experienced violence by a previous partner.

From media reporting and discussions with service providers, we know that many of those who died had prior contact with a variety of agencies in regard to domestic and/or family violence issues prior to their deaths. Often discussing their fears, safety concerns and threats made to themselves and others. An examination of these deaths could provide insight into prior attempts at both help seeking by victims and or perpetrators, prior interventions by various agencies, compliance with court orders by the respondent /perpetrator, and the possible presence of prior risk indicators.

Domestic violence in all its forms is unacceptable and the death of adult victims and children should not be seen as inevitable or unpreventable. Many domestic violence deaths have predictive elements to them. Research by the Australian Institute of Criminology has observed that a history of domestic violence is common in intimate partner homicides, and that in some cases, the homicide incident is the end result of a culmination of numerous prior incidents of domestic violence[10] . A prior history of domestic violence was recorded in 39 of the 74 intimate partner homicides (53%) that occurred nationally during 2005–06.

If this tragic cost in human life is to be stopped we need to learn from such events. This discussion paper explores the issues relevant to the establishment of a Domestic Violence Death Review Board in Queensland.

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8 Domestic Violence Death Review Committee Annual Report to the Chief Coroner 2004 Ontario Canada found that in 80% of homicides, victim separation was either actual or pending.

9 Davis & Mouzos, 2007. Homicide in Australia 2005 -06 National Homicide Monitoring Report

10 ibid

DOMESTIC VIOLENCE DEATH REVIEW ACTION GROUP

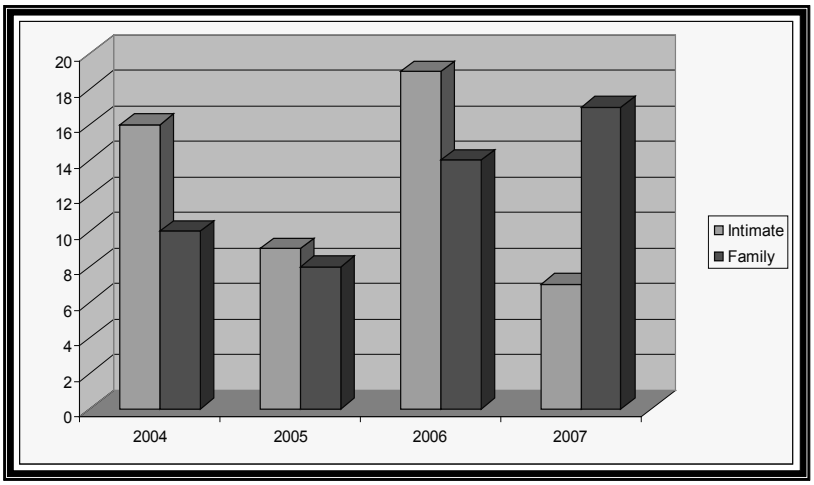
Placing domestic violence related deaths on the public agenda has been at the forefront of the work undertaken by the Domestic Violence Death Review Action Group. Established in 2004, the Domestic Violence Death Review Action Group has been working towards the establishment of a Queensland Domestic Violence Death Review Board and work undertaken to date has included a public petition campaign, the development of community education resources and the development of this discussion paper which was made possible through the generous support of the community.

DVDRAG membership is comprised of service providers with many years experience in the domestic violence field, members of the Murri community, academic researchers, lawyers, family members and individuals who are concerned that people continue to die from domestic violence when we know, in all probability, with enhanced system responses, some of these deaths could have been prevented. DVDRAG has forged links both internationally and within Australia with individuals/groups who have either already developed domestic violence death review boards or who are working towards their establishment.

Group members have spoken at several conferences and forums, met with government Ministers and other state politicians, magistrates, state coroner, academics and other key stakeholder and have gained widespread support for their work. The continuing occurrence of domestic violence related fatalities which are often described in death review reports as 'preventable homicides' continues to be of concern to all. The development of this discussion paper has arisen from those concerns and the desire to make a difference to the safety and well being of the lives of women and children living with violence.

In the four years since the Domestic Violence Death Review Action Group was established there have been 100 known homicides related to domestic and family violence in Queensland. Of these homicides, 51 were recorded as intimate relationships and 49 were recorded as family relationships.

Table A



(Australian Institute of Criminology 2008)

There were a further 84 homicides recorded as friend/acquaintance and it is unknown exactly how many of these deaths have arisen from an incident of domestic or family violence.

Domestic violence homicides need to be viewed in the broader context of domestic violence related deaths.

The current data does not account for others killed in domestic / family violence related incidents including new partners, friends, work colleagues or bystanders. Consideration also needs to be given to those who suicide as a result of domestic or family violence or who die in other circumstances e.g. traffic accidents. The availability of comprehensive data related to domestic and family violence related deaths is problematic and will be addressed further in this report.

Broadly speaking, domestic violence related deaths could include:

- All known homicides involving the death of partners and family members.
- Homicides involving death of others known to either or both the victim / perpetrator – e.g. new partners, friends, work colleagues.
- Homicide of persons unknown to either but who die as a direct result of a domestic violence incident e.g. police officers, bystanders.
- Suicide of perpetrators either as homicide/suicide or suicide.
- Suicide of victims of domestic violence.
- 'Accidental' deaths of victims of domestic violence e.g. drowning, car accidents, falls, drug overdoses etc.
- Natural deaths of victims which result from the long term effects of physical injuries e.g. depression, eating disorders, high blood pressure, reproductive injuries, stress related cancers and heart disease[11] . It is estimated that in 2002-2003 there were 37,437 years of healthy life lost associated with female victims of domestic violence.
- " Missing Persons".

While a Domestic Violence Death Review Board would not necessarily review all deaths associated with the above, it is important that any death review relative to domestic and family violence is conducted within a framework of understanding the broader context of the way in which domestic and family violence impacts on the health and well being of victims and their children.

11 Access Economics, 2004 The Cost of Domestic Violence to the Australian Economy: part 1

DOMESTIC VIOLENCE DEATH REVIEWS – WHAT ARE THEY?

A Domestic Violence Death Review is a process of examination carried out by a multi-disciplinary board/team to examine a number of deaths over a defined period of time looking for common traits, trends and missed opportunities for intervention. The identification of patterns or trends or traits can then assist with the development of improved responses to domestic and family violence. Mainly developed across the USA and Canada, some communities refer to them as fatality review boards and others, teams. This discussion paper uses the term death review board unless specifically referring to a named community/organisation.

The overall purpose of a Domestic Violence Death Review is to:

- Review a selection of domestic/family violence deaths.
- Collect relevant, up to date data about domestic/family violence related deaths.
- Uncover patterns and trends across several deaths.
- Inform policy, procedures and practice to assist with enhanced interventions to domestic & family violence.
- Make recommendations with respect to legislative change to provide enhanced protection to victims of domestic and family violence.
- Assess the response of agencies involved in assisting victims and/or perpetrators prior to the death to identify systemic gaps.
- Provide annual reports to government addressing the findings of the deaths reviewed.

Websdale (2003) likens the domestic violence death review process to the examination of the 'black box' following an air crash. Following such events, the airline industry responds by conducting reviews to find ways to prevent future crashes. Such investigations may be expensive, sophisticated and systematic but carry many benefits, not the least of which are the specific precautions that are subsequently introduced to prevent similar crashes from occurring.

Domestic and family violence also claims a significant number of lives each year. Possibly more than air crashes, and this raises the question of why comparable amounts of time, money, and expertise are not applied to investigating the causes of domestic violence deaths. Most intimate partner homicides are stylized killings that exhibit common patterns and antecedents. Although they share many of the characteristics of abuse cases that do not result in death, many of the cases that do end in death may be preventable.

Nevertheless, most domestic violence deaths are not subject to any systematic review, and resources are not spent trying to learn ways to better protect future victims of domestic and family violence.

