



Domestic and Family Violence
Death Review and Advisory Board
2017–18 Annual Report



Queensland
Government

We honour the voices of those who have lost their lives to domestic and family violence, and extend our sympathies to the loved ones who are left behind, their lives forever changed by their loss.

Our efforts remain with ensuring that domestic and family violence deaths do not go unnoticed, unexamined or forgotten.

A report of the Domestic and Family Violence Death Review and Advisory Board pursuant to section 91Z of the *Coroners Act 2003*.

Published in Brisbane, Queensland by the Domestic and Family Violence Death Review and Advisory Board.

All enquiries regarding this document should be directed in the first instance to the Secretariat, PO Box 1649, Brisbane, QLD, 4000, or by email: Coroner.DFVDRU@justice.qld.gov.au

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About this report

The Domestic and Family Violence Death Review and Advisory Board (the Board) is established by the *Coroners Act 2003* (the Act) to undertake systemic reviews of domestic and family violence deaths in Queensland. The Board is required to identify common systemic failures, gaps or issues and make recommendations to improve systems, practices and procedures to prevent future domestic and family violence deaths.

This report has been prepared by the Board in accordance with section 91ZB of the Act, which outlines that the Board must, within three months of the end of the financial year, provide a report in relation to the performance of the Board's functions during that financial year, to the Attorney-General and Minister for Justice (the Attorney-General).

The Annual Report must include information about the progress made during the financial year to implement recommendations made by the Board during that year, or previous financial years. The Attorney-General must also table a copy of this report in the Queensland Parliament within one month of receipt.

The views expressed in this report are reflective of the consensus decision-making model of the Board, and therefore do not necessarily reflect the private or professional views of a Member of the Board or their individual organisations.

It is acknowledged at the outset that many of these deaths occurred during the early implementation of significant reforms associated with the *Special Taskforce on Domestic and Family Violence (2015)* (the Special Taskforce). The Board has been mindful of this extensive reform agenda in its consideration of any missed opportunities for intervention or prevention, and recognises the dedication and hard work of those who are seeking to put an end to domestic and family violence in Queensland.

Perhaps one of the most confronting findings of this report is that even when services were operating as intended, these responses were unable to prevent the fatal outcomes. Notably, while one agency response may have met expected standards, this was not consistent across all services responding to the victim and/or perpetrator over time.

This highlights the critical importance of ensuring whole of system responses are established and operating consistently and effectively for both victims and perpetrators, as it is clear that we can, and should, do more.

Seek help

If you, or someone you know, need help, then the following services are available to assist.

- » DV Connect is a 24 hour Crisis Support line for anyone affected by domestic or family violence, and can be contacted on 1800 811 811 or www.dvconnect.org
- » Lifeline is a 24 hour telephone counselling and referral service, and can be contacted on 13 11 14 or www.lifeline.org.au
- » Kids Helpline is a 24 hour free counselling service for young people aged between 5 and 25, and can be contacted on 1800 55 1800 or www.kidshelponline.com.au
- » Mensline Australia is a 24 hour counselling service for men, and can be contacted on 1300 78 99 78 or www.menslineaus.org.au
- » Suicide Call Back Service can be contacted on 1300 659 467 or www.suicidecallbackservice.org.au
- » Beyondblue can be contacted on 1300 22 4636 or www.beyondblue.org.au

Guidelines for safe reporting in relation to suicide and mental illness for journalists are available here:
<http://www.mindframe-media.info/for-media/media-resources>

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Chair's message

This Annual Report outlines the work of the Board during the 2017–18 financial year. In its second year of operation, the Board has undertaken in-depth reviews of 20 cases involving 30 domestic and family violence deaths. In these cases, it is clear that it is not always the primary perpetrator who commits an act of lethal violence towards their victim.

While this is certainly the case in a significant proportion of these deaths in Queensland, at times the primary perpetrator may be the person who has died, either through homicide or suicide. Similarly, while statistically rare, in some instances a victim may kill – to escape their abuser, and/or in defence of them self or others. It is therefore important to highlight that where domestic and family violence is present in a relationship, there is a small but lethal risk to not just a victim, but also their children, other family members and, on occasion, the primary perpetrator themselves.

This report aims to extend the conversation about these types of deaths, and broaden our collective understanding of patterns of risk and harm that are present in relationships characterised by domestic and family violence.

Opportunities to extend upon current reforms are also considered, with recommendations that seek to address identifiable gaps in service provision being made. Significantly, the Board recognises that there is extensive work underway at a local level to respond to domestic and family violence, such as the current trial of integrated service responses, specialist domestic and family violence courts, the development of community toolkits and workforce development initiatives in Primary Health Networks.

It is hoped that, in time, key learnings from these trials can be applied to other communities across the state, so that all Queenslanders can benefit from these promising areas of practice. The importance of local initiatives in this area should not be underestimated, as it is certainly the case that one size does not fit all when responding to domestic and family violence.

Reviews of these deaths can be confronting, and I would like to take this opportunity to acknowledge the commitment and dedication of Board Members in the performance of their duties. In particular, our special thanks go to Assistant Commissioner Maurice Carless, from the State Crime Command, Queensland Police Service, who provided considerable insight into the challenges faced by police in responding to domestic and family violence, and opportunities to enhance such responses. The Board also welcomed Queensland Corrective Services Commissioner, Dr Peter Martin, who joined us in March 2018.

I would like to further acknowledge the assistance of Professor Lorraine Mazerolle, School of Social Science, University of Queensland, and her research team, who undertook a systematic analysis¹ of criminal justice system responses to domestic and family violence. This is an important body of work that has been used by the Board to inform its recommendations.

The systematic analysis is published alongside this report to help develop our evidence base as to what works, when and why, in responding to domestic and family violence.

In building upon activities undertaken during this reporting period, the Board identified a number of priorities moving into the future, including:

- » Exploring opportunities for earlier intervention and prevention to break the cycle of domestic and family violence, which is highlighted as a priority area of research within this report.
- » Considering opportunities to enhance the way the system identifies and responds to perpetrators of domestic and family violence.
- » Developing an understanding of intimate partner violence among older Queenslanders, and the unique support needs of this cohort.

¹ A systematic review is a research methodology that provides a concise, yet comprehensive and robust summary of high-quality research evidence. It is a valuable tool for policy-makers and practitioners aiming to identify interventions that are most effective for particular problems and populations.

Acknowledgements

The Queensland domestic and family violence death review process is informed by the collective knowledge and experience of the many domestic and family violence and child death review mechanisms that operate for the purposes of reducing these types of deaths.

During this reporting period, the Board has had the privilege of speaking with a range of experts, government agencies and community members regarding key issues identified throughout the review process.

In particular, the Board would like to acknowledge the contribution of:

- » Ms Cecilia Barassi-Rubio, Director, Immigrant Women's Support Service
- » Ms Elizabeth Wilson QC, Murray Gleeson Chambers
- » Ms Keiren Bennett, Queensland Corrective Services
- » Magistrate Colin Strofield
- » Mr Michael Byrne QC, Director of Public Prosecutions
- » Dr Brian Adams, Centre for Interfaith and Cultural Dialogue, Griffith University
- » Detective Superintendent Roger Lowe, State Crime Command, Queensland Police Service
- » Dr Darren Neillie, Royal Australian and New Zealand College of Psychiatrists
- » Carmel O'Brien OAM, PsychRespect
- » Dr Michael Cleary, Vice President, Australian Medical Association
- » Ms Rebecca Maurer, Integrated Service Response Manager, Logan-Beenleigh
- » Ms Dyana Amaya, High Risk Team Manager, Logan-Beenleigh

The Board would also like to extend its thanks to those who contributed to making its first public forum in May 2018 a success. This included the:

- » Attorney-General and Minister for Justice, the Honourable Yvette D'Ath MP, for opening the forum.
- » Domestic and Family Violence Implementation Council Chairperson, Ms Kay McGrath OAM, who provided a welcoming address.
- » Ms Cheryl Levy, Deputy Commissioner, Queensland Family and Child Commission, who presented alongside Members of the Board.
- » Griffith University Violence Research and Prevention Program for their support of this event, particularly Professor Paul Mazerolle and Dr Samara McPhedran, for facilitating and organising the event, respectively.

The Board would also like to acknowledge the significant efforts of everyone who is working towards reducing domestic and family violence within their communities.

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Executive Summary

Domestic and family violence has a devastating impact on individuals, families and the broader community.

This report outlines the Board's findings from the review of the deaths of 30 women, children and men who have lost their lives to domestic and family violence. For each of these deaths, there are children, other family members and friends left behind, forever changed by their loss.

Chapter 1 summarises the personal journeys of these deceased and other relevant parties, and outlines where advice and assistance was sought and received from both formal and informal supports.

Expanding our focus

The Board's 2016-17 Annual Report established the foundation for reporting domestic and family violence deaths in Queensland. This year, the Board is expanding its focus with further development and analysis of existing datasets in Chapter 2. This section provides the statistical framework for the Board's findings and recommendations throughout the rest of the report.

Key points include:

- » Between 1 July 2006 and 30 June 2018, there have been 294 domestic and family homicides in Queensland. This includes 153 homicides in an intimate partner relationship, 122 homicides in a family relationship and 19 collateral homicides.
- » Females are significantly over-represented as homicide deceased in intimate partner homicides (4:1), with males being the homicide offender in 80.8% of these cases.
- » People from culturally and linguistically diverse backgrounds made up 13.9% of domestic and family homicides in Queensland.
- » Over one-half of the homicides in a family relationship involve children as the deceased. A history of domestic and family violence was less prominent among family homicide cases compared with intimate partner homicides. Consequently, in this cohort, there was less likely to be contact with police and magistrates courts, and more likely to be contact with child safety services.
- » A total of 33 homicide-suicide events have occurred in Queensland since 2006, involving 40 homicide deceased and 33 suicide deceased. Service contact was comparatively low in this cohort, with limited evidence of contact with specialist and generalist services.
- » A total of 116 male homicide deceased were recorded in this period, accounting for two-fifths of all homicides. More males died in family homicides (n=65), in comparison to intimate partner homicides (n=33) and collateral homicides (n=18). Of these, the homicide offender was male in 72 cases, and female in 39 cases (in five cases the offenders were both a male and a female).
- » In all 20 female perpetrated intimate partner homicides involving a male deceased, where there was a reported history of violence in the relationship prior to the death, the deceased male was identified as the primary perpetrator.

- » Almost all of the collateral homicides featured a male deceased who was killed by a current or former abusive partner of the primary female victim. There was a history of violence in almost all of these cases, however, this was not between the homicide deceased and offender. This history of violence was instead between the homicide offender or deceased and the primary female victim.

Extending the conversation

Family homicides represent approximately half of all homicides that occur in an intimate partner or family relationship in Queensland.

Violence in a family relationship appears to be poorly understood and underreported. In the cases considered by the Board, it was apparent that patterns of violence extended throughout multiple family relationships (including across generations), and also into intimate partner relationships. For some cases, whether a person was a victim or perpetrator also differed dependent on the relationship. For example, one homicide offender was identified as a perpetrator of intimate partner violence, but reported being subjected to abuse from his adult children.

Currently, research and policy largely focuses on responding to intimate partner violence. This approach may not have the same impact in supporting those experiencing violence in a family relationship.

Further, in the cases reviewed where episodes of violence were disclosed, there was an apparent lack of recognition of the significance of such disclosures.

More research is required to better understand the unique dynamics of violence in family relationships, to ensure service providers are adequately equipped with the knowledge and tools to effectively respond.

Disrupting the cycle of violence

It was clear in some cases reviewed by the Board that a person's experience of violence commenced in childhood through exposure to parental domestic and family violence and/or as a direct victim of child abuse. For a significant proportion of victims and perpetrators, patterns of violence across intimate partner and/or family relationships were also evident throughout the life course.

In 13 of the cases considered by the Board in the 2017-18 reporting period, children were exposed to domestic and family violence including being direct victims of this abuse. This highlights the need for effective early intervention approaches for vulnerable and at-risk families.

It is also clear that post-separation, perpetrators would use child custody arrangements as an opportunity to further abuse the victim. Current frameworks to ensure the safety of victims and their children who are separating from abusive and violent partners are fragmented, complex and challenging to navigate. National reforms that aim to improve the family law system remain a priority area of focus for the Board.

A thread of repetitive victimisation across relationships was also common among the victims in the cases reviewed, including those where a female victim killed her current or former abusive intimate partner.

In its reviews of relevant deaths, the Board also noted that perpetrators with criminal affiliations posed a heightened risk of harm to their victims. It is clear that these victims faced additional barriers to separation, with a corresponding need for more intensive supports to help them safely separate.

Responding to cultural and linguistic diversity

During this reporting period, the Board reviewed a group of cases in which the victim and/or perpetrator was from a culturally and linguistically diverse background.

The true extent of domestic and family violence among this cohort remains largely unknown due to underreporting. However, it is clear that victims may not disclose abuse to formal and informal supports for a range of reasons, including language barriers, a lack of understanding of legal frameworks in Australia, and fear of repercussions from the perpetrator.

Among the cases considered in this cohort, there was varying levels of service contact. In some, the violence was almost invisible from formal services, while in others, service engagement was prolific with repeated attempts by the victim to seek help.

It is clear that services were not delivered in a culturally informed manner, which impacted on service engagement and effectiveness.

Consequently, there is a clear need for multi-cultural competency training across the service system, and for those working with people from a culturally and linguistically diverse background to have access to specialist advice and support.

Navigating the service system

The Board analysed individual service contacts for 19 of the 20 cases reviewed in this reporting period. Overall, for these 19 cases there were 536 domestic and family violence related contacts, with an average of 28.2 contacts per case.

Almost two-fifths of this contact was with police, highlighting the key role this service plays in responding to episodes of domestic and family violence.

In accordance with the Board's legislative function, the adequacy of this service system contact was explored. While the vast majority of contacts were considered to have met established legislation, policy and practice standards, there was a small proportion of contacts which were below a minimum standard of accepted practice.

Service providers were also more likely to meet minimum standards when engaging with victims, in comparison to their contacts with perpetrators. This highlights clear opportunities for improvement in the way services identify, and respond to, perpetrators.

While individual service responses may have accorded with established standards, there was a demonstrable lack of a cohesive service response across agencies to both victims and perpetrators. As such, more work is required to ensure all agencies are adequately equipped to consistently and effectively respond to both victims and perpetrators across the service system.

This cannot be achieved if agencies are working in isolation from each other.

Understanding and assessing risk

Risk assessment is critical in informing ongoing safety planning and risk management across the service system. In three-quarters of cases considered by the Board, a formalised screening or assessment tool was used at least once. However, generalist screening tools, for example those used in public mental health services, do not adequately assess for domestic and family violence and, therefore, fail to account for this risk in treatment and safety planning.

Existing specialist screening and risk assessment tools were developed with a focus on intimate partner violence in heterosexual relationships, with limited (if any) tools available to accurately identify risk in family relationships characterised by violence. Further, tools that are commonly used to screen and assess for domestic and family violence may not have been developed or validated in Australia. As such, their predictive ability is undetermined.

The Board analysed lethality risk factors to explore the presence of factors that have been found to be associated with intimate partner homicides. The most prominent risk factors in Queensland include: a history of domestic and family violence, actual or pending separation, sexual jealousy, and excessive alcohol and/or drug use by the perpetrator. Multiple risk indicators were a feature in most intimate partner homicides.

A key high risk indicator was also non-lethal strangulation. Where non-lethal strangulation was known to have previously occurred, there was on average 18 risk indicators. Where it was absent, there were just nine. This highlights the need for all service providers to be adequately equipped to identify and respond to non-lethal strangulation.

Responding to presenting and underlying needs

Health system responses to people experiencing domestic and family violence are also considered within the context of this report.

Significantly, perpetrators were identified as experiencing mental health issues in almost all cases considered by the Board. Half of these perpetrators had ongoing or recent contact with mental health service providers within two years of the death.

These findings highlight the clear role that health practitioners can play in responding to both victims and perpetrators of domestic and family violence.

There was also evidence that suggested practitioners did not adequately respond to open and repeated disclosures of abusive and threatening behaviours to intimate partners and family members. This extended to clear indicators of collusion in some cases where private practitioners failed to challenge such disclosures by perpetrators.

Crisis supports and responses

Safety planning by specialist services or other agencies was apparent in six cases considered by the Board. The importance of cross-agency safety planning, inclusive of both the victim and perpetrator, is highlighted within this section.

The Board further identified multiple cases where couples continued to reside together post-separation due to financial restrictions or a lack of alternative accommodation options. This increased the risk of further harm to the victims and their child/ren, and there is a continued need to ensure stable, accessible and affordable housing options for victims trying to separate from abusive relationships.

While there were some instances of coordinated case management across agencies, this appeared to be sporadic and often focused on either the victim or perpetrator, but not both parties.

There was also a lack of victim advocacy even when victims were engaged with specialist services, which is a key role of these agencies. On some occasions, victims were responsible for managing their own safety, including being required to negotiate complex referral and support pathways.

Current reforms which aim to improve the delivery of specialist services and supports to victims are considered in this chapter, with a view to improving engagement and safety outcomes.

Enforcement, safety and protection

In this reporting period, the Board had a clear focus on perpetrator accountability, particularly service responses to high risk and recidivist perpetrators of domestic and family violence.

Accordingly, the Board commissioned researchers to conduct a systematic review of criminal justice responses to domestic and family violence. This review focused on four areas: police, courts, corrections and multi-agency interventions.

A key finding from this report was the lack of robust evidence about what works to reduce recidivism in Australia.

In five cases considered by the Board, perpetrators had been referred to men's behaviour change programs to address their abusive behaviours. Issues were identified during the case review process with program availability, accessibility and appropriateness. Being mindful that, at all times, the safety and protection of the victim and their children must be prioritised, potential opportunities for enhancement in this area are considered.

Mechanisms to monitor high risk domestic and family violence offenders have been enacted in some jurisdictions, through enhancing legislative powers that initially focused on high risk sexual offenders. This approach is resource intensive and relies upon robust risk assessment processes.

Such initiatives are complicated within the context of domestic and family violence, given the known underreporting of this type of abuse.

Service integration and responsiveness

There is an increasing focus on integrated service responses to domestic and family violence as a way to reduce secondary victimisation and prevent victims from falling through the gaps.

In cases reviewed in this reporting period, the Board identified a fragmented approach to service provision. This was evident even in those cases where an integrated service response was known to be operating at the time of the deaths. Although there was some evidence of collaboration, agency responses were generally reactive to crisis, with services largely operating in isolation of one another.

To address this issue, a cohesive integrated service response is required, which includes cross-agency consideration of victim safety and perpetrator accountability through dynamic case planning and risk management processes. By harnessing and coordinating the collective efforts of multiple agencies, outcomes for victims and their children can be significantly improved.

All service providers, including GPs and mental health practitioners, play a role in ensuring that both victims and perpetrators receive a consistent, standardised and culturally informed service response, wherever they come into contact with services.

Recommendations

The Board is established to make recommendations to the Attorney-General for implementation by government and non-government entities to prevent or reduce the likelihood of domestic and family violence deaths in Queensland.

A key consideration throughout the Board's case review process has been the significant reforms currently underway across Queensland that aim to improve protective outcomes for victims and their children, and hold perpetrators to account.

While not discounting the significance of the issues identified from the reviews conducted within this reporting period, the Board recognises that some reforms may take time to embed within practice.

Accordingly, recommendations made by the Board in this reporting period aim to enhance this existing program of work or address identified systemic gaps. It is also hoped that the key learnings outlined in this report can be used to inform planning and implementation processes.

For such reforms to be effective, there must be a sustained focus and commitment to achieve intended outcomes, and to ensure that the current momentum is sustained over time.

Based on its review of these deaths, and in accordance with section 91D (e) of the Act, the Board therefore makes the following recommendations to the Attorney-General.

1. That the Queensland Government consider what services or programs are available to support children who experience or witness domestic and family violence across the state. These should be domestic and family violence informed, with a focus on early intervention and prevention, as well as targeted services to respond to children who have, or are, experiencing domestic and family violence, with a view to enhancing their availability and accessibility.

This should also include consideration of how to better identify and respond to cumulative harm; the roles and responsibilities of family support services in providing domestic and family violence informed assistance to at-risk families; and opportunities to expand existing culturally appropriate, trauma informed counselling services for children.

2. That the Department of Child Safety, Youth and Women ensure current efforts that aim to build workforce capacity include the delivery of appropriate multi-cultural competency training to both specialist and mainstream service providers to enhance responses to people experiencing domestic and family violence from culturally and linguistically diverse backgrounds.

This should take into consideration, but not be limited to, cultural risks and protective factors, different patterns of service engagement, and potential barriers to service access for both victims and perpetrators.

3. Noting that the Third Action Plan of the *Queensland Domestic and Family Violence Prevention Strategy 2016-26* will soon commence development, the Board recommends that a priority area of focus include improving system responses to victims and perpetrators of domestic and family violence from a culturally and linguistically diverse background.

This should aim to extend upon those activities already undertaken as part of the delivery of the Second Action Plan, and focus on enhancing the capacity of community members, including identified female leaders, to implement locally-led solutions, which build on initiatives currently underway at a state and national level.

4. That the Department of Child Safety, Youth and Women establish an appropriately resourced service to provide specialist consultancy advice and assistance to mainstream organisations who are providing support to victims and perpetrators of domestic and family violence from a culturally and linguistically diverse background.

This service should have sufficient expertise to provide advice about state and national legal and support services and systems to assist people from culturally and linguistically diverse backgrounds to understand and navigate these systems.

5. That Queensland Health and the Queensland Police Service examine the role of clinical forensic evidence in securing convictions for non-lethal strangulation within a domestic and family violence context, with a view to identifying opportunities for improvement and standardisation in processes.

6. That Queensland Health explore opportunities to increase public health clinicians' (including ambulance officers, accident and emergency staff, drug and alcohol services, mental health clinicians) knowledge of the signs of, and appropriate responses to, non-lethal strangulation within a domestic and family violence context.

This should include an evaluation of the current Queensland Health training modules (i.e. Understanding domestic and family violence, Clinical responses to domestic and family violence) to ensure they include relevant information to assist health practitioners identify and respond to non-lethal strangulation.

7. That the Queensland Police Service evaluates their existing training in relation to domestic and family violence to increase frontline responding officers' knowledge of the signs of, and appropriate responses to, non-lethal strangulation.
8. That Queensland Health explore data-linking opportunities with other relevant departments to improve the evidence base regarding the ongoing health impacts of non-lethal strangulation.
9. That the Royal Australian College of General Practitioners explore opportunities to increase general practitioners' knowledge of the signs of, and appropriate responses to, non-lethal strangulation within a domestic and family violence context, inclusive of appropriate referral pathways.

10. That the Queensland Government funds the development of a training package or module for professionals from generalist services (e.g. mental health services, child safety services, psychologists, general practitioners, alcohol and other drug treatment services). This should focus on how to respond to perpetrators, maintain the safety of victims and their children, and align with the *National Outcome Standards for Perpetrator Intervention Programs*.

This training package/module should be made available to all organisations, services and agencies who may come into contact with perpetrators of domestic and family violence.

11. That the Department of Child Safety, Youth and Women explore ways of supplementing men's behaviour change programs with initial and/or ongoing motivational work to support treatment adherence, reduction in recidivism risk, and improved safety for victims of domestic and family violence.
12. That the Department of Child Safety, Youth and Women conducts a feasibility study about the use of online men's behaviour change programs.

This study should:

- » focus on whether programs delivered in this modality are effective;
- » identify specific cohorts, contexts, and localities where this modality may be suitable (e.g. rural/remote, treatment-resistant perpetrators, young people);
- » be developed using the collective knowledge of experts in this area; and
- » be informed by, and adhere to, relevant best practice safety standards to ensure the protection of victims and their children remains a paramount priority.

13. That Primary Health Networks throughout Queensland play a leadership role in training and workforce development initiatives that seek to improve cross-agency responses to domestic and family violence within primary health care settings.

This should focus on enhancing local partnerships between specialist domestic and family violence support services, and primary health care providers.

Monitoring of recommendations

A critical component of any death review mechanism is the capacity to monitor, and report on, recommendations made throughout the review process. This ensures due consideration is given to the recommendations by agencies, and that these entities are also accountable for reporting on progress towards implementation.

Accordingly, under section 91D(1)(f) of the Act, the Board is required to monitor and report on the implementation of recommendations made to the Attorney-General during that financial year, or previous financial years.

In October 2018, the Queensland Government formally responded to the recommendations made by the Domestic and Family Violence Death Review and Advisory Board in its inaugural 2016 – 17 Annual Report (Appendix F).

The Queensland Government response noted that of the 21 recommendations, 11 were accepted, seven were accepted in principle, two accepted in part and one noted. The response committed to several new actions and highlighted current and planned initiatives which align with the tenets of the Board's report, as well as recommendations set by the Special Taskforce in 2015.

The Board welcomes this commitment by the Queensland Government and particularly acknowledges:

- » agreement to develop a specific suicide prevention strategy for implementation in domestic and family violence refuges supported by targeted risk management training;
- » trial placement of two Domestic and Family Violence Coordinators in the QPS Brisbane Police Communications Centre for a period of six months in 2018-19 which will provide frontline officers with access to dedicated, specialist support;
- » the imminent commencement of an Alcohol and Other Drug Clinical Practice Leader position within the Department of Child Safety, Youth and Women; as well as plans to commission a Domestic and Family Violence Workforce Capacity and Capability service;
- » plans to establish a new 42-bed alcohol and other drug residential rehabilitation and treatment facility which will include two family units;
- » the proposed participation in the STACY project, a research project being undertaken with the University of Melbourne focused on the concurrence of parental mental health, alcohol and other drug problems in families experiencing domestic and family violence and supporting practitioners to better respond to these complex issues;
- » the trial of three joint QPS and child safety investigation teams; and
- » placement of four child safety officers at QPS headquarters to streamline and facilitate timely exchange of relevant information.

In addition to these specialist and targeted responses, there are a range of other initiatives that will contribute more broadly to improved outcomes for victims and their families. For example, Queensland Health is currently developing a three year *Queensland Aboriginal and Torres Strait Islander Maternity Services Action Plan* which will facilitate access to culturally appropriate and responsive maternal health services and coordinate targeted services.

In accordance with its statutory functions, the Board will continue to monitor progress towards implementation of the 2016-17 recommendations, as well as those made within this report. It is particularly interested in the outcome of the review of the *Child Protection (Offender Reporting and Offender Prohibition) Act 2004* (CPOR Act) to consider broadening the scope of offences subject to monitoring provisions.

Although the Board welcomes the Government's response to its 2016-17 Annual Report, there is a need to ensure we do not solely rely on the progress and actions arising from the Special Taskforce report where new issues are identified.

In establishing the Board to capture and articulate learnings from deaths by domestic and family violence, the Queensland Government acknowledged the ongoing need to harness critical lessons from domestic and family violence deaths and maintain commitment, focus and resourcing to this important reform agenda. This approach recognises that work must continue beyond the Special Taskforce report and that we have an obligation to maintain momentum.

One of the greatest opportunities afforded by the systemic review of these types of deaths relates to its ability to identify nuances and emerging trends. In that sense, although there is an opportunity to incorporate the recommendations made by the Board into existing or other ongoing reform activities, care must be taken to ensure that critical detail is not lost in doing so. This can be easily overcome by ensuring thorough analysis, evaluation and review of initiatives to ensure they are appropriately optimised to incorporate the findings and specific elements of the Board's recommendations; or if there is no possibility of adding to current initiatives, that steps are taken to develop new actions where warranted.

Finally, although the Board welcomes the Queensland Government's clear commitment to enhancing the system response and recognises the significant work being undertaken across government agencies, it reaffirms its strong concern about the absence of a distinct culturally appropriate strategy to address family violence and the unique needs of Aboriginal and Torres Strait Islander families and communities.

The Special Taskforce considered this issue as part of its thorough and important review, but did not make specific recommendations despite the disproportionate rate at which violence affects this vulnerable cohort. In that sense, Recommendation 20 of the 2016-17 Board report is perhaps the most critical given it represents a clear and compelling new call for action.

The Board intends to continue its consideration of family violence and its impact on Aboriginal and Torres Strait Islander Queenslanders in 2018-19 through the review of youth suicides where family violence was identified as a prevailing issue for the deceased.

Overview

This section provides an overview of key activities undertaken by the Board throughout the 2017–18 financial year. The discussions and findings of the case review meetings held by the Board during this reporting period are explored in further detail in subsequent chapters.

Death review processes are a key component of a robust service system response to domestic and family violence. They function for the purpose of learning from tragedy, with the aim of improving systems, services and practice, and preventing future deaths.

Accordingly, the Board is established under section 91A of the *Coroners Act 2003* to:

- » identify preventative measures to reduce the likelihood of domestic and family violence deaths in Queensland;
- » increase recognition of the impact of, and circumstances surrounding, domestic and family violence and gain a greater understanding of the context in which these types of deaths occur; and
- » make recommendations to the Attorney-General for implementation by government and non-government entities to prevent or reduce the likelihood of domestic and family violence deaths.

During this reporting period, the Board submitted its first Annual Report to the Attorney-General for the 2016-17 financial year, which made 21 recommendations that aim to enhance service accessibility, availability and appropriateness.

To promote key findings of this report, throughout the year, Board Members and the Board Secretariat presented at a range of conferences and other forums, including:

- » *Working together to reduce the impact of domestic and family violence in our community*, Central Queensland Family Law Pathways Network (28 September 2017).
- » *Brisbane Region High Risk Team forum* (29 January 2018).
- » *Queensland Magistrates Conference 2018* (27 – 28 February 2018).
- » *ANROWS National Conference on Violence against Women and their Children* (15 – 17 May 2018).

On 8 May 2018, the Board also held a public forum to discuss lessons learned from its first year of operation and the key findings of its inaugural Annual Report.

This forum was opened by the Attorney-General, the Honourable Yvette D’Ath MP, and the Domestic and Family Violence Implementation Council Chairperson, Ms Kay McGrath OAM, provided a welcoming address.

The relationship between the Board and the Implementation Council was further strengthened this year, with the Board submitting six monthly updates to Council in accordance with reciprocal reporting arrangements established in October 2016.

In its 2016-17 Annual Report, the Board identified a need to focus on service responses to perpetrators as a priority area for 2017-18. This included:

- » considering ways to improve protective outcomes for victims;
- » to further ensure opportunities for intervention are more readily accessed and utilised; and
- » to explore opportunities for enhancing processes to better identify and monitor high risk perpetrators who present a sustained and extreme risk to others.

To fulfil this commitment and to address issues identified within this year's case review meetings, the Board engaged the University of Queensland (UQ) to complete a systematic review of criminal justice service responses to high risk and recidivist perpetrators of domestic and family violence.² This report also considers how to improve victim engagement with the criminal justice system.

The systematic review has been published alongside this report, and represents a valuable analysis of high quality research to inform service responses now and into the future. Findings from the UQ report have been taken into account by the Board in making its recommendations in this reporting period.

The Board also held four full-day case review meetings to consider 20 cases involving 30 deaths, with the majority of these deaths occurring between 2015 and 2017.³

Cases were selected based on the type of death, the extent of identifiable service system contact, and the availability of information.⁴

In this year of operation, the Board sought to extend upon its findings and recommendations from the 2016-17 Annual Report, and considered the following types of cases:

- » the deaths of people from a culturally and linguistically diverse background;
- » homicides in a family relationship;
- » intimate partner violence homicide suicides; and
- » female perpetrated homicides and collateral homicides (male deceased).

This has allowed the Board to *extend the conversation* about domestic and family violence deaths in recognition that, while there may be common themes and issues, there is also great diversity.

A key finding of this year's report is the need to better understand how systems intersect to identify and protect those at risk of harm. Significantly, even where individual agency actions accorded with legislation, policy and practice requirements, they were ultimately unable to keep the victim and their children safe from harm, and to prevent the fatal outcome.

Another key area of concern is the variability in agency responses to victims and/or perpetrators which meant that there was inconsistent service responses over time, even if one agency's actions met expected standards.

This highlights the need for a strong framework of protection for victims, and accountability for perpetrators, across the service system to ensure consistency in responses, irrespective of where someone presents for support or assistance.

It is also clear that the impact of domestic and family violence in our community does not just end when an abusive relationship finishes.

The impact can be felt across generations, as identified within the Board's review of homicides within a family relationship. It can also be experienced over the life course, with repetitive patterns of victimisation and perpetration being identified in multiple intimate partner and family relationships preceding the death/s for both victims and perpetrators.

Inclusive of the four case review meetings, there were seven ordinary Board meetings and the public forum.

Board Members are remunerated in accordance with the *Remuneration procedures for part-time chairs, and members of government bodies*. The State Coroner in his role as Chairperson, and public sector employees who are Board Members are not paid fees.

In accordance with Queensland Government requirements, actual fees for all Members are reported in Appendix A.

² Under Section 91D(1)(c) of the *Coroners Act 2003*, the Board has the function to carry out, or engage other persons to carry out, research to prevent or reduce the likelihood of domestic and family violence deaths.

³ All but two deaths occurred between 2015 and 2017, with the two earlier deaths being included due to the relevance of other cases within the review meeting. This includes one in 2012; one in 2014; 15 in 2015; eight in 2016; and five in 2017.

⁴ Dependent on the complexity of the case, sometimes the Board will need to wait for other investigation processes to progress to the point that sufficient information is available to undertake a full review of the death/s.





Section 1

In accordance with section 91D(b) of the Act, the Board is required to analyse data and apply research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland. To achieve this, the Board must first bring together the stories of those who have lost their lives to domestic and family violence (Chapter 1). Data from the Queensland Domestic and Family Violence Homicide and Suicide datasets is then analysed, before commonalities and key issues are identified (Chapter 2). From there, with the intent of continually building on the Board's findings, these issues are discussed within the context of current research, policy initiatives and practice reforms.

This report seeks to *extend the conversation* from the Board's 2016-17 Annual Report, through an in-depth review of homicides in a family relationship (Chapter 3).

Consideration is then given to the past histories of violence victimisation and/or perpetration for the homicide deceased, the homicide offender and the suicide deceased (Chapter 4). This chapter also considers the impact of domestic and family violence on children, as they are often the forgotten victims of this type of violence. In recognition of the diversity of the Queensland population, the unique strengths and experiences of people from a culturally and linguistically diverse background are discussed in Chapter 5.

Chapter 1: Understanding the journey

The Board is established under the Act to increase recognition of the impact and circumstances surrounding domestic and family violence and to enhance understanding of the context in which these types of deaths occur.⁵

In fulfilment of this function, the Board brings together the stories and journeys of those who have tragically lost their lives to, or who have been otherwise affected by, domestic and family violence.

This chapter provides a brief summary of each of the cases reviewed by the Board within the 2017-18 reporting period to enhance understanding of the complex dynamics of domestic and family violence, and highlight the personal, familial and community impact of these types of deaths.

While distressing, these stories also demonstrate strength and resilience, often in the face of relentless and enduring violence. The courage of the victims in these cases must be acknowledged.

It is increasingly apparent that some of the perpetrators of violence considered in these cases also have a prior history of trauma or victimisation in other relationships, and personal histories of child abuse or maltreatment. While this does not excuse their use of violence, it highlights the critical importance of everyone working together to break this cycle of violence.

While the material may be confronting for some readers, the Board trusts that we can all learn from these tragedies to prevent future deaths.

The majority of these deaths occurred between 2015 and 2017, although two earlier cases⁶ were included given their relevance to the other cases reviewed by the Board in its meetings.

Cases have been de-identified to protect the identities of the deceased and their loved ones. Under section 91ZD of the Act, the Board is prohibited from publishing identifying details for cases, and as such, the circumstances of the death and the nature of the relationship between the homicide offender and deceased have been removed in some cases.

Danielle and Yumi

Yumi, a female in her late 40s from a culturally and linguistically diverse background, is alleged to have fatally assaulted her child before taking her own life.

In the year prior to the deaths, Yumi repeatedly sought advice and assistance from a range of agencies relating to her husband, Donald's, problematic substance use and abusive behaviours, and the couple's financial difficulties.

Yumi was physically assaulted by Donald on at least two known occasions prior to the deaths. Most notably, a number of years prior to the fatal event she sustained serious facial injuries after Donald attacked her. This episode of violence was not reported to police or other agencies until some years later when she made disclosures to her GP, police and other service providers.

During a period of separation, Yumi contacted police a number of times reporting that she was extremely fearful of Donald when he would show up to her residence uninvited and highly intoxicated.

It is apparent that police took limited action with respect to these reported episodes of violence. On one occasion, officers did talk to Donald, however, this was at Donald's instigation in relation to him requesting police tell Yumi that it was safe for him to return to the family home. There is no evidence that Yumi's concerns for her safety were ever explored further by officers.

While Yumi sought advice and support from other specialist support services and legal practitioners, little help was forthcoming, with agencies indicating that she appeared to be seeking information as opposed to direct assistance.

Yumi's GP was her primary source of support and he referred the couple for relationship counselling. While it was noted that a protection order was discussed with Yumi, this was recorded as being a 'last resort' with no further information as to why this was deemed to be the case.

No protection order between the couple was established at the time of the deaths. Donald's engagement with services consisted of contact with a public hospital within the context of an acute episode of alcohol intoxication and suicidal ideation, one month before the deaths.

Zara and Narinder

Zara, a female in her early 40s from a culturally and linguistically diverse background, was killed by her husband, Rohan. Zara's mother, Narinder, was also killed as a bystander in the incident.

Other family members sustained considerable injuries in the course of attempting to intervene in the fatal assaults.

Pending separation and Rohan's problematic substance use were noted to be prevalent factors in prior episodes of domestic violence against, and the actual homicide of, Zara.

In the years prior to the homicides, Zara withdrew from family and friends as she was embarrassed at the way Rohan would behave at social gatherings, including becoming highly intoxicated.

Although this abuse was known to informal supports, there was also a distinct absence of service system contact in this case which might have allowed for better understanding of, and responses to, the patterns of violence within the relationship.

One occurrence did come to the attention of police some nine years before the homicides, where officers sought a protection order listing Rohan as the respondent and Zara as an aggrieved. On this occasion, records indicate that Rohan threatened to kill Zara, her brother, and the couple's children.

At this time, a sense of embarrassment and cultural shame relating to the abuse was reported by Zara to police to be the primary barrier to help-seeking.

⁵ Section 91 A of the *Coroners Act 2003*.

⁶ From 2012 and 2014.

Malaya

Malaya, a female in her mid-40s from a culturally and linguistically diverse background, was killed by her intimate partner, Dennis, within one year of the commencement of their relationship.

After the dissolution of her relationship to her former husband, which may also have been characterised by domestic and family violence, Malaya began a 'secretive' relationship with Dennis. She was reluctant to disclose this relationship to family as the couple were residing together while unmarried.

Her reluctance to disclose the details of their relationship to her family was reportedly the catalyst to several episodes of domestic violence in the days leading up to, and on the day of, her death.

Police intervention was sought on only one occasion just two days prior to the fatal incident, at which time police made an application for a protection order naming Dennis as the respondent and Malaya as the aggrieved.

The following day, during a prolonged episode of domestic violence, Malaya sustained fatal injuries while trying to escape from Dennis. He was subsequently convicted of manslaughter and sentenced to a term of imprisonment.

Although service system contact in relation to domestic violence between Malaya and Dennis was limited, Dennis had an extensive history of prior violence perpetration in former intimate partner relationships. This included:

- » reckless driving while in the company of his partner and infant child, so as to cause fear;
- » acts of non-lethal strangulation and other forms of physical violence; and
- » repeated threats to kill.

Three protection orders had previously been established against Dennis (with multiple other applications withdrawn).

On one occasion he was convicted for unlawful assault occasioning bodily harm while armed and served a period of imprisonment, some four years before the fatal event. During this time he was referred by corrective services to a crisis support service, although his engagement was sporadic and time limited. Dennis disengaged from this service when his counsellor left.

Yasmin

Yasmin, a female in her mid-30s from a culturally and linguistically diverse background, was killed by her former intimate partner, Zach, while pregnant with his child.

Zach exhibited coercive controlling behaviours towards Yasmin both during and after the relationship had ended, including extreme sexual possessiveness.

The dissolution of the relationship two months prior to the homicide, which was initiated by Yasmin due to prior episodes of physical violence, resulted in a significant escalation in the frequency and severity of Zach's abusive behaviour. This included acts of stalking, persistent verbal abuse and harassment, property damage, and threats to kill.

Yasmin reluctantly remained in the country despite fears for her safety as Zach convinced her that, under the guise of child custody legalities, she could not leave Australia. This meant that she was isolated from her family supports, although she had strong connections with her local expatriate community.

Post-separation, Zach expressed homicidal ideation to a range of informal and formal supports, however, these threats never came to the attention of police.

While he was engaged with multiple service providers in the lead up to the death, Zach would repeatedly disengage from these supports. Across providers, there also appeared to have been an inadequate assessment of his potential risk of harm, including by mental health professionals.

This included when he displayed significant abusive or controlling behaviours such as reporting that he was not able to guarantee the safety of himself or others if he was discharged from a mental health facility shortly after a serious assault against Yasmin.

Zach's history of violence perpetration extended to previous intimate partner relationships, with two protection orders being established listing Zach as the respondent (with multiple other protection orders being applied for).

A protection order was in place at the time of Yasmin's death, listing her as the aggrieved, with Zach due to appear in court two weeks after the death for breaching the conditions of this order. On this occasion, he had prevented Yasmin from leaving after she attempted to end the relationship (an act of hostage-taking). Witnesses were ultimately required to intervene to stop this episode of violence.

Family and friends of Yasmin's expressed concerns about this abuse, and on occasion, tried to assist by attending services with her. Yasmin also had contact with a public hospital for assault related injuries inflicted by Zach, and sought help from specialist domestic violence support services with respect to her experiences of abuse.

Luka

Luka, a male in his early 40s from a culturally and linguistically diverse background, died as a result of intentional self-harm.

Luka had a significant history of mental illness, problematic substance use and domestic and family violence perpetration, which was noted to have escalated in the years preceding the death after he started using methamphetamines.

Records indicate that Luka was verbally, emotionally and physically abusive against multiple intimate partners. In particular, Luka was extremely jealous and increasingly paranoid after he separated from his partner, Monica, and returned to live with the mother of his biological daughter, Wendy. This coincided with escalating substance use and periods of psychosis, which triggered frequent contact with a range of services.

Because of Luka's erratic and aggressive behaviour towards both women, he was identified as a high risk respondent by police in mid-2015.

Luka's coercive controlling abuse included monitoring their movements, repetitive accusations of infidelity, physical abuse, and acts of non-lethal strangulation. During certain periods, he was recorded as concurrently perpetrating abuse against both Wendy and Monica.

Although underlying issues of suicidal ideation, problematic substance use and morbid jealousy were consistently identified during Luka's intermittent engagement with mental health services, there was limited evidence of targeted interventions beyond pharmacotherapy.

Risk assessments generally identified Luka's risk of suicide or aggression as low, however, it was consistently noted that this risk was likely to increase significantly in the context of his persistent drug use. Luka was known to be non-compliant with his treatment plans and medication regime (partially because of his continued drug use).

Bradley, Maxine and Hayden

Bradley, a male in his early 50s, killed his daughter, Maxine, and grandchild, Hayden, before taking his own life.

Bradley was being managed by mental health services in the community under a Forensic Order after an attempted homicide-suicide event against other family members more than 10 years prior to the fatal event.

After a period of inpatient treatment, Bradley resided in the community with family under regular supervision, and after his wife died, Maxine and Hayden moved into the home to provide care and support for Bradley.

Bradley's family life was characterised by violence and he was identified as both a perpetrator and victim in different relationships within the family unit. Additionally, abuse was commonplace within the extended family unit, which was noted to cause him significant distress. These abusive dynamics, including being subjected to threatening behaviour from his adult sons, were continuously noted as a stressor by his treating practitioners.

Despite this, Bradley's family were considered by his treating team to be a source of support and a protective factor.

Nicholas

Nicholas, a male in his mid-50s, was killed by his biological brother, Francis.

Francis had only moved back to Australia within a year of the death, and there are limited records indicating a history of violence between the siblings.

Police intervention was sought on one occasion in relation to reports of physical violence between the brothers, some 12 months before the death. It was ultimately assessed by responding officers that neither party appeared fearful of one another, and that both parties were intoxicated. The matter was subsequently finalised by police with no further action taken.

Much of the identifiable service contact in this case was in relation to Francis' use of violence against his wife, Jenny. Police applied for a protection order in the year before the death listing Francis as the respondent and Jenny as the aggrieved after an episode of violence between the couple.

On one occasion, Francis is reported to have non-lethally suffocated his child when they tried to intervene while he was assaulting their mother.

Both Jenny and Francis separately attended police stations seeking advice in the seven days before the fatal event. Jenny disclosed her concerns for the welfare of both brothers to police after she reported Francis was exhibiting increasingly erratic behaviour and Nicholas had verbalised an intent to harm Francis. Police provided advice to Jenny about varying the current conditions on her protection order.

Meanwhile, Francis reported that same day that Nicholas had been harassing him, including suspicions that he had stolen his passport. Police advised Francis that they were unable to assist as the matters were 'civil in nature'.

No further action was taken by police prior to the fatal assault several days later.

Mental illness (largely untreated) and problematic substance use were identified as issues for both brothers, with Francis reporting to police after the homicide that he had wanted to *kill the monster in the deceased*.

Neither Francis nor Nicholas had identifiable contact with mental health care providers proximate to the death for these apparent mental health issues.

Kevin

Kevin, a male in his late 20s, was fatally struck by his father, Barry, during a physical altercation at the family home. Despite this, the contextual history of this case identifies Kevin as the perpetrator of violence in both his intimate partner and family relationships.

Kevin was reportedly experiencing mental illness, fleeting suicidal ideation and problematic substance use in the years leading up to his death after the breakdown of a former intimate partner relationship. His behaviour was noted to deteriorate over time, including several suicide attempts, a significant increase in his alcohol consumption, an escalation in mood swings, and increasingly abusive behaviours towards others.

There was an absence of formal reports of violence within this case, although neighbours and other informal supports were aware the abuse was occurring.

Although Kevin was intermittently engaged with mental health services to seek help for anger management issues and suicidality in the context of alcohol abuse, he disclosed feelings of anxiety linked to the service engagement.

He ultimately disengaged from these services, with limited proactive follow up by practitioners being a noted issue.

On the night of the death, it is clear that there had been a prolonged abusive episode against multiple family members by Kevin. Neighbours called the police at one point, however, upon their attendance, the matter was finalised by officers as 'no offence detected' with no further action taken.

Bronwyn

Bronwyn, a female in her early 20s, was killed by her stepfather, Graham.

The relationship between Graham and Bronwyn's mother, Karen, was characterised by a pervasive history of intimate partner violence, and associated conflict between Bronwyn and Graham was identified in the records. It is clear that Graham blamed Bronwyn for relationship 'issues' he experienced with Karen.

He had also previously made threats to kill both Bronwyn and Karen, particularly during periods of relationship separation between the couple.

A protection order listing Graham as the respondent and Karen as the aggrieved was in effect at the time of Bronwyn's death, however, she was not a named person on the order.

While records were extensive in this case, including from police, child safety services and health care providers, there was a distinct lack of ongoing intervention or support provided to Graham to address his abusive behaviours.

There is also limited evidence of formal intervention or attempts to source appropriate support for Graham's underlying issues when disclosures of relationship conflict and violence were made to health care providers.

From an early age, Bronwyn was recorded as a subject child in child safety notifications as a result of the domestic and family violence perpetrated by Graham towards Karen. She was also subjected to extreme violence in multiple former intimate partner relationships, including sexual abuse and assaults during pregnancy.

In addition, prior episodes of physical violence were recorded between step-siblings, as well as between other family members. Graham also had a history of perpetrating domestic and family violence against his former intimate partner.

Jim

Jim, a male in his early 50s, was fatally struck during a (purportedly) random encounter with his estranged son, Shane. Shane was suspected to be under the influence of methamphetamines at the time, after having been released from prison just days prior to the fatal assault.

The history and dynamics of this relationship are somewhat unclear given the period of estrangement which preceded the fatal assault. Records indicate that Shane may have been experiencing trauma related symptoms associated with a prior history of childhood abuse perpetrated by Jim.

Although there was no identifiable service system contact by either child safety or police in relation to this alleged abuse, it is clear from disclosures made by Shane that this abuse had significantly impacted on his mental health and wellbeing.

Commencing in early adolescence and continuing into adulthood, Shane was involved in significant recidivist offending of both a violent and non-violent nature, often in the company of others. He served several periods of incarceration and was subject to numerous community based supervision orders, but was largely non-compliant with the conditions of his orders.

Although intervention and treatment plans were developed to address Shane's criminogenic risks and needs - namely, problematic substance use, domestic violence perpetration, unemployment and unstable accommodation - there were a number of barriers which prevented successful rehabilitation outcomes. This included, but was not limited to, Shane's poor treatment responsiveness due to a strong pattern of disengagement.

Notably, both Shane and Jim were recorded as perpetrators of intimate partner violence in other relationships.

At the time of the death, there was also a protection order in place listing Shane as a respondent and another female family member as the aggrieved after police responded to an occurrence in which Shane was verbally abusive, ripped a door off its hinges and destroyed personal property.

Sam, Riley and Edward

Sam, a male in his late 30s, is alleged to have killed his two children and himself. Sam lived in a separate dwelling at the same property as his estranged wife, Olivia.

There is indication that Sam perpetrated predominantly non-physical acts of violence against Olivia, including threats to harm the children and himself, from at least 18 months before the fatal event when she first expressed an intention to end the relationship. Sam's abusive behaviour escalated in the context of the couple's subsequent separation and his declining mental health, which triggered contact with a range of services.

A protection order was current at the time of these deaths, which required Sam (respondent) to be of good behaviour towards Olivia (the aggrieved) and the children (named parties). The order was established after an episode of violence in which police responded and assessed Olivia to be at significant risk of future harm.

A further condition was imposed on the order which prohibited Sam from accessing weapons and police seized firearms from the home, which remained in their possession at the time of the deaths.

During civil protection order proceedings, Sam entered into a Voluntary Intervention Order which required his attendance at a perpetrator intervention program. He completed four sessions with a program that aimed to enhance understanding by fathers of the impact of domestic and family violence on their children (although, he did not participate in further sessions as recommended by the service provider). Issues with program availability and accessibility were noted in this case, with the perpetrator intervention program only running every six months.

Sam also had ongoing engagement with a mental health service provider within the community for suicidal ideation and symptoms of Posttraumatic Stress Disorder relating to his experiences of childhood sexual abuse.

Vivian and Harry

Vivian, a female in her early 40s, was the victim of a severe and prolonged physical assault, including acts of non-lethal strangulation, perpetrated by her husband, Harry, after she expressed an intent to end the relationship.

Harry was subsequently arrested and remanded in custody until he was released on bail some weeks later, with a protection order prohibiting him from contacting or approaching Vivian, and bail undertakings requiring him to reside at a specified location and report to police weekly.

Several weeks after being released on bail, Harry killed Vivian before taking his own life.

In the lead up to her death, Vivian was supported by several specialist domestic violence services and had contact with police and primary health care providers in response to financial, accommodation and counselling needs. Harry maintained contact with police pursuant to bail undertakings, as well as a primary health care provider for chronic health and mental health issues. He was noted to be non-compliant with his medication regime in the lead up to both assaults.

One of the couple's children was also admitted to a mental health facility in the lead up to the deaths because they were exhibiting signs of psychological trauma associated with their exposure to parental domestic and family violence.

While there is limited evidence of prior physical violence outside of these two abusive episodes, it is clear that Harry adhered to rigid gender roles within the family. Upon losing his capacity to work some years prior due to health issues, he struggled with Vivian being required to return to work and study to support the family.

Sophie and Alexander

Sophie, a female in her late 40s, was killed by her estranged husband, Alexander, before he took his own life.

Sophie and Alexander were married for over 30 years prior to their separation, some two years prior to the fatal event. Information suggests that Alexander was emotionally, psychologically and, to a lesser extent, physically abusive towards Sophie over the course of their relationship. The couple's son, Philip, also exhibited abusive behaviour towards the family and intimate partners, demonstrating a pattern of intergenerational violence within this familial network.

Sophie made several unsuccessful attempts to end the marriage, but was manipulated into reconciling with Alexander. This included him blaming her for breaking up the family and using her religious beliefs against her, citing that she was obliged to stay in the marriage for religious reasons.

The couple ultimately separated after an episode of violence in which Alexander attempted suicide and threatened to burn the family house down. Police responded on this occasion and made an application for a protection order listing Alexander as the respondent. He was also transported to hospital under an Emergency Examination Order before being admitted on a Recommendation for Assessment.

A protection order was issued thereafter, and Alexander engaged with mental health services (both public and private) in relation to his suicidal behaviours and longstanding depression.

A range of stressors were identified in the familial setting at this time, including Alexander's mental health and problematic substance use, and ongoing concerns with their son in the context of his anti-social, criminal behaviour.

Due to a lack of alternate accommodation options, Alexander was discharged into the care of Sophie. The couple subsequently maintained shared living arrangements for several years until Sophie was forced to move approximately one month prior to the deaths because of the ongoing abuse.

The dissolution of the relationship and relocation of Sophie and the couple's daughter, Eloise, saw a considerable escalation in Alexander's perpetration of violence towards Sophie.

Notably, Alexander was engaged with mental health services as an outpatient during this time, however, the service did not identify any associated deterioration during this time.

He was also intermittently engaged with private practitioners for a number of years prior to the deaths. While he was initially assessed as having Category B personality traits, including narcissism and anti-social behaviours, this diagnosis was dismissed by his treating practitioner.

Brittany and Jeremy

Brittany, a female in her early 20s, was killed by her estranged intimate partner, Jeremy, before he took his own life. Jeremy had a significant history of prior criminal offending and domestic violence perpetration with a former intimate partner.

Records indicate that Jeremy was both physically and sexually abusive towards Brittany and he threatened her with significant harm if she were to leave the relationship. He also used his criminal connections as a means of exerting further control against her.

With the support of a specialist domestic violence service, Brittany contacted police seeking assistance to leave the violent relationship. Police subsequently applied for a protection order and she was case managed as part of a high risk response after Jeremy repeatedly breached the conditions of this order.

Jeremy was sentenced to a term of imprisonment for contravening the no-contact conditions of the order after he made repeated suicide threats and threats to harm Brittany and her family.

During this time, Brittany was supported by services to move interstate, although she ultimately returned home.

Upon Jeremy's release from custody, no further episodes of intimate partner violence were reported between the couple, up until the weeks prior to the fatal assault.

Julian

Kylie, a female in her early 20s and the homicide offender in this case, was the victim of a severe physical assault perpetrated by her estranged partner (and the deceased), Julian, in the week leading up to his death. This included an act of hostage taking and non-lethal strangulation after Kylie attempted to end the relationship.

While much of the available information documents only those (reported) acts of violence which followed the couple's separation in the week immediately preceding the fatal assault, it is apparent that Julian was physically abusive towards Kylie over the course of their relationship. This violence escalated in frequency and severity in the final two months of their relationship.

Service system contact for both Julian and Kylie was particularly prevalent in the one month preceding the fatal assault. Kylie sought emergency accommodation and counselling support from specialist support services, as well as police intervention to retrieve her belongings, after she sustained severe injuries in an assault by Julian.

The police response in the weeks leading up to the death, including in the 24 hours prior, was limited and contravened established procedures. This included a failure to appropriately investigate or even record their attendance at the scene of the unlawful wounding offence (perpetrated against Kylie by Julian).

Julian, too, required police and medical intervention during this time after he was assaulted by a member of Kylie's family in an apparent act of retribution against him.

While Kylie was with another family member, Julian attended the premises and was fatally stabbed during an altercation.

Julian had a prior history of intimate partner violence perpetration with two former partners, which included physical violence (punching, kicking and spitting), coercive controlling behaviours such as controlling what they wore and who they contacted, and threats to harm himself or others.

Jonathon and Tiffany

Jonathon, a male in his early 30s, was killed by his intimate partner, Tiffany. After serving a period of incarceration in relation to this offence, Tiffany died by suicide shortly after being released to parole.

Records indicate that throughout her life, Tiffany, who identified as Aboriginal, was subject to repeated abuse across multiple intimate partner relationships. Post homicide, she also disclosed having substance dependency issues from a young age to cope with her unmet mental health issues and to deal with underlying trauma associated with this abuse history.

Jonathon and Tiffany's relationship commenced around seven years prior to the homicide, with issues of mutual problematic substance use and domestic and family violence being pervasive in the relationship.

Jonathon was identified as the primary perpetrator of violence in the majority of episodes of violence. The records identify that Jonathon inflicted serious physical violence against Tiffany on numerous occasions, including acts of non-lethal strangulation, as well as verbal and psychological abuse.

Tiffany was also listed as the respondent in two episodes of domestic violence requiring police intervention; the first matter was classified as a 'DV Referral' after Tiffany reportedly punched Jonathon during a verbal altercation while he was drunk, and the second matter was recorded as 'No DV' after Tiffany kicked in his front door demanding somewhere to sleep.

However, these acts of violence were not commensurate with the abuse she experienced at the hands of Jonathon. Jonathon ultimately served a period of incarceration for breaching the conditions of a protection order listing him as the respondent and Tiffany as the aggrieved.

He was also recorded as the respondent in multiple other domestic violence occurrences involving a former intimate partner, and a private application for a protection order was granted by the courts for this relationship.

Percy

Percy, a male in his mid-50s, was killed by his intimate partner, Tamara, after an argument between both parties escalated into physical violence.

The couple had only recently commenced their relationship and there was evidence that they had just separated, however, were still living together at the time of the fatal assault.

While there is a general paucity of known service system contact between the couple in this case, it is apparent that police intervention was sought by Tamara two months prior to the death in relation to an episode of domestic violence. On this occasion, Tamara alleged Percy refused to leave the premises and had withheld access to her child (from a different relationship).

On a separate occasion, Tamara contacted emergency services and stated that an argument had occurred between her and her 'roommate', Percy, whom she also identified as a former partner.

Neither of these service contacts were recorded as domestic and family violence related by police, although it was evident upon receipt of call recordings that Tamara had disclosed the couple were in a relevant relationship. She also expressed being afraid of the deceased as he would not leave the premises.

It is clear that Tamara had a personal history of prior victimisation from both intimate partners and other family members. This included being non-lethally strangled on at least three occasions, and being subjected to physical assaults, deprivation of liberty and emotional abuse. Percy had also been listed as a respondent on a protection order with a former spouse.

Michael

Michael, a male in his mid-40s, was killed by his new partner, Stephanie's, former partner, Simon.

Michael and Stephanie had only recently commenced an intimate partner relationship. The couple apparently met through Simon who had formed a friendship with Michael while they were incarcerated together.

Prior to their separation, Stephanie and Simon had been together for 10 years and their relationship was characterised by significant violence, including physical assaults, non-lethal strangulation, verbal abuse and threats to kill. While the couple's relationship was 'on and off' in nature, the violence remained constant.

Despite the presence of a protection order featuring no-contact conditions, violence continued, particularly in the context of conflict around child visitation and Simon's problematic substance use. On one occasion, Simon was charged with common assault, but police were unable to locate a statement that Stephanie had supplied and she opted to withdraw her complaint instead of providing another one.

Upon learning about the relationship between Michael and Stephanie, Simon sent abusive and threatening messages to the couple before he later confronted them at Stephanie's house and killed Michael.

Joshua

Joshua, a male in his early 30s, was killed by his former partner, Tara's, current partner, Dale.

Joshua commenced an intimate partner relationship with Tara six years prior, with violence starting after the birth of the couple's first child. Joshua was physically abusive towards Tara including multiple occurrences where she sustained head injuries and experienced a loss of consciousness. He also raped her and forced her to have sex repeatedly throughout their relationship.

Several months after the couple separated, Tara commenced an intimate partner relationship with Dale.

Joshua became suspicious that Tara was seeing another man when she began declining his sexual advances. He discovered Tara and Dale in bed together one day and confronted them both, before Dale pulled a shotgun on Joshua. After Dale left, Joshua threatened to kill Tara, their son and himself, and slashed her tyres on the way out.

One week later, Joshua again confronted Tara and Dale about their relationship, and when he approached Dale aggressively, he was killed by Dale.

Edwin

Edwin, a male in his late 30s, was killed by his new partner, Audrey's, estranged husband, Henry.

Edwin and Audrey had only recently commenced an intimate partner relationship several months earlier after the dissolution of Audrey's marriage to Henry.

This marriage had been characterised by sustained physical, sexual and emotional abuse perpetrated by Henry towards Audrey and their children. In particular, Audrey reported being raped, as well as experiencing prior physical assaults towards herself and her children.

This violence extended to other family members, whom Henry had previously threatened to kill on multiple occasions.

In the lead up to the death, Audrey applied for, and then requested to revoke, a protection order naming Henry as the respondent.

Police subsequently made their own application for a protection order in an effort to protect Audrey from further abuse, given the concerns they had about her safety.

Henry was engaged with public mental health services and a private practitioner for psychological intervention during this time.

Chapter 2: Expanding our focus

Key findings

- » Between 1 July 2006 and 30 June 2018, there have been 294 homicides in a domestic or family relationship in Queensland. This includes 153 intimate partner homicides, 122 homicides in a family relationship and 19 collateral homicides.
- » Females are significantly over-represented as homicide deceased in intimate partner homicide cases (4:1), with males disproportionately the homicide offender in these cases (80.8%).
- » In 2017-18, there were 40 apparent suicides in Queensland identified as domestic and family violence related. A male to female ratio of 4:1 was identified. In over three-quarters of these cases, the male suicide deceased was identified as the perpetrator of violence in the relationship.
- » People from a culturally and linguistically diverse background made up 13.9% of the domestic and family homicide cases, inclusive of 22 intimate partner homicides, 18 family homicides and one collateral homicide. The most common lethality risk indicators among this cohort were a history of domestic violence in the current relationship, prior attempts to isolate the victim, actual or pending separation, and a victim's intuitive sense of fear of the perpetrator.
- » Over one-half of the homicides in a family relationship involved children as the deceased. The presence of mental health issues was more pronounced among family homicide offenders than intimate partner homicide offenders. A reported history of domestic and family violence was, however, less prominent among family homicide cases. In this cohort there was also less likely to be contact with police and magistrates courts, but more likely to be contact with child safety services and mental health services (for the homicide offenders).
- » A total of 33 homicide-suicide events have occurred in Queensland since 2006, involving 40 homicide deceased and 33 suicide deceased. The majority of homicide deceased were female, with most homicide offenders/suicide deceased being male. The levels of contact with services were comparatively low in this cohort.
- » A total of 116 male homicide deceased were recorded in this period, accounting for two-fifths of all homicides. More males died in family homicides (n=65) in comparison with intimate partner homicides (n=33) and collateral homicides (n=18). For female perpetrated intimate partner homicide cases involving a male deceased, where there was a recorded history of violence, in all cases the deceased male was identified as the perpetrator of domestic and family violence prior to the death.
- » Almost all of the collateral homicides featured a male deceased, with most involving a former abusive spouse killing their primary victim's new spouse, or a current partner killing their new partner's former abusive spouse. There was a history of violence in almost all of these cases, most often psychological abuse or physical violence against the male perpetrator's former female partner.

In carrying out its statutory function, the Board is required to analyse data and apply research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland.⁷

This chapter provides a statistical overview of homicides within an intimate partner or family relationship that have occurred in Queensland since 2006. It also reports on different subsets of the cases that were considered by the Board within this reporting period, specifically: the deaths of people from a culturally and linguistically diverse background, homicides within a family relationship, intimate partner homicide-suicides, and male homicide deceased.

The intent of this analysis is to support discussions in the following chapters around some of the unique characteristics and overarching similarities between these and other types of deaths.

An expansion of the existing database of apparent suicides in the context of domestic and family violence from 2015 is also featured in this chapter. This adds further weight to our understanding of a relatively large, but under recognised, category of domestic and family violence deaths.

Notably, there is likely to be some underreporting in the data as a proportion of these deaths pre-date the establishment of the domestic and family violence death review process in Queensland in 2011.⁸ It is further recognised that there may be instances in which a history of domestic and family violence prior to the death went undetected and/or unreported and therefore may be underreported within these statistics.

The data also includes open and closed coronial cases, and as such, it may be subject to change.

⁷ As per 591D of the *Coroners Act 2003*.

⁸ As death review processes specifically gather in information about the history of domestic and family violence, by their nature they are likely to lead to improvements in data quality.

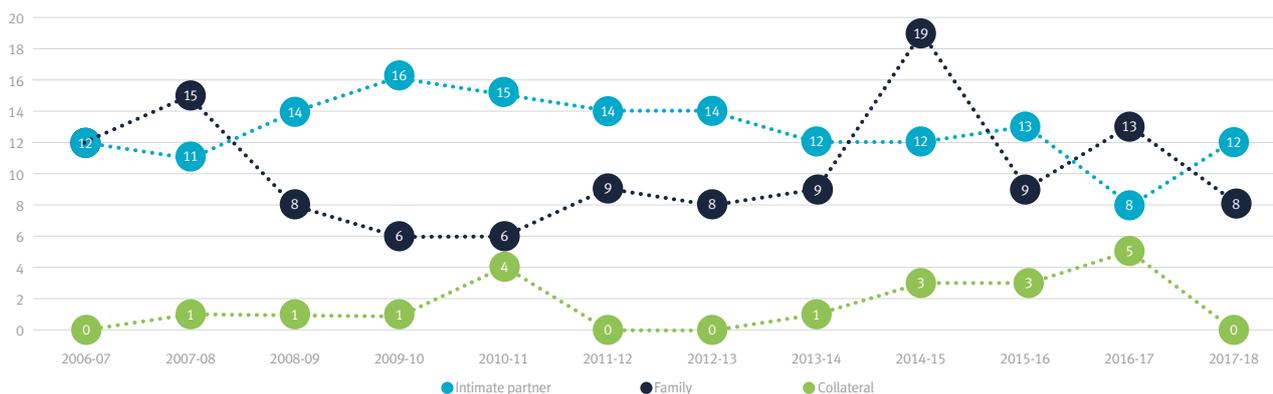
Homicides in a domestic and family relationship

Between 1 July 2006 and 30 June 2018, a total of 275 women, men and children were killed by a family member or by someone who they were, or had been, in an intimate partner relationship with.

A further 19 collateral homicides⁹ have also occurred in this period.

As shown in Figure 1, there have been 153 intimate partner homicides and 122 family homicides.

Figure 1: Domestic and family homicides, Queensland, 2006-07 to 2017-18



A total of 249 distinct homicide events occurred in this period, involving 294 homicide deceased and 278 homicide offenders.

Of the 249 homicide events involving one homicide deceased, the homicide offender was male in the vast majority of cases (Table 1). This was the case in intimate partner homicides, family homicides and collateral homicides.

Table 1: Gender of homicide offenders in single homicide event cases

	Male	Female	Male & female	Total cases
Intimate partner	118 (80.8%)	28 (17.8%)	1 (0.7%)	147
Family homicide	62 (72.1%)	19 (22.1%)	6 (5.8%)	87
Collateral homicide ¹⁰	15 (100.0%)	0	0	15

For the 19 multiple homicide events involving 45 homicide deceased, males were the offenders in 84.2% of cases.¹¹

Females were significantly over-represented as intimate partner homicide deceased (78.4%) (Figure 2). The deceased in collateral homicides were almost exclusively male.

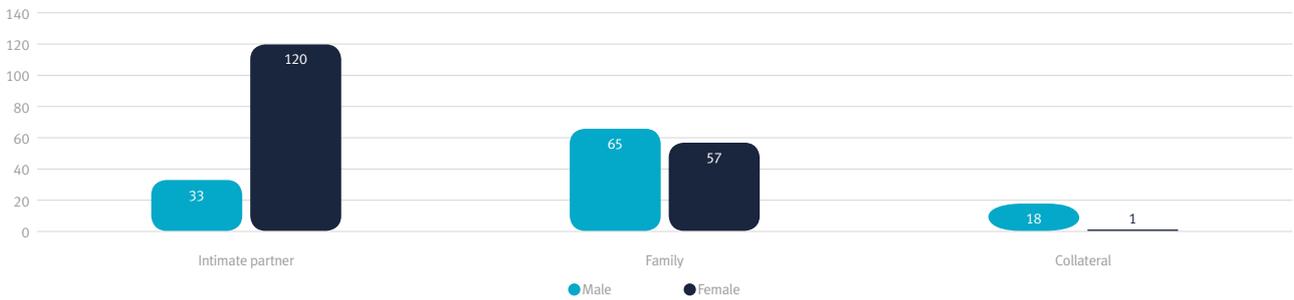
In contrast, there was little variability in terms of the gender distribution of family homicide deceased.

⁹ Collateral homicides include the death of a person who may have been killed intervening in a domestic dispute or a new partner who is killed by their current partner's former abusive spouse.

¹⁰ In one collateral homicide case, there were five homicide offenders (all male).

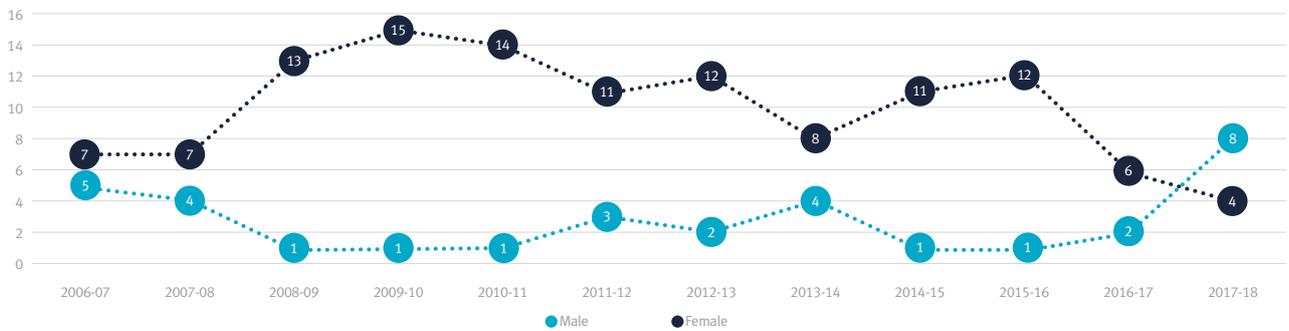
¹¹ Females were the homicide offender in 10.5% of multiple homicide events and in one event (5.3%) there were multiple offenders (one male and female).

Figure 2: Domestic and family homicides by relationship type and gender, 2006-07 to 2017-18



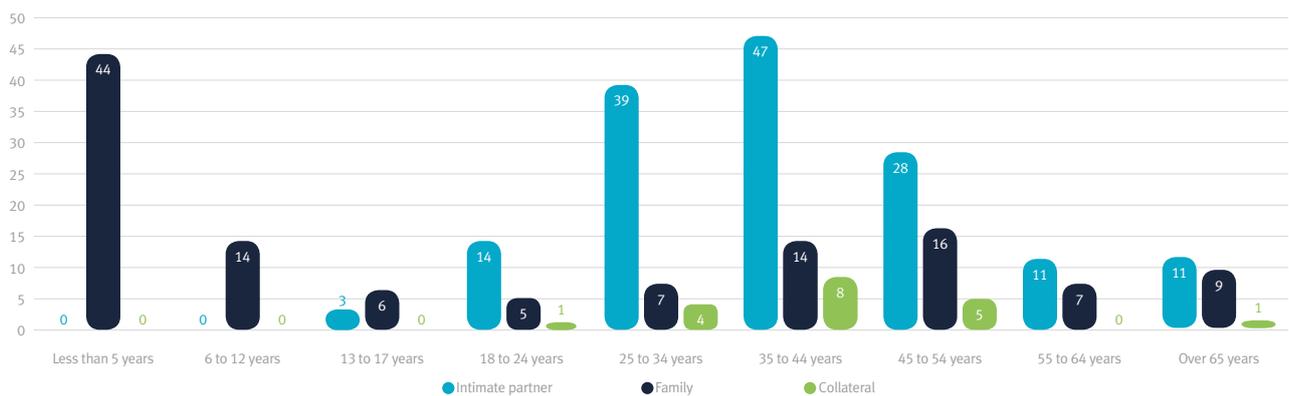
In 2017-18, there were more recorded intimate partner homicides involving male deceased than female deceased, for the first time (Figure 3).

Figure 3: Intimate partner homicides by gender of deceased, 2006-07 to 2017-18



The age of homicide deceased ranged from less than one day to 92 years, with the average recorded age being 33.8 years. For intimate partner homicides, the deceased was most likely to be aged 35 to 44 years or 25 to 34 years. In family homicides, children aged less than five years represented the highest number of deaths (Figure 4).

Figure 4: Domestic and family homicides by relationship type and age group, 2006-07 to 2017-18



Slightly more than one-half (52.5%) of all family homicide deceased were children. There was an even gender distribution for child homicide deceased.

There were 42 single child homicide events, with males responsible for 61.9% of these deaths, females 26.2% and both male and female 11.9%. Of the nine multiple homicide events¹² featuring at least one child deceased, a male was the homicide offender in 66.7% of cases, with females responsible for the deaths in 22.2% and a male and female responsible in one case (11.1%).

Aboriginal and Torres Strait Islander people were over-represented among domestic and family homicide deceased, with one-fifth (19.7%) of all recorded deaths in this period involving a person who identified as Aboriginal and Torres Strait Islander. This is significantly higher than the proportion of the Queensland population (4.0%) that identifies as Aboriginal and Torres Strait Islander.¹³

Figure 5: Aboriginal and Torres Strait Islander status of domestic and family homicide deceased, 2006-07 to 2017-18



Aboriginal and Torres Strait Islander persons represented 18.3% of intimate partner homicide deceased (28 of 153); 22.1% of family homicide deceased (27 of 122); and 15.8% of collateral homicide deceased (3 of 19).

Between 2006-07 and 2017-18, there were 41 domestic and family homicide deceased who identified as culturally and linguistically diverse, representing 13.9% of all domestic and family homicides in Queensland in this period.¹⁴ Though not a complete indicator of cultural and linguistic diversity, it has been reported that 21.6% of the Queensland population was born overseas and 11.1% of people were born in a non-main English speaking country.¹⁵

Figure 6: Domestic and family homicides by ethnicity group, 2006-07 to 2017-18



Domestic and family homicides occurred across all police districts in Queensland. The highest number of recorded homicides occurred in the Northern region, with 78 deaths (or 26.5%) between 2006-07 and 2017-18. This is despite this region representing only 11.2% of the Queensland population.¹⁶

¹² This included four cases where only (multiple) children died and five cases where at least one child and one adult died in the homicide event.

¹³ Queensland Government Statistician's Office. (2017). *Aboriginal and Torres Strait Islander Peoples in Queensland, Census 2016*. Brisbane: State of Queensland. <http://www.qgso.qld.gov.au/products/reports/atsi-pop-qld-c16/atsi-pop-qld-c16.pdf>

¹⁴ From the database, culturally and linguistically diverse is defined as having ethnicity listed as other than Caucasian or nationality listed as other than Australian from various sources of data within the coronial file. Culturally and linguistically diverse specifically excluded Aboriginal and Torres Strait Islander people who have been identified in that particular category.

¹⁵ State of Queensland. (2018). *Diversity Figures June 2018*. Brisbane: Department of Local Government, Racing and Multicultural Affairs.

¹⁶ Queensland Police. (2018). *POLSI Profiles: Northern Police Region*. Brisbane: Author. <https://www.police.qld.gov.au/rti/published/about/orgStrct/Documents/Northern%20Region%20Resident%20Profile.pdf> Accessed 4 September 2018

Table 2: Domestic and family homicides, by Queensland police district, 2006-07 to 2017-18

	Intimate partner	Family	Collateral	Total
Brisbane Region	25	23	7	55
North Brisbane	11	12	2	25
South Brisbane	14	11	5	30
South Eastern Region	30	22	3	55
Logan	5	8	0	13
Gold Coast	25	14	3	42
Southern Region	29	20	5	54
Ipswich	10	6	0	16
Darling Downs	9	5	2	16
South West	3	3	0	6
Moreton	7	6	3	16
Central Region	30	19	3	52
Sunshine Coast	5	4	1	10
Wide Bay Burnett	7	6	2	15
Capricornia	11	8	0	19
Mackay	7	1	0	8
Northern Region	39	38	1	78
Townsville	13	4	1	18
Mount Isa	2	14	0	16
Far North Queensland	24	20	0	44
Queensland	153	122	19	294

Domestic and family violence homicides

A history of domestic and family violence was able to be established in 62.6% of all domestic and family homicide cases between 2006-07 and 2017-18. This is likely to be an under-representation given the known underreporting of domestic and family violence.¹⁷

A history of violence was most apparent in intimate partner homicides (70.6%) and collateral homicides (84.2%), compared with family homicides (49.2%).