DOMESTIC VIOLENCE DEATH REVIEWS - FOUNDATION

Internationally, domestic violence death review boards have been established in the USA, Canada and the UK. While they differ in their construct and function, basically these multi-disciplinary teams are seeking to identify gaps at a systemic level. Most communities refer to these teams as Domestic Violence Fatality Review Teams/ Boards.

The catalyst for the establishment of domestic violence fatality reviews was the death of Veena Charan in San Francisco California in 1990.

Veena was gunned down by her husband, Joseph Charan, in front of her son, teachers and other students. Joseph Charan then killed himself. Veena had been separated from her husband for 15 months and prior to her death she had contacted six agencies regarding her husband's violence. Some of these agencies were reported to have known that Joseph Charan owned a gun and had threatened to kill his wife. Veena had gained custody of their nine year old son and her estranged husband had attempted to kidnap the child from the same school where he eventually shot and killed Veena. He had also vandalized her home, scrawled graffiti on the walls and rammed his car through the garage door. In the weeks prior to the murder/suicide, Joseph Charan was charged with felony wife beating and received a 12 months suspended sentence. He had breached a civil restraining order on several occasions.

A landmark investigation into this homicide/suicide was conducted by the San Francisco Women's Commission and the City and County of San Francisco. They found significant gaps at a community and systems level. The Charan Report[12] concluded that the **community had failed to protect Veena Charan.**

The recommendations from this report became a watershed which changed the way government and community responded to domestic violence. What started in San Francisco has spread across the USA with most states having established Domestic Violence Death Review Boards as part of an overall coordinated systems response to domestic violence.

12 *Commission on the Status of Women, City and County of San Francisco. San Francisco's Response to Domestic Violence: The Charan Investigation. San Francisco, California: October 1991.*

INTERNATIONAL EXPERIENCE

Following the release of the Charan Report, Domestic Violence Fatality Reviews have been established across several states and communities within the USA, some provinces in Canada as well as the UK. Annual Reports released by these boards have consistently highlighted a reduction in domestic homicides within their communities. Depending upon community needs and available resources, death review teams can vary along any number of parameters such as the types of deaths reviewed, review team composition, size of jurisdiction, and data maintenance systems. A major factor in local team functioning is the size of the jurisdiction's population. Some death reviews may focus solely on intimate partner deaths while others take a broader view and look at all homicides that are either domestic or family violence related and suicides of either victims and perpetrators.

• Ontario Canada

The Domestic Violence Death Review Committee (DVDRC) of Ontario Canada is a multi-disciplinary advisory committee which was established under the authority of the Coroners Act in 2003[13] . The Committee investigates domestic violence related deaths and reports the findings of fatalities to the Chief Coroner by way of an annual report. The purpose of the committee is to assist the Office of the Chief Coroner of Ontario to review deaths of persons that occur as a result of domestic violence, and make recommendations to help prevent such deaths in the future.

The mandate of the committee is to help reduce domestic violence generally, and domestic homicides in particular. The committee achieves this by:

- Thoroughly reviewing all intimate partner and ex-partner homicides,
- Identifying systemic issues, problems, gaps, or shortcomings of each case and making recommendations to address these concerns,
- Creating and maintaining a comprehensive database about the perpetrators and victims of domestic violence fatalities and their circumstances,
- Helping to identify trends, risk factors and patterns from the cases reviewed to make recommendations for more effective intervention and prevention strategies and,
- Reporting annually on domestic violence fatalities to enhance public understanding and awareness of the issues,

The DVDRC of Ontario found that women victims were predominantly the primary victims and that many of the homicides were both predictable and preventable, based on an analysis of risk factors. In the majority of cases reviewed, ten or more risk factors associated with potentially lethal violence were present in the circumstances,

Some examples of international models include:

• London UK

Multi-agency Domestic Violence Murder Review panels were set up in various boroughs throughout London to examine and explore the positives and negatives of the support previously offered to victims prior to their deaths.

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13 Domestic Violence Death Review Committee Annual Report to the Chief Coroner Ontario Canada 2004

The need for greater identification of risk indicators and the implementation of appropriate risk management strategies has been identified by several death review teams / boards including the multi-agency domestic violence death reviews conducted in London.

The London report highlighted the necessity for a risk assessment process based upon the need to enhance safety, manage lethal situations, to make better use of intelligence and to increase the standard of the investigation and supervision. Increased understanding of the nature of risk will enable service providers in partnership to plan the use of scarce resources. The rationale for the development of a risk management approach is based on a model for prevention, not prediction. It ensures that a risk management plan aimed at specific risk variables is put into place. When properly applied, risk assessment can serve as a paradigm for effective case management of domestic violence.

• USA Experience

There have been Domestic Violence Fatality Teams set up across hundreds of communities and jurisdictions within the USA, (approximately 30 have been established in California) bringing together professional and community members to analyse deaths in the hope of identifying ways to prevent such deaths in the future and to help the community heal from these deaths.[14]

Most death reviews are formed and function with a legislative mandate, are guided by established protocols, have enhanced guidelines and accountability with respect to confidentiality, and are linked through the development of a national network of fatality reviews.

An examination of the outcomes of death reviews by the Santa Clara Domestic Violence Death Review Board shows a significant decrease in domestic / family homicides. Over a ten year period, 1997 - 2007 there has been a 94% decrease in domestic homicides. This dramatic decrease in domestic homicides is highlighted in the table below.

Table B

Santa Clara County Domestic Homicides 1997 -2007

	1997	2007
Asian Victims	**17**	
African American	**5**	
Hispanic	**12**	**3**
Caucasian	**14**	
Other	**3**	
Total Domestic Homicides	***51***	***3***

Source*: Websdale, Town & Johnson, 1999, p65: Santa Clara Domestic Violence Council, 1997, p.5)*

The Santa Clara Domestic Violence Death Review Committee contributed this significant decrease in homicides to several factors. Firstly, the over-representation of Asian victims in the 1997 homicide reviews was addressed by the inclusion of 3 representatives of the Asian community on the Death Review Committee, increased awareness and increased support services in those communities.

14 Domestic Violence Fatality Reviews: Recommendation from a National Summit 1999

The Report also suggested that enhanced policies, procedures and prosecution around domestic violence attributed to the decrease in homicides.

> **"It is our belief that Santa Clara County's policies and procedures around domestic violence helped decrease the number of domestic violence related deaths. Although there were four (4) such deaths in 2007, we did not lose a single victim in the five thousand two hundred and six (5,206) cases referred to the District Attorney's office for prosecution. We believe this clearly shows that the policies of this county and the educational efforts around domestic violence have helped decrease the number of fatal incidents." (p5,2007)**

Significant amongst the findings from the Santa Clara Domestic Violence Death Review Report was the fact that during the previous twelve months, there were no deaths from African American or Asian Communities – groups who had previously figured highly in domestic violence related deaths within their county. The Santa Clara Domestic Violence Death review Report also notes that they did not have any female perpetrators during this period.[15]