Among intimate partner violence homicides where the deceased was female, the deceased was recorded as the victim of violence in 95.3% of cases. In two cases (2.3%), the deceased was identified as both a victim and perpetrator of violence, and in a further two cases (2.3%), the female deceased was identified as a perpetrator of violence.

In contrast, for intimate partner violence homicides with a male deceased, the male was the perpetrator of violence in the relationship in 68.2% of cases, and was recorded as both using and experiencing violence in a further 27.3% of cases.¹⁸

This is explored in further detail below.

¹⁷ Birdsey, E., & Snowball, L. (2013). Reporting violence to police: A survey of victims attending domestic violence services. *Crime and Justice Statistics, Issue paper 91*. Sydney: NSW Bureau of Crime Statistics and Research.

¹⁸ In one case, involving a male intimate partner homicide offender, the male deceased was recorded as the victim of violence in the relationship.

Separation was a feature in a significant proportion of cases where a history of domestic and family violence was identifiable. As outlined in Table 3, this was apparent in about one half of intimate partner and collateral homicide cases¹⁹, but rare in family homicide cases.

Table 3: Presence of separation in homicides with a history of domestic and family violence, 2006-07 to 2017-18

	Intimate partner		Family		Collateral	
	Number	Percent	Number	Percent	Number	Percent
Actual separation	32	29.6%	5	8.5%	9	52.9%
Pending separation	19	17.6%	5	8.5%	0	-
No separation	57	52.8%	49	83.1%	8	47.1%
Total	108		59		17	

The type of violence used in the relationship was recorded in 140 cases (76.1%). The most commonly recorded forms of violence were physical (42.1%), followed by psychological/emotional (28.6%), verbal (13.6%), and sexual (2.9%).

An escalation of violence was recorded in over one-third (34.2%) of cases. Other notable characteristics in the relationship included:

- » controlling behaviours (38.6%);
- » children exposed to violence (37.5%);
- » obsessive or jealous behaviours (36.4%); and
- » stalking (14.1%).

A protection order was established in almost one-third (32.1%) of homicides with a history of domestic and family violence.

Where the deceased was a female, she was listed as the aggrieved in almost all protection orders that were issued (Table 4). In contrast, for male deceased, only four were listed as aggrieved parties.

Table 4: Status of deceased on protection orders, 2006-07 to 2017-18

	Male	Female	Total
Aggrieved	4 (18.2%)	32 (86.5%)	37 (62.7%)
Respondent	10 (45.5%)	1 (2.7%)	11 (18.6%)
Cross-orders	3 (13.6%)	2 (5.4%)	5 (8.5%)
Named person	5 (22.7%)	2 (5.4%)	7 (11.9%)

A history of mental health issues, problematic substance use and suicidality was more prevalent among perpetrators than victims of violence (Table 5). Interestingly, the prevalence of these factors among female victims was higher when they were the homicide offender compared with when they were the homicide deceased. Whereas, among male perpetrators, there was little difference in these characteristics.

¹⁹ In collateral homicides this history of violence was not between the homicide offender and deceased as these deaths are best conceptualised as acts of associated domestic and family violence. The history is instead between either the homicide offender or deceased and a person they were in a relevant relationship with (such as a current or former intimate partner).

Table 5: Presence of problematic substance use, mental health and suicidality issues

	Victim of violence		Perpetrator of violence	
	Homicide deceased (n=123)	Homicide offender (n=25)	Homicide deceased (n=25)	Homicide offender (n=123)
Mental health issues	14 (11.4%)	8 (32.0%)	6 (24.0%)	41 (33.3%)
Problematic substance use	30 (24.4%)	10 (40.0%)	14 (56.0%)	62 (50.4%)
Suicide ideation	4 (3.3%)	3 (12.0%)	4 (16.0%)	21 (17.1%)
Suicide attempts	0	1 (4.0%)	1 (4.0%)	16 (13.0%)

Apparent domestic and family violence suicides

A domestic and family violence death includes the suicide or apparent suicide of a person who was, or had been, in a relevant relationship with another person that involved domestic and family violence.²⁰

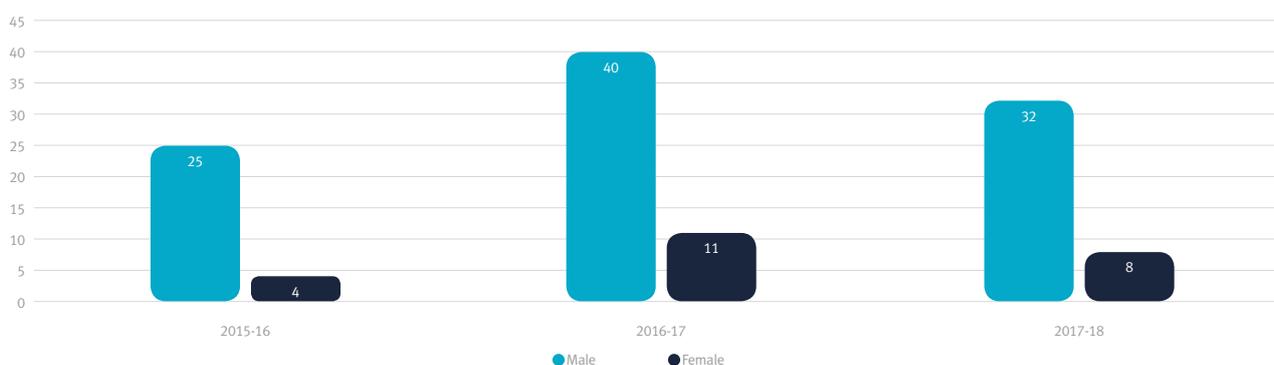
The Board reported on preliminary data in relation to apparent domestic and family violence suicides in its 2016-17 Annual Report, with continued refinements to the case identification and data collection processes since this time. This has resulted in a revision of data that was presented in 2016-17 as additional information has become available.²¹

From 1 July 2015 to 30 June 2018, there have been 120 apparent domestic and family violence suicides recorded in Queensland. This includes:

- » 29 apparent suicides in 2015-16;
- » 51 apparent suicides in 2016-17; and
- » 40 apparent suicides in 2017-18.

A male to female ratio of 4:1 was recorded across this period, which is reflective of general suicide trends, in which a greater proportion of men die by suicide than women (Figure 7).

Figure 7: Apparent domestic and family violence suicides by gender, 2015-16 to 2017-18

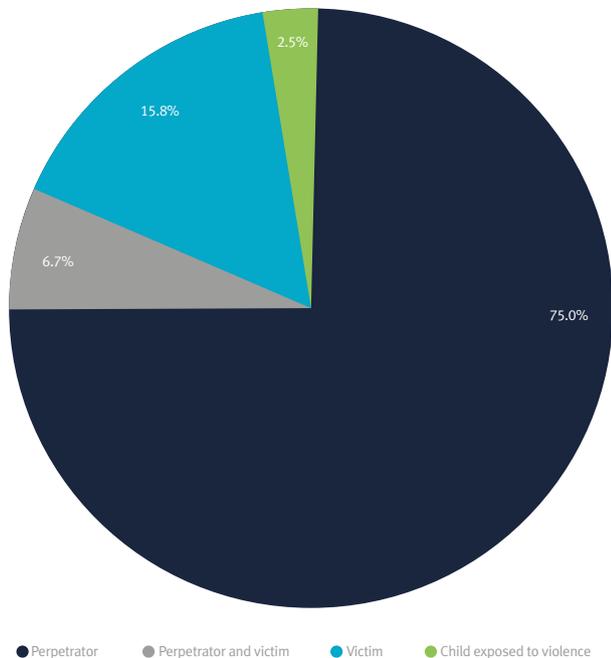


Similarly, most apparent suicide victims were identified as the perpetrator of domestic and family violence within the index relationship (Figure 8).

²⁰ Section 91B of the *Domestic and Family Violence Protection Act 2012*

²¹ It is important, however, to note that this data is preliminary, with the decision to classify a death as a suicide residing with the investigating coroner upon consideration of all available information.

Figure 8: Domestic and family violence role in apparent suicides, 2015-16 to 2017-18



Seventeen (14.2%) of the apparent suicide victims identified as Aboriginal and Torres Strait Islander. A similar proportion of cases involved people from culturally and linguistically diverse backgrounds (n=19; 15.8%).

There was a peak in apparent suicides in the 35 to 44 year age group (Figure 9), which is consistent with general age trends in suicide.²²

During this reporting period, there were five apparent suicides of children aged 10 to 17 years who were exposed to violence in their family of origin.

A history of mental health issues, either formally diagnosed or in the opinion of family and friends, was prevalent in over two-thirds of cases (68.3%). A recorded history of hospitalisation through Emergency Examination Orders (EEO) or Emergency Examination Authorities (EEA) was a feature in 30.8% of cases.

A prior history of suicide ideation (70.8%) and suicide attempts (48.3%) was also prominent.

Further, a history of problematic substance use was recorded in 67.5% of apparent suicides, with substance use recorded at the time of the death in 53 cases (44.2%).

Actual (55.0%) and pending (14.2%) separation was a feature in the majority of apparent suicides in this reporting period.

The most common form of recorded violence among the apparent suicide cases was physical (59.2%) followed by verbal (45.8%) and psychological and emotional (40.8%) (Figure 10). Children were reportedly exposed to domestic and family violence in 37.5% of cases.

²² Potts, B., Kolves, K., O’Gorman, J., & De Leo, D. (2016). *Suicide in Queensland: Mortality rates and related data 2011-2013*. Brisbane: Griffith University.

Figure 9: Age distribution of apparent suicides, Queensland, 2015-16 to 2017-18

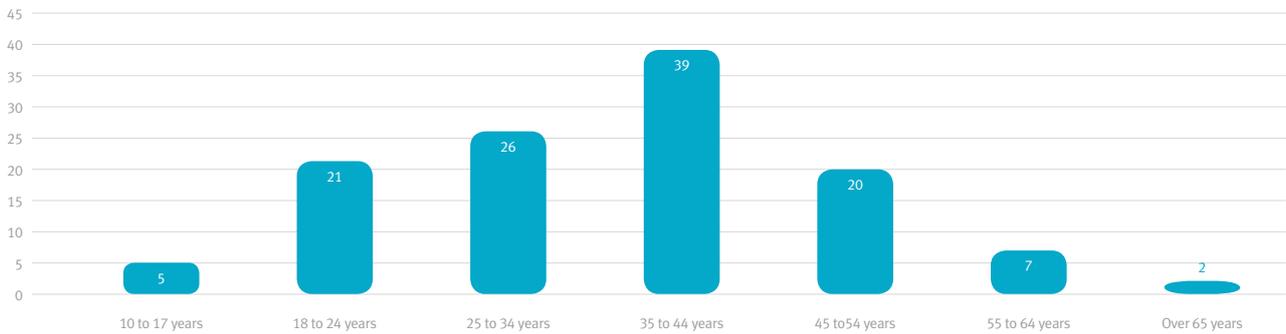
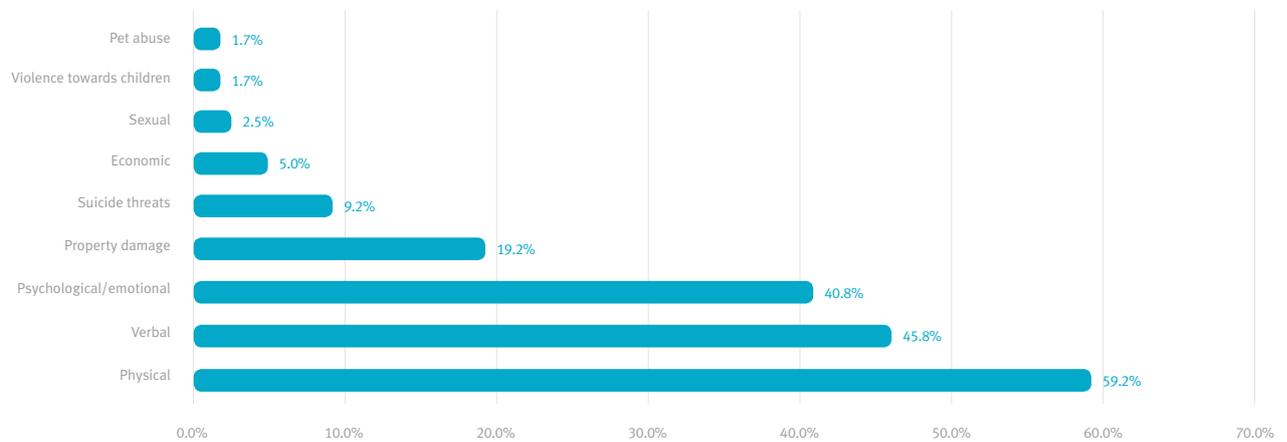


Figure 10: Forms of domestic and family violence, apparent suicide cases, 2015-16 to 2017-18



Domestic violence protection orders were in place in 61.7% of the cases. Where the deceased was male, they were most likely to be the respondent on the protection order (Table 6). In contrast, for female deceased who had a protection order in place at the time of the death, on each occasion they were listed as the aggrieved.

Table 6: Status of deceased on protection orders, 2015-16 to 2017-18

	Male	Female	Total
Respondent	57 (87.7%)	0	57 (77.0%)
Aggrieved	2 (3.1%)	9 (100.0%)	11 (14.9%)
Cross-orders	5 (7.7%)	0	5 (6.8%)
Named person	1 (1.5%)	0	1 (1.4%)

Cross-orders were in place in 6.8% of cases, and in one case, the suicide deceased was a child who was listed as a named person on a protection order. A breach of protection orders was recorded in over one-half (56.8%) of cases when a protection order was in place.

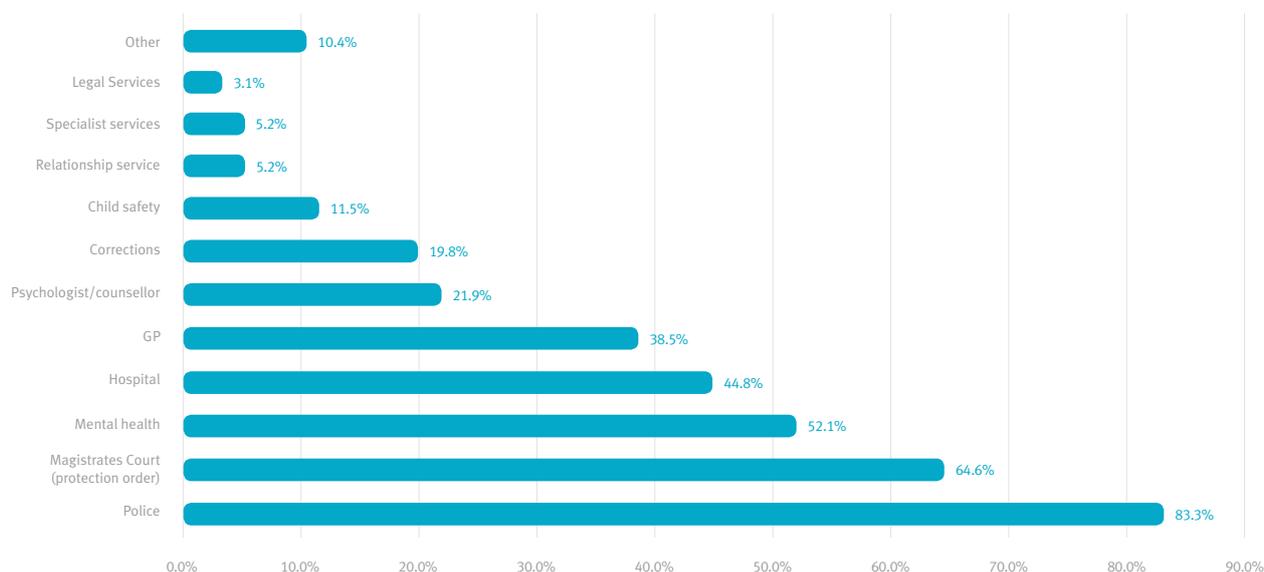
There was evidence of the domestic and family violence escalating prior to the suicide in 45.0% of cases. In over three-quarters (75.9%) of cases, this was in the context of relationship separation.

Preliminary review of these service system records²³ indicates that police had contact with suicide victims in 83.3% of cases (Figure 11).

There was also a high prevalence of contacts with mental health services, hospitals and private practitioners (e.g. GPs, psychologists), which is different to the pattern of service system contact for domestic and family violence homicide cases (see Figures 13 and 14).

²³ Records were available for 96 cases, with a history of contact with services recorded in 89 cases (92.7%).

Figure 11: Service system contact, apparent suicides, 2015-16 to 2017-18



People from a culturally and linguistically diverse background

Between 2006-07 and 2017-18, 41 of the 294 homicides within an intimate partner or family relationship involved victims from a culturally and linguistically diverse background (13.9%).²⁴

This included 22 intimate partner homicides and 18 homicides in a family relationship, the latter being inclusive of nine child victims and nine adult victims. There were six homicide-suicides involving eight homicide deceased who were from a culturally and linguistically diverse background.

For homicides in a family relationship, 12 of the victims were female (66.7%) and six were male (33.3%).

A history of domestic and family violence was established in more than two-thirds (68.3%) of homicides of people from a culturally and linguistically diverse background. This was most prominent in intimate partner homicides (72.7%).

The vast majority of intimate partner homicide deceased were female (86.4%), with almost all (90.9%) intimate partner homicide offenders being male.²⁵ Actual (six cases) or pending (six cases) separation was a feature in over one-half (54.5%) of the intimate partner homicides of victims from a culturally and linguistically diverse background.

While the deceased was recorded as being from a culturally and linguistically diverse background, it is noted that five (25.0%) of these male intimate partner homicide offenders were not from a culturally and linguistically diverse background.

A history of domestic and family violence was reported in 16 of these intimate partner homicide cases (72.7%), however, this is likely to be an underreporting.

The forms of violence reported included psychological (10 cases; 62.5%), physical (10 cases; 62.5%), economic (two cases; 12.5%), and verbal (one case; 6.3%). Other key characteristics in these intimate partner homicide cases include:

- » controlling behaviours (10 cases; 62.5%);
- » escalation of violence (eight cases; 50.0%);
- » obsessive/jealous behaviours (six cases; 37.5%);
- » stalking (three cases; 18.8%); and
- » children exposed to violence (three cases; 18.8%).

²⁴ Backgrounds included Polish, Bangladesh, Sudanese, Pacific Islander, Lebanese, Asian, Bosnian, Kazakhstan, Fijian, Chinese, Samoan, Japanese, Indian, (former) Yugoslavian, Guyana, New Zealander, Philippino, Kenyan, Indonesian, Brazilian, Argentinian, Ukrainian, and Italian.

²⁵ 20 homicide offenders were male, with one female, and in one case the co-offenders were male and female.

Protection orders were in place in six cases, with the deceased recorded as the aggrieved in five cases (all females) with cross-orders in place in the remaining case. Breaches of protection orders were recorded in two cases where the male was listed as the respondent.

For those cases that occurred between 2011 and 2016²⁶, service system contact was recorded in nine of the 17 intimate partner homicides where there was a history of domestic violence, with details outlined in Table 7 below.

Table 7: Known service system contact in intimate partner homicides from a culturally and linguistically diverse background, 2011-2016

	Primary victim	Primary perpetrator
Police	5 (55.6%)	4 (44.4%)
Corrective Services	0	2 (22.2%)
Mental Health	1 (11.1%)	1 (11.1%)
Hospital	3 (33.3%)	3 (33.3%)
GP	2 (22.2%)	2 (22.2%)
Psychologist	2 (22.2%)	2 (22.2%)
Child safety	1 (11.1%)	0
Relationship counsellors	1 (11.1%)	1 (11.1%)
Specialist services	2 (22.2%)	1 (11.1%)
Legal	1 (11.1%)	0
Magistrates Court for protection orders	7 (77.8%)	6 (66.7%)

²⁶ This includes for the period where complete, or near complete, records are available. In more recent cases, the criminal and coronial investigations may be ongoing. As such, only cases within the period 2011 to 2016 are included with respect to service system contact. This data, however is subject to change when additional information becomes available.

Intimate partner homicide lethality risk factors²⁷

Lethality risk indicators prevalent in intimate partner homicide cases involving a deceased from a culturally and linguistically diverse background included a history of violence in the current relationship, prior attempts to isolate the victim, and actual or pending separation (as outlined in Table 8).

Table 8: Common lethality risk indicators, culturally and linguistically diverse background cases, 2009-2017

	Number	Percent
History of domestic violence (current relationship)	11	78.6%
Prior attempts to isolate the victim	10	71.4%
Actual or pending separation	10	71.4%
Victim's intuitive sense of fear of perpetrator	9	64.3%
Prior threats to kill victim	7	50.0%
Controlled most or all of victim's daily activities	6	42.9%
Prior destruction or deprivation of victim's property	6	42.9%
Obsessive behaviour displayed by perpetrator	6	42.9%
Sexual jealousy	6	42.9%
Child custody or access disputes	5	35.7%
Escalation of violence	5	35.7%
Victim and perpetrator living common-law	5	35.7%
Depression – in the opinion of family/friend/acquaintance	5	35.7%
Other mental health or psychiatric problems – perpetrator	5	35.7%
New partner in victim's life	5	35.7%

Family homicides

Between 2006-07 and 2017-18, a total of 122 homicides have occurred within family relationships, slightly less than the number (153) that have occurred in intimate partner relationships.

As shown in Figure 1, the numbers of family homicides fluctuates over time, with an average of 10.2 such deaths each year, which is slightly lower than the average annual number of intimate partner homicides (12.8).

The most common type of homicide in a family relationship are filicides, with slightly more sons (and step-sons) than daughters (and step-daughters) being killed (Table 9).

Equivalent numbers of fathers (and step-fathers) and mothers (and step-mothers) were the victims of homicide. Brothers (including step-brothers) were more likely to be the victim of sibicide than sisters (including step-sisters).

With regards to filicide cases, five of the 63 involved the killing of an adult child (three of these were considered by the Board in this reporting period). All juvenile step-children²⁸ were under the age of five years, and the offender had known the deceased for less than two years.

²⁷ The Queensland Lethality Risk Factor Data-set utilises the risk coding form developed by the Ontario Death Review Committee who, have identified 39 factors prominent in intimate partner homicides. The coding sheet and definitions are provided in Appendix B.

²⁸ That is aged under 18 years at the time of their death.

Table 9: Family homicides by relationship category, 2006-07 to 2017-18

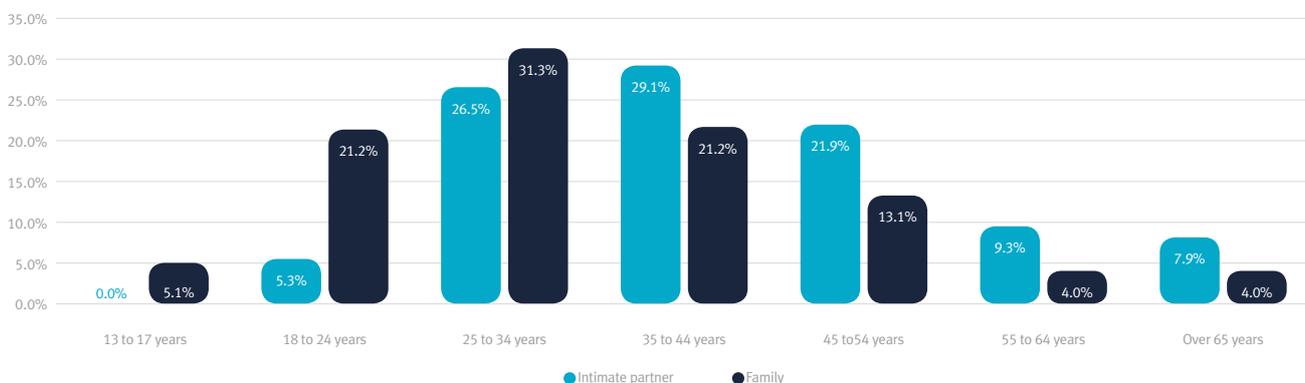
	Total	Child	Adult
Filicide	65	58	7
Son	28	25	3
Daughter	26	23	3
Step-son	7	7	0
Step-daughter	4	3	1
Parricide	30	0	30
Mother	13	0	13
Father	11	0	11
Step-mother	2	0	2
Step-father	4	0	4
Siblicide	12	1	11
Brother / step-brother	10	0	10
Sister	2	1	1
Other family²⁹	15	5	10
Total	122	64	58

As outlined in Table 1, while males are more likely than females to be homicide offenders, the gender ratio was narrower for family homicides compared with intimate partner homicides.

Between 2006-07 and 2017-18, slightly more family homicide deceased were male (n=65; 53.3%) than female (n=57; 46.7%).

Intimate partner and family homicide offenders were most likely to be in the 25 to 34 years and 35 to 44 years age groups (Figure 12). A higher proportion of family homicide offenders were aged 18 to 24 years, in comparison to intimate partner homicides where a higher proportion were aged 45 to 54 years.

Figure 12: Age distribution, homicide offenders, 2006-07 to 2017-18



29 This included: grandmother, grandfather, grandson, granddaughter, nephew, niece, uncle, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, Indigenous kin.

There was little variation between family and intimate partner homicides in terms of the proportion of deceased (22.3% vs 18.3%) and offenders (16.3% vs 20.9%) who identified as being Aboriginal or Torres Strait Islander. Similarly, there was no difference in recorded rates of homicide deceased who were culturally and linguistically diverse (14.8% vs 14.4%).

The presence of mental illness (either symptoms or diagnoses) was more pronounced among offenders of family homicides compared with intimate partner homicides (37.5% and 26.1% respectively). Reported rates of problematic substance use were higher among cases of intimate partner homicides, in comparison to family homicide (Table 10).

Table 10: Presence of mental health issues, problematic substance use and suicidality, in family and intimate partner homicide cases, 2006-07 to 2017-18

	Intimate partner		Family	
	Deceased	Offender	Deceased	Offender
Mental health	22 (14.4%)	40 (26.1%)	15 (12.3%)	39 (37.5%)
Problematic substance use	54 (35.3%)	66 (43.1%)	9 (7.4%)	32 (30.8%)
Suicide ideation	5 (3.3%)	22 (14.4%)	6 (4.9%)	12 (11.5%)
Suicide attempt	1 (0.7%)	15 (9.8%)	2 (1.6%)	6 (5.8%)

A history of reported domestic and family violence was more prevalent in intimate partner homicide cases (70.6% vs 49.2%). As would be expected, indicators of domestic and family violence which are associated with an increased risk of intimate partner violence were shown to be far more prevalent in intimate partner homicides compared with family homicides (Table 11).

However, this finding does highlight the need for further exploration of what characteristics are present in family relationships that may be indicative of a heightened risk of harm to inform prevention activities.

Table 11: Known risk factors for intimate partner homicide by death type, 2006-17 to 2017-18

	Family		Intimate partner	
	Number	Percent	Number	Percent
Separation (actual or pending)	10	16.9%	57	47.2%
Escalation of violence	16	26.7%	44	40.7%
Stalking	2	3.3%	18	16.7%
Obsessive / jealous behaviours	5	8.3%	55	50.9%
Controlling behaviours	12	20.0%	56	51.9%

Children were exposed to violence in the home in almost one half (48.3%) of all cases of family homicides, compared with less than one-third of intimate partner homicides (31.5%).

Where there was an established history of violence, protection orders were more commonly present in cases of intimate partner homicide (40.7%) than family homicides (18.3%).

Service system contact

Between 2011 and 2017, there was a total of 175 domestic and family homicides. A history of domestic and family violence was established in 114 (65.1%) of these cases. Complete service system records were available for 94 of the cases (82.5%) where there was a history of violence.

Table 12: Breakdown of cases where service system records were available, 2011 to 2017

	Victim				Perpetrator		
	Cases	History of DFV ³⁰	Records available	System contact	History of DFV	Records available	System contact
Intimate partner	85	65	55	48	65	53	45
Family	75	37	31	20	33	30	26
Collateral	15	12	8	8	12	7	5

Figure 13 and 14 outline the prevalence of service system contact for victims and perpetrators of violence in the cases between 2011 and 2017.

It must be noted that this contact may have been in relation to domestic and family violence in the relationship between the homicide deceased and the homicide offender, or in relation to violence in another relevant relationship (e.g. in a family homicide, the contact may have been in relation to intimate partner violence perpetration by the homicide offender towards their former partner).

Intimate partner violence victims were more likely to have had contact with police, Magistrates Courts (for civil proceedings associated with the issuing of protection orders), hospitals (including emergency departments) and specialist domestic violence services in comparison with victims of violence in a family relationship. Conversely, victims of family violence were more likely to have contact with child safety services prior to the homicide event.

Where the homicide deceased was a child, there was contact with child safety services in 92.3% of cases (for either the deceased child or another sibling) where there was a history of parental domestic and family violence.³¹

There was greater similarity in the pattern of service system contact for perpetrators when comparing intimate partner and family homicides. Family violence perpetrators were, however, more likely to have contact with child safety services, but less likely to have contact with Magistrates Courts (in relation to civil protection order proceedings).

³⁰ DFV = Domestic and family violence.

³¹ In contrast, where the deceased of a family homicide was an adult, contact with child safety services was only evident in one case.

Figure 13: Service system contact, intimate partner and family homicide, primary victims of violence, 2011 to 2017

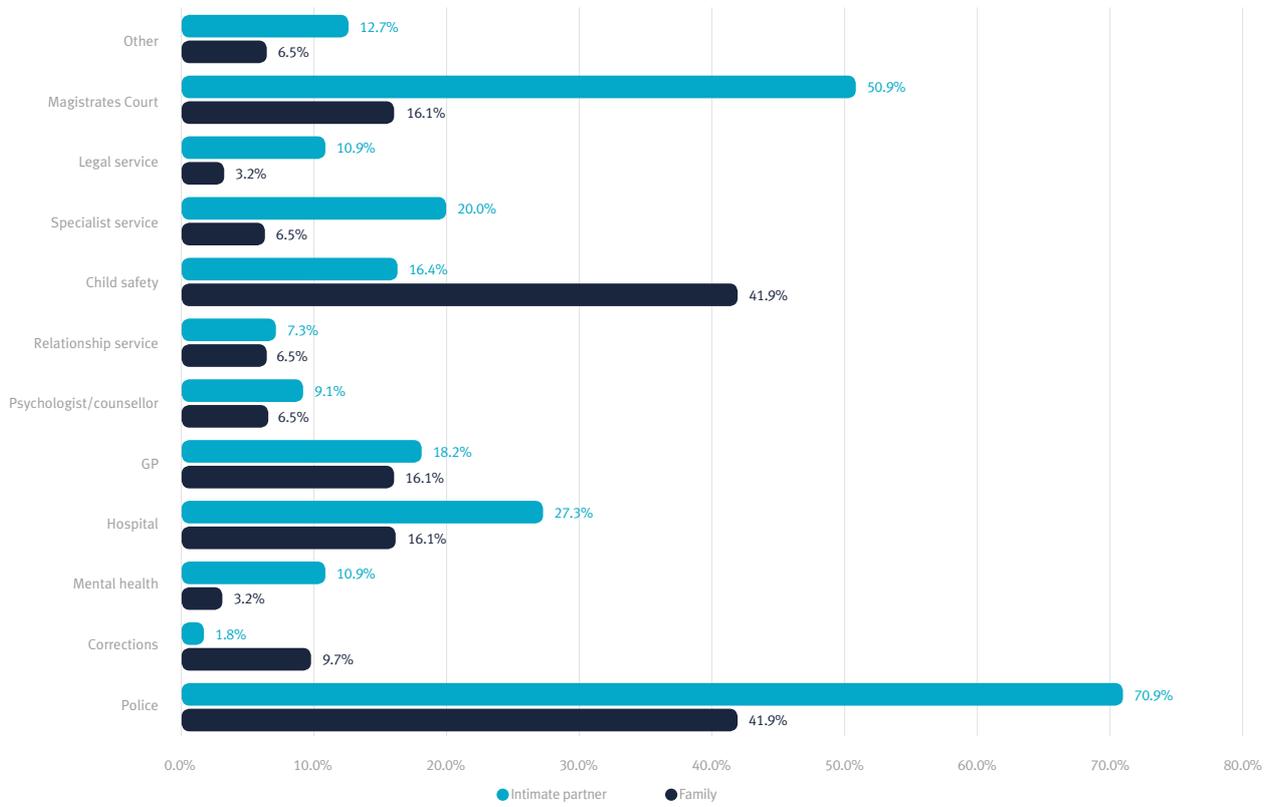
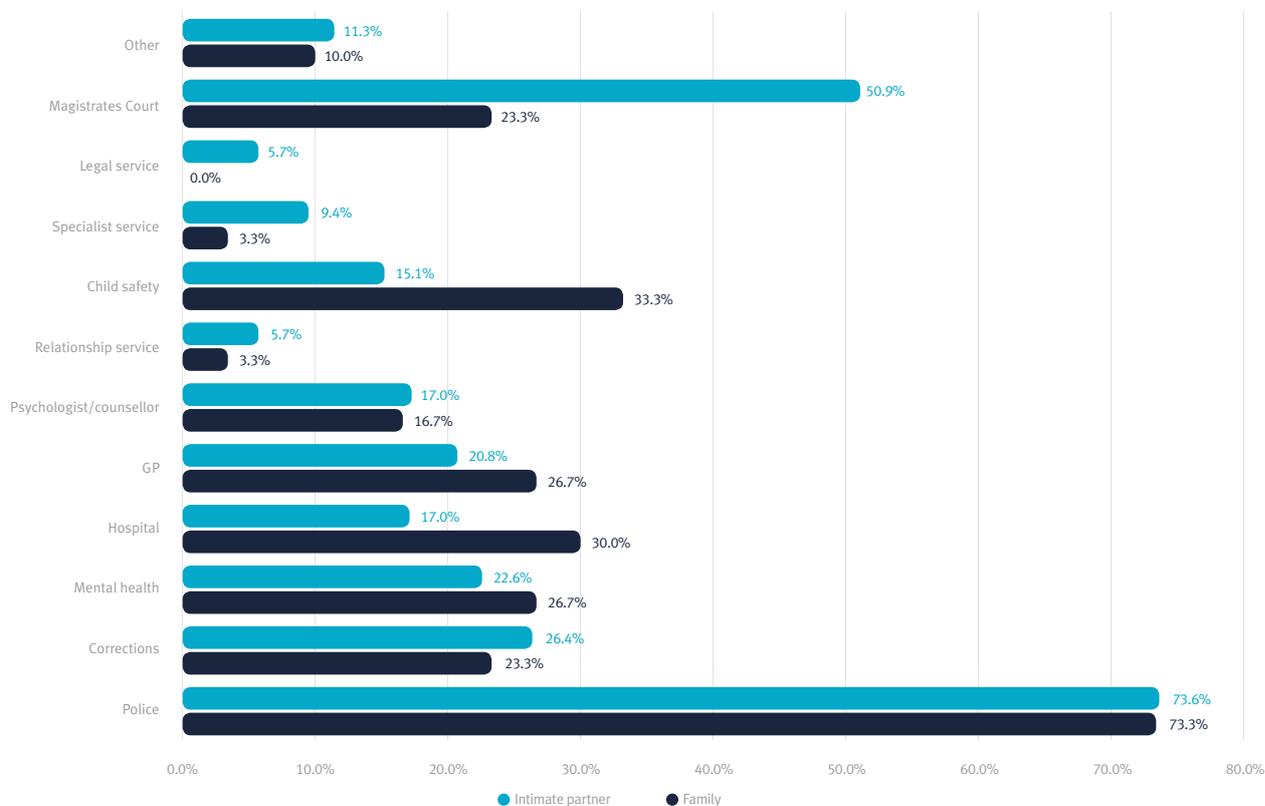


Figure 14: Service system contact, intimate partner and family homicide, primary perpetrators of violence, 2011 to 2017



Intimate partner homicide-suicides

Between 2006-07 and 2017-18, a total of 33 homicide-suicide incidents were recorded in Queensland. This resulted in 73 fatalities, including 40 homicide deceased and 33 suicide deceased.

There was a gender paradox, with the majority of homicide deceased being female (31 of 40; 77.5%) and the majority of suicide deceased (who were also the homicide offenders) being male (29 of 33; 87.9%). This is consistent with the understanding of domestic and family homicide as well as suicide; where males are overwhelmingly over-represented as both homicide offenders and suicide deceased. Of the homicide deceased, 11 were children and 29 were adults. There were five cases involving homicide deceased from a culturally and linguistically diverse background.

The average age of offenders in homicide-suicides was older (47 years) compared to homicide only cases (37.5 years), which aligns with research findings.³²

The 33 homicide-suicide incidents featured 27 single homicide deceased, inclusive of 20 intimate partner homicide-suicides and seven family homicide-suicides. Of these latter seven cases, five involved the killing of a child by the offender before they took their own life. The other incidents involved the homicide of adult family members.

There were six incidents involving multiple homicide deceased, including five double homicide-suicides and one triple homicide-suicide. Three cases involved the homicide of an intimate partner and another family member, with three cases featuring the homicide of family members only.

These homicide-suicides occurred across most regions in Queensland (Table 13), with the majority taking place in the Gold Coast and Central Queensland Police Service Districts.³³

32 Cohen, D., Llorente, M., & Eisdorfer, C. (1998). Homicide-suicide in older persons. *American Journal of Psychiatry*, 155, 390-396.

33 The QPS Divisions, District and Regions Map is available at: https://www.police.qld.gov.au/RegionalPolicing/Documents/State_Divisions_Districts_Regions.pdf

Table 13: Homicide-suicide incidents by QPS district, 2006 to 2017

	Homicide-suicide incidents
Brisbane region	6
South Eastern region	10
Southern region	1
Central region	11
Northern region	5
Total	33

Consistent with international research^{34,35}, gunshot wounds are significantly over-represented as a cause of death among cases of homicide-suicide, compared with domestic and family homicides generally. In Queensland, 42.5% of homicide deceased in homicide-suicides died from gunshot wounds, in comparison to 12.3% of all domestic and family homicides.