Table C

Santa Clara County Domestic Homicides 1997 -2007

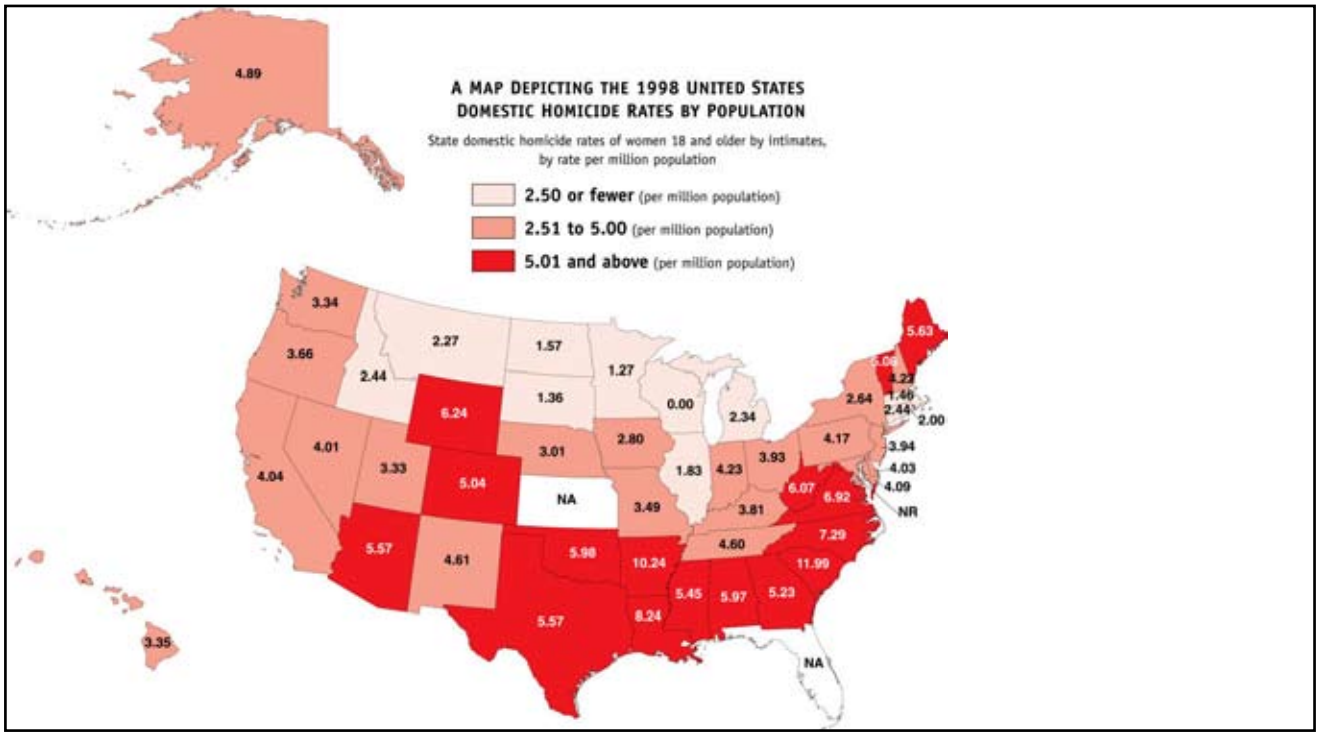
	1997	2007
Total Domestic Homicides	**51**	**3**
Prior involvement with Police / Prosecutions	11	1
Restraining Orders	6	0
Separated	26	2
Male Perpetrators	44	
Female Perpetrators	7	0

Source: *Websdale, Town & Johnson, 1999, p65: Santa Clara Domestic Violence Council, 1997, p.5)*

Between 1998 and 2003 there has been a significant decrease in domestic violence related deaths across the USA. In 1998, there were 16 states which recorded 5.01 or more deaths per million population and 8 states which recorded 2.5 or fewer deaths per million population. There were no states where no domestic violence deaths were recorded. Within 5 years this has changed considerably. In 2003 there were 3 states who recorded no deaths, 28 states which recorded 2.5 and fewer deaths per million population and only 1 state which recorded 5.01 or higher deaths per million population. [16]

15 *The 2007 Santa Clara Report identified 4 deaths but 1 of these deaths was a suicide and 3 were homicide.*

16 *Silent Witness National Initiative retrieved 18th September 2008 http://www.silentwitness.net/index.htm*


A MAP DEPICTING THE 1998 UNITED STATES
DOMESTIC HOMICIDE RATES BY POPULATION
State domestic homicide rates of women 18 and older by intimates,
by rate per million population
2.50 or fewer (per million population)
2.51 to 5.00 (per million population)
5.01 and above (per million population)
4.89
3.34
3.66
2.44
2.27
1.57
1.27
6.24
1.36
0.00
2.34
2.64
2.44
2.00
4.01
3.33
3.01
2.80
4.17
3.94
4.04
5.04
NA
1.83
4.23
3.93
4.03
6.07
6.92
4.09
3.49
3.81
NR
5.57
4.61
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4.60
7.29
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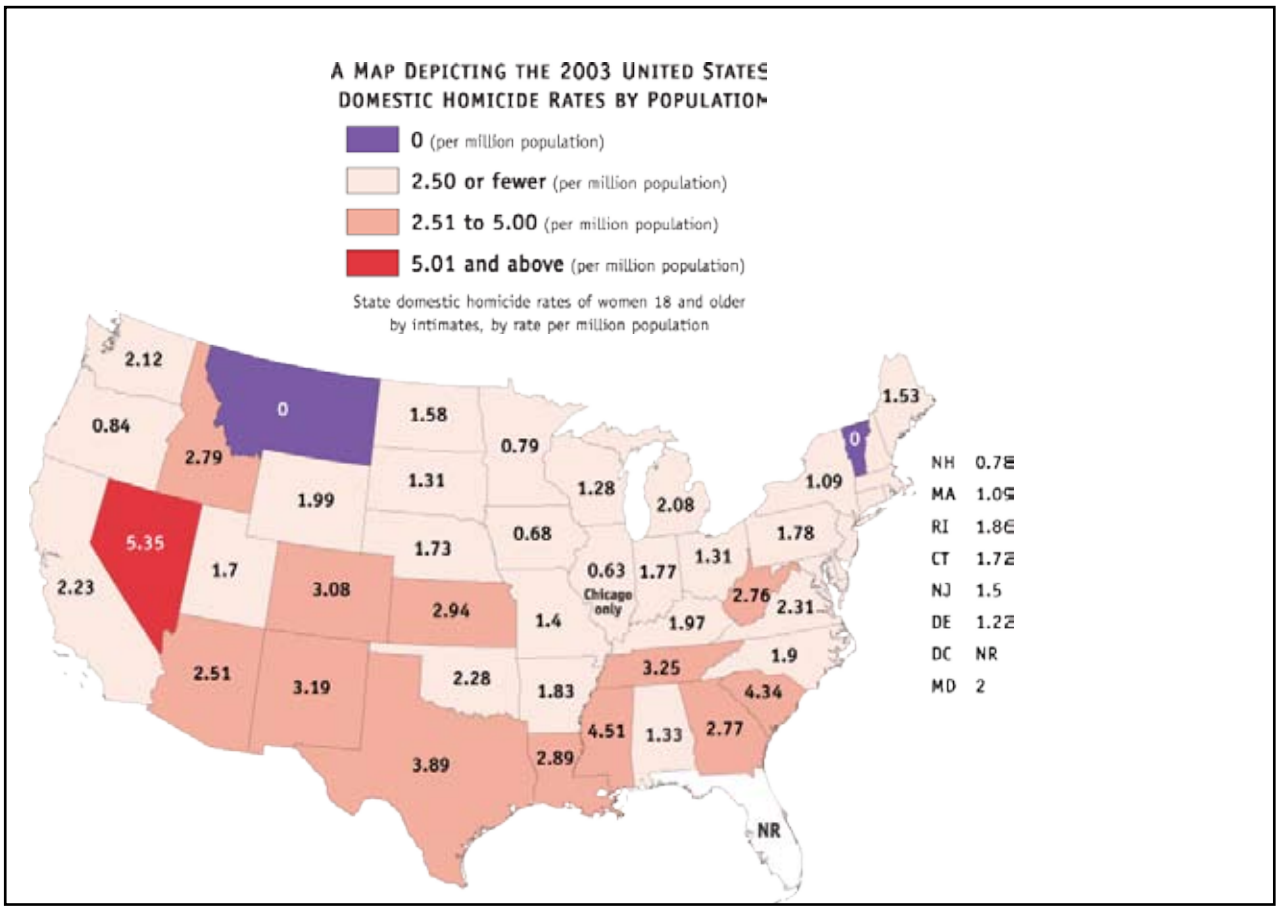
5.97
5.23
5.57
8.24
3.35
NA


A MAP DEPICTING THE 2003 UNITED STATES
DOMESTIC HOMICIDE RATES BY POPULATION
0 (per million population)
2.50 or fewer (per million population)
2.51 to 5.00 (per million population)
5.01 and above (per million population)
State domestic homicide rates of women 18 and older
by intimates, by rate per million population
2.12
0
1.58
0.79
1.53
0.84
2.79
1.99
1.31
1.28
2.08
1.09
0
1.78
5.35
1.7
1.73
0.68
0.63
1.77
1.31
2.23
3.08
Chicago
only
2.76
2.31
2.94
1.4
1.97
1.9
2.51
3.19
2.28
1.83
3.25
4.34
4.51
1.33
2.77
3.89
2.89
NR
NH 0.7
MA 1.0
RI 1.8
CT 1.7
NJ 1.5
DE 1.2
DC NR
MD 2

There have been a variety of positive outcomes from fatality reviews with a general reduction of domestic homicides across most states of the USA. Positive outcomes include the identification of risk indicators and the implementation of appropriate legislation to address them.