History of domestic and family violence in homicide-suicide cases

A history of domestic and family violence was identified in 25 of the 33 cases (75.8%). This included 16 intimate partner homicide deceased, 14 family homicide deceased and one collateral homicide deceased. The homicide deceased was the victim in 21 cases (67.7%), the perpetrator in two cases (6.5%), a child exposed to parental intimate partner violence in seven cases (22.6%), and a bystander (known to the victim of violence) in one case (3.2%).

The types of domestic and family violence identified in relationships prior to the homicide-suicides is detailed in Table 14.

Table 14: Forms of domestic and family violence

	Intimate partner	Family
Psychological / emotional	10	9
Physical	9	4
Sexual	2	0
Verbal	0	4
Financial	2	0

For intimate partner homicide-suicides where there was a reported history of violence, 13 of the 16 incidents occurred in the context of relationship separation (81.3%), including eight cases of actual separation and five cases of impending separation.

Protection orders were in place in 25.0% of intimate partner homicide-suicides and 21.4% of family homicide-suicides, although these may not always have been between the homicide deceased and offender. There was an escalation of violence in 37.5% of intimate partner homicide-suicides, with a prior history of stalking (43.8%), as well as obsessive/jealous (75.0%) and controlling behaviours (81.3%). For family homicide-suicide cases with a history of violence, these characteristics were far less prevalent or may have been present in the parental relationship for child homicide-suicide cases.³⁶

Where there was a history of domestic and family violence, homicide offenders (and also the suicide deceased) had higher levels of mental health issues, problematic substance use and suicide ideation in comparison with homicide deceased (Table 15).

34 Eliason, S. (2009). Murder-suicide: A review of the recent literature. *Journal of American Academic Psychiatry and Law*, 37, 371-376.

35 Podlogar, M.C., Gai, A.R., Schneider, M., Hagan, C.R., & Joiner, T.E. (2018) Advancing the prediction and prevention of murder-suicide, *Journal of Aggression, Conflict and Peace Research*, 10 (3), 223-234.

36 Escalation of violence (21.4%), stalking (14.3%), obsessive / jealous (14.3%), controlling (35.7%).

Table 15: Presence of mental health issues, problematic substance use and suicidality, in homicide-suicide cases, 2006-07 to 2017-18

	Homicide deceased (n=40)	Homicide offender / suicide deceased (n=33)
Mental illness	4 (10.0%)	20 (60.6%)
Problematic substance misuse	2 (5.0%)	11 (33.3%)
Suicide ideation	1 (2.5%)	10 (30.3%)
Suicide attempts	-	8 (24.2%)

The prevalence of service system contact is reported in Table 16. Overall, the levels of service system contact were relatively low, with police being the most common recorded contact in these cases.

There was limited contact with specialist domestic and family violence services by homicide-suicide deceased and offenders.

Table 16: Service system contact, homicide deceased and offenders, 2006-2017³⁷

Service	Homicide deceased (n=40)	Homicide offender / suicide deceased (n=33)
Police	12 (33.3%)	16 (41.4%)
Corrective services	0	3 (10.3%)
Mental health	2 (5.6%)	8 (27.6%)
Hospital	3 (8.3%)	4 (13.8%)
GP	6 (16.7%)	5 (17.2%)
Psychologist / counsellor	2 (5.6%)	4 (13.8%)
Relationship service	4 (11.1%)	2 (6.9%)
Child safety	4 (11.1%)	4 (13.8%)
Specialist service	3 (8.3%)	2 (6.9%)
Legal service	2 (5.6%)	0
Magistrates Court (protection orders)	7 (19.4%)	6 (20.7%)
Other	3 (8.3%)	2 (6.9%)

³⁷ Service system information was available for cases involving 36 homicide deceased and 29 homicide offenders

Male deceased (female perpetrated homicides and collateral homicides)

A total of 116 male homicide deceased have been recorded between 1 July 2006 and 30 June 2018, accounting for two-fifths (39.5%) of all homicides. As outlined above, the largest proportion of male homicide deceased occurred within a family relationship (65 cases, 56.0% of all male homicides). This included 32 male children and 33 male adults killed in a family homicide event.

Figure 15 reveals the number of male homicide deceased each year. There has been recent increases in the number of male intimate partner homicide deceased and collateral homicides in Queensland. Notably, there were five collateral homicides recorded in 2016-17, and in 2017-18, for the first time, there were more male intimate partner homicides than female intimate partner homicides.

Figure 15: Male homicides by relationship type and year, 2006-07 to 2017-18



As shown in Table 17, males were responsible for the vast majority of family homicides involving male deceased, and all collateral homicides.

Table 17: Gender of offenders in domestic and family homicides with a male deceased, 2006-07 to 2017-18

	Male	Female	Male & female
Intimate partner	4 (12.1%)	28 (84.8%)	1 (3.0%)
Family	50 (76.9%)	11 (16.9%)	4 (6.2%)
Collateral	18 (100.0%)	0	0
Total	72 (62.1%)	39 (33.6%)	5 (4.3%)

One-fifth (21.6%) of intimate partner homicides involved male deceased. Of these 33 cases, 28 featured a female intimate partner offender, four cases featured a male intimate partner offender and one case featured both a female intimate partner and a male accomplice.

Female perpetrated homicides

A history of domestic and family violence was established in 20 (71.4%) of the male intimate partner homicides. In each of these cases, the male homicide deceased was identified as the primary perpetrator of domestic and family violence prior to the death. This included 14 cases where the deceased was only recorded as a perpetrator and six cases where the deceased was recorded as both using and experiencing violence.

With respect to the violence perpetrated by the homicide deceased against their female intimate partner (and homicide offender), physical violence was the most common (n=14, 70.0%), followed by verbal (n=7, 35.0%) and psychological/emotional (n=4, 20.0%).

An escalation in violence by the perpetrator was reported in six cases (30.0%) prior to the death. Obsessive/jealous behaviours (n=7, 35.0%), controlling behaviours (n=3, 15.0%), and children exposed to violence (n=5, 25.0%) were also present.

Protection orders were current in one-half (n=10, 50.0%) of the cases with a reported history of violence. The deceased was recorded as the respondent in five cases (50.0%), the aggrieved in three cases (30.0%) (although they were known to use violence in the relationship), and two cases featured cross-orders (20.0%).

Five homicide deceased and eight homicide offenders identified as Aboriginal and Torres Strait Islander. One homicide deceased was reported to be from a culturally and linguistically diverse background.

Separation was a feature in eight of the 28 cases (28.6%) of female perpetrated intimate partner homicide cases, which is lower than in the intimate partner homicide cases featuring a female deceased (45.0%).

Records pertaining to service system contact have been obtained for 18 cases between 2007 and 2015 (Table 18). In these cases, a pattern of service system contact was similar for male homicide deceased (who were the primary perpetrators) and female homicide offenders (who were the primary victims).

Table 18: Service system contact, male homicide deceased, 2006-07 to 2014-15 (n=18)

	Male homicide deceased		Female homicide offenders	
	Number	Percent	Number	Percent
Police	12	66.7%	12	66.7%
Corrective services	2	11.1%	2	11.1%
Mental health	2	11.1%	1	5.6%
Hospital	1	5.6%	3	16.7%
GP	0	-	0	-
Psychologist	1	5.6%	1	5.6%
Relationship service	1	5.6%	1	5.6%
Child safety	0	-	0	-
Specialist service	1	5.6%	2	11.1%
Legal service	0	-	0	-
Magistrates Court	7	38.9%	7	44.4%
Other	1	5.6%	1	5.6%

Lethality risk factors have been applied to the 11 female perpetrated intimate partner homicides where full records are available. It is critical to note that this coding form assesses the prior history of violence in the relationship and the 'perpetrator', for the purposes of coding, is not necessarily the homicide offender.

As can be seen in Table 19, a history of domestic violence was most prevalent in these cases (noting this history pertained to the homicide deceased being the primary perpetrator of violence), followed by actual or pending separation, and excessive alcohol and/or drug use by the perpetrator (and homicide deceased).

There were some observable differences between cases involving a male deceased and a female deceased (noting the small sample size of the cases). Among female intimate partner homicide deceased, there were higher frequencies of: threats to kill, controlling all or most daily activities, and sexual jealousy by the perpetrator.

Collateral homicides

Eighteen of the 19 reported collateral homicides involved male deceased (94.7%). In each of these cases, the homicide offender was a male.³⁸

Of the 18 male collateral homicides, five involved a bystander intervening in an episode of domestic and a family violence. This occurred at a private residence in three cases and in a public location on two occasions. In two cases, the deceased was the perpetrator who was killed by witnesses intervening in an episode of domestic and family violence involving the perpetrator and the victim. For four of the five cases, the homicide offender was affected by substances (generally alcohol) at the time.

There was an established history of intimate partner violence in each of these cases. However, there is limited information available about the nature and extent of this abuse.³⁹

The remaining 13 cases involved a new partner of the homicide offender's former partner⁴⁰ (10 cases) or the former partner of the homicide offender's new partner (three cases). In three of these cases, the offender also killed his former intimate partner as well as the new partner.

The average age of the homicide deceased (40.8 years) and offender (39.5 years) were considered to be equivalent in these cases. A history of domestic and family violence has been established in 11 of the 13 cases (84.6%).

Information for nine cases from 2011 to 2017 is available to describe the extent and nature of violence in the intimate partner relationship of interest.

A history of violence was apparent in eight of the nine cases (88.8%) of this sub-sample, which is higher than in other cases and may be attributable to the primary victim of violence not dying in seven of nine cases; meaning that there is additional information pertaining to the prior relationship history than would otherwise be available.

Psychological abuse (n=7, 87.5%), physical violence (n=4, 50.0%), and verbal abuse (n=3, 37.5%) were most commonly identified. There was evidence of an escalation of violence in three cases, with the primary perpetrator demonstrating stalking (n=4, 50.0%), obsessive/jealous (n=6, 75.0%), and controlling behaviours (n=3, 37.5%). Protection orders were in place in five cases with the male in the (former) intimate partner relationship identified as the respondent in all cases.

Separation was a feature in almost all cases (n=8, 88.8%). Mental health problems were identified among five of the nine offenders (55.6%) and three of the deceased (33.3%).

³⁸ With the exception of one case that featured five people charged with homicide including three males and two females.

³⁹ In one case, a stranger intervened in a domestic dispute between a couple in a public place, where he fatally struck the male in self-defence. The surviving victim reported that while the couple had arguments her husband was never violent or physical although it is believed that the episode the bystander intervened in became physical. The other three cases, there was a clear history of violence, with the homicide offender being the primary perpetrator of violence in these relationships.

⁴⁰ This includes cases where the offender suspected the homicide deceased was romantically involved with his former partner.

Table 19: Lethality risk factors, female and male intimate partner homicides

	Female (victim) killed by male (perpetrator)		Male (perpetrator) killed by female (victim)	
History of violence outside of the family by perpetrator	27	46.6%	3	27.3%
History of domestic violence (current relationship)	47	81.0%	9	81.8%
Prior threats to kill victim	30	51.7%	0	0.0%
Prior threats with a weapon	15	25.9%	1	9.1%
Prior assault with a weapon	12	20.7%	4	36.4%
Prior threats to commit suicide by perpetrator	18	31.0%	4	36.4%
Prior suicide attempts by perpetrator	15	25.9%	2	18.2%
Prior attempts to isolate the victim	29	50.0%	2	18.2%
Controlled most or all of victim's daily activities	27	46.6%	1	9.1%
Prior hostage-taking and/or forcible confinement	16	27.6%	1	9.1%
Prior forced sexual acts and/or assaults during sex	9	15.5%	1	9.1%
Child custody or access disputes	8	13.8%	2	18.2%
Prior destruction or deprivation of victim's property	15	25.9%	3	27.3%
Prior violence against family pets	8	13.8%	2	18.2%
Prior assault on victim while pregnant	9	15.5%	1	9.1%
Choked/strangled victim in past	16	27.6%	3	27.3%
Perpetrator was abused and/or witnessed DV as a child	6	10.3%	2	18.2%
Escalation of violence	22	37.9%	3	27.3%
Obsessive behaviour displayed by perpetrator	23	39.7%	4	36.4%
Perpetrator unemployed	27	46.6%	6	54.5%
Victim and perpetrator living common-law	29	50.0%	7	63.6%
Presence of step children in the home	11	19.0%	3	27.3%
Extreme minimisation and/or denial of spousal assault history	17	29.3%	3	27.3%
Actual or pending separation	32	55.2%	7	63.6%
Excessive alcohol and/or drug use by perpetrator	31	53.4%	5	45.5%
Depression – in the opinion of family/friend/acquaintance	11	19.0%	2	18.2%
Depression – professionally diagnosed	15	25.9%	1	9.1%
Other mental health or psychiatric problems – perpetrator	15	25.9%	4	36.4%
Access to or possession of any firearms	11	19.0%	1	9.1%
New partner in victim's life	17	29.3%	2	18.2%
Failure to comply with authority	24	41.4%	3	27.3%
Perpetrator exposed to/witnessed suicidal behaviour in family of origin	2	3.4%	1	9.1%
After risk assessment, perpetrator had access to victim	8	13.8%	0	0.0%
Youth of couple	3	5.2%	2	18.2%
Sexual jealousy	33	56.9%	3	27.3%
Misogynistic attitudes – perpetrator	11	19.0%	0	0.0%
Age disparity of couple	9	15.5%	1	9.1%
Victim's intuitive sense of fear of perpetrator	32	55.2%	5	45.5%
Perpetrator threatened and/or harmed children	12	20.7%	2	18.2%



Chapter 3: Extending the conversation

Key findings

- » Violence in a family relationship is a complex phenomenon that is relatively common, but not well understood; although, there are some emerging areas of focus in research and practice such as adolescent violence towards parents and elder abuse.
- » Among the cases considered by the Board, it was apparent that this type of violence was not restricted to a specific familial dynamic, with patterns of violence perpetration and/or victimisation being identified across both intimate partner and family relationships.
- » Where family violence came to the attention of services, there appeared to be a lack of recognition of, and response to, this type of abuse.
- » Current frameworks to address domestic and family violence largely focus on responding to intimate partner violence. These approaches may not be as applicable to violence within family relationships.
- » Further research is required to better understand the nuances of violence within a family relationship, and to identify ways to prevent and respond to this type of abuse.

In accordance with section 91A(b) of the Act, the Board is established to increase recognition of the impact of, and circumstances surrounding, domestic and family violence deaths, and to gain a greater understanding of the context in which these types of deaths occur.

A total of 20 cases involving 30 deaths have been reviewed in detail by the Board during the 2017-18 reporting period. Of these, 13 deaths occurred within a family relationship. This chapter considers the Board's findings in relation to these types of deaths, in the context of current research.

Noting the publication of its inaugural Annual Report in November 2017, in its second year of operation the Board has focused on extending upon their initial findings.

As such, while recognising the presence of certain risk indicators which were previously canvassed by the Board, including, for instance, sexual proprietariness and non-lethal strangulation, Members have purposively focused on other identifiable issues in this year's report.

This does not, however, mean that these factors were not also present within the cases subject to review by the Board in this reporting period. These risk indicators were present in the majority of cases, including:

- » Extreme sexual proprietariness, possessiveness and morbid jealousy (11 cases; 55.0%).
- » Post-separation violence and systems abuse⁴¹ (13 cases; 65.0% occurred during a period of separation).

- » Non-lethal strangulation (12 cases; 60.0%).
- » Technology facilitated abuse (10 cases; 50.0%).

It is, however, important to note that these factors were not always present in the index relationship, but may have been present in (current or former) intimate partner and/or family relationships.⁴²

Homicides within a family relationship

As outlined in Chapter 2, homicides in a family relationship represent almost half of all homicides that occur within an intimate partner or family relationship in Queensland every year.

Within this reporting period, the Board undertook in-depth reviews of 13 deaths that occurred within a family relationship.⁴³

In considering these deaths, the Board noted that there was a distinct absence of research or evidence that could assist in understanding the unique circumstances of homicides in a family relationship.

While there are indeed national studies that discuss the prevalence and incidence of violence and homicides within family relationships, there appears to be limited studies that comprehensively draw these factors together within adult familial relationships.

⁴¹ This refers to the ongoing use of systems by a perpetrator to continue to abuse their victim, typically after a relationship separation (e.g. child custody matters through Family Law Court).

⁴² Two of these non-lethal strangulation cases that occurred within the homicides in a family relationship were in the context of intimate partner violence perpetration by the homicide offender and not within a family relationship.

⁴³ In a number of these cases there was no prior history of family violence and the homicide event appeared to be related to intimate partner violence perpetration or victimisation that was occurring between the homicide deceased/offender and a third party.

An absence of such research may impede the capacity of the service system to understand, respond and potentially prevent these types of deaths.

While the actual circumstances of these family homicides were diverse, the Board identified a range of commonalities indicative of apparent systemic issues. This included that:

- » There appeared to be less recognition that violence within family relationships also falls within the scope of the *Domestic and Family Violence Protection Act 2012* (the DFVPA 2012). This included by people and families experiencing violence⁴⁴, but also service providers who may have been in a position to respond.
- » The cases appeared to lack the familiar pattern of escalation and 'predictability' so often seen within intimate partner homicides.
- » There appeared to be a lower prevalence of some key indicators of risk commonly found within intimate partner homicides such as obsessive controlling behaviours and separation, and an increased prevalence of other factors such as the homicide offender experiencing a mental illness. Problematic substance use was also prominent among perpetrators of family violence.
- » Service system contact in these cases may have been in relation to intimate partner violence perpetration and victimisation (in other relationships for the homicide offender/deceased), which highlights the intersection between the two types of violence, and likely represents one of the strongest opportunities to intervene.

For these reasons, it may be the case that there is an increased risk of harm as victims experiencing family violence appeared less likely to recognise they were experiencing abuse and did not seek help. Conversely, where help was sought, victims of family violence were less likely to receive a robust service response in comparison to victims of intimate partner violence.

Defining violence within family relationships

Violence within family relationships appears to be a complex phenomenon that is relatively common, but poorly understood.

As defined by the DFVPA 2012, a family relationship exists between two persons if one of them is, or was, the relative of the other. A relative of a person is someone who is ordinarily understood to be, or have been, connected to the person by blood or marriage and may include: a child, step-child, parent, step-parent, sibling, grandparent, aunt, nephew, cousin, half-sibling, mother-in-law or aunt-in-law.⁴⁵

It is important to note, however, that there is no consistency in naming conventions when describing violence between family members in research or across jurisdictions.

For example, the term 'family violence' is often used to characterise violence in Aboriginal and Torres Strait Islander extended families and communities, inclusive of intimate partner violence.⁴⁶

In other Australian jurisdictions, family violence is inclusive of violence within both intimate partner and family relationships. The broad umbrella term of 'domestic and family violence' is also collectively used to describe violence in both spousal and non-spousal relationships.

As it stands, due to obvious need, many of our service responses have evolved to assist 'battered women' fleeing from violence⁴⁷, and while these services and supports may have subsequently been extended to include other family relationships, they may not be as relevant to the needs of people experiencing family violence.

As outlined in Chapter 2, analysis of data from homicides within family relationships in Queensland shows significantly more heterogeneity in their case characteristics than those homicides in an intimate partner relationship. These cases rarely have the same level of controlling, jealous or obsessive behaviours as seen in intimate partner homicides; there is limited evidence of an escalation of violence prior to the death; and, as would be expected, they do not occur in periods of separation.⁴⁸

Further, in the cases reviewed by the Board, it is also apparent that while intimate partner and family violence perpetration and/or victimisation may have been occurring within the broader familial network, in some cases there was limited evidence of violence between the homicide offender and deceased prior to the death.

⁴⁴ This is exemplified by the reported frequency of a history of domestic violence in family homicides of 48.0% in Queensland in comparison to that reported for intimate partner homicides of 68.2%.

⁴⁵ s19 of the *Domestic and Family Violence Protection Act 2012*.

⁴⁶ Al-Yaman, F., Van Doeland, M., & Wallis, M. (2006). *Family Violence among Aboriginal and Torres Strait Islander Peoples*. Canberra: Australian Institute of Health and Welfare.

⁴⁷ For example in Queensland, the initial domestic violence protection legislation excluded violence in non-spousal relationships, which were not included until amendments in 1999 to the *Domestic Violence (Family Protection) Act 1989*.

⁴⁸ Excluding perhaps one case which occurred during a period of estrangement between the parent and child.

Whether a person was identified as the perpetrator or victim of violence also differed based on the relationship dynamics. In some cases, the homicide deceased or offender were noted to both use, and experience, violence within their intimate partner and/or family relationships.

For example, one homicide offender had a history of being an intimate partner violence perpetrator against his spouse, but he was noted to have been abused by his adult children and other family members. Records also indicate he may have abused his children when they were younger, including allegations of sexual abuse.

In its final report, the Special Taskforce predominantly focused on intimate partner violence or the broad term 'domestic and family violence', with very limited attention specifically given to violence in family relationships.⁴⁹

Similarly, the 2015 *Victorian Royal Commission into Family Violence* (the Royal Commission) made 164 recommendations to address the scale and impact of abuse within intimate partner and family relationships in Victoria. As of 1 November 2017, 63 recommendations had been progressed from the Commission's Final Report, which focus predominantly on intimate partner violence.⁵⁰ Of the few implemented recommendations specifically related to family violence, the primary focus is on the needs of people experiencing elder abuse.⁵¹

As such, while it can reasonably be considered that many of the recommendations from these reports may inadvertently improve outcomes for victims of family violence, there are few that specifically seek to address this area of concern.

The Special Taskforce report did, however, find that elder abuse was a significant and growing problem in Australia, and that victims encountered substantial barriers to seeking help. This included isolation, a reluctance to take action against their children, threats to their independence (i.e. that they will be put into care/placement), as well as a lack of recognition of themselves as a 'victim'.

This report further identified that older victims may not be aware that protection orders can be made for non-physical abuse, or that orders can apply to non-spousal relationships.⁵² Some of these issues were also identified in the cases reviewed by the Board that considered violence perpetrated by adult children against their parents.

In one case, while police did respond to a call for service on the morning of the death, the father minimised the extent of the violence being perpetrated by his adult son towards multiple family members. In an absence of interviews with other parties, the matter was subsequently dismissed as a 'loud conversation' and finalised by police with no further action taken. However, records suggest that the abusive altercation was ongoing after police left the property for at least four hours until the fatal event.

Understanding violence in family relationships

Much of the current research and evidence that informs our responses to domestic and family violence in Queensland has evolved from studies conducted on violence within heterosexual intimate partner relationships. This means its relevance to other relationship types may need to be tested or explored further.

For example, the Duluth Power and Control Wheel⁵³ adopts a strongly gendered understanding of violence perpetration within heterosexual intimate partner relationships, which means its application to other types of relationships is questionable.

These limitations are perhaps most relevant with respect to strategies that aim to assess and manage risk within relationships characterised by domestic and family violence. Many of the screening and risk assessment tools used have been developed from studies that examine intimate partner violence. As such, they may not be sufficiently reliable or valid in predicting risk of harm in family relationships.

There is some evidence, however, to suggest that youth-parent violence, in particular, has similarities to the tactics of control that are used in intimate partner violence.⁵⁴ In this relationship dynamic, controlling behaviours, including emotional abuse and threats of physical violence, may be effective in gaining power over the parent. It is hypothesised, however, that while there may be some similarities, youth-parent violence is more complex and may be an indicator of a more systemic family violence pattern, inclusive of (parental) intimate partner violence, other intra-familial violence and child abuse.⁵⁵ Participants may play various roles in violent relationships, for example, an adolescent male may assault his mother and, at the same time, be victimised by the father or another member of the family. In complex cases, the cycle of violence may lead to collusion between fathers and sons against partners or mothers.

49 Special Taskforce on Domestic and Family Violence. (2015). *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland*. Brisbane: Author.

50 For example: recommendation 2 (amend the Family Violence Protection Act 2008 to embed the risk assessment and management framework); recommendation 26 (strengthen guidelines around child protection in family violence matters); recommendation 86 (convene a committee of experts on perpetrator interventions and behaviour change programs). Available online: <https://www.vic.gov.au/familyviolence/recommendations.html>

51 Specifically, resourcing the development and delivery of information on family violence using channels such as seniors online, information distributed with Victorian Seniors Cards, Seniors Week and the Seniors Information Centre (Recommendation 153), and; ensuring that the Human Resource Management Standard in the Community Care Common Standards Guide specifies that workers delivering services must have successfully completed certified training in identifying family violence and responding to it, and, reviewing the existing Community Services Training Package courses relevant to providing ageing support to ensure that each course has a core, rather than elective, unit that adequately covers all manifestations of family violence (Recommendation 154).

52 Recommendations from the Special Taskforce on Domestic and Family Violence in Queensland in relation to elder abuse included: The Queensland Government to commission a specific review into the prevalence and characteristics of elder abuse in Queensland to inform development of integrated responses and a communications strategy for elderly victims of domestic and family violence (Recommendation 11); The Queensland Government to include specific elements in the communication strategy that target elder abuse, and where to go for support (Recommendation 12), and; The Queensland Government to make representations to the Commonwealth Government to consider reforms to the funding of carers that continue to support the invaluable care that most carers provide but remove capacity for the payments to be used as a tool for financial control and domestic and family violence of elderly people (Recommendation 13).

53 The Duluth Power and Control Wheel was developed as a tool to inform understandings of the patterns of abusive behaviours used by perpetrators to establish and maintain control over their partners. See more here: <https://www.theduluthmodel.org/wheels/faqs-about-the-wheels/>

54 Eckstein, N. (2004). Emergent issues in families experiencing adolescent-to-parent abuse. *Western Journal of Communication*, 68(4), 365-388. As cited in Daly & Nancarrow. (2008).

55 Downey, L. (1997). Adolescent violence: A systemic and feminist perspective. *Australian and New Zealand Journal of Family Therapy*, 8, 70-79. As cited in Daly & Nancarrow. (2008).

It has further been hypothesised that volatile attachment relationships are one of the main drivers of violence in families.⁵⁶ Common features in families where violence has been identified include:

- » hyper-alertness in one or more family member/s, in which they continuously scan the violent family member for signs of emotional dysregulation and impending danger;
- » fairly sudden and dramatic increased levels of arousal in one or more family member/s in the face of real or imagined abandonment, or as the result of emotion that becomes overwhelming;
- » a seeming 'addiction' to engaging in emotionally or physically abusive interactions, with each party feeling that they are the 'real victim';
- » an overwhelming and palpable feeling expressed by one or more family member/s that they are not being heard or understood, or are feeling alone in the middle of those who profess to love them; and
- » selectively responding to (or ignoring) actions of the perpetrator before seeking the company of this person when the isolation becomes unbearable, increasing the risk of further violence occurring.

These patterns of violence were certainly evident in the cases reviewed by the Board involving violence within a family relationship.

As outlined in more detail in Chapter 5, it appears that in some cultures there may be a more nuanced acknowledgment and recognition of violence which occurs in non-spousal relationships.

While the scientific literature is largely silent with regards to violence in family relationships more generally, violence between some specific familial relationships has been explored.

Child to parent violence

Abuse of parents by children or adolescents is an area that has been comparatively well researched. This type of abuse is not uncommon, and cases can be categorised by a sense of shame and stigma which inhibits help-seeking behaviours, and a lack of supportive frameworks and policies to address this issue.⁵⁷

Women, and in particular, single mothers, are at the greatest risk of becoming targets of abuse perpetrated by adolescent sons.⁵⁸

A recent comprehensive review of child-parent violence⁵⁹ identified that adolescent perpetrated physical abuse against a parent has a 12-month incidence rate of between 5 and 21%.⁶⁰ The estimated prevalence of verbal, psychological and emotional abuse is much higher, but with greater variability (between 33 and 93%). Among young people involved with the criminal justice system, the rates may be higher still. Accordingly, this may be a potential setting in which to detect and respond to this type of abuse.

While we know that violence within intimate partner and family relationships may have different patterns of risk and harm, there may also be some similarities, particularly in relation to causality.

Childhood exposure to violence is consistently associated with perpetration of violence against parents, with up to 50-80% of these perpetrators having been exposed to, or been victims of, family violence.⁶¹

Further, child to parent abuse has been found to be more common in families where a parent (not necessarily the target) has a history of aggression or violence towards the child/ren.⁶²

Research in this area shows that abused mothers provide varying explanations for this violence, including family dysfunction, personality disturbances in the child, mental illness in the child, social or cultural influences, and gender power imbalances.⁶³

Coping strategies reportedly used by mothers experiencing this type of abuse include seeking help and support, discipline, avoiding the child, emotional withdrawal, and engagement/negotiation. Mothers of adolescent perpetrators who may have presented with a co-occurring mental illness were found to be more likely to be supportive, protective and tolerant of abuse. They were also more likely to seek help through police and other authorities, and to protect the child from other less sympathetic family members.

Among this cohort, mothers outlined dismissive attitudes from health and educational services who described their concerns as excessive responses to 'normal teenage behaviour'. Overall, this study identified that abused mothers received little support to help them deal with this violence.

While attracting increasing attention in research, adolescent family violence lacks an appropriate dedicated service system response in Australia.⁶⁴ A recent study by the Monash Gender and Family Violence Research Program into adolescent family violence in Victoria recommended the development of an integrated service response for vulnerable children and young people.

In addition, the authors called for specific training for first responders (including police and teachers), and recommended the development of interim or respite care options for families experiencing adolescent family violence. Schools were further identified as a crucial interface and point of intervention between violent adolescents, families and support services.

Also highlighted was the need for future research to support the development of effective and targeted responses that address different gender patterns of adolescent violence perpetration⁶⁵.

56 Asen, E., & Fonagy, P. (2017). Mentalizing family violence part 1: Conceptual framework. *Family Process*, 56, 6-21.

57 Tew, J., & Nixon, J. (2010). Parent abuse: Opening up a discussion of a complex instance of family power relations. *Social Policy and Society*, 9(4), 579-589.

58 Fitz-Gibbon, K., Elliott, K., & Maher, J. (2018). *Investigating Adolescent Family Violence in Victoria: Understanding experiences and practitioner perspectives*. Melbourne: Monash Gender and Family Violence Program, Faculty of Arts.

59 The National Centre for Excellence in Youth Mental Health.

60 Simmons, M., McEwan, T.E., Purcell, R., & Ogloff, J.R.P. (2018). Sixty years of child-to-parent abuse research: What we know and where to go. *Aggression and Violent Behavior*, 38, 31-52.

61 Ibid.

62 Brezina, T. (1999). Teenage violence toward parents as an adaptation to family strain: Evidence from a national survey of male adolescents. *Youth Society*, 30(4), 416-444.

63 Stewart, M., Burns, A., & Leonard, R. (2007). Dark side of the mothering role: Abuse of mothers by adolescent and adult children. *Sex Roles*, 56, 183-191.

64 Fitz-Gibbon, K., Elliott, K., & Maher, J. (2018). *Investigating Adolescent Family Violence in Victoria: Understanding experiences and practitioner perspectives*. Melbourne: Monash Gender and Family Violence Research Program.

65 For example, it remains unclear why there is an incremental increase in the severity of episodes of violence perpetrated by sons between 10 and 17 years of age, whereas for daughters who use violence, the abuse declines after peaking at about 13 years of age.

As described by the Board in its 2016-17 Annual Report, Carinity and Ipswich's Domestic Violence Action Centre (DVAC) have developed an early intervention program aimed at breaking the cycle of domestic and family violence. This program targets boys aged 11 to 17 years who engage in abusive, controlling and coercive behaviours in their own family relationships (which are often directed towards their mother).

The 20 week program includes group therapy, individual counselling and joint counselling sessions. An interim evaluation report was recently delivered to the Department of Child Safety, Youth and Women (DCSYW) with a final evaluation due in August 2019. The Board looks forward to the outcome of this evaluation, as it is clear that earlier intervention represents one of the greatest opportunities to stop the cycle of violence.

The impact of childhood exposure to domestic and family violence is discussed in more detail in Chapter 4, and integrated service responses to domestic and family violence are considered in Chapter 11.

Sibling to sibling violence

Research into violence within sibling relationships predominantly focuses on children, with scant research relating to violence between adult siblings. However, it has been established that abusive behaviours between siblings as children can extend into adulthood.

A range of family characteristics may play a role in the perpetration of physical violence between adult siblings, including: family disorganisation, experiences of violence at the hands of a parent, and the disciplinary style of parents.⁶⁶

Father-to-child violence has also been found to be a significant predictor of sibling violence.⁶⁷ Exposure to inter-parental violence as children has also been shown to influence hostility between siblings⁶⁸, which can impact upon these relationships into adulthood.

In addition, sibling violence during adolescence has been shown to be a predictor of intimate partner violence perpetration later in life.⁶⁹

Elder abuse

Violence in a family relationship can also encapsulate elder abuse, which is defined as any act within a relationship of trust which results in harm to an older person. Elder abuse can include emotional, psychological, financial, physical or sexual abuse, or neglect.

Elder abuse may also be considered domestic and family violence if there was a relevant relationship⁷⁰ between the victim and perpetrator, but the presence of a 'relevant relationship' is not a defining factor for this abuse.

According to The Office of the Public Guardian (Qld), elder abuse manifests differently to the usual dynamics of domestic and family violence, particularly with regards to whom is likely to be the perpetrator and what types of abuse may occur.⁷¹

In recognition of this, service system responses are increasingly becoming better tailored to addressing the needs of those at risk of elder abuse.⁷²

For example, an elder abuse helpline is operated by the Elder Abuse Prevention Unit (EAPU) by Uniting Care Community, and is funded by the Department of Communities, Disability Services and Seniors. A review of five years of call data between July 2010 and June 2015 from this helpline identified the predominant relationship of the perpetrator to victim to be family, specifically: sons (31.2%), daughters (29.0%), other relatives (9.9%), and spouse/partners (9.1%).⁷³ The primary abuse types recorded during this period were psychological and financial, with a much lower prevalence of reported sexual, physical and social abuse, and neglect.⁷⁴

With respect to the lower rates of abuse by elderly spouses/partners (9.1%), Board Members expressed concerns that this may be underreported. It may be the case that elderly people experiencing intimate partner violence are potentially not aware that their experiences of abuse may be considered both domestic and family violence and elder abuse.

There may also be other specific barriers which prevent older people from reporting abuse and leaving abusive situations, including:⁷⁵

- » diminished cognitive functioning and mental or physical disability;
- » lack of awareness about what amounts to abuse;
- » social alienation;
- » being too old to re-enter the workforce;
- » having too much invested in families or partners to leave; and
- » perceived or actual lack of access to services.

66 Eriksen, S., & Jensen, V. (2006). All in the family? Family environment factors in sibling violence. *Journal of Family Violence*, 21(8), 497-507.

67 Noland, V.J., Liller, K.D., McDermott, R.J., Coulter, M.L., & Seraphine, A.E. (2004). Is adolescent sibling violence a precursor to college dating violence? *American Journal of Health Behavior*, 28, S13-23.

68 Piotrowski, C.C., Taylor, K., & Cormier, D.C. (2014). Siblings exposed to intimate partner violence: linking sibling relationship quality & child adjustment problems. *Child Abuse & Neglect*, 38(1), 123-134.

69 Noland, V.J., Liller, K.D., McDermott, R.J., Coulter, M.L., & Seraphine, A.E. (2004). Is adolescent sibling violence a precursor to college dating violence? *American Journal of Health Behavior*, 28, S13-23.

70 As defined by the *Domestic and Family Violence Protection Act 2012*.

71 The Office of the Public Guardian (Qld). 2016. Submission to Australian Law Reform Commission Inquiry on 'Protecting the Rights of Older Australians from Abuse'.

72 For example, the Queensland Government has developed a resource for health professionals to assist in assessing and responding to elder abuse. This six-step approach includes: (1) Identify the abuse; (2) Provide emotional support; (3) Assess risk; (4) Safety planning; (5) Document; and (6) Refer.

73 Elder Abuse Prevention Unit. (2015). *The EAPU Helpline: results of an investigation of five years of call data*. Report for the International Association of Gerontology and Geriatrics Asia & Oceania Regional Congress 2015.

74 Notably these forms of violence may be under-identified and underreported, with research suggesting that relatively few instances of abuse are reported to authorities. See: Acierio, R., Hernandez, M.A., Amstadter, A.B., Resnick, H.S., Steve, K., Muzzy, W., & Kilpatrick, D.G. (2010). Prevalence and correlates of emotional, physical, sexual and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. *American Journal of Public Health*, 100(2), 292-297.

75 As reported from the Australian Domestic and Family Violence Clearinghouse in the Special Taskforce on Domestic and Family Violence. (2015). *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland*. Brisbane: Author.

Government responsibility for the management and prevention of elder abuse lies at both a state and federal level. While the responsibility for safeguarding vulnerable adults is dealt with primarily by the state governments, responsibilities for ageing and aged care has increasingly been appropriated by the Commonwealth.^{76,77}

Help-seeking and service responses

For those homicides in a family relationship reviewed by the Board within this reporting period, there were sometimes extensive patterns of prior violence perpetration for the homicide deceased and/or offender. However, this tended to be across the broader familial network or with (current or former) intimate partners, as opposed to within the index relationship.

In its discussions of these cases, the Board identified that there seemed to be a greater tolerance of male to male violence perpetration among both formal and informal supports. For those cases where the primary victim of violence was male⁷⁸ and the abuse came to the attention of services, the response was minimal and the behaviours do not appear to have been identified as potentially domestic and family violence related.

For example, one father was told to *not let his sons stand over him* after he disclosed to a police officer that they were threatening to *bash* him if he did not give them money and drive them around. In this case, the father had a severe mental illness and his treating team and multiple practitioners repeatedly noted that the abusive family dynamics were a significant stressor in his life. Despite this, his family were continually assessed as being a protective factor and his treating team considered that, despite the abusive dynamics, his relationships with them reduced his risk of relapse or future harm (to self or others).

There may also be other barriers to help-seeking for victims of family violence, particularly when the victim-perpetrator relationship consists of a parent and a child, as there is often an innate desire to protect a child from harm or adverse events (even in adulthood).

This has been highlighted in a Monash University study, which reported that parents who are the victim of adolescent family violence see police intervention as the 'last resort'.⁷⁹ As a result, the research found that many families live with violent and abusive behaviours.

Within this study cohort, parents reportedly desired a therapeutic and service-centred response that was delivered outside of the realm of the justice system to address this type of abuse.

While it appears that there are distinct differences between violence that occurs within family relationships, in all cases the primary perpetrators of violence were noted to use abusive tactics within both their intimate partner and family relationships.

In four cases, violence was also bi-directional or multi-directional in which family members were identified as both using, and experiencing, violence in their relationships. This was either in the same relationships, with other family members, and/or (current or former) intimate partners.

In one case, family members disclosed that the perpetrator (and deceased) would abuse them in the middle of, or subsequent to, an episode of intimate partner violence against his girlfriend. They specifically noted that this appeared to be a catalyst of his aggressive outbursts, whereby he would get angry, throw things around and cause fights. He would also threaten self-harm, with family members noting that they would hide knives from him to prevent further harm.

76 Australian Law Reform Commission. (2017). *Elder Abuse: A National Legal Response*. Canberra: Australian Government. <https://www.alrc.gov.au/publications/elder-abuse-report>

77 The Queensland Government, unlike other jurisdictions, has no state-wide elder abuse policy frameworks or practice guidelines that govern the identification of, and response to, experiences of elder abuse in the ageing population. The absence of a National Plan to guide reform and action within this space has also proven to be a limitation to achieving national consistency in legislation, policy and practice frameworks. At the request of the Attorney-General of Australia, the Australian Law Reform Commission (ALRC) has recently completed an inquiry on 'Protecting the Rights of Older Australians from Abuse'. This final report includes 43 recommendations for law reform to safeguard older people from abuse and support their choices and wishes. Large sections of this report fall outside the scope of consideration of the Board in that the abuse described is not within a relevant relationship (i.e. paid carers). However, of note, the ALRC recommended that: (a) A National Plan be developed to combat elder abuse; (b) A national prevalence research study be conducted by the Australian Institute of Family Studies to inform the evidence base and policy responses; (c) 'Assets of care' arrangements be expressed in writing and state based tribunals should have jurisdiction to resolve such family disputes; and (d) Safeguarding laws should be introduced in each state and territory, and safeguarding services should be made more readily available for those at risk. The Council of Attorneys-General, comprising the Commonwealth and all State and Territory Attorneys-General, has since committed to the development of a National Plan to be drafted by late 2018.

78 Notably, in all of the cases the perpetrator was also male.

79 Fitz-Gibbon, K., Elliott, K., & Maher, J. (2018). *Investigating Adolescent Family Violence in Victoria: Understanding experiences and practitioner perspectives*. Melbourne: Monash Gender and Family Violence Research Program.

Enhancing awareness and understanding

Based on a review of the 10 homicides within a family relationship completed by the Board, it is clear that there was a lack of recognition of family violence by victims, family, friends, and neighbours, which contributed to missed opportunities to intervene.

In one case, the neighbours reported that they were aware of repeated episodes of violence perpetrated by an adult son against his parents and other family members. However, there was limited action taken by them in response to these concerns (aside from on the morning of the fatal event).

In a statement after the death, one neighbour disclosed that the yelling emanating from the family's address was so frequent that they got used to it and would just shut the front door. In this regard, there appeared to be a sense of normalisation of the abuse apparent within this family.

While recent efforts have focused on addressing cultural perceptions of intimate partner violence as a 'private matter'⁸⁰, or in raising awareness of elder abuse, there may also be a need to consider ways to improve our understanding of abuse within a family relationship.

This is complicated by the apparent limited focus on this issue in research and practice at a state and national level.

As it stands, the current National Research Agenda of Australia's National Research Organisation for Women's Safety Ltd (ANROWS) supports the delivery of key outcomes of the *National Plan to Reduce Violence Against Women and their Children 2010-2022* (the National Plan). As intended, it is specifically working towards preventing violence against women and their children. The scope of the research agenda does, therefore, not specifically extend to violence within a family relationship as articulated in this chapter.

Similarly, while the Royal Commission examines family violence more broadly, including in the context of elder abuse and adolescent violence against parents, recommendations from the report are lacking a research focus on seeking to enhance understanding of the nuances and dynamics of this form of violence.

The Board considers it integral to build upon the work already having been achieved in this area by incorporating a more inclusive understanding of the unique dynamics of family violence (beyond intimate partner violence) into our research and practice agendas. The primary focus of this work should be to identify ways to prevent and respond to this type of violence.

Priority area for research: *Research into violence within family relationships is needed to consider: its intersectionality with intimate partner violence, whether there are specific risk indicators of harm that are unique to violence within a family relationship, and to consider referral pathways and gaps in service provision to families experiencing violence.*

⁸⁰ For example, the "Do something" bystander campaign, which provides education to bystanders on how and when they can intervene safely and effectively if they see or are concerned about domestic and family violence. <https://campaigns.premiers.qld.gov.au/dosomething/>



Chapter 4: Disrupting the cycle of violence

Key findings

- » Early intervention approaches that target vulnerable or at-risk families are of critical importance in breaking the cycle of violence, with some evidence in the cases reviewed that a person's experiences of violence commenced in childhood and continued throughout their life.
- » In 13 of the 20 cases, records indicate that children were exposed to domestic and family violence, and in seven of these cases, this resulted in notifications to the statutory child protection system.
- » For those cases where a relationship separation had occurred, perpetrators would use shared custody arrangements as an opportunity to facilitate further abuse against the primary victim of violence.
- » Protection orders listing the children as named persons were in place in seven cases, with no-contact conditions established in three cases.
- » Current frameworks to ensure the safety of victims of violence and their children who are separating from abusive and violent partners are fragmented, complex and challenging to navigate. National reforms that aim to improve the family law system remain a priority area of focus for the Board.
- » The Board also considered three cases of female perpetrated intimate partner homicide against a male partner. The female homicide offender was identified as the primary victim of violence in all cases.
- » Female perpetrated intimate partner homicides are rarely planned or premeditated, and generally occur in the middle of an episode of domestic and family violence in which the female is the primary victim. As such, the Board considered the legal defences available for women who kill an abusive partner, and the potential for unintended consequences in some cases.
- » The Board noted that for perpetrators of domestic and family violence who have links to outlaw motorcycle gangs, there was a heightened risk of future harm for their victim. The victims in these cases were threatened by their partner's criminal connections, did not consider themselves to be safe even when a perpetrator was incarcerated and faced increased challenges in attempting to separate from their abusive partner.

This chapter considers the history of domestic and family violence across intimate partner and family relationships for the homicide offender, the homicide deceased, the suicide deceased and other relevant parties in the cases reviewed by the Board. It also briefly summarises current research that may assist in helping us understand, and potentially disrupt, patterns of violence within and across relationships.

The impact of domestic and family violence on children is also discussed, as are the specific circumstances in which a female primary victim of violence may kill their abusive partner. Finally, consideration is given to the increased risks associated with perpetrators of violence who have criminal affiliations.

Notably, within the context of this report a primary perpetrator is defined as the person most responsible for violence in the relevant relationship that preceded the domestic and family violence death. This is distinct from the actual fatality, as the primary perpetrator of violence was not always the homicide offender in the cases reviewed.

Consequently, a perpetrator could be the homicide offender, homicide deceased, suicide deceased, or surviving perpetrator. The use of this term also recognises that a perpetrator of violence may be using abusive tactics against multiple persons at any given time.

Similarly, a primary victim is the person who was subjected to domestic and family violence in the relevant relationship that preceded the domestic and family violence death. This victim of violence is not always the homicide deceased and, on occasion, may themselves use violence, although the motivating factors may be different.⁸¹ As such, within this report, the primary victim of violence could be the homicide deceased, homicide offender, suicide deceased or surviving victim.

As per its legislative mandate, the Board was able to draw on a range of records to inform its review of these deaths.⁸² It is clear from these records⁸³ that violence commenced in childhood for some victims and perpetrators, and permeated throughout their family and intimate partner relationships.

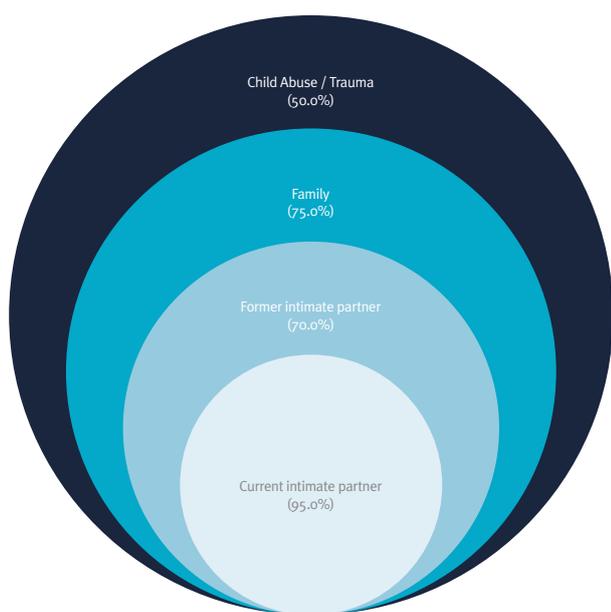
⁸¹ For example, violent resistance is a term used to describe when a woman uses violence to resist or avoid coercive controlling violence being used against them. See: Johnson, M. P. (2008). *A typology of domestic violence: Intimate terrorism, violent resistance, and situational couple violence*. Boston, MA: Northeastern University Press.

⁸² Where applicable, this included the coronial file, police brief of evidence, police history of recorded domestic and family violence or other related issues (such as mental health episodes or prior self-harm), and agency records.

⁸³ Given the known underreporting of this type of violence it is noted that the true extent of the abuse experienced by the victims and/or perpetrators may never be known.

These apparent histories of violence victimisation and perpetration across the life course are outlined in Figure 16. In eight cases, there was evidence to suggest that adult perpetrators and victims had prior histories of child abuse or experienced other traumatic events in childhood.⁸⁴ A history of victimisation across relationship types was also apparent, not only for victims, but also for some perpetrators, as shown in Figures 17 and 18.

Figure 16: Experiences of violence throughout the life course for victims and perpetrators⁸⁵



Upon analysis, there is also a gender disparity in the cases, with all perpetrators of violence being identified as male, and all females having a prior history of primary victimisation (though it is noted that there is evidence to suggest six also used violence within their relationships).

These findings highlight the complexity of a person's prior abuse history, in which they may have both experienced and used violence. It also highlights the importance of responding to a prior history of abuse and trauma, including for perpetrators of violence, and in ensuring interventions are better tailored to respond to both presenting and underlying needs.

Figure 17: History of violence victimisation, Board review cases, 2017-18

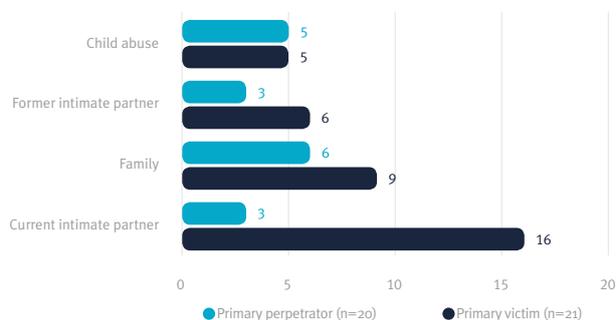


Figure 18: History of violence perpetration, Board review cases, 2017-18



These findings are supported by research which has identified that (some) women who experience serious and complex intimate partner violence in one relationship are likely to transition into subsequent relationships characterised by conflict and aggression.⁸⁶

This same study showed that a history of exposure to parental intimate partner violence is associated with an increased likelihood of violence victimisation in intimate partner relationships, for both men and women.

While this remains an under-explored area of research, a person's prior experiences of abuse may lead to the development of negative self-cognitions, normalise abuse experiences, and influence their expectation of violence as a tactic in social conflicts.⁸⁷

This emerging life course perspective may provide a possible explanation to better understand and respond to situations in which a person experiences repetitive victimisation across family or intimate partner relationships.⁸⁸

⁸⁴ Two additional individuals involved in collateral homicide cases had childhood experiences of abuse and trauma.

⁸⁵ This was observed in relation to the 20 cases considered by the Board during this reporting period.

⁸⁶ Carbone-Lopez, K., Rennison, C.M., & Macmillan, R. (2012). The transcendence of violence across relationships: New methods for understanding men's and women's experiences of intimate partner violence across the life course. *Journal of Quantitative Criminology*, 28, 319-346.

⁸⁷ Ibid.

⁸⁸ Ibid.

Intergenerational transmission of violence

Considering how violence is transmitted across generations may further assist in understanding the link between violence in intimate partner and family relationships.

Theories pertaining to the intergenerational transmission of violence suggest that exposure to abuse in the family of origin increases the likelihood of perpetrating^{89,90}, or being a victim of, violence in intimate partner relationships later in life.

That is, using social learning principles, children may learn that violence is an effective means of conflict resolution with intimate partners, or a means of gaining control.⁹¹ Further, children may not have the opportunity to socially learn the positive consequences of adaptive conflict resolution and effective communication.⁹²

Intergenerational transmission of family violence is proposed to involve two types of modelling:⁹³

- » **generalised modelling:** occurs when childhood exposure to family aggression communicates the acceptability of aggression between family members. This is not specific, and increases the likelihood of any form of family aggression in the next generation.
- » **specific modelling:** occurs when individuals reproduce the particular types of aggression they were exposed to.

It is important to note, however, that the majority of children who are exposed to domestic and family violence do not go on to perpetrate or become victims of violence. Those that have been exposed to violence, however, may be more likely to have extreme views in terms of accepting or rejecting abuse⁹⁴ and may develop attitudes that justify their own use of violence.⁹⁵

The transmission of violence across generations has also been shown to be role and gender specific, with exposure to violence by the father (including bi-directional violence) predictive of intimate partner violence perpetration.⁹⁶ Observing violence perpetrated by mothers only, and direct experiences of child abuse, do not have such a relationship.

While intergenerational transmission of violence may be able to explain bi-directional couple violence, it is considered less able to account for the use of coercive control in intimate partner relationships.⁹⁷

Research further indicates that violent offending is also transmitted from fathers to sons to a greater extent than non-violent offending.⁹⁸ In a sample of perpetrators of domestic and family violence who were on probation, those who witnessed inter-parental violence were more likely to be generally violent offenders (i.e. those who perpetrate violence towards their family and others) than those who had not experienced or witnessed violence.⁹⁹

Notably, among the cases reviewed by the Board in this reporting period, six of the perpetrators had a history of violent offending outside of an intimate partner and/or family relationship.

Early intervention and prevention

Efforts to break this cycle of violence have largely focused on early intervention in school and adolescent health settings. For example, educational programs that explore gender equality, conflict resolution and social expectations may be of benefit, and are able to be delivered to all young people as a population level intervention.

As part of the implementation of recommendations from the Special Taskforce, the *Respectful Relationships Education Program* has been adopted for all students from Prep to Year 12 as a primary prevention program.¹⁰⁰ This is delivered as part of the curriculum and is available to all schools in Queensland, however, it is not currently mandated for use. Similarly, other jurisdictions do not mandate delivery of the program as part of school curriculum. However, steps are being taken by Victoria, in particular, to compulsorily roll the program out to schools following recommendations from the Royal Commission.

Strong support from friends (but not family), greater spirituality, and greater emotional intelligence have been identified as promoting increased resilience among young adults who had been exposed to and/or were the victim of violence as a child.¹⁰¹ Providing interventions which focus on these protective factors may further assist in the psychosocial development of children from violent families.

In addition, screening for violence during pregnancy (and providing a subsequent appropriate intervention for those screened at risk) may assist in improving attachment between mother and infants, and provides an opportunity for early intervention for at risk families.¹⁰²

89 Cui, M., Durtschi, J.A., Donnellan, M.B., Lorenz, F.O., & Conger, R.D. (2010). Intergenerational transmission of relationship aggression: A prospective longitudinal study. *Journal of Family Psychology, 24*(6), 688-697.

90 Black, D.S., Sussman, S., & Unger, J.B. (2013). A further look at the intergenerational transmission of violence: witnessing interparental violence in emerging adulthood. *Journal of Interpersonal Violence, 25*(6), 1022-1042.

91 Ehrensaft, M.L., Cohen, P., Brown, J., Smailes, E., Chen, H., & Johnson, J.G. (2003). Intergenerational transmission of partner violence: A 20-year prospective study. *Journal of Consulting and Clinical Psychology, 71*, 741-753.

92 Black, D.S., Sussman, S., & Unger, J.B. (2013). A further look at the intergenerational transmission of violence: witnessing interparental violence in emerging adulthood. *Journal of Interpersonal Violence, 25*(6), 1022-1042.

93 Kalmuss, D. (1984). The intergenerational transmission of marital aggression. *Journal of Marriage and the Family, 46*(1), 11-19.

94 VicHealth study cited in Flood, M. & Fergus, L. (2008). *An assault on our future: the impact of violence on young people and their relationships*. Sydney: White Ribbon Foundation.

95 Edleson, J. (1999). Children's witnessing of adult domestic violence. *Journal of Interpersonal Violence, 14*(8), 839-870.

96 Eriksson, L., & Mazerolle, P. (2014). A cycle of violence? Examining family-of-origin violence, attitudes, and intimate partner violence perpetration. *Journal of Interpersonal Violence, 30*(6).

97 Dardis, C.M., Dixon, K.J., Edwards, K.M., & Turchik, J.A. (2014). An examination of the factors related to dating violence perpetration among young men and women and associated theoretical explanations: A review of the literature. *Trauma, Violence, & Abuse, 16*(2).

98 Van de Weijer, S.G.A., Bijleveld, C.C.J.H., & Blokland, A.A.J. (2014). The intergenerational transmission of violent offending. *Journal of Family Violence, 29*(2), 109-118.

99 Fowler, D.R., Cantos, A.L., & Miller, S.A. (2016). Exposure to violence, typology, and recidivism in a probation sample of domestic violence perpetrators. *Child Abuse & Neglect, 59*, 66-77.

100 Recommendations 24, 25, 26. Special Taskforce on Domestic and Family Violence. (2015). *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland*. Brisbane: Queensland Government.

101 Howell, K., & Miller-Graff, L. (2014). Protective factors associated with resilient functioning in young adulthood after childhood exposure to violence. *Child Abuse & Neglect, 38*(12), 1985-1994.

102 Safe Start screening has been in place within Queensland Health funded facilities for some time. This was discussed in the 2016-17 Annual Report of the Board which found that the tool did not detect the presence of violence in some cases, and when it was unable to be administered due to the partner being present, it wasn't re-administered at a later appointment. The Board subsequently recommended that the Department of Health should liaise with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to promote routine screening for domestic and family violence, and enhanced responses to high-risk and vulnerable families in private obstetrics and health facilities (Recommendation 5). The Queensland Government has accepted this recommendation, with an 'Antenatal screening for domestic and family violence guideline' now developed which is in the process of being implemented.

At a more targeted, individual level, programs for vulnerable or at-risk families may help parents learn safer conflict resolution skills to assist in breaking the cycle of violence. Children may also need access to appropriate role models to ‘unlearn’ maladaptive behaviours.

The importance of targeted intervention and engagement with services for young people at risk should not be underestimated. They should, however, occur within the context of a range of broader, multi-layered system responses which seek to hold perpetrators to account, while providing protective support to victims and their children.

While the Third Action Plan of the National Plan prioritises early intervention and prevention initiatives, the focus is not specific to interventions for children at risk of developing, or who are currently exhibiting, maladaptive behaviours associated with their exposure to domestic and family violence.

It, instead, focuses on challenging attitudes and behaviours that excuse, justify and promote violence against women and their children by enhancing community awareness through national campaigns, engaging business and sporting organisations, and through education initiatives embedded in schools and workplaces.

Linked to the Third Action Plan, the *National Framework for Protecting Australia's Children 2009-2020* also seeks to support early intervention initiatives. However, proposed strategies are similarly focused on increased community awareness and encouragement of families to seek help earlier.¹⁰³ This includes:

- » community awareness raising activities focused on effective parenting practices and strategies to enhance safe and supportive environments;
- » improved coordination of services, resources, and activities in high incidence locations to better meet the needs of vulnerable parents (or expectant parents) of young children; and
- » implementing joined up responses to families with young children across agencies and sectors by examining local models to identify critical success factors to inform future planning.

The Board considers this to be a priority area that warrants further exploration, to inform our understanding of what evidence-based early intervention and prevention initiatives may best support children at risk.

It is clear that there is a need to do more to support children exposed to domestic and family violence across the service system. This is particularly pertinent given that children may actually represent one of the largest clients of specialist services, particularly women's refuges.

An independent audit¹⁰⁴ of domestic and family violence specialist services was undertaken recently as part of the Special Taskforce reforms. The audit identified that there were just seven services operating in Queensland that specifically focused on supporting children who are affected or exposed to domestic and family violence.¹⁰⁵

Further, the current practice standards for working with women affected by domestic and family violence¹⁰⁶ and children and young people living with domestic and family violence¹⁰⁷ were developed and published over 15 years ago. As such, neither resource is contemporary, with the national practice standards for working with children not easily accessible online.

The DCSYW is leading the review and re-development of these practice standards in Queensland. This review will include support for victims, including case management, counselling and court support, and support for children and young people, including those at risk of using violence in the future.

Based on cases reviewed by the Board, there is a clear need for contemporary best-practice guidance for practitioners on working with children and young people who may be affected by domestic and family violence. Accordingly, the Board looks forward to the implementation of these resources in 2018-19.

Recommendation 1:

That the Queensland Government consider what services or programs are available to support children who experience or witness domestic and family violence across the state. These should be domestic and family violence informed, with a focus on early intervention and prevention, as well as targeted services to respond to children who have, or are, experiencing domestic and family violence, with a view to enhancing their availability and accessibility.

This should also include consideration of how to better identify and respond to cumulative harm; the roles and responsibilities of family support services in providing domestic and family violence informed assistance to at risk families; and opportunities to expand existing culturally appropriate, trauma informed counselling services for children.

103 Third Action Plan 2015-2018, *Driving Change: Intervening Early*, National Framework for Protecting Australia's Children 2009-2020. https://www.dss.gov.au/sites/default/files/documents/12_2015/pdf_third_action_plan_for_protecting_australias_children.pdf

104 KPMG. (2016). *Domestic and Family Violence Services Audit: Final Report*. Produced for the Department of Premier and Cabinet, Queensland Government. <https://www.csyw.qld.gov.au/resources/gateway/campaigns/end-violence/dfv-services-audit-report.pdf>

105 This excluded generalist services for children and young people and the child protection sector.

106 Department of Families. (2002). *Practice Standards for Working with Women Affected by Domestic and Family Violence*. Brisbane: Queensland Government.

107 Gevers, L., & Goddard-Jones, M. (2003). *Working with Children and Young People Living with Domestic Violence*. Canberra: Commonwealth Government of Australia (Office of the Status of Women).

Children living with violence

Exposure to domestic and family violence can result in cumulative harm¹⁰⁸ to a child, and can have significant long-term effects on their development and psychosocial outcomes. This can include the ability to form attachments and healthy respectful relationships in adulthood.¹⁰⁹

In 13 cases considered by the Board, there was evidence to suggest that children were exposed to, or were a direct victim of, domestic and family violence. This included:

- » the perpetrator using the children to manipulate the victim to remain in, or reconcile, the relationship;
- » the perpetrator using the children to monitor the primary victim's (their mother) behaviour;
- » exposure to direct and indirect acts of violence;
- » the perpetrator making threats to seriously harm or kill the children as a means to exert control over the victim (their mother); and
- » in addition to the four children¹¹⁰ who were murdered in the cases, there were 18 children present during the homicide event across nine cases.¹¹¹

In one case, there was evidence to suggest that one of the teenage children was himself showing signs of using violence against their mother (who was the primary victim of violence). In another case, two of the children were experiencing significant mental health problems associated with their ongoing exposure to violence within their family of origin, including suicidal behaviours. This resulted in one of the children being admitted to a public mental health facility.

Observable changes in the behaviours of the victim children in another case (including increased anxiety, hypervigilance, physical aggression and physical health issues) were so concerning to an extended family member that they notified child safety services.

In another case where the perpetrator was killed by the primary victim's new partner, threats were made by the perpetrator to kill the victim's child as an act of revenge in the context of perceived sexual infidelity (despite the prior dissolution of the relationship). The children in this case were exposed to extreme levels of violence in the family home, including one witnessing the rape and physical assault of their mother (the victim) by their father (the homicide deceased and perpetrator). The children also witnessed multiple other acts of abuse, including their father smashing their mother's head into a steering wheel while she was driving with them in the car.

One victim unsuccessfully attempted to end her marriage with her abusive husband several times, but was manipulated into reconciling with him through his use of coercive controlling violence. This included making the victim feel guilty for breaking up the family. He also used her religious beliefs against her, with some evidence that he would involve church elders in his attempts to force a reconciliation. After she managed to flee the relationship, the perpetrator was able to gain access to this victim under the guise of a pre-arranged child visitation and killed her in a premeditated attack, despite attempts by bystanders to intervene.

Research suggests that it is common for perpetrators of domestic and family violence to hurt children as a means to harm their mother¹¹², and that children are more vulnerable to abuse after separation.¹¹³ Perpetrators may also seek to undermine the mother-child relationship, involve children in violence and make threats to harm the children.¹¹⁴

For those couples who were separated, contact to arrange child visitations and during handovers were identified as a period of high risk as it provided an opportunity for the perpetrator to continue their abusive behaviours.

In their discussions around this issue, the Board focused on:

- » the inclusion of children as named persons, and the use of no-contact conditions, on protection orders;
- » the use of risk assessment processes in domestic and family violence related court proceedings;
- » the trial and implementation of specialist domestic and family violence courts in Queensland; and
- » the presumption towards shared parenting within the context of domestic and family violence.

¹⁰⁸ Cumulative harm is defined as harm experienced by a child as a result of a series or pattern of harmful events and experiences that may have occurred in the past or are ongoing. There is a strong possibility of multiple inter-related risk factors existing over critical developmental periods. The effects of cumulative harm can diminish a child's sense of safety, stability and well-being. Bromfield, L. & Miller, R. (2007:2) Specialist Practice Guide: Cumulative harm. Every child, every chance, Department of Human Services, Victoria in Department of Child Safety, Youth and Women, Practice Guide: The assessment of harm and risk of harm; January 2015.

¹⁰⁹ Price-Robertson, R., Rush, P., Wall, L., & Higgins, D. (2013). Rarely an isolated incident: Acknowledging the interrelatedness of child maltreatment, victimisation and trauma (CFCA Paper No. 14). Melbourne: Australian Institute of Family Studies. Available online at: www.aifs.gov.au/cfca/publications/rarely-isolated-incident-acknowledging-interrelatedn

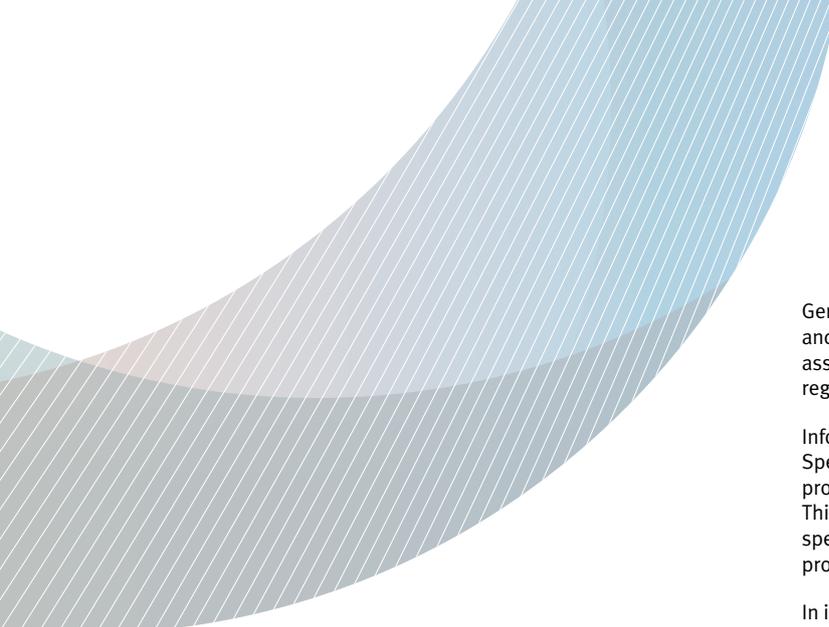
¹¹⁰ In one of the cases, the primary victim of violence killed her child; in the others, the deceased was killed by their abusive father or another family member who had a prior history of violence perpetration.

¹¹¹ Some children were present in the home during the homicide event, but it is unclear whether they were direct witnesses to the homicide event.

¹¹² Fish, E., McKenzie, M. and MacDonald, H. (2009) 'Bad mothers and invisible fathers'. *Parenting in the context of domestic violence*. Discussion Paper, no.7, Domestic Violence Resource Centre Victoria.

¹¹³ Bagshaw, D., Brown, T., Wendt, S., Campbell, A., et al (2010) *Family violence and family law in Australia: The experiences and views of children and adults from families who separated post-1995 and post-2006*. Attorney-General's Department: Canberra.

¹¹⁴ Australian Domestic and Family Violence Clearinghouse (2011) *The impact of domestic violence on children: A literature review*. Australian Domestic and Family Violence Clearinghouse for the Benevolent Society: Sydney.



Among the intimate partner homicides considered by the Board, there were children in 10 cases. At the time of the deaths, a protection order was in place in seven of these cases (70.0%), with the children listed as named persons on each of these orders.

However, conditions preventing contact between the perpetrator (respondent) and the named children were only in place in three cases.¹¹⁵ The aggrieved had applied to have no-contact conditions removed in two additional cases to allow the respondent to have access to their children.

In the two other cases¹¹⁶, there was no indication that the victim sought to have no-contact conditions included.

In one of the cases where the victim sought to remove the no-contact conditions, police made an application to have them reinstated as they feared for the wellbeing of the children due to the severity of domestic and family violence. Despite the officer's concerns, the court issued a protection order with standard conditions stipulating the respondent be of good behaviour to the aggrieved and the named children only.

In this regard, it is salient to note that current legislative provisions allow magistrates to include children as named persons on orders, and to impose no-contact conditions where there is an identifiable risk to children.

Generally speaking, where children are present in the relationship and an application for a protection order is made, a risk assessment may be beneficial to inform a magistrate's decision regarding what conditions may be required.

Information sharing provisions recently enacted as part of the Special Taskforce reforms¹¹⁷ enable such information to be provided to magistrates to assist in their decision making.¹¹⁸ This information can be supplied by another prescribed entity, a specialist domestic and family violence service, or another service provider.¹¹⁹

In integrated service response trial sites¹²⁰, relevant risk assessment information is delivered to the magistrate considering a protection order application or breach proceeding either through the prosecution or legal representatives. This process is currently under review to identify any opportunities for improvement.

The introduction of specialist domestic and family violence courts¹²¹ has also improved the information provided to the court to inform judicial decision making where they are operating. This includes records pertaining to an alleged respondent's prior history of domestic and family violence in other relationships.¹²²

The recent evaluation of the Southport specialist domestic and family violence court indicated that principles of this trial model may be transferrable to other locations, particularly in rural and regional communities.¹²³ This evaluation found that the application of a specialist court approach is replicable only in high volume locations where there are adequate numbers of magistrates and a concentration of legal and support services. However, there may be benefit in embedding the underlying principles and function of this approach into conventional court models.

This involves not seeking to replicate the features of the Southport specialist court, but instead, crafting alternative approaches, adapted to local needs and contexts.

115 In one of these three cases, there were provisions allowing contact if the aggrieved provided written approval to facilitate access to the child for contact visits.

116 That is, where there was a protection order in place, but there were no no-contact conditions, or the aggrieved had not sought to vary the order to remove no-contact conditions.

117 S5A of the *Domestic and Family Violence Protection Act 2012*.

118 Department of Communities, Child Safety and Disability Services. (2017). *Domestic and Family Violence Information Sharing Guidelines*. Brisbane: Queensland Government. <https://www.communities.qld.gov.au/resources/gateway/campaigns/end-violence/info-sharing-guidelines.pdf>

119 According to the Queensland Domestic and Family Violence Information Sharing Model, prescribed entities include: police, corrective services, justice, education, ambulance, housing, public health services, child safety and other departmental agencies that provide services to people who may experience or perpetrate domestic and family violence.

120 As per recommendations 77 and 78 of the Special taskforce Final Report.

121 Specialist domestic and family violence courts offer: a dedicated magistrate with expertise in domestic and family violence; a court coordinator to oversee court operations; a specialist domestic and family violence court registry where specialist court staff offer support and information; dedicated prosecutors; duty lawyers; court support workers for the aggrieved; support/liaison works for the respondent; access to domestic and family violence perpetrator programs; and, specialist domestic and family violence registry training. A complete specialist domestic and family violence court is in operation at the Gold Coast with this model currently being implemented in Beenleigh, Townsville, Mount Isa and Palm Island.

122 A specialist domestic and family violence magistrate will circuit to Mount Isa and Palm Island where a culturally responsive approach will be offered to Aboriginal and Torres Strait Islander court users. The Beenleigh specialist court will commence handling civil matters in 2017-18 and will also manage criminal DFV matters after major refurbishment to the courthouse to facilitate a second dedicated DFV courtroom, safety precinct for female aggrieved, a specialist court registry, and extra meeting rooms.

123 Bond, C., Holder, R., Jeffries, S., & Fleming, C. (2017). *Evaluation of the Specialist Domestic and Family Violence Court Trial in Southport*. Griffith University.

The presumption towards shared parenting

In five cases where a couple had separated, the primary victim made attempts to facilitate informal shared custody arrangements with no evidence that they withheld contact to their child/ren on any occasion even when they were subjected to ongoing abuse post-separation. Facilitating this contact may have been an attempt for the primary victim to 'keep the peace' and avoid further abusive episodes, along with an expressed commitment in some cases to ensure their children had access to their father.

There was no Family Law Court orders in any of these cases.¹²⁴

In four of these cases, the family resided together post-separation due to financial pressures, as well as to facilitate a shared parenting arrangement. This placed the primary victims at very high risk, and in one case, breaches were reported to police in relation to a perpetrator taking intimate photos of the victim without her consent. Officers reported being unable to take any action as the couple were residing together.

The presence of informal shared parenting arrangements in these cases is likely to be reflective of patterns of engagement with the family law system more broadly. In three cases, the separation had also only recently occurred, meaning there was limited opportunity to formally progress such arrangements.

The general presumption towards shared parenting in cases where there is parental domestic and family violence and mental health concerns can be particularly problematic as it means arrangements are established without formal oversight, with no corresponding opportunity to intervene.

Greater access to support for women who are trying to separate from an abusive partner to establish parenting arrangements has been called for previously.¹²⁵ Recent research has identified that victims of violence experience increased levels of stress and trauma as a result of contact with courts in relation to domestic and family violence matters.¹²⁶ While many victims sought help from mental health practitioners in relation to these stressors, others actively avoided such assistance for fear of how this would be perceived and used during the court proceedings.

Victims' experiences through the system are further complicated by the intersections between state and national legislative frameworks.

For example, family law orders made under the Commonwealth jurisdiction override protection orders initiated at the state or territory level where there is any inconsistency.¹²⁷ However, recent changes in Queensland mean that magistrates are empowered to review, vary, suspend or discharge family law orders when making protection orders to address any such inconsistencies.¹²⁸

While not explored further in this report, there are a range of ongoing issues with how the family law system responds to domestic and family violence, with a national review currently underway.¹²⁹ The Board looks forward to the outcomes of this national review, and considers that relevant findings from death review processes would be of value in informing responses in this area.

Protection of children and young people

In seven cases considered by the Board, the families had also been in contact with child safety services in relation to domestic and family violence within two years of the deaths. It was noted that assessments of harm completed by child safety officers were heavily informed by the presence (or lack thereof) of prior child protection notifications and police reports of domestic and family violence. In the absence of these recorded histories, these cases were generally closed by way of a Child Concern Report¹³⁰ with no further action taken.

This is inherently problematic as research indicates that the majority of violence goes unreported to services.¹³¹ As such, in the absence of prior formal reports, and without further assessment or investigation, non-physical indicators of coercive control which are linked to an increased risk of harm may go undetected and un-responded to.

Notably, research indicates that almost one-quarter of child protection concerns that featured reports of domestic and family violence that were not investigated resulted in a subsequent child protection report within one year.¹³²

124 While magistrates are to have regard to any family law order of which the court has been made aware of, it is ultimately the obligation of the applicant to inform the court of such. This includes where a police officer files an application on behalf of the aggrieved or where a Police Protection Notice is issued. This was identified as an issue in the evaluation of the Southport specialist court, where the development of strategies to allow the gathering of information pertaining to family law orders and child safety matters prior to court appearances was recommended. In all locations where a specialist court is being trialled or established, registry staff are now required to enquire about the existence of Family Law Orders at the time the applicant is lodging the application. At any other Magistrates Court location, where an order is identified, the Magistrates Court Registry will obtain the current Family Law Order from the appropriate court for provision to the Magistrate considering the DVO application.

125 Bagshaw, D., Thea, B., Wendt, S., Campbell, A., McInnes, E., Tinning, B., & Arias, P. F. (2010). *Family Violence and Family Law in Australia: The experiences and views of children and adults from families who separated post-1995 and post-2006*. Canberra: Commonwealth Attorney-General's Department.

126 Douglas, H. (2018). Domestic and family violence, mental health and well-being, and legal engagement. *Psychiatry, Psychology and Law*, 25(3), 341-356.

127 Taylor, A., Ibrahim, N., Wakefield, S., & Finn, K. (2015). *Domestic and Family Violence Protection Orders in Australia: An investigation of information sharing and enforcement: State of knowledge paper*. Sydney: ANROWS.

128 S68R of the *Family Law Act 1975* (Cth).

129 The terms of reference include consideration of whether, and if so what, reforms to the family law system are necessary or desirable across a range of areas, including (amongst others): family violence and child abuse, including protection for vulnerable witnesses; the protection of the best interests of children and their safety; collaboration, coordination, and integration between the family law system and other Commonwealth, state and territory systems, including family support services and the family violence and child protection systems; families with complex needs, including where there is family violence, drug or alcohol addiction or serious mental illness. Australian Law Reform Commission. *Review of the Family Law System*.

130 A Child Concern Report is a matter where child protection concerns do not meet the threshold for recording a notification or taking any statutory intervention.

131 Gracia, E. (2004). Unreported Cases of Domestic Violence against Women: towards an epidemiology of social silence, tolerance and inhibition. *Journal of Epidemiological Community Health*, 58, 537-537

132 Humphreys, C., & Healey, L. (2017). *PATHways and Research into Collaborative Inter-Agency practice: Collaborative work across the child protection and specialist domestic and family violence interface: Final report*. (ANROWS Horizons 03/2017). Sydney, NSW: ANROWS.