Observers and participants in the criminal justice system report that domestic violence police reports have significantly improved in documenting witnesses, weapons, and the injuries and demeanour of the victim and perpetrator at the scene. This improvement at the evidence gathering stage of the case allows prosecutors to make more informed charging decisions.

Other death review reports have led to significant legislative reform. In 2005, following a recommendation from the Hennepin County Death Review Team, the Minnesota Legislature passed a law making strangulation during domestic abuse a felony offense.

"Strangulation is often one of the last abusive acts committed by a violent domestic partner before murder." Hennepin County Fatality Review Team 2004 report

Putting strangulation forward as a significant risk indicator is based on the work of Strack and McClane (2001) who undertook research into three hundred strangulation cases submitted for misdemeanour prosecution to the San Diego City Attorney's Office. The study revealed that a lack of training may have caused police and prosecutors to overlook symptoms of strangulation or to rely too heavily on the visible signs of strangulation. Because most victims of strangulation had no visible injuries or their injuries were too minor to photograph, opportunities for higher level criminal prosecution were missed. Follow up research on the risks associated with non-fatal strangulation in cases of domestic violence was conducted by Glass, Laughon, Campbell, Block, Hanson, Sharps and Taliaferro (2004). This study found that prior non-fatal strangulation was a significant risk factor for attempted or completed homicide of women with prior non-fatal strangulation associated with 45% of attempted homicides and 43% of homicides.

The establishment of a Death Review Board in Queensland would allow for the identification of trends, gaps in service systems and barriers to effective intervention as has occurred in Santa Clara and other overseas communities and the review of current policies, procedures and interventions would hopefully have the same life saving results. The domestic violence death review process would be quite different to existing reviews conducted by both the Coroners Office [17] and the Child Death Review Team[18] having its own focus and specific proposed outcomes aimed at prevention of not only domestic and family violence homicides but domestic & family violence in general.

17 Coroner's Act 3.11
18 Child Safety Legislation Amendment Act 2004 7A

IDENTIFYING SYSTEMIC GAPS

The failure of legal and community systems to protect victims and hold abusers accountable is cited repeatedly in Domestic Violence Fatality Review Annual Reports. The Washington State Domestic Violence Fatality Team Report (2006) identified shortcomings in policy, practice, knowledge, training, collaboration, resources, communication and referrals that worked to amplify 'abusers' ability to control and terrorize their partners, or conspired to create insurmountable obstacles to the safety and autonomy of domestic violence victims and their children.

> **"Most homicides are preceded by multiple efforts by the victim to get help and multiple opportunities for the legal system and community to hold the abuser accountable for their violence. The actions and choices of both victims and abusers are substantially influenced by the institutional, social and cultural reality which surrounds them." David (2008),**

Currently, incidents of domestic violence deaths are seen as individual, discreet events, which in terms of homicide investigation and prosecution they are. Within Queensland, there are several different systems which examine violent deaths, namely the Coroner's Office, Police, the National Homicide Monitoring Program and the Child Death Review Team. However, none of these reviews or investigations looks at domestic and family violence related fatalities specifically, or analyse a group of domestic homicides occurring in a selected time frame searching for patterns and issues common across them. Nor do they undertake a specific examination of the gaps within systemic responses which may act as a barrier to effective safe interventions.

As stated by David (2007), death reviews are not inquiries into who is culpable. This is a matter for the coroners and criminal courts. A death review board would investigate events prior to the death, the circumstances surrounding the death, and actions that may be taken to prevent deaths occurring in similar circumstances in the future.

Many of the existing death review processes that currently exist in Queensland are punitive in nature often making cooperation by other agencies difficult, and also allowing for the broader issues of systems reform to be ignored. Domestic Violence Death Reviews are only interested in systemic and procedural weakness, not the actions or negligence of individuals. It is the operating procedures, laws and systems in place at the time of the death that are scrutinized. (Websdale 2003)

No Blame – No Shame

Generally Domestic Violence Death Review teams have adopted the same philosophical basis: that domestic violence related fatalities are preventable and the primary focus must be on prevention. They adopt a 'no-blame and shame' ethos, rather focusing their attention on ensuring that the responsibility is ascribed to the perpetrator for domestic or family violence. A focus is also on improving interagency cooperation and communication and mutual understanding. (Websdale, Sheeran & Johnson 2004)

Information from death reviews combined with information from other sources: (research, crime data etc.) allows for the identification of patterns and trends across domestic violence fatalities. It is envisaged that the reports from a domestic violence death review would compliment and enhance existing processes, not duplicate them. While organisations/agencies that have had contact with

a victim and/or perpetrator prior to a death may conduct internal reviews of the homicide/death, these are usually conducted in isolation from other organisations and opportunities to gain a better understanding of the gaps in collaboration and coordination are missed.

Hobart (2004) cautions that effective reviews go beyond counting cases and focus on the provision of critical analysis of gaps, barriers and weak points in the system and community response. Effective reviews make recommendations and implement changes and have clear mechanisms for working to implement those recommendations. Hobart further suggests that effective death reviews require leadership which can bring people together, provide excellent facilitation, support information gathering, and provide the Domestic Violence Death Review Team with a vision which includes social change to ending violence against women.

Whilst mention has been made of ensuring that blame in not placed on individuals within systems, so to must blame be avoided with respect to choices and decisions made by victims. Victim blaming is often what drives women away from services and works to keep them away. The domestic violence death review process is not about making evaluation of the decisions and choices victims may make on behalf of themselves and their children.

Child Death Reviews

Child death reviews in Queensland are conducted by the Commission for Children and Young People and Child Guardian which reviews the deaths of all Queensland children irrespective of cause of death. The Commission for Children and Young People is an independent statutory body charged with the responsibility for protecting and promoting the rights, interests and well being of Queensland children and young people under the age of 18. The function of the Child Death Review process is to maintain a register of the deaths of all children and young people, review causes and patterns of deaths for children and young people, conduct broad research into child deaths, make recommendations for improvements to laws, policies, procedures and practices to help reduce the likelihood of child deaths, and prepare an annual report to parliament and the public on child deaths. (Commission for Children and Young People and Child Guardian 2007)

The association between exposure to domestic violence and the negative impact on children's health, development and well being has been well documented through a body of international and Australian research which finds that domestic violence and child abuse frequently co-exist. (Laing 2000) The first national study of the prevalence of domestic violence in Australia (Australian Bureau of Statistics 1996) found that 61 percent of women who reported violence by a current partner had children in their care at some time during the relationship. Other research currently estimates that child abuse and domestic violence co-exist in between 30 and 60 percent of cases. (Edleson, 1999). Edleson further suggests that, while the co-existence of child abuse and domestic violence is now widely recognised, evidence is emerging that in cases where both domestic violence and child abuse occur, it represents the greatest risk to children's safety and a large number of cases in which children are killed have histories of domestic violence.