While it was noted that child safety officers did not want to be intrusive in some of these cases, such contact may have been an opportunity for support or referral for the victims and their children.

In two cases, child safety services considered that the perpetrator seeking psychological support was a protective factor. However, steps were not taken by officers to seek clarifying information regarding treatment progress or outcomes, or to determine the presence of any other risk indicators in either case. While treatment engagement is a positive sign, this should be thoroughly explored within the context of other indicators of harm. In at least one of these cases, it is known that the primary victim, the children's mother, had raised concerns to police that she believed the perpetrator to be in an unfit mental state and she was concerned for the safety of the children after he made threats to harm them.

Domestic and family violence and child abuse and maltreatment have historically been seen as distinct issues. Most recently, the *Queensland Child Protection Commission of Inquiry* (2013) reported that improvements to the current system could be made through aligning programs across portfolios (including domestic and family violence) to ensure they are complementary and are meeting clients' needs.¹³³

As part of these reforms, and those associated with the Special Taskforce, the DCSYW has invested significantly to improve the proficiency of child safety workers' understanding of domestic and family violence.

As at May 2018, 1500 child safety officers and community workers have received the David Mandel's *Safe and Together*¹³⁴ training. This is a strengths based approach to supporting mothers and children to stay together safely at home, while holding fathers who use violence to account.

In addition, as part of ongoing reforms to the child safety system, Family and Child Connect and Intensive Family Support services are funded to employ specialist domestic and family violence workers to enhance responses to families at risk.

Prior history of victimisation (female homicide offenders)

In its 2016-17 Annual Report, the Board identified issues with the way in which services respond to victims who may themselves use violence. This is particularly pertinent as the DFVPA 2012 requires that consideration be given to the person most in need of protection in circumstances where there are mutual allegations of violence.¹³⁵

In brief, research clearly indicates that in some circumstances, female victims of violence may themselves react to abuse by using violence, and that this is generally in defence of themselves or others.¹³⁶ In some circumstances, victims may also pre-emptively use violence to try and prevent what they see as an inevitable attack by their abusive partner.¹³⁷

In recognition that there is a paucity of research or established interventions to guide improved responses in this area, the Board has previously recommended that the Queensland Government commission research which aims to identify how best to respond to the person most in need of protection where there are mutual allegations of violence and abuse.¹³⁸

The Queensland Government has accepted this recommendation and will consult with ANROWS and the Queensland Government Statistician's Office Crime Research Reference Committee to build on the existing research and evidence base.

Nevertheless, this issue has again been identified in four cases reviewed by the Board. In all of the female perpetrated intimate partner homicides, the female offender had a prior history of primary victimisation, but they were also noted to have themselves previously used violence. This prior history of victimisation was in both current and former relationships (intimate partner and/or family).

For example in one case, multiple episodes of violence in the weeks preceding the death were reported to the police, including an unlawful wounding which resulted in hospitalisation for that female victim of violence. There was evidence to also suggest a prior history of non-lethal strangulation by the homicide deceased perpetrated against the homicide offender (and victim). She further reported experiencing ongoing symptoms of Posttraumatic Stress Disorder after being drugged and raped by an older male (relationship unknown) during adolescence.

In this case, shortly before the deaths, a male family member of the female homicide offender (and primary victim) also attacked her abusive partner in what was best conceptualised as an act of retribution for the violence that was being inflicted on her by the primary perpetrator, whom she later killed.

¹³³ Queensland Child Protection Commission of Inquiry. (2013). *Taking Responsibility: A roadmap for Queensland Child Protection*. Brisbane: Author.

¹³⁴ This is a strengths-based training program and approach to helping child welfare and its partners make good decisions for children impacted by domestic violence perpetrators. The model aims to improve practice and create better outcomes for children and families exposed to domestic violence.

¹³⁵ Section 4(2)(e) of the *Domestic and Family Violence Protection Act 2012*.

¹³⁶ Swan, S.C. & Snow, D.L. (2003). Behavioral and psychological differences among abused women who use violence in intimate relationships. *Violence Against Women*, 9, 75-109 – cited in Swan et al., 2008.

¹³⁷ Violent resistance refers to violence used by (predominantly) female victims as a means of self-defence for protection against their perpetrators. The use of violence towards an abuser may appear counterintuitive to avoiding physical harm however, victims tend to use it as an active coping strategy. Refer to: Leone, J. M., Johnson, M. P., & Cohan, C. L. (2007). Victim help seeking: Differences between intimate terrorism and Situational couple violence. *Family Relations*, 56(5), 427-439.

¹³⁸ Recommendation 16 of the 2016-17 Annual Report of the Domestic and Family Violence Death Review and Advisory Board.

Data on intimate partner homicides in Queensland also show that, where there is an identifiable history of violence, all female intimate partner homicide offenders were the primary victims of violence in that relationship prior to the homicide. In contrast, almost all male homicide offenders had a history of perpetrating intimate partner violence against the female deceased.

While female perpetrated intimate partner homicides are statistically rare, this finding is consistent across Australian jurisdictions.

National data reported by the Australian Domestic and Family Violence Death Review Network revealed that 28 males were killed by a female intimate partner between 2010 and 2014.¹³⁹ In all but two cases where the nature of the violence was established, the female homicide offender was identified as a victim of violence in the relationship.¹⁴⁰ One-quarter of the female homicide offenders were listed as an aggrieved in a protection order at the time of the homicide.¹⁴¹

There is also a substantial amount of international research that has examined female perpetrated homicides.

With respect to women who kill or seriously assault their partner, studies have found that they are more likely to be cohabitating and married (not separated), and this finding is of particular interest as it suggests that women commit an act of aggression when they have not been able to flee.¹⁴²

Further, when a woman kills her abusive male intimate partner, it is (generally) while a violent or threatening incident is occurring, indicating that the assault was not planned or premeditated.¹⁴³

Females are also more likely to have previously experienced injuries, suggesting that the homicide may have been a defensive reaction to prior abuse.¹⁴⁴

For example, one female homicide offender killed her male partner in the middle of an episode of violence, stating later that she armed herself with a knife to protect herself from further assaults. She later disclosed that if she had not stabbed him, then she believed that he would have got the knife from her and *use it on me or belt the **** out of me.*

In terms of predicting intimate partner homicides, no matter the gender of the partner who is killed, the best predictor of the homicide is a history of domestic violence¹⁴⁵, in which a partner is exposed to repeated emotional, sexual or physical abuse that forms part of a controlling pattern of behaviour.¹⁴⁶

Legal defences for women who kill their abusive partner

In one case reviewed by the Board, records indicate that a female homicide offender reported an intention to use a 'battered women's syndrome' defence, but she was not supported by multiple legal practitioners who had been appointed to assist her.

As such, the Board heard from a range of experts regarding the operability, or otherwise, of specialised homicide defences for abused women.

In 2010, Queensland introduced a defence of killing for preservation in an abusive domestic relationship.¹⁴⁷ It is apparent that the risks associated with utilising this defence are significant. A failure of this defence could result in a conviction of murder, which carries a mandatory life sentence (including a minimum non-parole period of 20 years). By comparison, a plea to a lesser charge of manslaughter generally results in a sentence of six–eight years with a non-parole period of about three to five years.

Subsequent to the introduction of this partial defence in Queensland, of the cases finalised through court proceedings between 2011 and 2017, there were five female intimate partner homicide offenders convicted of manslaughter and sentenced for an average period of 7.7 years (with a range from 6.5 to 9 years).

Other outcomes included one case where the female defendant was found not guilty¹⁴⁸, and one case where the female defendant was discharged through the mental health court system.

Nationally, the Australian Domestic and Family Violence Death Review Network have also found that for those matters in which criminal proceedings had been finalised, 20 of 27 (74.1%) female homicide offenders¹⁴⁹ were convicted of manslaughter, two were convicted of murder (7.4%), and one (3.7%) pled guilty to lesser charges.¹⁵⁰ Two female offenders were acquitted (7.4%) and another two had their charges dropped (7.4%).

¹³⁹ Australian Domestic and Family Violence Death Review Network. (2018). *Data Report 2018*. Sydney: Author.

¹⁴⁰ The female was the primary victim in 60.7% of cases, recorded as a victim and perpetrator in 17.9% of cases, and as a primary abuser in 7.1% of cases. Offender status was unable to be determined in 14.3% of cases.

¹⁴¹ The *New South Wales 2015 - 2017 Domestic Violence Death Review Team Report* indicated that of 35 men who were killed by their female intimate partner in the reporting period, 31 of those men had been the primary domestic violence aggressor in the relationship. The NSW Domestic Violence Death Review Team Report 2015 – 2017; NSW Coroner: NSW Government. Similarly, Victorian statistics from 2000 – 2010 show that 83.3% of men who died from homicide were also the primary perpetrator of violence in the relationship prior to the death. Ibid 1 in the Royal Commission into Family Violence, Australian Government; Volume V; March 2016.

¹⁴² Jordan, C. E., Clark, J., Pritchard, A. & Charnigo, R. (2012). Lethal and Other Serious Assaults: Disentangling Gender and Context. *Crime and Delinquency*, 58(3) 425 – 455.

¹⁴³ Ibid.

¹⁴⁴ Swatt, M.L., & He, N. (2006). Exploring the difference between male and female intimate partner homicides: Revisiting the concept of situated transactions. *Homicide Studies*, 10, 279-292.

¹⁴⁵ Campbell, J. C., Glass, N., Sharps, P. W., Laughon, K. & Bloom, T. (2007). Intimate Partner Homicide: Review and Implications of Research and Policy. *Trauma Violence Abuse* 8: 246.

¹⁴⁶ Braaf, R. (undated). Preventing Domestic Violence Death – Is Sexual Assault a Risk Factor? *Australian Domestic & Family Violence Clearinghouse*.

¹⁴⁷ The amended legislation (notably Section 304B) was designed to create a partial defence for victims of domestic and family violence who kill their abuser in their reasonably grounded belief that this was necessary for their own preservation, in circumstances that ordinarily would be considered murder. As a partial defence, if this provision is successful the defendant will be convicted of manslaughter as opposed to murder which carries a mandatory life imprisonment sentence in Queensland. That is, it is used to reduce a verdict of murder to one of manslaughter. The onus is on the prosecution to exclude the defence of preservation (or other defences) beyond reasonable doubt.

¹⁴⁸ Based on a consideration of the evidence before them the jury could not find beyond a reasonable doubt that this female homicide offender was guilty. Irrespective the Queensland Domestic and Family Violence Death Review Process utilises the national definition of a domestic and family violence homicide as agreed by the Australian Domestic and Family Violence Death Review Network. The definition of homicide is broader than the legal definition and includes all circumstances in which an individual's intended act, or failure to act, resulted in the death of another person, regardless of whether the circumstances were such as to contravene provisions of the criminal law. This applies to cases where a relevant relationship exists, and the death occurs in the context of domestic and family violence.

¹⁴⁹ Between 1 July 2010 and 30 June 2014.

¹⁵⁰ Australian Domestic and Family Violence Death Review Network. (2018). *Data Report 2018*. Sydney: Author.

Of further interest are the rates and context of female homicide offenders who identify as Aboriginal and Torres Strait Islander. Indigenous women are over-represented as both deceased and offenders in domestic homicides and, where they commit homicide, the deceased is almost exclusively someone they have a family or domestic relationship with.¹⁵¹

In an Australian study, over one-quarter of the female homicide offenders between 2000 and 2010, where the female had a history of intimate partner violence victimisation, identified as Aboriginal and/or Torres Strait Islander.¹⁵² Further, Indigenous women were over-represented among cases involving a guilty plea, with over 40% of all guilty pleas entered by Aboriginal and Torres Strait Islander women.¹⁵³

It is clear that there may be additional challenges faced by Aboriginal and Torres Strait Islander women in providing evidence of their past histories of abuse to the court. This is attributable to the cohort tending to have lower levels of engagement with police or other services. They may also be listed as both an aggrieved and respondent in protection orders, despite significant personal histories of prior victimisation.¹⁵⁴

Notably, a victim in one case reviewed by the Board who identified as Aboriginal was listed as using violence in some of the police records. However, these records clearly show that she was subject to multiple acts of serious abuse by the homicide deceased, including non-lethal strangulation and repeated physical assaults. She was, however, noted to be reluctant to seek any assistance, including from health services, and later disclosed that she would instead self-medicate with cannabis and other substances to avoid dealing with the emotional aspects of the abuse.

Issues with the use of self-defence and other defence provisions have also been identified with respect to 'non-confrontational' homicides where the abuser is killed in their sleep or is not otherwise immediately threatening violence. While immediacy is not an element of any defence, it is difficult to prove that a killing was in self-defence or preservation when there is no recent act or threat by the abusive partner. This is particularly the case where the jury may not understand why the victim did not leave or seek assistance from police or other services.¹⁵⁵

Similar to Queensland, legislative reform has been introduced in other jurisdictions in an attempt to address this phenomenon, however, there has been unintended consequences with some of these amendments. For example, in 2005, Victoria introduced the offence of 'defensive homicide' as an alternative to murder. This was later abolished in 2014 after a review by the Victorian Law Reform Commission¹⁵⁶ found the defence was not being used as intended, with it being used predominantly by men who killed other men in violent confrontations. Additional legislation¹⁵⁷ was introduced in September 2014 that seeks to address the issue of homicide in the context of domestic and family violence by simplifying self-defence and introducing jury directions on family violence.¹⁵⁸

Critics have called for reconsideration of the self-defence and preservation provisions that currently exist in Queensland.¹⁵⁹ For example, it has been argued that while legislative reforms in other jurisdictions (e.g. Victoria and Western Australia) require judges and jurors to appreciate the abused woman's reality (termed '*Walking in her Shoes*'), Queensland's reforms have not taken this into account where an acquittal is sought on the basis of self-defence.¹⁶⁰ Instead, s304B emphasises the necessity to judge reasonableness from the perspective of the abused woman in enabling a verdict to be downgraded to manslaughter.¹⁶¹

¹⁵¹ Ibid.

¹⁵² Australian Bureau of Statistics, 2010 in Sheehy, E., Stubbs, J., & Tolmie, J. (2012). Battered women charged with homicide in Australia, Canada and New Zealand: How do they fare? *Australian & New Zealand Journal of Criminology*, 45(3): 383 – 399.

¹⁵³ Bradfield, 2001: 156 in Sheehy, E., Stubbs, J., & Tolmie, J. (2012). Battered women charged with homicide in Australia, Canada & New Zealand: How do they fare? *Australian & New Zealand Journal of Criminology*, 45(3): 383 – 399.

¹⁵⁴ In its 2016-17 Annual Report, the Board noted the pervasive issues experienced by Aboriginal and Torres Strait Islander women who are victims of domestic and family violence and 'called for a change' in the way that we respond to family violence in Aboriginal and Torres Strait Islander families and communities.

¹⁵⁵ It is noted, however, that in a broader subsample of cases referenced above from Australia, Canada and New Zealand there were a number of acquittals in these types of circumstances. Sheehy, E., Stubbs, J., & Tolmie, J. (2012). Battered women charged with homicide in Australia, Canada and New Zealand: How do they fare? *Australian & New Zealand Journal of Criminology*, 45(3): 383-399.

¹⁵⁶ <http://www.lawreform.vic.gov.au/all-projects/defences-homicide> Accessed 3 July 2018.

¹⁵⁷ *Crimes Amendment (Abolition of Defensive Homicide) Act 2014*.

¹⁵⁸ For example: that family violence is not limited to physical abuse and may include sexual abuse and psychological abuse; may involve intimidation, harassment and threats of abuse; may consist of a single act; may consist of separate acts that form part of a pattern of behaviour that can amount to abuse, even when some or all of those acts may, when viewed in isolation, appear to be minor or trivial; and that: people may react differently to family violence and there is no typical, proper or normal response to domestic and family violence; it is not uncommon for a person who has been subjected to domestic and family violence to stay with an abusive partner after the onset of violence or to leave and then return to the partner; and not to report family violence to police or seek assistance.

¹⁵⁹ For example, Edgely, M., & Marchetti, E. (2011). Women who kill their abusers: how Queensland's new abusive domestic relationship defence continues to ignore reality. *Flinders Law Review*, 13, 125-176.

¹⁶⁰ Hopkins, A. & Eastaer, P. (2010). Battered Women Who Kill in Victoria, Western Australia and Queensland. *Alternative Law Journal*, 35 (3), pp 132 – 137.

¹⁶¹ Ibid.

Criminal affiliations

While it has been identified in only a relatively small number of the cases reviewed by the Board to date, the impact of having a partner with Outlaw Motorcycle Gang (OMCG) connections was significant for victims, and detrimentally affected their ability to separate from their abusive partners.

This was noted to include:

- » a reluctance by the victims to seek help or disclose their experiences of violence;
- » the primary victim being subjected to monitoring and surveillance by other gang members, including when the perpetrator was incarcerated;
- » threats by the perpetrator against the victim and their family involving other gang members;
- » ready access to illegal firearms by the perpetrator; and
- » a general lack of trust by the victim in the system's capacity to protect them as criminal networks may extend across the state (or interstate), increasing the difficulty of a victim being able to safely separate.

Indeed, one victim felt so terrorised by her partner that she expressed the view that she would be better off moving into the perpetrator's home *so that he can monitor me and know where I am at all times*, and that she was safest when she just *pleases* him.

Gang culture is typically misogynistic and violence against partners, including sexual violence, and multiple perpetrator violence¹⁶² (e.g. gang rape as a form of initiation) can be prevalent.¹⁶³ Partners and other gang members may feel compelled to establish their proprietariness over a female partner and go to great lengths to ensure that sensitive information about criminal activity is not disclosed to authorities.¹⁶⁴

Women who are associated with OMCG members may also experience high levels of sexual violence, often in the form of coercive sexual practices, although this is not just in intimate partner relationships.¹⁶⁵

Violence against female partners of gang members may further be an extension of the power and control that gangs exhibit, coupled with the perception that women are property that is owned by a member or the gang.¹⁶⁶ Additionally, it has been suggested that influences from within the gang, including misogynistic attitudes, influence the abusive behaviours of gang members.

Practitioners are confronted with challenges when working with women associated with OMCG experiencing domestic and family violence, as there may be competing pressures and risks.

For example, research demonstrates that women associated with gangs refuse to take out protection orders as they fear they will have the opposite intended effect by increasing their risk.¹⁶⁷ Additionally, the threat of sanctions associated with breaching protection orders holds little deterrent for gang members, who may involve third parties to monitor the victim or take retribution against them. Victims also report being unconvinced about the capacity of police and other services to protect them or their families from retaliation.¹⁶⁸

Relationship separation is also a known high risk period, and this risk is exacerbated in gang-affiliated couples due to the victims' potential knowledge of criminal actions of their partner or the gang more generally.¹⁶⁹

The New Zealand Family Violence Death Review Committee recently reported that victims with gang-affiliated abusive partners may be unable to communicate openly with police due to the inherent risk of being seen to cooperate with them.¹⁷⁰ This committee also considered that aggressive behaviour by a gang-affiliated victim may be a strategy to protect themselves in the face of ongoing violence, and did not mean that they were safe.

It is clear that victims of violence are often well aware of the risks they face for leaving an abusive relationship, including financial hardship, lack of accommodation and risk of lethal retaliation.¹⁷¹ These risks often outweigh the perceived benefits of terminating an abusive relationship and this is exacerbated with gang affiliated couples.

Indeed, in one case, the victim refused to provide her consent for information to be shared with corrective services who wanted to take punitive action against the perpetrator as she knew that it would increase risks to herself and her family.

162 Salter, M. (2014). Multi-perpetrator domestic violence, *Trauma, Violence & Abuse*, 15(2), 102-112.

163 Firmin, C. (2011). *This is it. This is my life... Female Voice in Violence. Final Report on the impact of serious youth violence and criminal gangs on women and girls across the country*. London: Race on the Agenda. As cited in Salter, 2014.

164 Salter, M. (2014). Multi-perpetrator domestic violence, *Trauma, Violence & Abuse*, 15(2), 102-112.

165 Cooper, L. (2004). *Dilemmas in Working with Women with Complex Needs. SAAP Project Report*. Canberra: Australian Government Department of Family and Community Services.

166 Brown, V.A. (2007). Gang member perpetrated domestic violence: A new conversation. *University of Maryland Law Journal of Race, Religion, Gender and Class*, 7(2), 395-413.

167 Cooper, L., & Bowden, M. (2006). Working with women associated with bikie gangs: practice dilemmas. *Australian Social Work*, 59(3), 3013-313.

168 Firmin, C. (2011). *This is it. This is my life... Female Voice in Violence. Final Report on the impact of serious youth violence and criminal gangs on women and girls across the country*. London: Race on the Agenda. As cited in Salter, 2014.

169 Brown, V.A. (2007). Gang member perpetrated domestic violence: A new conversation. *University of Maryland Law Journal of Race, Religion, Gender and Class*, 7(2), 395-413.

170 Family Violence Death Review Committee. (2016). *Fifth Report: January 2014 to December 2015*. Wellington: Family Violence Death Review Committee.

171 Meyer, S. (2012). Why women stay: A theoretical examination of rational choice and moral reasoning in the context of intimate partner violence. *Australian and New Zealand Journal of Criminology*, 45(2), 179-193.

It is because of these issues that it may be advantageous for practitioners to prioritise spending more time with the most complex cases, such as female victims looking to escape from OMCg partners, as referral to external support services may lead to service disengagement.¹⁷² However, this comes at the cost of servicing a higher volume of clients.

The Queensland Police Service Organised Crime Gangs Group has recently developed their own *Domestic and Family Violence Strategy* for gang affiliated victims of violence. Key elements of this strategy include:

- » empowering victims to report domestic and family violence through engagement and strengthening relationships in the community to ensure safety and build trust;
- » daily monitoring of intelligence reports to identify potential incidents of domestic and family violence and respond appropriately;
- » fostering innovative and proactive solutions to reduce the incidence of domestic and family violence; and
- » recognising and understanding the effects of trauma on children who may have been exposed to domestic and family violence.

¹⁷² Cooper, L., & Bowden, M. (2006). Working with women associated with bikie gangs: practice dilemmas. *Australian Social Work*, 59(3), 3013-313.

Chapter 5: Responding to cultural and linguistic diversity

Key findings

- » In this reporting period, the Board reviewed a cohort of domestic and family violence deaths where the deceased was from a culturally and linguistically diverse background.
- » Understanding the true extent of domestic and family violence among this population is difficult because of identifiable barriers to help-seeking.
- » Where victims and/or perpetrators were engaged with services, there was no evidence that cultural strengths were considered or incorporated into service planning or delivery, which represented a missed opportunity to respond in a culturally responsive and holistic way.
- » Frontline service providers require enhanced multi-cultural competency training, and access to specialist advice and support, to ensure they are able to respond effectively.

Within the Australian context, the term culturally and linguistically diverse is generally defined as a person born overseas in countries other than those where English is the main language. It may also be used more broadly to describe people who are Australian-born and have at least one parent who was born overseas; those who speak a language other than English at home; or people of a diverse religion.¹⁷³

During 2017-18, the Board reviewed five cases involving seven deaths in which the victim and/or perpetrator was from a culturally and linguistically diverse background and died in the context of intimate partner or family violence.

The female victims in the index relationships were all from a culturally and linguistically diverse background. Perpetrators were from a culturally and linguistically diverse background in only two cases.

On review of the circumstances surrounding the deaths, it was clear that people from a culturally and linguistically diverse background were less likely to seek support for their experiences of intimate partner or family violence. When help was sought, there was, at times, a lack of response from services, or the response was not culturally informed or appropriate.

As such, this chapter considers domestic and family violence among culturally and linguistically diverse families and communities, including known risk and protective factors, and barriers to help-seeking.

Issues with service provision identified within the cases subject to review by the Board are also discussed, as it relates to the victim and/or perpetrator's cultural and linguistic diversity.

While it is recognised that Aboriginal and Torres Strait Islander people are also culturally and linguistically diverse, their unique experiences are not considered within this chapter.¹⁷⁴

Rates of domestic and family violence

Immigrants and refugees¹⁷⁵ to Australia constitute a complex and diverse population. According to the Australian Bureau of Statistics (ABS), there are around 275 cultural and ethnic groups recognised in Australia, a figure that is growing over time.¹⁷⁶

Ascertaining the true extent of domestic and family violence in culturally and linguistically diverse families and communities is difficult as studies and surveys have produced mixed findings.¹⁷⁷

As it currently stands, there is limited information and no uncontested national data available on the prevalence of violence against women from culturally and linguistically diverse backgrounds.¹⁷⁸

¹⁷³ Department of Social Services, *Hearing her voice: Report from the kitchen table conversations with culturally and linguistically diverse women on violence against women and their children*. Commonwealth of Australia (Department of Social Services) 2015.

¹⁷⁴ The Board explored in depth the experiences of domestic and family violence among Aboriginal and Torres Strait Islander peoples in the 2016-17 Annual Report.

¹⁷⁵ Within this cohort there was none of the victims or perpetrators had a refugee background, although at least one of the perpetrators had experienced war within his country of origin, and this was noted to have had significant psychological impact on him, inclusive of a diagnosis of Posttraumatic Stress Disorder

¹⁷⁶ Australian Bureau of Statistics (2011) *Australian standard classification of cultural and ethnic groups (ASCCEG)*, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/1249.o>.

¹⁷⁷ Morgan, A & Chadwick, H, Australian Institute of Criminology, Summary Paper: Key issues in domestic violence, (2009), www.aic.gov.au/media_library/publications/rip/rip07/rip07.pdf

¹⁷⁸ Department of Social Services, *Hearing her voice: Report from the kitchen table conversations with culturally and linguistically diverse women on violence against women and their children*. Commonwealth of Australia (Department of Social Services) 2015.

Generally, ABS data indicates that rates of physical assault victimisation were highest for Australian-born people, followed by those born in mainly-English speaking countries (such as the United Kingdom, Ireland, New Zealand, Canada, South Africa and the United States of America).¹⁷⁹ Similarly, the *International Violence against Women Survey* indicates that women from English-speaking backgrounds reported higher levels of physical, sexual and any other violence compared to non-English speaking background women over their lifetime.¹⁸⁰

However, with respect to these results, there is consistent evidence that suggests that women from culturally and linguistically diverse backgrounds are less likely to report domestic and family violence to police or access mainstream services.¹⁸¹ As such, the lower prevalence rates may be because of a range of factors, including an underreporting of abuse by participants.¹⁸²

It is also noted that domestic and family violence and sexual assault can be interpreted differently across cultures; and, in some cultures and languages, there is no direct translation or agreed definition of domestic violence or sexual assault (often, particularly within a marriage), which further limits the recognition or reporting of this issue.

Nature of domestic and family violence

At the outset, it is important to note that there are many similarities across cultures in the experiences of victims of domestic and family violence.

In 2014-15, female leaders of culturally and linguistically diverse communities hosted a series of 'kitchen table' conversations throughout Australia with women from more than 40 ethnic and cultural backgrounds about violence against women and their children. This culminated in a report outlining key issues and suggested responses raised by participants in the conversations.¹⁸³

With respect to the nature of violence, this consultation report noted:

- » There was a *nuanced understanding of the range of behaviours that constitute domestic and family violence* expressed by participants, however, this term itself was not commonly used among culturally and linguistically diverse communities.
- » The women referred not only to physical violence, but other behaviours aimed at exerting power and control over women such as isolation from family and friends, threats against children, control of finances and emotional abuse.

- » Intimate partner violence was the most frequently identified form of violence, however there was significant acknowledgement among participants that domestic violence can and does occur between other family members, and that a victim may be subject to abuse by multiple family members. For example, it was noted that culturally and linguistically diverse women are more likely to live in extended family households, and some participants referred to violence and abuse perpetrated by mothers-in-law (often in tandem with a husband or a husband's siblings), adolescent sons and other family members.
- » As the culturally and linguistically diverse population in Australia ages, abuse of parents or elderly relatives (particularly those with reduced mobility or dementia) is becoming more common.
- » Sexual assault, particularly by a spouse or partner, was less readily spoken about or identified by participants. It was suggested that some culturally and linguistically diverse communities do not recognise forcing a spouse or partner to have sex as sexual assault because sexual access is considered a husband's right.

Issues arising for culturally and linguistically diverse victims of domestic and family violence were commensurate with those experienced more generally within the community. This includes finding accommodation, achieving financial independence, gaining or undertaking employment, obtaining legal advice and locating appropriate, affordable child-care.

Risk and protective factors

At the outset, it is important to challenge perceptions that domestic and family violence is considered to be more acceptable in some cultures.

Victims from all cultures leave or take steps to protect themselves from domestic and family violence, and in doing so, assert its unacceptability. Similarly, all communities, including Anglo-Australian ones, have values, systems and practices that may condone, support or disguise some types of violence; although, these may present differently across cultures.

Strong family connections are an important protective factor among culturally and linguistically diverse communities and are often a stabilising force that assists immigrants to weather the turbulent process of migration and resettlement.¹⁸⁴ Indeed, several of the individuals in the cases reviewed by the Board drew great strength and support from, and had a strong sense of pride and belonging with, their country of origin.

In this respect, strong cultural ties may serve as a protective factor keeping victims connected with their community.

¹⁷⁹ Australian Bureau of Statistics (2010), *Crime victimisation, Australia, 2009-2010*. <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4530.02009-10?OpenDocument#Publications>

¹⁸⁰ Mouzos, J., & Makkai, T. (2004). *Women's Experiences of Male Violence: Findings from the Australian component of the International Violence Against Women Survey (IVAWS)*. Research and Public Policy Series No. 56. Canberra: Australian Institute of Criminology. http://www.aic.gov.au/media_library/publications/rpp/56/rpp056.pdf

¹⁸¹ M Bonar and D Roberts, *A review of literature relating to family and domestic violence in culturally and linguistically diverse communities in Australia*, Western Australia Department for Communities, Perth, 2006, in Morgan and Chadwick, *Key issues in domestic violence*, op. cit., p. 5.

¹⁸² In this sense, personal, cultural, religious and language factors may serve as a barrier to this cohort's participation in these types of surveys; or, those who did participate may have been less likely to report episodes of physical and sexual violence, or openly discuss that information with survey interviewers. This may also be due to definitional issues whereby victims from culturally and linguistically diverse backgrounds may not understand what constitutes abuse, or they have a reluctance or inability to participate in anonymous survey data collection.

¹⁸³ http://plan4womenssafety.dss.gov.au/wp-content/uploads/2015/07/cald_womens_safety_report.pdf

¹⁸⁴ Shetty, S. and Kaguyutan, J. Immigrant victims of domestic violence: Cultural changes and available legal protections. Applied Research Forum, National Online Resource Centre on Violence Against Women, February 2002.

As a notable example, one victim had strong connections and friendships with other members of her South American community within Australia, which extended to helping other newly arrived people to access employment and participate in study. She also maintained close connections with her family within her country of origin.

Disappointingly, none of the cases reviewed by the Board included instances where cultural strengths were incorporated or considered by service providers, even in cases when friends were present when help was sought. This represents a missed opportunity to respond in a culturally informed, holistic and effective way by seeking to harness and use existing protective supports.

Women and children from culturally and linguistically diverse backgrounds may experience heightened vulnerability to violence for a myriad of reasons¹⁸⁵, including:

- » Limited or no ability to speak English, which may make it harder to seek support from police, services and the courts, especially if those professionals do not routinely offer interpreters;
- » A lack of financial autonomy, particularly in circumstances where visa restrictions limit a person's capacity to participate in employment or training opportunities; and
- » Social isolation from the broader community and, in some cases, other members of their cultural group in Australia.

There were certainly examples of the above within the cases reviewed by the Board, particularly in relation to social isolation. In one case the victim kept her relationship a secret from her family for cultural reasons (which was a source of conflict between the couple). Another victim of violence had made few friends in Australia and withdrew from family and community engagements because of her husband's erratic and abusive behaviours and problematic substance use.

In another case, the primary perpetrator of violence attempted to socially isolate his partner by removing all of her friends and family from her social media accounts and sending abusive messages to her family who were overseas.

Cultural barriers to help-seeking

Further compounding risk for victims of domestic and family violence from a culturally and linguistically diverse background are additional barriers they may face in accessing support, including:

- » family and/or community resistance or pressure;
- » fear of government or officials based on experiences of similar institutions in their home country;
- » language barriers, including low literacy levels;
- » limited access to information about family violence and services in their preferred language;
- » limited knowledge about community supports or how to access these supports;
- » limited specialist culturally and linguistically diverse services or family violence workers from culturally and linguistically diverse backgrounds; and
- » systemic barriers to access, such as a lack of interpreters, a lack of cultural knowledge and respect, and in some cases, even racism on the part of service providers.

In the cases reviewed by the Board during this reporting period, while some victims were observed to speak in 'broken English', an inability to effectively communicate in English was not identified. In all three cases¹⁸⁶ where a protection order was in place at the time of the death, a negative response was provided when asked on the protection order application whether an interpreter was required.¹⁸⁷

It is clear that responding to the needs of culturally and linguistically diverse victims of domestic and family violence requires a greater understanding of violence in the victim's cultural context than just the interpretation of language. This may present a challenge to services who work with victims (and perpetrators) from a range of cultures who may present with distinctive understandings of abuse, violence and normalised behaviours within their own cultural context.

For example, it was noted in one case that in the primary victim's country of origin (Japan), domestic violence traditionally refers to physical and emotional violence perpetrated by teenage males against their mothers.¹⁸⁸ Research also indicates that, help-seeking behaviours among Japanese women differ from those of women from western cultures.¹⁸⁹ Specifically, Japanese women seek help so they can be given directions about what they should do, not options.

That is, they need more directive advice which is contrary to the philosophy of social service providers in Australia. Practitioners working with victims of domestic violence typically adopt a strengths-based, collaborative approach that identifies and builds on the strengths and abilities of the individual. Practitioners help the client do things for themselves under this framework, empowering them to make their own choices about their safety and enhancing their self-esteem.

¹⁸⁵ Ibid.

¹⁸⁶ That is, Malaya, Yasmin and Wendy.

¹⁸⁷ This was recommended by the Special Taskforce on Domestic and Family Violence (recommendation 114)

¹⁸⁸ Koza, J. (1999). Domestic Violence in Japan. *American Psychologist*, 54, 50-54. Traditionally, the Japanese family structure is highly patriarchal with women having a comparatively lower status, which may be compounded by a sense of shame and secrecy within Japanese families. Generations of living in a totalitarian regime has also influenced the understanding of violence in Japan, with violence considered an accepted means of discipline and punishment. These traditional cultural norms may have underpinned this victim's view of her victimisation, however it was evident that she repeatedly attempted to contact a range of services in relation to her domestic violence concerns.

¹⁸⁹ Nipoda, Y. (2002). Japanese culture and therapeutic relationship. In W.J. Lonner, D.L. Dinnel, S.A. Hayes, & D.N. Sattler (Eds). *Online Readings in Psychology and Culture* (unit 10, Chapter 3). Center for Cross-Cultural Research, Western Washington University, Bellingham, Washington, USA.

However, research shows that Japanese women may not respond in help-seeking situations as a sign of respect to the help provider and if they do not agree with something the provider says, they will simply disengage.

Help-seeking from outside the cultural group may also be seen to be shameful in collectivist cultures, which further hinders an effective therapeutic relationship.

This was more than evident in one case, where the victim repeatedly sought assistance from multiple service providers, but her need was continuously identified as one which required only the provision of information, as opposed to direct support.

Cultural stigma and a sense of shame was also noted as a barrier to reporting in another case where the family were of Indian ethnicity. On the rare occasion where reports were made, the abuse was only disclosed once circumstances reached crisis point.

Evidence suggests that in Indian communities, domestic and family violence is distinctly associated with cultural norms of patriarchy, hierarchy and multi-generational families.¹⁹⁰ A strong sense of cultural continuity based on family unity is emphasised, while there is very little social acceptance of separation and divorce, even where family violence is apparent. Harmful practices of oppression and violence against women may manifest from this cultural norm and women feel a culturally moralistic pressure to avoid separation.¹⁹¹

In some cases, migrants and refugees may also report lifetime experiences of rape, sexual assault, war, civil unrest and other types of conflict, which often results in physical, mental and sexual health conditions.¹⁹²

For example, although not an excuse for his abusive behaviours, one perpetrator had a traumatic history of exposure to violence in his country of origin. This included witnessing acts of torture committed against his own family and involvement in active weapons combat. These experiences impacted on this perpetrator's ability to participate in community life in Australia.

Another primary victim of violence also inferred that she had witnessed 'horrible' things in her own country (although, further details are unknown).

Past experiences of abuses of power or betrayals of trust carried out by systems in home countries may make victims or perpetrators fearful to speak out or seek help from persons outside of their cultural communities or trusted relationships. This can serve as a significant barrier to accessing support, especially in relation to an issue as sensitive as domestic violence.¹⁹³

Navigating complex systems

There was also evidence of limited understanding of service systems, and difficulties in accessing information or navigating the system, irrespective of language proficiency. For example, one victim had varied success in seeking legal information and support from services about how to safely separate from her abusive partner.

Financial restrictions and limitations were also noted for several of the victims. In one case, the victim was unable to access the shared assets that she and her partner owned, which prevented her safely fleeing the relationship. However, these shared assets also prevented her from being able to access legal assistance through the Women's Legal Service.

The *National Partnership Agreement on Legal Assistance Services*¹⁹⁴ requires legal assistance only be provided to people with assets in very limited circumstances. While the intent of this agreement is to improve access to justice for disadvantaged people, and maximise the delivery of legal assistance services within available resources, this can be problematic in the context of domestic and family violence.

For example, even where a victim may be referred to private legal practitioners, they are not specialists so do not have the same skills and experience as a dedicated service. As such they may find it difficult to engage with clients experiencing complex trauma.

The National Partnerships Agreement is under review by the Commonwealth Attorney-General, and it is important that consideration is given as to how it should apply to victims of domestic and family violence to ensure they have access to specialist legal supports.

Complex laws and/or a lack of knowledge about legal systems may also serve to increase the risk of further harm by impacting on the capacity of a victim to secure protection for herself and her children.