"I often thought my father might kill us when he was drunk. He held me and my mother and my brother at gunpoint once. It went on for hours. I remember the wall we were standing against. I tried to be good and do what I was supposed to do." (survivor cited in Herman 1992, p. 98)

Death reviews conducted by the Child Death Review Team involving domestic or family violence are examined through the lens of child protection with little or no focus on the circumstances or context

in which this violence occurred, including the existence of domestic violence perpetrated against their mothers or other adults.

This is not just a local issue, Websdale (1999) suggests that most child death reviews have not always understood the link between adult domestic violence and the killing of children. With a specific focus on the nature and appropriateness of prior child protection interventions, the broader systems that respond to domestic violence are ignored, even when an adult or adults may die in the same incident.

In establishing a Domestic Violence Death Review Board in Queensland, it would be imperative to consider ways in which mutual cooperation between these review processes would work for the betterment of both adult victims and children.

Legal Interventions

It is well recognised that 'leaving' a relationship does not mean 'leaving' violence and many of the deaths of women and children have occurred post separation[19]. Laing (2000) points out the risks victims face at this time including the expectation that they will negotiate parenting and contact arrangements. There is a lack of recognition that abusive spouses can use issues of contact and residence to continue to exercise coercive control over their partners. It is assumed that separating couples can put aside their differences 'for the sake of the children', an assumption which does not reflect understanding of the nature and dynamics of domestic violence nor the heightened risks associated with separation. The following case study has been developed using information in the public arena through various media reports.

Case Study : April 2004.

Two young children are suffocated by their father who then suicides.

These deaths occurred following a Family Court decision for the father to return the children to their mother. There had been a lengthy history of domestic violence prior to separation which included verbal, emotional and physical abuse and included violence which was ongoing through pregnancy. There had been several interventions by police and courts. A police officer advised the woman to **"leave or she would be leaving in a box".** In March 2004, she left the family home taking her two young children with her. Her husband found her at her mother's place and she was once again compelled to call the police. A domestic violence protection order was in place and the perpetrator was charged with breaching the order. He entered a not guilty plea and was released on bail. When the mother of the children was hospitalized, the father successfully applied to the Family Court for custody of the 2 children aged 10 weeks and 18 months. His application was successful and he gained custody of the children. This decision was eventually overturned but instead of returning the children to their mother, as ordered by the court, the father killed them and himself.[20]

" Why didn't they listen" Mother's comments to the media following the homicides.

19 Laing 2000, Personal Safety Survey 2005

20 Australian Women's Weekly June 2004," A Father's Deadly Rage"

There has been no review of these deaths from a systems perspective, nor through the lens of domestic violence. Whilst subjected to a child death review, the report makes no mention of the violence and risks from domestic violence to both the mother and children, nor does it make any recommendations regarding broader systemic reform.[21]

FINANCIAL CONSIDERATIONS

Domestic violence deaths extract an exacting cost on:

- Surviving family members – this includes emotional, spiritual and financial costs.
- The emotional and financial cost associated with supporting surviving children.
- Service providers who may have known the victim and experience vicarious trauma.
- Community and government services including police, courts, prison, Community Corrections, counselling, accommodation services and child protection.

In 2004, the Office for the Status of Women commissioned Access Economics to undertake a study of the costs of domestic violence to the Australian economy. This compelling report estimated 408,100 people, 87% of which were women, experienced domestic violence during the pervious year. The financial cost for domestic violence for this twelve month period is estimated at $8.1 billion. This cost incorporates the cost of pain, suffering and premature mortality.

Table D

Cost Category	Types Of Costs Include:
Pain, Suffering and premature Mortality	Costs of pain, suffering and premature mortality
Health Costs	Private and public health costs associated with treating victims, perpetrators and children
Production Related Costs	Lost wages and lost productivity
Consumption Costs	Property replacement and bad debts
Administration Costs	Costs of legal services, childcare, child protection, interpreter services, temporary accommodation, perpetrator programs and funeral costs
Transfer Costs	Income support, victim compensation, child support, financial assistance and lost taxes
Second Generation Costs	Costs associated with child care, changing schools, counselling, child protection, remedial education increased juvenile crime and increased future use of government services

21 *2004 – 2005 Child Death Review Report from the Commission for Children and Young People (p.121)*

Access Economics notes that according to the Women's Safety Study, as many as 79% of domestic violence physical assaults are not reported to police and other forms of domestic violence such as emotional abuse would have even lower rates of reporting. However, even given the low rates of reporting domestic violence, the estimated annual cost to the legal system is $298 million. These figures are highlighted in the table below.

Estimated Summary of Costs to the Legal System

Cost	($M)
Perpetrator Incarceration	231.1
Court System	14.2
Private Legal (perpetrator)	31.7
Police	3.5
AVOs and Family Court	17.4
Coroner	.01
Total Value	**297.9**

Source: Access Economics, 2004 p. 54

The San Diego Family Justice Centre estimates that each domestic homicide in San Diego costs the community over $2.5 million dollars in police, prosecution, court, victim services, jail sentences etc. (Gwinn & Strack, 2006)

The cost of establishing and maintaining a death review board would be small in relation to the overall costs associated with domestic violence deaths and yet could have significant results in terms of a reduction in homicides and flow on saving of costs to the community.

PROPOSED MODEL

The successful development of a Domestic Violence Death Review Board in Queensland would be contingent on several factors which include consideration of an appropriate model, allocation of financial resources to establish and fund the model and conducting statewide consultation on the model. As previously stated, the development of this discussion paper has been made possible through the generous support of community groups and individuals. However, funds did not allow for comprehensive consultation on the issues under discussion herein. The Domestic Violence Death Review Action Group would encourage government to develop a two fold consultation strategy that incorporates a specific consultation process with Indigenous groups and communities. The Domestic Violence Death Review Action Group acknowledges the over-representation of Aboriginal & Torres Strait Islander people within homicide statistics, together with the fact that 32% of Queensland's homicides occur in outer rural or remote communities. The development of a Domestic Violence Death Review Board in Queensland would need to reflect consideration of these issues.

Issues to be considered:

In development of a model, the following issues need to be considered:

1. Rationale
2. Legislative Framework
3. Goals and Objectives
4. Terms of Reference
5. Location of the Review Board
6. Funding
7. Scope of Reviews
8. Board Membership and Responsibilities
9. Cultural Consideration
10. Confidentiality, Liability and & Information
12. Operational Issues
13. Data
14. Protocols
15. Accountability & Reporting Mechanisms

Each of these considerations is addressed within a Queensland context.

1: Rationale

The rationale for the establishment of a Queensland Domestic Violence Death Review Board can be drawn from the evidence presented on findings from international domestic violence death reviews as outlined on pages 12-17 of this discussion paper.

Specifically, the establishment of a Domestic Violence Death Review Board would be underpinned by the belief that:

- Reviews allow for a better understanding of the nature and pattern of lethal domestic violence and abuse.
- Recommendations from reviews can lead to social and systems reforms – and ultimately prevention.

2: Legislative Framework

International experience indicates the necessity of having a legislative base to support the establishment and operation of a Domestic Violence Death Review Board, providing it with structure, terms of reference and the necessary legal framework for accessing confidential case information.

Existing Death Review Boards are given investigative powers regarding access to medical and criminal records, briefs of evidence, and other relevant information such as reports by children's services and psychologists (Websdale 2006).

David (2006) stated that death review boards need to have the necessary power and protections to work effectively and that legislation should provide for:

- Establishment, terms of reference, membership and tenure.
- Host agency responsibility and reporting arrangements.
- Powers to request and obtain information.
- Requirement for secure holding of documentation.
- The means to ensure confidentiality of information discussed and reviewed, and exemption of the team's deliberation from both freedom of information and privacy legislation.
- Indemnity of members – immunity from liability of members for discovery and disclosure in relation to their work on the Board and immunity from criminal or civil action in relation to findings of the team concerning the work of their agency or their own professional practice. This principle supports the notion that domestic violence death reviews are focused on the identification of systemic gaps not individual culpability.

Identified by Stewart (2008), some other key components of legislation would include: establishing the independence of the Board, powers of investigation and processes for reporting and accountability.

One international example of the use of legislation can be seen in California. In 1996 the California legislature passed Penal Code Section 11163.3 (et. seq.) which allowed for the formation of domestic violence death review teams in all Californian counties. It also deemed all information shared in death review committee meetings as confidential and not subject to disclosure or discovery by a third party.

In some other jurisdictions, the legislative framework for the establishment of a Death Review Board has been incorporated into the Coroners Act.

3: Goals and Objectives

- To review domestic and family violence related deaths and create a source of information on the lethal nature of domestic and family violence.
- To collect, analyse and interpret data on domestic and family violence related deaths.
- To develop a database on domestic and family violence related deaths.
- To identify gaps in service systems and work to improve protective services to victims of domestic and family violence.
- To provide an annual report documenting identified trends, issues, systemic gaps, recommendations for improved policies, procedures and practices within the agencies that serve victims of domestic and family violence.

4: Terms of Reference

Terms of reference are key to setting the parameters for death reviews. They should reflect the goals and objectives as stated and would generally be incorporated into the legislative framework of the proposed death review model. We recommend that they include the following:

- To examine the events leading up to the deaths of people who died within the context of domestic or family violence in order to gain a better understanding of domestic and family violence.
- To maintain confidentiality of all information brought to the notice of the committee in the context of its deliberations.
- To examine the contacts made with services by the victim and offender in order to identify gaps and failures in service systems.
- To examine issues of access to services, the appropriateness and quality of services and other relevant interventions available to the victim and offender.
- To recommend improvements to service delivery and systems and law reform, as appropriate.

  To monitor progress in the implementation of recommendations.
- To report to Parliament annually on findings of death reviews, recommendations made and progress of implementation of previous recommendations made.

5: Location of the Review Board

The Domestic Violence Death Review Board may need to be 'housed' within an agency or department which has the experience and expertise to manage the functions of such a Board. The Office of the State Coroner would be one such place, provided adequate resources are allocated to this and the legislative framework supports the establishment of a multi-disciplinary team/Board.

Part of the rationale for locating the Domestic Violence Death Review Board within the Office of the State Coroner would be that the existing expertise is there in managing death investigation processes, collecting and examining relevant data, and investigating and interviewing people associated with death reviews.

Alternate locations which could be explored include the State Ombudsman Office or the development of a separate entity supported by legislation and funding. Consideration should be given to the need for the Board to have the ability to maintain independence and autonomy. To this extent it would not be considered appropriate to 'house' the Board within the Queensland Police Service, Department of Health or Department of Communities who could all be seen to have a conflict of interest.

If a separate entity was established, opportunities for co-location within an agency such as the Ombudsman or the Coroner's office should be explored. This would allow economies for sharing resources and still enable the board to maintain independence.

6: Funding

Specific funding would need to be allocated for the establishment and function of the review Board which would include:

- **Staffing**

The review Board would need to be supported by staff that could undertake research including the collection, analysis and summation of documents to be reviewed; conduct interviews to gain further information (this could also be completed by board members) and provide a range of administrative duties.

Staffing arrangements would consist of at least 1 administration officer and 2 research assistants who possess the necessary skills and qualifications.

- **Board Costs**

It is essential that in calculating financial resources to be allocated for the establishment of a Board that resources are allocated to:

- Paying Board members a sitting fee
- Travel and accommodation costs (as required)
- Meeting costs including catering
- Printing costs including the costs associated with the printing and dissemination of an annual report
- Extraordinary meeting costs which may include:
    - Re-imbursement to members of sub-committee
    - Flexibility to allow for Board members to conduct meetings outside the Brisbane area if deemed by the Board as necessary, to provide a more comprehensive review of a particular death.

The flexibility of the Board having the option to meet outside of Brisbane is important when considering that from the 56 homicide incidents in the category of intimate or family relationship which occurred in 2005-2006, 68% occurred in major cities, 23% in outer regional, 4% in remote areas and 5% in very remote areas. (David & Mouzos 2007)

7: Scope of Reviews

In determining the scope of the reviews, several pertinent issues need to be considered. These include:

a. Relationship context of the victim to the offender

b. Control tactics of the offender in respect to issues of domestic / family violence

c. Definition of the deaths to be reviewed

a. Relationship Context

The Queensland Domestic and Family Violence Protection Act 1989 (The 'Act') define relationships covered by the Act as:

- **Spousal relationships**

People who are married, separated or divorced; biological parents of a child; or two people of the same or opposite sex who are living together or have previously lived together as a couple.

- **Intimate personal relationships**

People who are or were engaged to be married to each other including a betrothal under cultural or religious tradition. It also includes people who are or were previously dating and whose lives have become enmeshed.

- **Family relationships**

People who are relatives of each other by blood or marriage such as a grandparent, aunt, uncle, step-parent, sibling, cousin or child (18 years and over). The relatives of those who are in or have been in a defacto relationship are included. A relative also includes a person it is reasonable to regard as a relative. This acknowledges that for some people the concept of a relative may be wider such as for Aboriginal people, Torres Strait Islanders, members of certain non-English speaking background communities, and people with particular religious beliefs.

- **Informal care relationships**

People in a situation where one person is or was dependent on another person, (a carer) who assists them in an activity of daily living (personal care activities). This may include dressing, preparing meals or shopping. The personal care must be required because of a disability, illness or impairment. The care must be provided in an informal way and not involve the payment of a fee or care as part of an arrangement, for example in-home care nurses.

However, the Act does also provide for the protection of those people who are at risk of violence and or abuse as a result of their relationship with the aggrieved victim and are named on their order as needing protection.

The definition of relationships as defined by the Queensland Domestic and Family Violence Protection Act 1989 could be adequate for the purpose of a Domestic Violence Death Review providing it allowed for the inclusion of other groups of people whose death is considered to have occurred as a direct result of their relationship to someone who is or has been in a domestic violence relationship as

defined by the Act whether a Protection Order was in place or not. This could include new partners, friends and work colleagues.

b. Control Tactics of the Offender (Intent)

The intent of the perpetrator can also be an important factor in ensuring that all relevant or related deaths are captured in a review process.

In determining the scope of the Domestic Violence Death Reviews, consideration needs to be given not only to the type of relationship but also to the intent of the behaviour that resulted in death. The Washington State Fatality Review defines a domestic violence fatality as a death which arises from an abuser's efforts to seek power and control over the victim. This then allows for the inclusion of deaths that occur post separation when a new partner is killed, when a family member is seeking to provide assistance or when other non related persons are killed.

c. Definition of Deaths

The terms fatality, unlawful death and homicide are often used interchangeably when referring to someone who has been killed/died in a domestic violence related manner.

The current definition used by the National Homicide Monitoring Program states that the term homicide refers to a person killed, while a homicide incident is an event in which one or more persons are killed at the same place and time. Homicide is defined by the criminal law of each Australian state and territory.

The Queensland Criminal Code Act 1899 Section 294 defines homicide as "any person who causes the death of another, directly or indirectly, by any means". Murder / Manslaughter are the crimes associated with the homicide.

The 2007 Report of the Santa Clara Domestic Violence Death Review Committee suggests that finding a workable definition of the term "domestic violence related death" was imperative to the commencement of establishing death reviews.

A suitable definition for the Queensland Domestic Violence Death Review Board could be:

> *'Domestic violence fatality': the death of a person brought about on any background of domestic or family violence'* Stewart 2008

This includes:

- the homicide of a victim of domestic, family violence (including where the relationship was a dating relationship)
- the homicide of the domestic violence perpetrator at the hands of the victim
- the suicide of a victim of domestic violence
- the suicide of the homicide offender
- family annihilation
- the homicide of children who have witnessed domestic violence and/or been direct victims of violence, abuse and neglect

- the homicide of collateral victims, for example, a police officer attending a domestic violence incident, a friend or relative assisting the victim, a perceived sexual rival or the new partner of the offender's former partner
- The death of a victim of domestic violence in other circumstances e.g. traffic accidents including hit run accidents, drug overdoes, falls or missing persons.