For example, one primary victim of violence had genuine concerns about the legalities of her being able to return home overseas with her (unborn) child, as her abusive partner told her he would not grant approval for her to do so until the child was an adult. This effectively forced her continued residence in Australia and restricted her access to important protective social and family support. Sadly, this victim was in the process of obtaining legal advice on this point at the time of her death and that of her unborn child.

While none of the victims in these cases were on temporary visas, the Board noted that there are clear issues with current provisions in this area. While family violence provisions have been introduced to allow victims applying for permanent residence in Australia to continue with their applications, subsequent to a separation, this applies only to certain visa sub-classes.

¹⁹⁰ Sarkar, S. (2016). *Underreporting in India: Unheard whimpers*, Prentice Hall

¹⁹¹ Sen, A. (2005). *The argumentative Indian*. London, UK: Penguin

¹⁹² Supporting women from culturally and linguistically diverse backgrounds who are victim/survivors of sexual violence. Challenges and opportunities for practitioners. ACSSA Wrap No 9 – Feb 2011 <https://aifs.gov.au/publications/supporting-women-cald-backgrounds-who-are-victimsurvivors-sexual-violen/refugee-and-immigrant-women-australia>

¹⁹³ Wendt, S. Zannettino, L. (2014). Domestic Violence in Diverse Contexts: A Re-examination of Gender. *Social Science*. Available online: <https://books.google.com.au/books?isbn=1317616510>

¹⁹⁴ <https://www.ag.gov.au/LegalSystem/Legalaidprogrammes/Pages/National-Partnership-Agreement-on-Legal-Assistance-Services.aspx>

These provisions also rely on a person's capacity to present 'acceptable evidence' of family violence, such as court orders or statutory declarations.¹⁹⁵ This capacity may be limited in situations in which there was a lack of reporting of domestic and family violence prior to the separation.

There are further complications if there are children within the relationship, or in circumstances in which there are cross orders established. The latter in particular may have implications for 'character tests'¹⁹⁶ and may be used as a tool by the perpetrator to control the primary victim of violence.

The supports available to non-residents trying to escape violence can also be very limited across multiple domains, (financial, social and familial) which may reduce the capacity of a victim to be able to separate. For instance, temporary visa holders are not eligible to access services through Centrelink, and as such may have no income to meet the basic needs of themselves and their children. They are also prohibited from accessing Medicare and public housing which means many victims of violence on temporary visas end up returning to their abusive spouse.

These issues were explored in the 2015-17 Report of the *New South Wales Domestic and Family Violence Death Review Team*¹⁹⁷ who made five recommendations for the Commonwealth Government that focused on:

- » the development of an initiative to enable vulnerable individuals with impermanent visa status, or without a valid visa, to access medical care;
- » expanding Family Violence Provisions for spousal visas to other visa classes;
- » professional development courses and training for Migration Agents in Australia to be updated to include a specified focus on domestic and family violence;
- » identifying ways that non-residents experiencing domestic and family violence can be better supported in respect to access to appropriate supports (i.e. women's shelters); and
- » updating the *Life in Australia* booklet¹⁹⁸, or producing another publication, to be distributed to all persons entering Australia on a provisional or permanent visa about domestic and family violence, and the supports available to victims.¹⁹⁹

The Board supports the recommendations made by the NSW Death Review Team, and reinforces the need for national reform in this area.

Service accessibility and cultural appropriateness

The cases demonstrated marked differentiation in the level and frequency of service system contact.

In the two cases involving violence in lengthy intimate partner relationships, there was no prolonged pattern of service system contact. In one case, there was almost a total absence of service contact until the year preceding the deaths. There was also an escalation in service system contact just prior to the fatality in three cases, whereas there was almost negligible contact in two cases.

While recognising that *one size does not fit all*, clients from culturally and linguistically diverse communities need the option to choose whether to receive assistance and support from culturally specific or mainstream service providers.²⁰⁰ Further, where mainstream organisations are providing a service to someone from a culturally and linguistically diverse background, secondary consultations with appropriate specialist organisations are required to support culturally respectful service provision.

While this is a core element of inclusive practice, there was limited evidence of referral or consultation with a culturally specific service provider in the cases reviewed by the Board. There was, perhaps unsurprisingly, a lack of subsequent engagement for both victims and perpetrators, even in cases where there was relatively frequent system contact, and in locations where culturally appropriate services were available.

For example, one perpetrator had frequent contact with the health system in the years preceding his death in regards to mental health issues, yet there is no evidence that any attempt was made to link him with the Queensland Transcultural Mental Health Centre (QTMHC).²⁰¹ There also appears to have been no apparent attempt to link him with specialist support, even though records indicate that his experiences as a refugee from a war torn country were clearly associated with his ongoing mental health concerns (including PTSD).

This, too, was the case for another victim when responding officers did not appear to consider the benefit of a referral to a culturally appropriate specialist service in light of her direct disclosures to them that she was embarrassed to seek help because of a sense of cultural shame.

195 Department of Home Affairs. Fact sheet – family violence provisions. <https://www.homeaffairs.gov.au/about/corporate/information/fact-sheets/38domestic> Accessed on 19 September 2018

196 Under section 501 of the *Migration Act 1958*, a person does not pass the character test if they fall within any of the grounds specified within five broad categories: substantial criminal record; conviction for immigration defence offences; association with persons suspected of engaging in criminal conduct; past and present criminal or general conduct; and, significant risk of particular types of future conduct.

197 Domestic Violence Death Review Team. (2017). *Report 2015 to 2017*. Sydney: Author. Recommendations 20.1 to 20.5

198 The Australian Government has an existing 'Family Safety Pack' for men and women coming to Australia available here: <https://www.dss.gov.au/family-safety-pack>

199 As at 19 September 2018, there had been no response from the Minister of Home Affairs in relation to these recommendations.

200 Victorian Royal Commission into Family Violence, Summary and Recommendations (2016), viewed 14 April 2016, http://www.rcfv.com.au/MediaLibraries/RCFamilyViolence/Reports/RCFV_Full_Report_Interactive.pdf

201 This is a free, state-wide service which provides information, referral, resources and a clinical consultation service.

With well over 200 cultures represented in Queensland alone, there is a challenge for the service system to adequately meet the specific cultural needs of persons from these diverse communities. As such, it is not plausible to expect service providers to become experts on each particular culture.

Developing multicultural competency may, however, assist in understanding and responding to diversity.

The Griffith University Centre for Interfaith and Cultural Dialogue (ICD) has developed the *Courage, Understanding and Respect: The CURE framework for productive diversity*. The framework aims to build respect, develop skills and establish an environment for people to value the traditions and perspectives of others, through a comprehensive four step program which is focused on equipping services to respond to diversity.²⁰²

It is also important to acknowledge that work is currently underway to address the unique needs and vulnerabilities of victims from a culturally and linguistically diverse background.

The *National Plan to Reduce Violence against Women and their Children 2010-2022*²⁰³, through its latest iteration, the *Third Action Plan 2016 – 2019*²⁰⁴, seeks to improve efforts to reduce domestic and family violence in culturally and linguistically diverse communities.

Key actions include to:

- » Support community-driven initiatives to change attitudes towards violence and gender equality;
- » Engage community and faith leaders to help change community attitudes about gendered violence and gender inequality;
- » Support vulnerable women recovering from violence, and assist them to rebuild their independence;
- » Support the development of innovative work between specialist culturally and linguistically diverse, and mainstream, organisations with a particular focus on improving support for women in regional areas from a culturally and linguistically diverse background²⁰⁵;
- » Develop appropriate visa arrangements for temporary residents experiencing violence; and
- » Progressively design, trial and evaluate innovative models of perpetrator interventions to understand what works, and to tailor initiatives targeted at male perpetrators from a culturally and linguistically diverse background.

As part of the National Plan, the Commonwealth Department of Social Services (DSS) supported grants to develop and implement locally-led solutions to drive long term, sustainable change in community awareness and behaviours to reduce violence against women and their children in culturally and linguistically diverse communities. Applications closed in May 2017, with 18 organisations selected in 2017-18 to deliver the *Culturally and Linguistically Diverse Communities Leading Prevention* activity.

While these are promising areas of practice, it is important for additional initiatives to be developed and implemented, across more communities.

Utilising community-led programs is important to assist in tailoring a local response to the particular needs of a specific cultural or language group and in empowering the community to lead change.

In alignment with the National Plan, DSS recently procured an organisation to develop and promote local domestic and family violence prevention toolkits. The purpose of this toolkit was to provide local governments with practical tools and resources to assist them in partnering with their communities to implement local solutions to prevent domestic and family violence.

This toolkit is intended to be developed in consultation with relevant stakeholders, and is designed to be inclusive for culturally and linguistically diverse communities. The toolkit is currently being trialled and is due to be finalised in 2019.

At a state level, in 2015, a leadership group in South East Queensland was established as a 'strategic think tank' to explore the challenges and experiences identified in domestic and family violence prevention work as it relates to culturally and linguistically diverse communities.

²⁰² To achieve system wide engagement, this framework suggests that higher level engagement (through definers, defenders and developers of social change) is required, as well as engagement between components of delivery in the service system, between service providers and the community, and between and within communities.

²⁰³ Refer to: <https://www.dss.gov.au/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children-2010-2022>

²⁰⁴ https://www.dss.gov.au/sites/default/files/documents/10_2016/third_action_plan.pdf

²⁰⁵ In addition, the *Safer Pathways for Culturally and Linguistically Diverse Women* also provided funding for organisations to help culturally and linguistically diverse women living in regional areas that are experiencing, or at risk of experiencing, domestic and family violence or sexual assault to access the support they need, and to reduce barriers for accessing mainstream specialist domestic and family violence and sexual assault services. Eight organisations were selected to receive funding.

This group (the Access Group) developed a blueprint to drive initiatives across South East Queensland, including the cities of Logan, Ipswich, Beenleigh and the Gold Coast in 2016. In terms of its scope, the blueprint sets out that state and local government agencies, service providers, community organisations and peak bodies will work collaboratively with culturally and linguistically diverse communities and their representative associations to:

- » form networks across the region for collaboration and capacity building;
- » achieve collective impact by combining local knowledge, expertise and resources; and
- » create and implement culturally responsive projects that prevent domestic and family violence within culturally and linguistically diverse communities through respectful dialogue, understanding and meaningful partnerships.

In 2017, the Access Group also developed a toolkit as part of the Federal 'Living Together, Living safely' project called Sharing Strength – A Toolkit to Engage Culturally and Linguistically Diverse Communities Experiencing Domestic and Family Violence' to support cultural capacity building and knowledge among service providers.²⁰⁶

The resource provides information and case studies designed to educate and inform service providers about culturally specific issues. It also provides practice recommendations about how to encourage and respond to disclosures made from culturally and linguistically diverse victims, engaging interpreters, working with male culturally and linguistically diverse perpetrators, developing appropriate risk, assessment and management strategies, and safety planning.²⁰⁷

The Second Action Plan of the *Queensland Domestic and Family Violence Prevention Strategy 2016-26* also commits to continuing to work in partnership with culturally and linguistically diverse communities and the domestic and family violence service system to develop culturally appropriate services and supports.

Recommendation 2:

That the Department of Child Safety, Youth and Women ensure current efforts that aim to build workforce capacity include the delivery of appropriate multi-cultural competency training to both specialist and mainstream service providers to enhance responses to people experiencing domestic and family violence from culturally and linguistically diverse backgrounds.

This should take into consideration, but not be limited to, cultural risks and protective factors, different patterns of service engagement, and potential barriers to service access for both victims and perpetrators.

Recommendation 3:

Noting that the Third Action Plan of the Queensland Domestic and Family Violence Prevention Strategy 2016-26 will soon commence development, the Board recommends that a priority area of focus include improving system responses to victims and perpetrators of domestic and family violence from a culturally and linguistically diverse background.

This should aim to extend upon those activities already undertaken as part of the delivery of the Second Action Plan, and focus on enhancing the capacity of community members, including identified female leaders, to implement locally-led solutions, which build on initiatives currently underway at a state and national level.

Recommendation 4:

That the Department of Child Safety, Youth and Women establish an appropriately resourced service to provide specialist consultancy advice and assistance to mainstream organisations who are providing support to victims and perpetrators of domestic and family violence from a culturally and linguistically diverse background.

This service should have sufficient expertise to provide advice about state and national legal and support services and systems to assist people from culturally and linguistically diverse backgrounds to understand and navigate these systems.

²⁰⁶ Gallant, C. (2017). *Sharing Strength: A toolkit to engage culturally and linguistically diverse communities experiencing domestic and family violence*. Brisbane: Department of Social Services. <https://indd.adobe.com/view/6eb914c6-cbcf-4441-ad8e-138d7ffd02d9>

²⁰⁷ The toolkit also identifies areas where culturally and linguistically diverse community members may require additional support and training, including a need to improve awareness about referral pathways, individual rights and responsibilities in Australia, domestic and family violence legal processes, education about what domestic and family violence is, rights of women on spousal/temporary visas, how to contact the police or DV Connect, and how to identify police liaison officers and find them. The toolkit provides advice on how to best work with community leaders and members, assist culturally and linguistically diverse women to build support networks, encourage communities to utilise support services, and improve service delivery to culturally and linguistically diverse communities.





Section 2

This section fulfils the legislative function of the Board as per section 91E of the Act, in which the Board must consider any interaction with, and the effectiveness of, any support or other services provided to the deceased person and the person who caused the death.

This section starts by analysing the domestic and family violence related service contacts in the cases reviewed by the Board in this reporting period (Chapter 6). Consideration is then given to looking at certain elements of the service system in which issues were identified including risk assessment processes (Chapter 7). The importance of responding to a person's presenting and underlying needs within the health system (Chapter 8), and supporting victims during periods of acute crisis are then discussed (Chapter 9).

The role of services in protecting victims and holding perpetrators to account is considered within the context of a systematic review undertaken by the University of Queensland in Chapter 10 of this report. Finally, service integration and responsiveness is considered as a means to ensure a whole of system response to victims and perpetrators of domestic and family violence (Chapter 11).

Chapter 6: Navigating the service system

Key findings

- » Across 19 of the 20 cases reviewed in this reporting period, there was a total of 536 domestic and family violence related service contacts. This ranged from two to 73 contacts, with an average of 28.2 per case.
- » Police were overwhelmingly represented as the most frequent point of contact, highlighting the significant role this agency plays in responding to domestic and family violence.
- » About one-half of contacts involved the detection of domestic and family violence, although this did not always equate to any action being taken. In two-fifths of contacts, agencies took direct action in response to the reported domestic and family violence, and one-tenth of contacts involved a referral to another agency.
- » For most contacts, services acted in accordance with legislation, policy and practice standards. In about 15% of contacts, however, the action or inaction was below standards. For a smaller percentage, the response exceeded standards.
- » A higher proportion of contacts with perpetrators were considered inadequate compared with contacts with victims only, or where responses were to both parties. This indicates the need to focus on enhancing responses to perpetrators, while continuing to respond to victims' safety needs.
- » While the service response from individual agencies may have met standards, this was not consistent across the service system for both victims and perpetrators, highlighting the need for a strong framework of protection for victims and accountability for perpetrators wherever they present to services.
- » This chapter establishes the foundation for discussions in the following chapters that consider risk assessment and management processes, and the way in which health, justice and specialist services respond to people experiencing domestic and family violence.

In accordance with section 91E of the Act, the Board is required to consider:

- » the interaction with, and effectiveness of, any support or other services provided to the deceased and the person who caused the death;
- » the general availability of services; and
- » failures in systems or services that may have contributed to, or failed to prevent, the death.

The Board is also established to identify key learnings and elements of good practice in the prevention of, and reduction in, the likelihood of domestic and family violence deaths in accordance with section 91D(1)(d) of the Act.

This chapter provides a broad overview of applicable service system contact prior to the death/s in the cases reviewed by the Board during this reporting period. The focus of this chapter is on the nature of the contact and the way in which services may interact in responding to both victims and perpetrators of domestic and family violence. The following chapters discuss the issues identified with system responses across health, justice and specialist services in more detail.

In its 2016-17 Annual Report, the Board explored in significant detail the roles of generalist and specialist services in responding to domestic and family violence.²⁰⁸ This included discussions on health service system contact (maternity and antenatal care, mental health, alcohol and other drug services, private practitioners, and relationship counsellors); criminal justice system contact (police, courts, and corrective services); and child safety services.

As such, this chapter seeks to extend upon this foundational report, and focuses predominantly on issues identified with the interactions between different sectors and services in responding to domestic and family violence.

At the outset it is important to acknowledge that reform activities which aim to improve responses to domestic and family violence, at both a state and national level, are ongoing and are influencing service delivery across many systems. Notably, reforms stemming from the Special Taskforce, which contributed to the design and implementation of the *Queensland Domestic and Family Violence Prevention Strategy 2016-2026*, continue to be implemented across the state.

In all 20 cases considered by the Board during 2017-18, the perpetrators and victims had identifiable contact with a variety of generalist and specialist services prior to their deaths.

²⁰⁸ Domestic and Family Violence Death Review and Advisory Board. (2017). *Annual Report 2016-17*. Brisbane: Author.

For the homicides in a family relationship, this service system contact may not have pertained to violence within the index relationship, but instead was related to intimate partner and/or family violence perpetration and victimisation in other relationships.

In four cases, the index relationship had relatively recently commenced (less than 12 months at the time of the homicide), but there was a substantial history of violence perpetration and/or victimisation in former relationships.

For the three collateral homicides, while the homicide offender and deceased had no direct 'relevant relationship' as defined by the DFVPA 2012, these deaths were identified as acts of associated domestic and family violence.²⁰⁹ In these cases the index relationship between the perpetrators and victims had been in place for at least ten years.

The prevalence of contact with services for the cases reviewed by the Board during 2017-18 is featured in Figure 19.

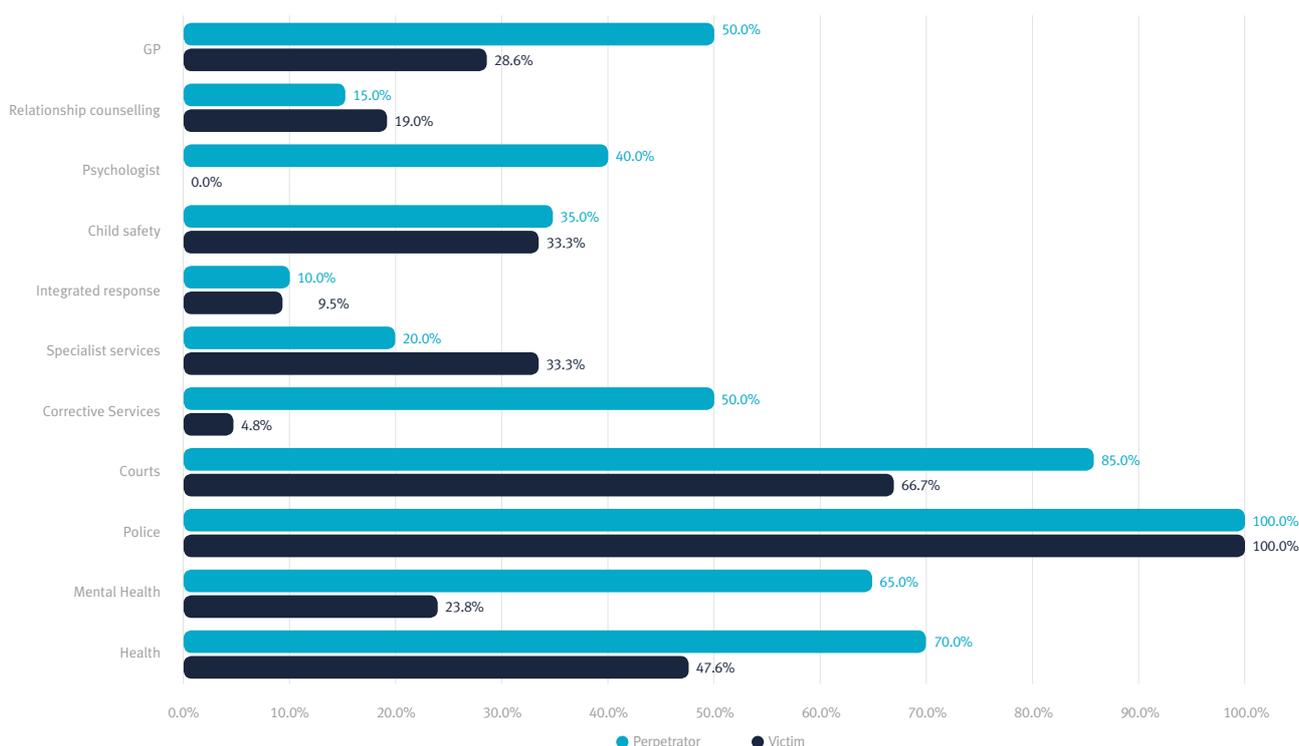
Of the cases reviewed, perpetrators had higher levels of contact with health, mental health, GPs, corrective services and psychologists. In contrast, victims had more engagement with specialist services.

Within this section, a 'domestic and family violence related contact' is defined as contact with an agency where the individual (perpetrator or victim):

- » made disclosures regarding violence in a relevant relationship;
- » presented with observable consequences of domestic and family violence (e.g. assault related injuries at a hospital); or
- » had previously reported domestic and family violence was occurring or had occurred, and contact with this agency was ongoing.

This definition recognises that victims and perpetrators may have contact with a range of mainstream and specialist services in relation to domestic and family violence. It also acknowledges that generalist service providers are in a valuable position to detect domestic and family violence, and respond accordingly.

Figure 19: Service system contact, victims and perpetrators, Board reviewed cases



²⁰⁹ Section 9 of the *Domestic and Family Violence Protection Act 2012* defines associated domestic violence as violence by a respondent towards: a child of an aggrieved; a child who usually lives with an aggrieved; a relative of an aggrieved; or, an associated of an aggrieved.

Across 19 of the 20 cases reviewed by the Board during this reporting period, there was a total of 536 service system contacts in relation to domestic and family violence prior to the deaths.

There were on average 28.2 relevant contacts with services in the cases, ranging from two to 73. By some margin, the quantity of contacts was lower among the homicides in a family relationship, averaging 15 contacts per case.

By comparison, the deaths of people from a culturally and linguistically diverse background averaged 30 contacts; homicide suicides averaged 34.5 contacts; and, male deceased cases averaged 31.3 contacts.

One case was excluded from this analysis as the homicide offender had extensive contact with services regarding mental illness and the nature of the violence within the family of origin was so extensive that it was not possible to use the same methodology as with the other cases.

As shown in Figure 20 and Table 20, police had the highest level of contact of relevant services, highlighting the significant role this agency plays in responding to domestic and family violence. Police had on average 10.6 contacts prior to the deaths, ranging from one to 37.

Other high volume contacts included Magistrates courts, public mental health services, private practitioners (e.g. psychologists, counsellors, GPs), and specialist services.

While some other agencies (for instance, corrective services) may have had significant contact with perpetrators and/or victims, there were infrequent occasions where this contact specifically pertained to domestic and family violence. Contact may have been instead for general compliance with a community based order which had not been issued in relation to domestic and family violence.

While these extraneous contacts may provide further opportunities for services to detect and respond to violence perpetration and victimisation, only those contacts which directly related to domestic and family violence (such as where disclosures were made regarding abusive behaviours) are reported on in this analysis.

Agencies have varying roles to play in responding to domestic and family violence, however, given the discrete functions that these services fulfil, there may be a lack of clarity about the role each organisation has in responding to domestic and family violence.

Certain services have a primary role in responding to domestic and family violence (e.g. specialist services) even where it may not be their only responsibility (e.g. police). Other services may play a secondary role as gatekeepers (e.g. private practitioners, public health) as they are in a critical position to detect abuse and refer accordingly. Gatekeepers assist in consolidating referral pathways for people who present at mainstream services through to specialist services.

Generally speaking, services play a role in:

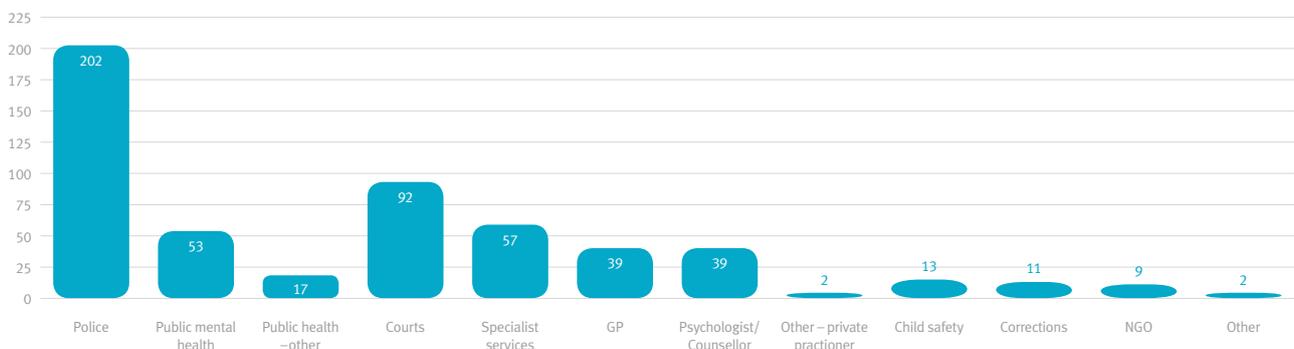
1. detecting domestic and family violence (e.g. through disclosures, screening, assessment);
2. taking direct action (e.g. delivering men's behaviour change programs, pursuing charges for a contravention of an order); and/or
3. referring victims and perpetrators to other services (e.g. referring to a men's behaviour change program, or a specialist service).

Not all agencies or services are in a position to perform each of these functions (for example, a GP may not be required to take direct action, but they are in a position to detect violence where it is disclosed, and to refer to other agencies who are positioned to take action).

As shown in Figure 21, almost one-half of service contacts were instances in which agencies detected indicators of domestic and family violence. These contacts generally included a victim or perpetrator disclosing abuse or other indicators of harm. On some occasions, this may also have included presentations for injuries from a domestic and family violence related assault. In others, assistance may have been directly sought from the agencies regarding domestic and family violence.

About two-fifths resulted in direct action being taken to the reported violence (e.g. criminal charges, treating injuries), and the remaining one-tenth of contacts included some form of referral.

Figure 20: Frequency of contact with service systems in all cases²¹⁰

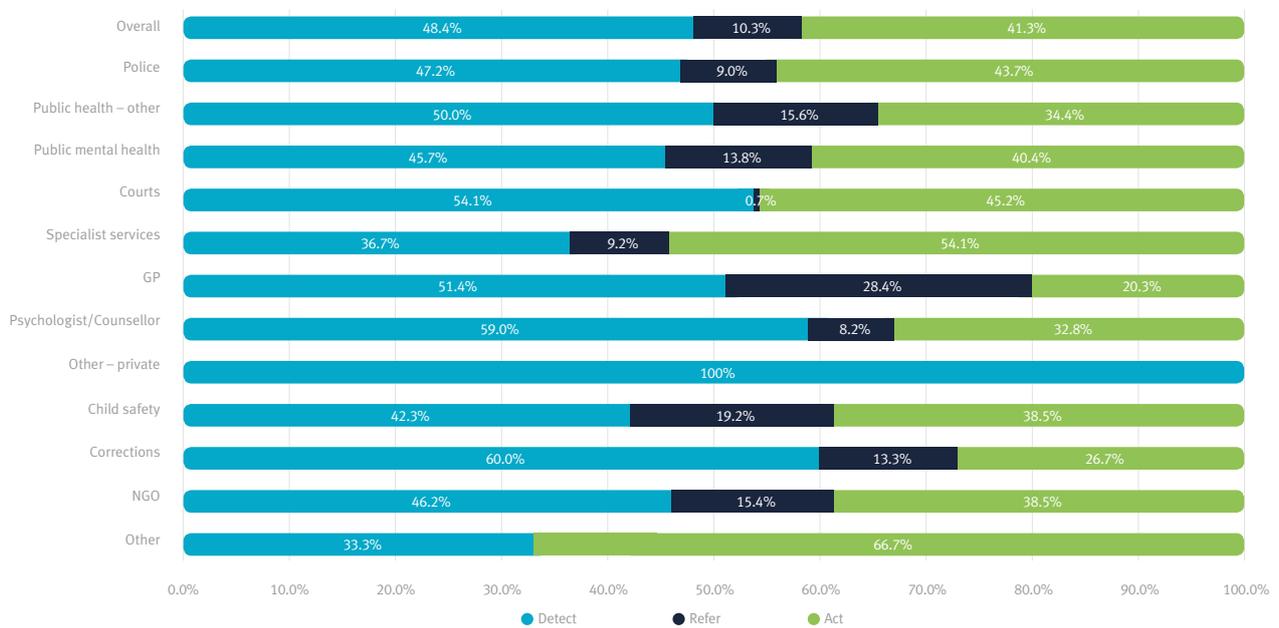


²¹⁰ 'Other' refers to any other service the individual may have been engaged with, inclusive of non-government organisations that do not have a specialist domestic violence function.

Table 20: Frequency of contact with service systems, by death case review type

	Culturally and linguistically diverse	Family homicides	Homicide – suicides	Male deceased	Total
Police	55	27	26	94	202
Public mental health	13	2	21	17	53
Public health - other	4	0	4	9	17
Psychologist / counsellor	13	6	11	9	39
GP	14	7	17	1	39
Private practitioner – other	2	0	0	0	2
Courts	27	10	14	41	92
Specialist services	8	0	38	11	57
Corrections	6	0	1	4	11
Child Safety	0	8	3	2	13
Other	8	0	3	0	11
Total	150	60	138	188	536

Figure 21: Service system engagement, by contact type



As required under the Act, in its reviews of these cases, the Board considered service provision by agencies who came into contact with victims and perpetrators.

Death review mechanisms focus on improving systemic responses to domestic and family violence, however it is critical to acknowledge that it is the perpetrator, not the system, that is the cause of the problem.

Similarly it is not the role of a death review mechanism to assign blame to any agency's action or inaction prior to the death. Service responses are dynamic and influenced by a range of individual, situational and structural characteristics. As such in its reviews of these deaths, the Board seeks, as much as possible, to represent the complex nature of this work, and the structural factors that may impede service responses.

In practice this represents a balancing act, so that key learnings, and opportunities for improvement can be identified, and responded to.

To achieve this, the Board considers the adequacy of service system contact to both victims and perpetrators within the context of governing legislation, practice standards and agency policies (where available).²¹¹ As such, for the purpose of this report, individual agency responses have been broadly allocated into three categories, specifically those that exceed standards, met standards and were below standards.

Exceed standards: these are defined broadly as those that exceeded the minimum standards of governing legislation, policies and procedures. For instance, evidence that a responding police officer took additional steps to ensure that a victim was protected, above what is outlined in the DFVPA 2012, and specified in the QPS Operational Procedures Manual (QPS OPM).

For example, in one particular collateral homicide, a responding police officer took a range of steps to protect the victim and her children by:

- » challenging the perpetrator's use of violence within the relationship and discussing the impact his abuse may be having on the victim and their children;
- » recognising threats of suicide by the perpetrator as potentially indicative of coercive controlling violence, and seeking to make the distinction between whether this was a mental health or domestic violence related issue;
- » attending the victim's residence the following day to source a formal statement pertaining to the occurrence after it was determined inappropriate to do so at the scene as she was upset and fearful;
- » applying to extend the conditions of the pre-existing temporary protection order to include no-contact conditions given concerns for the safety of the victim and their children;
- » charging the perpetrator with breaching the conditions of the temporary protection order; and
- » taking out a police application for a protection order upon learning that the victim had sought to revoke the privately applied temporary protection order in place at the time.

Met standards: the agency response met the minimum standards of the relevant legislative, policy and practice frameworks. An example being where a crisis support service arranged emergency accommodation for a victim.

In one case, after a victim of domestic and family violence was hospitalised with injuries following a serious assault, the hospital social worker:

- » provided social work intervention;
- » referred to a specialist domestic and family violence service for counselling and emergency accommodation support;
- » liaised with police to ensure that criminal investigations were in progress; and
- » recognised safety concerns and initiated safety planning when the perpetrator attended the hospital to visit the victim.

Below standards: are contact points which were identified as not meeting minimum standards as specified by legislation, policy and procedures. These contacts in particular represent missed opportunities for intervention as it is likely that the agency took no action despite the disclosures.

For instance, following the serious assault and non-lethal strangulation of one victim, the perpetrator was admitted to a mental health unit for treatment.

Despite identifying the perpetrator as *violent* and a high risk to his wife and children during assessment, including being shown a photo of the injuries to the victim (provided to them by the perpetrator while *smiling*), the treating team:

- » requested the victim attend a face-to-face family meeting to *clear the air* as the perpetrator was denying the allegations;
- » planned to discharge the perpetrator into the care of his adult son within hours of the assault and only changed plans when his son refused to take him after voicing concerns about the active risk his father posed and the need for mental health treatment; and
- » released the perpetrator from the mental health unit, unsupervised, on day leave to attend court without first advising police or the victim to inform their safety planning.

Upon arriving to court for the domestic violence proceedings, the victim found the perpetrator blocking the entrance to the courtroom and police intervention was required.

This perpetrator never returned to the mental health unit for treatment as he was apprehended by police following the conclusion of the court hearing. The treating team subsequently notified his young daughter that he had absconded and they did not know his whereabouts.

²¹¹ As per section 91Y of the Act, the Board has the authority to request records pertaining to a homicide offender, homicide deceased and/or suicide deceased and in its requests for this information, agency policies and practice frameworks will also be requested.

Nature of service system contact

Of the 536 contacts, a total of 961 identifiable actions were reported (falling under the categories of detect, refer or direct action).

For the vast majority of contacts, services acted in accordance with legislation, policy and practice standards, across each domain. In about 15% of contacts, the action or inaction taken was below standards, and in a smaller percentage there was identifiable practice that exceeded standards (Figure 22).

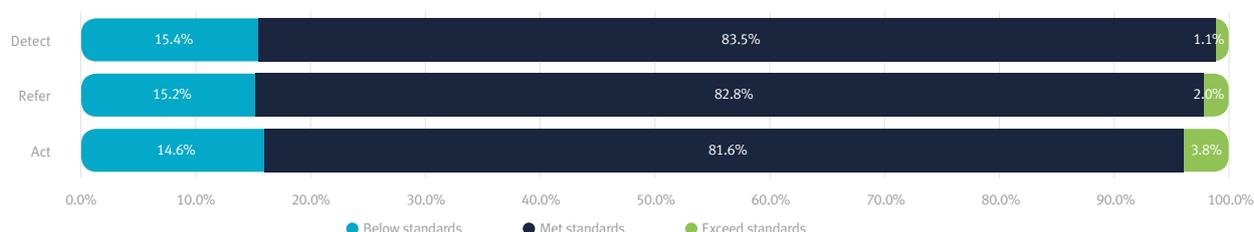
This demonstrates that staff who work in the challenging field of domestic and family violence, as well as generalist services are, for the most part, responding to victims and perpetrators as anticipated. However, in a small but meaningful proportion of interactions, the service response was inadequate which may have resulted in victims' safety not being ensured and perpetrators not being held accountable.

For example, in one case, while the initial police response was exceptional in identifying a high risk situation²¹², there were clear failings in a second police response involving the couple. On the latter occasion, the perpetrator attended a police station to seek advice about ongoing issues with his estranged wife and, in response, was provided advice about how to remove himself from, or defuse, any situation which may result in him breaching the protection order. Immediately after leaving the station,

the perpetrator then contacted police to report allegations of domestic violence, stating the victim had 'blown up'. On attendance, one of the responding officers was told by the victim of multiple breaches of the protection order by the perpetrator (including a physical assault and allegations that he had taken explicit photos without her consent). The officer ultimately determined that there was insufficient evidence to pursue breach charges (despite visible marks to the victim's face) and advised her that she should have called police at the time the injury was inflicted. He also failed to disclose these reports to the operational shift supervisor and recorded the occurrence as a 'No DV', specifically a *heated* argument between a divorcing couple.

In another case, a perpetrator made clear and direct threats to kill his former intimate partner in a telephone call to a specialist service that worked with men who use violence. The counsellor did not notify police or any other service of these threats to kill, but *strongly encouraged* the perpetrator to get help from his psychologist. Further, this worker failed to record the disclosure appropriately in the client's service records with this direct threat being recorded as a generally negative view towards women with the perpetrator having *some thoughts about harming all women*.²¹³ This same perpetrator, on the day prior to the homicide, told police that he would *go to jail* over changes to the protection order that were made to increase the levels of protection afforded the victim. No action was taken by police in response to this disclosure, despite the couple having previously been referred for a high risk response.

Figure 22: Overall quality of contact, by contact type



²¹² Including taking the perpetrator into custody, seizing his weapons, applying for a protection order and initiating referral pathways to child safety and other specialist support services.

²¹³ The primary perpetrator in this case recorded his conversations with service providers so it is very clear what was said, and how this was ultimately documented.

It is important to note that even where individual agency actions were identified as meeting practice standards and requirements on one occasion, this was not consistently seen across all agencies working with the victim and/or perpetrator. This meant that gaps were identified by the Board in the way that services interact with each other to protect victims from harm, and hold perpetrators to account. Efforts to improve responses to people experiencing domestic and family violence across the system through service integration are ongoing in Queensland and are discussed in further detail in Chapter 11.

Where someone presented multiple times to a service there was also variability identified in the way in which individual practitioners responded to the victim and/or perpetrator. Noting that in some cases there were extensive histories of violence across relationships, these discrepancies are in part reflective of changing legislative and service delivery requirements which aim to improve responses in this area. However, it is worth noting, as inconsistent and inadequate service responses may impact a person's willingness to seek help or engage with services in the future.

Even where service responses meet legislative or practice standards, death review processes present an opportunity to critically reflect on what more could have been done to support a person's journey through the system, with a view to driving continuous improvement in this area.

In analysis of these service contacts, it is clear that greater variability was observed with services that had fewer points of contact (e.g. mainstream non-government agencies, corrective services).

Whereas, Figure 23 shows that police performed at a satisfactory level of service in 86.2% of contacts. Courts²¹⁴ and specialist services met expectations at even higher levels (95.9% and 89.8% respectively).

Notably, significant proportions of contacts with private practitioners (e.g. GPs, psychologists, counsellors) were recorded as below expectations and in need of improvement.