8: Board Membership & Responsibilities

Memberships

Members of the Queensland Domestic Violence Death Review Board would be appointed to the position by Cabinet following the established procedure and tenure as with Government appointments on other boards.

The proposed membership of the Death Review Board would include:

- State Coroner
- Police Commissioner
- Representation from the Domestic Violence Sector
- Representation from the Department of Justice and Attorney General
- Representation from Queensland Health which could include representation of Mental Health Services
- Representation from Aboriginal and Torres Strait Islander services / communities.

The position of chair should reflect the committee's independent status.

It would be considered important for the Domestic Violence Death Review Board to reflect consistency with Queensland's "whole of government response to domestic and family violence".

For effectiveness of outcomes, the committee's membership should consist of high level members and senior officers who should be appointed by their ministers to the Board. It is essential that members are in a position and/or have the authority within their own agencies to progress findings and recommendations of the committee. It would also be important for members to have considerable experience and skills in the understanding of domestic violence and risk assessment processes and for this to form a criteria in appointing or reappointing members to the Review Board.

Other persons and or groups with pertinent expertise who could be co-opted by the Chair on a specific needs basis to add further to the death review process include:

- Representation from migrant services / communities
- Representation from the Family Court
- Representation from academia e.g. criminology
- Victims of Homicide Support Group
- Representation from Department of Communities / whole of government committee.
- Department of Child Safety or representation from the Child Death Review Team

As stated earlier in this discussion paper it would be imperative for the Domestic Violence Death Review Board to develop mutually cooperative ways of linking with existing responses/infrastructure relating to children.

Sub-Committees

As has been the case in several overseas death review committees, the Death Review Board could have the option of developing sub-committees to further advance the work of the Board. Examples of sub-committees which may be useful are ones that specifically address:

- Lethality/risk assessment
- Policy and practice implementation
- Education and training
- Police systems
- Court systems
- Legislation
- Research, Education & Training

Responsibilities:

The responsibilities of the Death Review Board would include:

- Conducting a confidential review of each domestic/family violence related death within the scope and the set terms of reference
- Creating and maintaining a comprehensive database about the victims and perpetrators of domestic violence deaths and the circumstances leading to those deaths
- Identifying the presence or absence of systemic gaps or risk factors that may have contributed to the deaths reviewed
- Identifying trends and patterns across deaths
- Making recommendations to the Queensland Government through an annual report. To ensure accountability it is recommended that this report be tabled in parliament to ensure transparency and accountability. It is crucial that the recommendations from the Domestic Violence Death Review Board are implemented to effect the change needed to stop domestic violence related deaths.

9: Cultural Considerations

It is imperative that a Queensland Domestic Violence Death Review Board encompasses a cultural sensitivity approach across all of its operations.

The Queensland Domestic & Family Violence Research Centre has developed an information booklet[22] which draws together research and other data on Aboriginal and Torres Strait Island Family Violence. Citing the work of Memmott, Stacy, Chambers and Keys (2001), this document provides an understanding of Aboriginal people's preference for the term 'family violence' as a more suitable term to describe violence in Indigenous households. Family violence encapsulates the extended nature of Indigenous

22 *Aboriginal and Torres Strait Island Family Violence: Facts and Figurers 2007*

families as well as the kinship relationships in which violence can occur. Family violence may include all types of violence, all types of relationships and may include more than one perpetrator.

This paper acknowledges that it is within this context that homicides and other deaths occur. Indigenous women and men experience disproportionate levels of family violence including death, in comparison to the rest of the community. Comprising less than 3% of the population, the risk of homicide is elevated with 2005-2006[23] homicide data showing 11% of female victims and 12% of male victims were Indigenous.

The complexity of issues surrounding Indigenous family violence have been well documented in the Aboriginal & Torres Strait Islander Women's Task Force on Violence Report (1999). This report and the recommendations contained within should form a starting point for deliberations on the development of review process for Indigenous family violence deaths.

"Women said they felt unsafe because of the failure of the justice system to protect them. This has increased the vulnerability of women and children to violent attacks and life threatening situations. A number of Elders, women and Community representatives indicated that they believe the situation will worsen before it improves". P 217

"The Task Force believes the number of violent offences is much higher than the officially recorded data. The Task Force researchers heard many stories about crimes that women did not report for fear of reprisals from the perpetrator, his kinfolk or the justice system. "p xiv

In consideration of the over-representation of Indigenous women and men in homicide data, a specific and well resourced strategy should be developed to involve Indigenous people in discussion on the way forward in respect to family violence death reviews. This could include the employment of an Indigenous worker / consultant working with an Indigenous reference group to develop a process with which Indigenous family violence death could be reviewed. This may involve reviewing Indigenous deaths as part of an overall review of domestic / family violence deaths with Indigenous representation on the Board or it may be the development of a separate parallel process.

10: Confidentiality, Liability and Immunity

Concerned with issues of confidentiality and liability some states have enacted confidentiality laws to protect the deliberations and findings. These laws immunize teams from civil suits and disciplinary action. For example, Florida legislation provides that documents and other information brought to a death review team "are not subject to discovery or introduction into evidence in any civil action or disciplinary proceeding by any department or employing agency..."

Further to this, a person who is a member of a domestic violence review team /board may not testify in any civil action or disciplinary proceeding as to any records or information produced or presented to the team during meetings or other activities.

23 Australian Institute of Criminology Data

The issues of confidentiality, liability and immunity have emerged as highly significant issues for domestic violence death review teams in the United States. It is clear that these issues must be resolved prior to commencement.

> *Confidentiality and other issues concerning the provision of medical records, disclosure of findings, exemption of files from freedom of information applications, exemption from subpoena and discovery, immunity of members from liability. While the literature identifies fatality review teams established without legislation which have sought to address and provide for these issues, it seems that many obstacles to successful operation would exist in the absence of a statutory base and, in particular, to obtaining access to information which would otherwise be protected by privacy legislation* (Virginia Department of Health 2001, Stewart 2004)

11: Access to Records & Information

The powers to compel and request data, information and records from all relevant government and non-government agencies must be clearly articulated in the legislation. This would include addressing any issues of privacy, confidentiality and jurisdiction such as the division between state and federal jurisdictions. In addition to the legislation specifically drafted for the Death Review Board, for any powers to compel other agencies to be effective other consequential amendments would need to be made to all relevant legislation pertaining to those agencies. This may also be of critical importance to facilitate the release of information from Federal agencies and courts, such as the family law courts, Centrelink and the like. Naturally this will require collaboration and cooperation between state and federal governments, such as the recent measures that have been considered by the Council of Australian Governments for the National Child Protection Framework. It is likely that processes and protocols would also need to be implemented on the ground to give effect to the legislation.

Additional research and consultation will need to be undertaken to identify the exact legislative provisions and supporting policy that is required to ensure this matter is appropriately addressed in the model adopted in Queensland.

12: Operational Issues

While the operation of death reviews vary along several lines, the operational process could be considered as the:

- Identification of relevant events by the police, coroner's office, news items or other means; to be conveyed to the team's convener
- Selection of cases for in-depth analysis by the Board considerate of legislative and other regulations relevant to this.
- Requests by the convener or support staff for relevant agencies to produce documentation from their agency which relates to the parties to the event
- Secure circulation of documentation to members once received by the convener
- Setting up of a meeting for the review team to conduct a review of the cases

Conducting Reviews

The timeframe for conducting the review stage of the process may be dependent on factors relevant to the timing and progress of any criminal proceedings but usually death reviews are conducted on domestic related deaths which have occurred in the preceding year. This is an issue that needs further research and investigation to resolve how the reviews would be conducted in the Queensland context.

At its meeting to deliberate over the event, the team discusses content of the documentation and additional information brought to the table through other sources – i.e. interviews. Additional information may be canvassed during the course of the review.

Some teams may review domestic homicides/suicides at regular meetings over a prescribed period (for example, one year) and make aggregate recommendations based on the outcomes of a number of reviews.

(Webster et al 2003 & Stewart 2004)

The US National Domestic Violence Fatality Review Initiative recommends that owing to reasons of confidentiality, discovery and liability, closed murder cases or open suicide/murder cases were the most appropriate to review. They also suggest that much could be learnt from examining not only deaths, but also cases involving attempted murder and other serious assault cases.

While the Queensland Domestic Violence Death Review Board would need to determine how and in what manner it conducts reviews, the US experiences shows the most commonly used manner is:

- Deciding which cases are to be reviewed
- Identifying where documents should be sourced from, and get access to these
- Review of existing documents
- Conducting interviews with family/friends/work colleagues /service providers when appropriate, and especially when family and friends consent to this. Processes would need to be developed to ensure this is done in a manner that is mindful of their issues of grief but also allows them to have a 'voice' if that is what they are wanting. The purpose of interviewing family / friends would still be within the context of examining systems responses and the focus on such interviews, or written statements would be directed to any prior interventions by various parts of the system and not on the homicide or death itself.

What are we to review?

Following is an example of the types of documents which could be sought and reviewed by the board. The US National Domestic Violence Fatality Review Initiative listed the following documents which could be examined as part of a death review.

- Police department logs or data including history of 911 calls
- Information on protection orders – applications and orders
- Civil court data relating to child custody and divorce
- Child Protection summary data and prior abuse histories

- Newspaper reports
- Criminal Histories of both victim and perpetrator
- Medical examiners reports
- Autopsy reports
- Medical reports including emergency hospital room data
- Workplace reports if there has been reports of abuse and or harassment
- Summaries of psychological reports appearing in public documents such as police files and probation and parole files
- School data of children reporting abuse at home
- Pre-sentence investigation reports
- Parole information including notification to the victim
- Shelter / domestic violence data for victims if appropriate and legally permissible
- Statements from neighbours, friends, witnesses and family. This may be contained in police files as transcripted material or court documents / transcripts from trials
- Prosecution records
- Weapons records
- Batter Intervention services reports
- Mental health reports
- Legal files

Clearly, the above is provided as a reference only and a Queensland Domestic Violence Death Review would need to develop its own examination requirements and methods. They should have access to research and any mapping of systems that has already been done in Queensland to assist them to identify all potential relevant sources of information.

13: Data

The need for comprehensive, available data relative to domestic and family violence deaths has been noted by both researchers and Domestic Violence Death Review Boards. Websdale (1999) found that data is often very limited or unavailable and hampers a comprehensive statistical analysis of deaths which would allow for the trends and patterns around domestic deaths to emerge.

The establishment of a Domestic Violence Death Review Board in Queensland would need to be supported by the development of an accompanying multi- agency data collection system which could incorporate previously unrecorded information relating to incidents involving domestic violence and fatalities including:

1. Risk Indicators which may include information on:

    Separation

    Threats

Stalking

Strangulation

Pregnancy

Escalation of violence

Weapons

Custody / Family law issues

Jealousy over new partners

Social isolation

Immigration issues

Cultural issues

Threats and /or violence to children

2. Information on court orders including protection orders and cross applications

3. Criminal charges including breaches and bail conditions

4. Prior criminal history relative to domestic and family violence or other assaults/violence

5. Information on victim's prior attempts at leaving

6. Information on intervention by both government and non-government services – police, courts, domestic violence service, refuge, medical services etc.

7. Information on intervention with perpetrator's including men's programs

Information gathered would then be reviewed by the Board in appropriate cases and greatly assists the board to develop a yearly report identifying trends, patterns and gaps in service systems and to make meaningful recommendations to address them.

14: Protocols

Several of the overseas death review teams have developed comprehensive protocols which underpin the work of the review process. Many of these protocols have been developed by government at the time of implementing a death review process. Most notable among these are the California's Domestic Violence Death Review Team Protocol – A Case for Prevention available at: http://safestate.org/index.cfm?navId=352

The California Protocol includes information on:

Mission

Goals

Review Process

Membership

Confidentiality

Data Collection

Recommendations for improving the domestic violence system

Sample Confidentiality agreements

Sample data collections forms

The above could provide a useful guide for the development of a similar document in Queensland.

15: Reporting Mechanisms

A critical aspect of the work undertaken by domestic violence death reviews[24] is the production of a report, usually annually which outlines key recommendations aimed at improving the domestic violence system. The Report would document their findings across several deaths reviewed in a defined time frame. This Report is then presented to government, the broader community and specifically to those organisations within the domestic violence service system. To ensure accountability and ensure recommendations are given serious consideration, it is recommended that the Annual Report of the board is presented to parliament and that the government be required to provide a response to the recommendations within 6 months.

Many Death Review reports contain:

Specific information on the death reviews conducted - usually documented as case studies

Data analysis of the deaths reviewed

Findings of the death review including the identification of risk indicators, patterns, trends and systemic flaws.

Details of opportunities which may have existed for intervention

Recommendations which can be made may include those associated with:

- Collaboration and partnerships
- Training
- Legislative reform
- Policy and practice
- Gaps in service provision
- Allocation of resources
- Community awareness considerations

A Queensland Domestic Violence Death Review Board would need to develop its own parameters for reporting which is reflective of its terms of reference. However, the above could provide an overarching framework for the development of annual reports.

24 Reports reviewed Santa Clara, San Diego, Washington State

RECOMMENDATIONS

Domestic Violence Death Review Boards have been operating in many overseas communities for many years and much has been done to fine tune their operations. The development of a Queensland Domestic Violence Death Review Board could be streamlined by following a well documented and proven model. In conclusion, the Domestic Violence Death Review Action Group recommends the following:

- That the Queensland Government accepts this discussion paper for consideration and commits to prioritising the development of a multi-disciplinary Queensland Domestic Violence Death Review Board.
- That a Queensland Domestic Violence Death Review Board be developed as a multi-disciplinary board comprising both government and non-government professionals with suitable skills and expertise.
- That the feasibility of allocating a Domestic Violence Death Review Board independently or within the State Coroners Office be explored including issues associated with legislative powers, funding and staffing.
- That the Queensland Government incorporates the establishment of a Domestic Violence Death Review Board into a whole of government framework.
- That the Queensland Government allocates the necessary resources to allow for the development of a Domestic Violence Death Review Board and its function for a 3 year pilot period.
- That a working group be convened to oversee the development of a Domestic Violence Death Review Board. Membership of the working/reference group is to be drawn from both government and non-government and will bring together people with the necessary skills and expertise.
- That the reference group undertakes to develop terms of reference, membership criteria, case review processes, board functions, key protocols necessary for the Board to access all relevant information and the evaluation processes.
- That a separate process is developed to allow for the employment of an indigenous worker / consultant supported by an indigenous reference group to consult with indigenous organisations and community on the way forward for the development of a Domestic Violence Death Review process that is culturally appropriate.
- That further statewide consultation occurs on the recommendations presented in this paper.

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List of Sample Forms

Attached are the following sample forms used by other jurisdictions as part of their response to Domestic and Family Violence. These sample forms are purely illustrative, but may be of some assistance in the development of relevant protocols in Queensland.

- *Solano County Domestic Violence Death Review Case Review Form*- 5 pages
- *Solano County Domestic Violence Death Review Team Confidentiality Agreement* Solano County, 2007 Solano County Domestic Violence Fatality Review Team, accessed http://www.ndvfri.org/ 10th August 2008
- *Government of South Australia, Family Safety Framework: Risk Assessment Form.* Government of South Australia, 2007 An Integrated Response to Domestic Violence: South Australia's Family Safety Framework, Women's Safety Strategy. http://www.justice.vic.gov.au/wps/wcm/connect/DOJ+Internet/resources/file/eb21454eba7698d/MacKenzie_1315_Tue.pdf