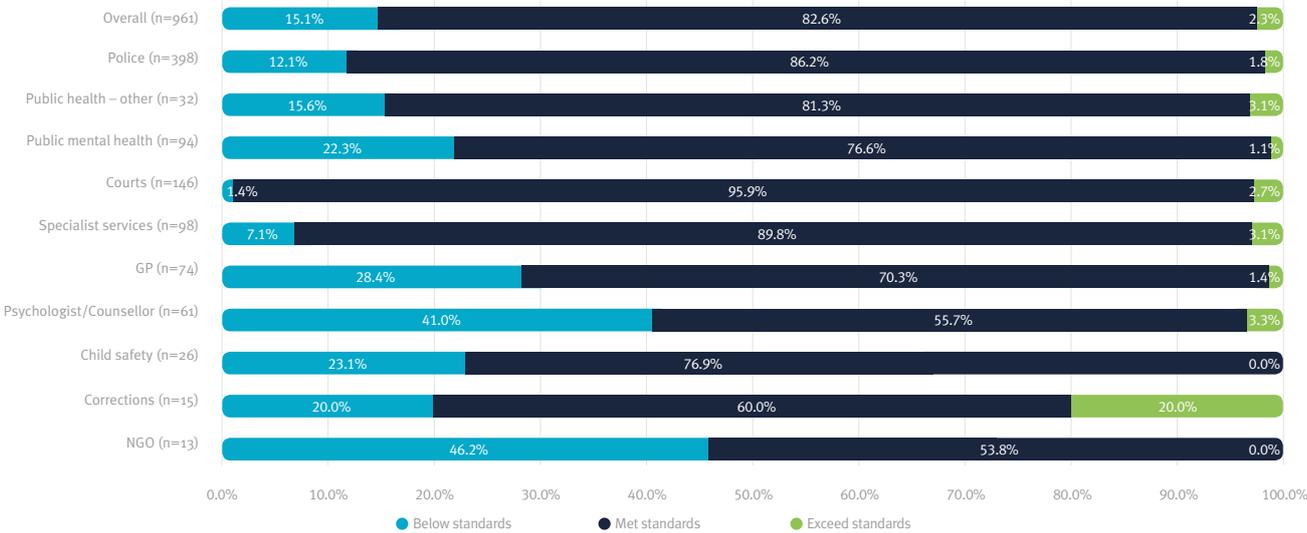
This was demonstrated in the cases through:

- » a failure to detect domestic and family violence despite overt disclosures (psychologists in four cases, GPs in five cases);
- » minimisation of disclosures by, and collusion with, the perpetrator (psychologists in two cases, GPs in two cases); and
- » inappropriate referrals (or lack of referrals) to other services (psychologists in two cases, GPs in four cases).

Further analysis reveals that, in comparison to service responses for victims or when the victim and perpetrator had contact with a service collectively (for example, when police attend a domestic violence occurrence, or courts issued a protection order), the service provided exclusively to perpetrators was in greatest need of improvement.

As shown in Figure 24, this was most evident when services were required to detect violence and were in a position to refer accordingly.

Figure 23: Adequacy of contact by service



²¹⁴ The use of the term 'courts' refers to outcomes within the court jurisdiction. This term recognises that courts do not provide a service per se, but that judicial officers are required to uphold the rule of law; which has important implications for the safety and protection of victims of violence.

Figure 24: Quality of service contact, perpetrators and victims



Interestingly, there was also variability in the overall adequacy of service responses between the different cohorts of domestic and family violence deaths reviewed by the Board (Figure 25).

For instance, for the homicides in a family relationship over one-quarter of contacts in relation to detecting violence were identified as being below expectations. Almost one half of service contacts in this cohort requiring direct action were identified as being in need of improvement. This exemplifies the issues identified in Chapter 3, which highlighted that the service system appears to lack the skills and capability to identify, and respond to, violence in a family relationship.

Of concern is that issues were identified in one-quarter of service contacts in relation to detecting domestic and family violence among the homicide-suicide cohorts.

These issues are particularly problematic given that service responses are quasi-hierarchical. If domestic and family violence is not detected, then agencies will not take action or refer victims or perpetrators for support or intervention.

A lack of recognition of indicators of domestic and family violence represents one of the clearest missed opportunities to intervene, and potentially prevent these deaths. It also highlights the need

for agencies to be better equipped to detect domestic and family violence, through a combination of training and standardised, empirically validated screening and risk assessment tools.

It is also the case that issues were not just isolated to one entity or agency. Where there was a shortcoming or failure by one agency this had flow on implications for other agencies working with the victim and/or perpetrator.

For example, it was identified in one case that a victim was not advised of a decision to grant bail to her former partner after a near fatal assault against her. Had she not sought to confirm the perpetrator's status with Queensland Corrective Services (QCS), she would never have known he was released.

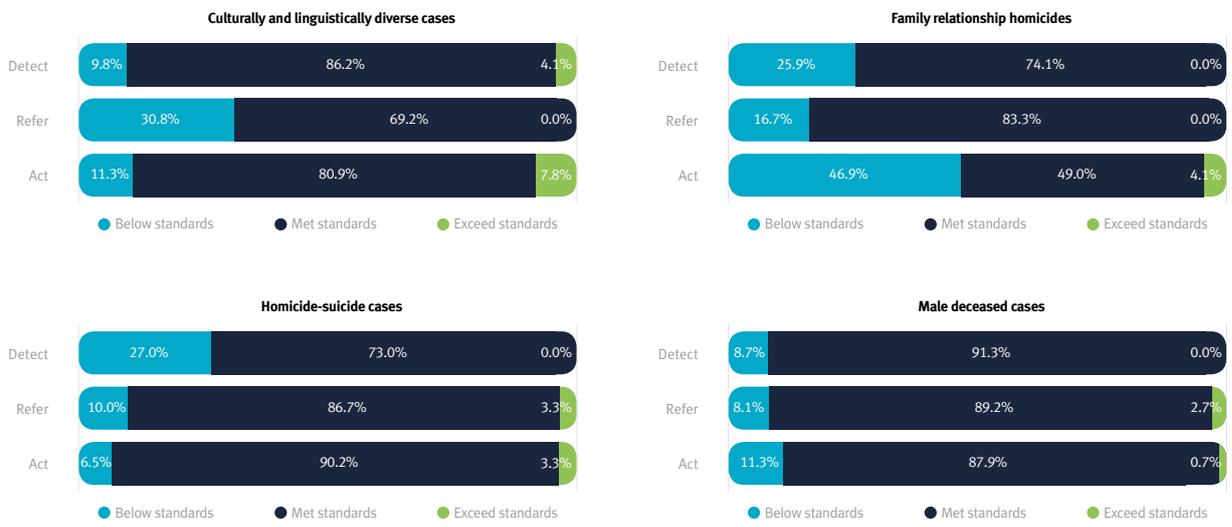
This placed the onus on the victim (and the homicide deceased) to monitor and maintain her own safety, and represents a lack of informed risk management processes being in place during a high risk period.

While recent amendments have broadened the ability of QCS officers to proactively advise victims of domestic and family violence of changes to a perpetrator's custodial status²¹⁵, it is a requirement that victims apply to be placed on a register to become eligible to receive this information.²¹⁶

²¹⁵ As per section 324A of the *Corrective Services Act 2006*, QCS must provide information about: a prisoner's eligibility dates for discharge or release; a prisoner's date of discharge or release; the fact and date of death or escape of a prisoner; and, details of any other circumstances that could reasonably be expected to endanger the person's life or physical safety.

²¹⁶ It is unknown if the victim in this case had applied to QCS to be placed on this victim's register, however it is unlikely as the assault leading to the perpetrator's arrest (and briefly being remanded in custody) was the first recorded episode of violence in the relationship for over 20 years.

Figure 25: Overall adequacy of service contact by contact type, various death types





Chapter 7: Understanding and assessing risk

Key findings

- » In 75.0% of the cases reviewed by the Board in this reporting period, a formalised screening or assessment tool was utilised during at least one service contact.
- » Generalist risk assessments, such as those used by child safety services and in public mental health settings, do not adequately detect domestic and family violence.
- » Similarly, specialist risk screening and assessment tools focus almost exclusively on intimate partner violence in heterosexual relationships. As such there is an identified gap in validated tools that accurately identify risks of violence in other types of relationships (including family relationships).
- » Advances are currently underway at a state and national level to improve risk screening and assessment tools to better identify, and respond to domestic and family violence.
- » The lethality risk indicators most prevalent among intimate partner homicides in Queensland include: history of domestic and family violence; actual or pending separation; sexual jealousy; and, excessive alcohol and drug use by the perpetrator. In most cases, there were multiple risk indicators present prior to the death, indicative of a heightened risk of harm.
- » Where non-lethal strangulation was present, there were on average 18.1 risk indicators but where this was absent, there were just 9.1 indicators. This highlights the need for the service system to respond swiftly to this key indicator of harm where it comes to the attention of services.
- » An exploratory comparison of lethality risk indicators for a sub sample of family homicides show that the most prevalent risk factors were in relation to individual characteristics of the perpetrator (e.g. problematic substance use, mental health issues).

In accordance with section 91D(b) of the Act the Board is required to analyse data, and apply research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland.

This chapter considers the use of screening and risk assessment tools within the cases reviewed by the Board. It also includes analysis of lethality risk indicators from the Queensland Domestic and Family Homicide dataset, and discusses findings that indicate some risk factors may interact, or co-occur, leading to a higher level of risk.

While this is still preliminary analysis, it is the only data of its kind that is specific to Queensland, and has important implications for policy and practice.

Screening and risk assessment processes are an important mechanism to assist services in identifying domestic and family violence, planning for the safety of victims and their children, and in determining whether a perpetrator may present a risk of future harm to others.

At the outset, it is important to acknowledge that there is a key distinction between screening and risk assessment. Screening is a routine process to determine if domestic and family violence has or is occurring to inform further action, referral or intervention.

Risk assessment is a comprehensive process to determine the degree of harm likely to occur as a result of past, present or future violence. In essence an empirically validated risk assessment tool should be predictive, valid and reliable. In practice this means that the tool is able, with a degree of accuracy, to predict future violence and that different people can apply the tool to a case with the same outcome.

Currently, screening and risk assessment tools focus almost exclusively on intimate partner violence in heterosexual couple relationships where the perpetrator is a man and the victim is a woman. The recently released *National Risk Assessment Principles for Domestic and Family Violence* report from ANROWS notes that there is only a strong evidence base in risk assessment for this relationship type, and not for others such as violence occurring within a family relationship.²¹⁷

As discussed in Chapter 4 of this report, it is apparent that violence in these latter types of relationships is more disparate, and does not appear to have a similar level of predictability that is apparent in heterosexual intimate partner relationships which are characterised by coercive controlling violence.

217 Toivonen, C., & Backhouse, C. (2018). *National Risk Assessment Principles for domestic and family violence* (ANROWS Insights 07/2018). Sydney, NSW: ANROWS.

In the cases reviewed by the Board, screening and risk assessment processes also tend to be used more often within the context of service provision to victims of domestic and family violence,²¹⁸ but there has been limited evidence of tools being used to screen for risk of harm among perpetrators of violence.²¹⁹ This is important within the context of perpetrator accountability as it shifts responsibility for the violence from the victim, to the person who is responsible for inflicting harm.

While there are a range of tools that are dedicated to assessing 'risk' within relationships characterised by domestic and family violence, the concept of risk is also often poorly defined and understood.²²⁰ Risk may relate to risk of future violence victimisation, recidivism, or lethality. Generally, in terms of risk assessment and management within the context of domestic and family violence, risk is understood as the likelihood of future harm and/or lethality based on information pertaining to past behaviours.²²¹

A lack of a nuanced understanding of risk assessment processes may have detrimental outcomes in certain circumstances. In one case, a perpetrator who exhibited high levels of coercive control within his intimate partner relationship was screened by a mental health service as at risk of financial abuse by his former spouse (primary victim) just days before he committed a near lethal assault. This assessment process also screened him as being at risk of physical violence from his teenage son, who himself exhibited significant mental health issues that were associated with his exposure to parental domestic and family violence.

Outside of screening and risk assessment processes used within public and community mental health settings, risk within a domestic and family context also rarely accounts for suicidal intent or behaviour.

Consequently, in 2016-17, the Board recommended that domestic violence refuges should implement suicide risk screening processes after considering two cases where a female victim fleeing an abusive relationship completed suicide in a refuge.

The Queensland Government has accepted this recommendation, and will implement a staged approach to the development of a suicide prevention framework within domestic and family violence women's shelters.

In Queensland, there are significantly higher numbers of domestic and family violence suicides than homicides, however, the intersectionality between suicide and domestic and family violence is not well-understood.

The scientific literature regarding domestic violence and suicide generally focuses on two typologies: homicide-suicide and suicide by victims of domestic and family violence. For the most part, research has not explored the nature of suicide among perpetrators exclusive of homicide-suicides, despite evidence that domestic and family violence suicides are more common than domestic and family violence homicides.²²²

²¹⁸ Specialist domestic violence tools were administered to victims in 11 cases and primary perpetrators in four cases. In contrast, generalist tools that cover domestic violence as part of broader risk assessment (e.g. mental health, corrective services) were more often administered to perpetrators than victims (14 and four respectively).

²¹⁹ Tools that are used to assess perpetrators include:
Abusive Behavior Inventory – a 40 item instrument to measure the frequency of abusive behaviours across a 6-month period, which is applicable to both perpetrators and victims of domestic violence, and was used by a generalist service in one of the cases considered by the Board (Shepard, M.F., & Campbell, J.A. (1992). *The Abusive Behavior Inventory: A measure of psychological and physical abuse. Journal of Interpersonal Violence, 7*(3), 291-305.

The Historical Clinical and Risk Management (HCR-20) is an actuarial violence risk assessment. This instrument is a general violence risk assessment tool, and not tailored to domestic and family violence (Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). *HCR-20V3: Assessing risk of violence – User guide*. Burnaby, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.)

²²⁰ Backhouse, C., & Toivonen, C. (2018). *National Risk Assessment Principles for domestic and family violence: Companion resource. A summary of the evidence-base supporting the development and implementation of the National Risk Assessment Principles for domestic and family violence (ANROWS Insights 09/2018)*. Sydney, NSW: ANROWS.

²²¹ Backhouse, C., & Toivonen, C. (2018). *National Risk Assessment Principles for domestic and family violence: Companion resource. A summary of the evidence-base supporting the development and implementation of the National Risk Assessment Principles for domestic and family violence (ANROWS Insights 09/2018)*. Sydney, NSW: ANROWS.

²²² Davis, R. (2010). Domestic violence-related deaths. *Journal of Aggression, Conflict and Peace Research, 2*, 44-52.

It is estimated that 30% of suicides are related to 'intimate partner problems'²²³, though the true number of suicides where actual domestic and family violence has occurred remains unknown. Relationship breakdown is, however, well established as being associated with suicide²²⁴, particularly in males.²²⁵ Yet, this concept is generally broad and ill-defined, and the exact nature of the 'relationship breakdown' is lost, with details about possible domestic violence not concurrently reported.

Significantly, a review of the Queensland Domestic and Family Violence Suicide dataset demonstrates that suicide risk tends to be greater for male perpetrators of domestic and family violence. This is likely to be reflective of the disproportionate rates at which men die by suicide comparative to women; and the greater number of suicides that occur in Queensland comparative to homicides.²²⁶

Even within the homicides cases reviewed by the Board, there is evidence to suggest that the perpetrator expressed suicidal intent or behaviour prior to the fatal event in seven cases. For the homicide suicides, prior suicidal intent occurred at even greater rates than in the homicide only cases. A prior history of suicide ideation or attempts was apparent in four of the six cases where the homicide offender also apparently took their own life, compared with three of the 13 homicide only cases.

Use of risk screens and assessments by services

As mentioned above, there are a range of risk screening and assessment tools in use by various agencies and services throughout Queensland and nationally, which contributes to inconsistent practice, and definitional issues across stakeholders. Training and quality assurance around the use of these tools also appears to be insufficient to achieve robust, standardised assessment outcomes.

It is, however, noted that there has been increasing focus on this issue at a state and national level which aims to ensure consistency, such as the ongoing trial of the Common Risk Assessment Framework in Queensland²²⁷; a review of the DCSYW Structured Decision Making Tool; and the recent evaluation of the QPS Domestic Violence Protective Assessment Framework (DV-PAF).

Table 21. Prevalence of risk screens and assessments by service type

	Victim		Perpetrator	
	Cases	No. of screens / assessments	Cases	No. of screens / assessments
Police	6	7	3	3
Public health	1	2	7	11
Private practitioners	0	0	0	0
Specialist services	5	13	2	5
Child safety	3	3	2	2
Corrective services	1	2	5	6
Courts	0	0	0	0
Other services	1	1	0	0

223 Problems include divorce, break-up, verbal abuse, jealousy, conflict, physical abuse, discord.- Karch et al, (2008), as reported in Davis 2010.

224 Evans, R., Scourfield, J., & Moore, G. (2014). Gender, relationship breakdown and suicide risk: A review of research in Western countries. *Journal of Family Issues*, 1-26. DOI: 10.1177/0192513X14562608 Accessed on 22 April 2016.

225 Scourfield, J. & Evans, R. (2015). Why might men be more at risk of suicide after a relationship breakdown? Sociological insights. *American Journal of Men's Health*, 9, 380-384.

226 For instance, as reported in detail in Chapter 2, in 2017-18 there were 40 suicides which were identified as being associated with domestic and family violence, in comparison to 20 homicides in intimate partner or family relationships.

227 In response to recommendations from the Special Taskforce on Domestic and Family Violence final report, the (then) Department of Communities, Child Safety and Disability Services commissioned the ANROWS to deliver several key outcomes, including the development of a best practice common risk assessment framework to support service provision in an integrated response. The Special Taskforce envisioned the risk assessment framework to assist in: (a) establishing a shared understanding and language for risk; (b) the triaging process; (c) helping to identify high risk cases; and (d) identifying whether thresholds of risk for information sharing have been met and developing the appropriate response in each case. Coroner John Hutton called for the development of such a common risk assessment tool in his findings after the intimate partner homicide of Noelene Beutel, which was referenced and reinforced in the Special Taskforce Final Report. As a result, ANROWS developed a Common Risk Assessment Framework (CRAF) which features three levels of assessment: Level 1 - screening tool / routine asking questions; Level 2 - risk assessment and safety planning; and, Level 3 - Complex risk assessment and safety management. The CRAF is intended for use by generalist and specialist services to inform the level of risk and accompanying response (e.g. referral to high risk team or specialist service). The CRAF is being trialled as part of the integrated response trial, and will be subject to evaluation. The CRAF is not an actuarial assessment, and as such requires practitioners to utilise professional judgement, and rely on a victim's sense of safety to inform the categorisation of risk.

As outlined in Table 21, in the cases reviewed by the Board, specialist domestic and family violence screening and risk assessment tools were used by:

- » police (DV-PAF for victims, as well as a professional judgement assessment to identify perpetrators considered to be high risk);²²⁸
- » public health services (the maternity health 'Safe Start' tools that screen for domestic and family violence²²⁹);
- » corrective services (assessment tools prior to referral to men's behaviour change programs); and
- » specialist services who use a variety of screening and risk assessment tools during intake and case management²³⁰, and as pre-program screening tools for perpetrators.

Additionally, generalist screening and risk assessment processes that considered domestic and family violence were undertaken by:

- » public health services (mental health consumer assessments);
- » corrective services (risk needs and rehabilitation assessments);²³¹
- » child safety services (Structured Decision Making tool); and
- » other services (i.e. family support services).

While the use of formalised screening or risk assessment occurred at least once in 75.0% of the cases reviewed by the Board, there was a lack of consistency and standardisation across cases. It is also clear that while it may have been organisational practice, risk screens and assessments were not routinely administered at each service contact and there were identified instances where the tools were inappropriately administered.

Public health settings

In one case, a generalist screen used in a public health service failed to incorporate collateral information from a family member who disclosed to the service the perpetrator's homicidal ideation directed to the victim. After questioning the perpetrator, who admitted to the disclosures, the threats were dismissed as *frustration and driven by his character*. On this occasion, the perpetrator was assessed as a medium risk of aggression but the case was closed with no follow-up and no referral to police or other services.

Within a public health setting, assessment processes may seek to identify risks across multiple domains, not specifically targeting domestic and family violence. For example, mental health services administer consumer mental health assessments to assess the presenting individual for risk of: suicide, self-harm, aggression, vulnerability and absconding. This risk tool is highly client-centred and does not screen for particular risks to the individual's family. This represents a missed opportunity for the service to assess whether someone poses a risk to others as well as themselves.

This issue was recently considered within the context of Queensland Health Service delivery to people experiencing a mental illness. The Mental Health Sentinel Events Review Committee (the Sentinel Events Review)²³² identified deficiencies in the assessment processes in place within Queensland Health at the time, with little evidence they were able to predict future risk.²³³

Consequently, the Sentinel Events Review called for the incorporation of a graduated risk assessment and management approach, to better assess the risk an individual may pose to others, including family, carers, and the community. A three level violence risk assessment was recommended²³⁴, inclusive of:

1. initial risk screen as part of the intake assessment;
2. a risk assessment conducted by a clinician where violent behaviour or elevated risk is identified in the risk screen; and
3. a specialist risk assessment where a high risk of violence has been identified.

²²⁸ Some police districts in Queensland have implemented high risk domestic violence case management processes, with perpetrators categorised as high, extreme or lethal risk based on information accessible to police in QPRIME (e.g. repeat calls for service, high risk of violence flags).

²²⁹ The Safe Start tool is used for screening domestic and family violence Queensland Health facilities and was introduced when the National Perinatal Depression Initiative was agreed upon in 2008. Queensland Health have published a guideline regarding *Antenatal Screening for Domestic and Family Violence*. https://www.health.qld.gov.au/__data/assets/pdf_file/0032/712688/qh-gdl-456.pdf Accessed 16 August 2018

²³⁰ For example, the Spousal Assault Risk Assessment (SARA) tool has broad usage internationally, and (an adapted version) was used by a specialist domestic violence service in one of the cases considered by the Board. This 20 item semi-structured assessment to assess risk of future violence in men and is used to guide decision making. A further tool, the Domestic Violence Risk Assessment was developed in South Australia features an actuarial scale as well as includes the victim's own assessment of their safety and risk levels.

²³¹ QCS assess offenders at various points throughout their correctional episodes. These tools are used to assess (among other things): recidivism; immediate risks and needs upon entry to prison and admission to community-based supervision; rehabilitation needs; and, reintegration needs. Domestic and family violence is assessed in some of these generalist assessments, for example in assessing for rehabilitation needs (e.g. Benchmark assessment in the community, rehabilitation needs assessment in custody) to determine if an offender should be referred to intervention or treatment pathway. In the community, Probation and Parole officers may also administer specialist domestic and family violence assessments to inform referrals to an intervention program (e.g. men's behaviour change program). However, dedicated domestic and family violence risk screens and tools are not used by QCS to project future risk of harm or re-offending.

²³² The *Mental Health Sentinel Events Review Committee* was established in 2015 to review recent fatal events involving people with mental health issues in Queensland. The intention was to provide expertise and leadership in public mental health, and forensic mental health care that balanced best practice care with operational practicality. A final report (the Sentinel Events Review) was released in 2016 and provides high level guidance for clinicians, administrators, and policymakers on opportunities to improve the identification and quality of care for severely mental ill patients while simultaneously considering public safety.

²³³ Mental Health Sentinel Events Review Committee. (2016). *When Mental Health Care Meets Risk: A Queensland sentinel events review into homicide and public sector mental health services*. Brisbane: Queensland Health.

²³⁴ Recommendation 22. Mental Health Sentinel Events Review Committee. (2016). *When Mental Health Care Meets Risk: A Queensland sentinel events review into homicide and public sector mental health services*. Brisbane: Queensland Health.

As a result of the implementation of these reforms, forensic mental health service risk screens now incorporate specific prompts for domestic and family violence, seeking to identify both victimisation and perpetration.

Further, a new violence risk assessment tool has been developed and is being trialled in five Hospital and Health Services ahead of a planned state-wide implementation in 2019.

To support the third tier assessments, practitioners are being trained to conduct longitudinal risk assessment, including how to obtain and weight information to inform management approaches. The Spousal Assault Risk Assessment (SARA) has been incorporated into a suite of tools available to clinicians to undertake specialist assessments of risk, to inform the development of risk mitigation strategies where necessary.

However, as there is a paucity of formalised and validated risk assessments that focus on violence in a family relationship, clinicians will be reliant on supplementary assessments and/or professional judgement, enhanced by further training, to detect family violence.

Additionally, the Sentinel Events Review called for enhanced input from families and carers into the management and treatment planning of individuals, and for comprehensive assessments by clinicians to be informed by collateral information obtained from families and carers.²³⁵ Notably, it was recommended that clinicians ask about the safety of family members (including spouses) throughout risk assessment and treatment planning.²³⁶

Due to the commonalities in findings identified in the cases reviewed by the Board, and those of the Sentinel Events Review Committee, the Board reiterates the critical importance of this reform agenda and the need for a continued focus on effective implementation of relevant recommendations across Queensland Health facilities.

Child safety assessments

Child safety services utilise structured decision making (SDM) tools that are designed to complement and inform professional judgement and assist practitioners in making key decisions across the child protection continuum.²³⁷

The SDM highlights the differences between risk and harm, with the risk of future harm assessed with an actuarial risk tool (the family risk evaluation). By definition, while the SDM tools include questions in relation to domestic and family violence, they are not specifically designed to assess for parental intimate partner violence, and thereby they lack sufficient rigour to be used in this context.

In three cases considered by the Board in this period, there were instances where disclosures of parental intimate partner violence were identified through SDM processes that were not incorporated into the assessment of the child's risk of future harm.

As outlined in further detail in Chapter 4 there is a need for a greater recognition of, and response to, the impact of domestic and family violence on children; even in circumstances where a child is not a direct victim of this abuse.

This issue is being addressed through a current review of this tool led by the DCSYW. In addition, child safety services is investing in the development of its workforce to increase understanding of domestic and family violence through ongoing professional development and training.²³⁸

A focus on continuous improvement

Work is also underway nationally to enhance risk assessment processes for domestic and family violence. In July 2018, ANROWS finalised and published *National Risk Assessment Principles for Domestic and Family Violence* (Table 22).²³⁹ These are intended to provide an overarching national understanding of risk assessment and management in the area of domestic and family violence, as part of the Third Action Plan under the *National Plan to Reduce Violence against Women and their Children 2010-2022*.

²³⁵ Recommendation 10. Mental Health Sentinel Events Review Committee. (2016). *When Mental Health Care Meets Risk: A Queensland sentinel events review into homicide and public sector mental health services*. Brisbane: Queensland Health.

²³⁶ Recommendation 13. Mental Health Sentinel Events Review Committee. (2016). *When Mental Health Care Meets Risk: A Queensland sentinel events review into homicide and public sector mental health services*. Brisbane: Queensland Health.

²³⁷ The SDM was developed and refined by the National Council on Crime and Delinquency's Children's Research Centre in the United States of America.

²³⁸ Queensland Government. 2018. *Supporting Families Changing Futures: 2018 Update*. Available online: <https://www.csyw.qld.gov.au/campaign/supporting-families>

²³⁹ Toivonen, C., & Backhouse, C. (2018). *National Risk Assessment Principles for domestic and family violence* (ANROWS Insights 07/2018). Sydney, NSW: ANROWS

Table 22: National Risk Assessment Principles for Domestic and Family Violence ²⁴⁰

Principle 1: Survivors' safety is the core priority of all risk assessment frameworks and tools.
Principle 2: A perpetrator's current and past actions and behaviours bear significant weight in determining risk.
Principle 3: A survivor's knowledge of their own risk is central to any risk assessment.
Principle 4: Heightened risk and diverse needs of particular cohorts are taken into account in risk assessment and safety management
Principle 5: Risk assessment tools and safety management strategies for Aboriginal and Torres Strait Islander peoples are community-led, culturally safe and acknowledge the significant impact of intergenerational trauma on communities and families.
Principle 6: To ensure survivors' safety, an integrated, systemic response to risk assessment and management, whereby all relevant agencies work together, is critical.
Principle 7: Risk assessment and safety management work as part of a continuum of service delivery.
Principle 8: Intimate partner sexual violence must be specifically considered in all risk assessment processes.
Principle 9: All risk assessment tools and frameworks are built from evidence-based risk factors.

While the ANROWS principles of risk assessment identify a victim's knowledge of their own risk as central to any risk assessment, there is evidence that victims of domestic and family violence are not always well placed to understand the risks they face.

Research demonstrates that almost half of women who survive attempted intimate partner homicide had not recognised their lives were in danger.²⁴¹

Indeed, among Queensland intimate partner homicide cases between 2011 and 2015, just over one-half (50.8%) of victims expressed an intuitive sense of fear of the perpetrator prior to the homicide.²⁴²

Of the cases considered by the Board in this reporting period, 65.0% of victims²⁴³ expressed an intuitive sense of fear of the perpetrator and 45.0% of victims perceived themselves to be at heightened risk of harm by the perpetrator.

Further, a proportion of victims expressed fear that the perpetrator may harm themselves (55.0%), and openly expressed that they did not consider that the perpetrator was capable of inflicting serious or lethal violence (30.0%). Such expressions of fear were not prevalent at all in the family violence homicides.

In this respect, it may be necessary to broaden our understanding of victim's expressions of fear and how it may be articulated by them, to enhance service responses. It is also imperative that any form of risk assessment captures objective determinants of risk.²⁴⁴

²⁴⁰ Toivonen, C., & Backhouse, C. (2018). *National Risk Assessment Principles for domestic and family violence* (ANROWS Insights 07/2018). Sydney, NSW: ANROWS.

²⁴¹ Nicolaidis, C., Curry, M.A., Ulrich, Y., Sharps, P., McFarlane, J., Campbell, D., Gary, F., Laughon, K., Glass, N., & Campbell, J. (2003). Could We Have Known? A Qualitative Analysis of Data from Women Who Survived an Attempted Homicide by an Intimate Partner. *Journal of General Internal Medicine*, 18, 788-794.

²⁴² Domestic and Family Violence Death Review and Advisory Board. (2017). *Annual Report 2016-17*. Brisbane: Author.

²⁴³ This was either in the index relationship, or in associated intimate partner relationships for cases of family homicide.

²⁴⁴ For example, a history of domestic and family violence, history of non-lethal strangulation, sexual jealousy.



Lethal risk

With the benefit of hindsight and all available information, it is clear that lethal risk was apparent in many of the cases reviewed by the Board. However for some of these cases it was considered unlikely that they would have been assessed as ‘high risk’ as there was no known prior reports of severe physical abuse. This is despite evidence to suggest these relationships were categorised by high levels of coercive control, which highlights the need for ongoing awareness regarding non-physical risk indicators, as discussed in the Board’s 2016-17 Annual Report.

As outlined in this report a growing body of research has identified a range of factors that are present in relationships characterised by domestic and family violence and may be indicative of a heightened risk of harm.

However, while these risk factors may be present in the relationship, causality has not been established and as such, their predictive validity is largely undetermined. For example, some demographic factors which are present in homicide cases (e.g. couple residing in a de-facto relationship or a perpetrator unemployed) may be indicative of broader population trends. As such they have limited relevance in terms of preventative activities, or in assessing future risk of harm.

To further consider this issue, the Ontario Domestic and Family Violence Death Review Committee lethality coding system²⁴⁵ has been applied to 78 intimate partner homicides in Queensland from 2011 to 2017, where complete records are available.

As outlined in Chapter 2, this coding form is applied to the history of domestic and family violence between the victim (who may be a homicide offender or deceased) and the perpetrator (who may be a homicide offender or deceased).

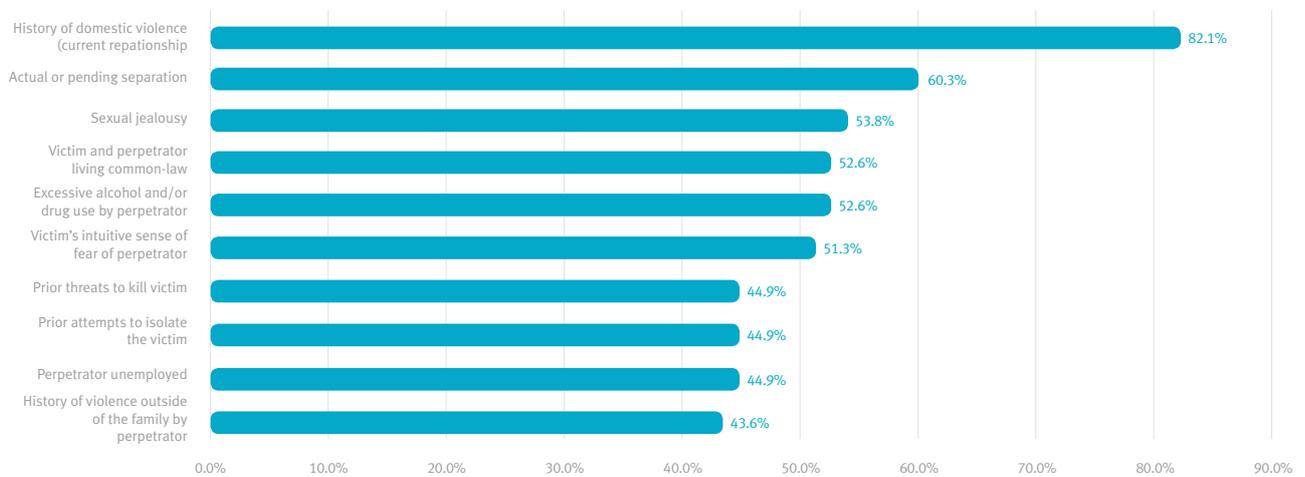
The most prominent lethality risk indicator is a history of domestic and family violence (Table 23). Other prevalent factors included: actual or pending separation, sexual jealousy, excessive alcohol and drug use by the perpetrator, and a victim’s intuitive sense of fear (Figure 26).

²⁴⁵ In its analysis of these cases, the Board has adopted the coding system developed by the Ontario Domestic Violence Death Review Committee to explore lethality risk indicators associated with intimate partner homicides. The Ontario Coding system is the most comprehensive available that has been directly developed on the review of these types of fatalities. It has also been adopted due to similarities in basic population demographics between Queensland and Canada. The Ontario Death Review Committee, through review of hundreds of cases and examination of the evidence base, identified 39 factors prominent in intimate partner homicides. The coding system has recently been amended to include an additional factor (history of violence against former partners). The coding sheet and definitions are provided in Appendix B.

Table 23: Prevalence of lethality risk factors among intimate partner homicides, 2011-2017 (selected cases)

Risk factor	Number	Percent
History of domestic violence (current relationship)	64	82.1%
Actual or pending separation	47	60.3%
Sexual jealousy	42	53.8%
Victim and perpetrator living in common-law	41	52.6%
Excessive alcohol and/or drug use by perpetrator	41	52.6%
Victim's intuitive sense of fear of perpetrator	40	51.3%
Prior threats to kill victim	35	44.9%
Prior attempts to isolate the victim	35	44.9%
Perpetrator unemployed	35	44.9%
History of violence outside the family by perpetrator	34	43.6%
Obsessive behaviour displayed by perpetrator	31	39.7%
Failure to comply with authority	31	39.7%
Controlled most or all of victim's daily activities	30	38.5%
Escalation of violence	28	35.9%
Prior threats to commit suicide by perpetrator	25	32.1%
New partner in victim's life	24	30.8%
Choked / strangled victim in the past	23	29.5%
Prior destruction or deprivation of victim's property	22	28.2%
Extreme minimisation and/or denial of spousal assault history	22	28.2%
Other mental health or psychiatric problems – perpetrator	21	26.9%
Prior hostage taking and / or forcible confinement	19	24.4%
Prior threats with a weapon	18	23.1%
Prior suicide attempts by perpetrator	18	23.1%
Perpetrator threatened and/or harmed children	18	23.1%
Depression – in the opinion of family / friend / acquaintance	17	21.8%
Prior assault with a weapon	16	20.5%
Presence of step children in the home	16	20.5%
Depression – professionally diagnosed	16	20.5%
Child custody or access disputes	15	19.2%
Prior assault on victim while pregnant	13	16.7%
Prior forced sexual acts and/or assaults during sex	12	15.4%
Access to or possession of any firearms	12	15.4%
Misogynistic attitudes – perpetrator	12	15.4%
Prior violence against family pets	11	14.1%
Age disparity of couple	11	14.1%
Perpetrator was abused and/or witnessed DV as a child	9	11.5%
After risk assessment, perpetrator had access to victim	9	11.5%
Youth of couple	5	6.4%
Perpetrator exposed to/witnessed suicidal behaviour in family of origin	3	3.8%

Figure 26: Highest ranking lethality risk factors, intimate partner homicides, 2011 to 2017



As revealed in Table 19 in Chapter 2, there are some differences in the presence of risk indicators for homicide cases where a female was killed by a male intimate partner and those where a male was killed by a female intimate partner. Notably, in female perpetrated intimate partner homicides with a male deceased, there were lower frequencies of threats to kill, controlling behaviours, sexual jealousy, hostage taking, and attempts to isolate the victim by the perpetrator (and homicide deceased).

Similarly, there are stark differences in the frequency of lethality risk indicators for cases featuring a deceased who identified as Aboriginal and Torres Strait Islander, or a person from a culturally and linguistically diverse background (Table 24).

Cases involving Aboriginal and Torres Strait Islander homicide deceased had on average 13.9 lethality risk factors, which was slightly higher than for people from a culturally and linguistically diverse background (11.2) and non-Indigenous and not culturally diverse cases (11.3).

There were a range of factors that were more common among Aboriginal and Torres Strait Islander intimate partner homicide deceased, including: excessive use of alcohol or other substances (93.3%); a history of violence outside the family by the perpetrator (86.7%); failure to comply with authority (86.7%); perpetrator unemployed (80.0%); sexual jealousy (80.0%); and, prior assault with a weapon (60.6%). In contrast, Aboriginal and Torres Strait Islander intimate partner homicides were far less likely to occur in the context of separation, which was present in just 6.7% of cases.

It is important to note that for some Aboriginal and Torres Strait Islander women, particularly those residing in rural and remote areas, leaving an abusive relationship may be complicated by the threat of retaliation or extended violence from other family members.

This means that the victim may ultimately have to leave their community to separate from the relationship and escape detection. However, relocating may pose additional challenges through the loss of spiritual connections and extended family support, the impacts of which are exacerbated when there are children involved.²⁴⁶ These factors may account for the lower levels of separation (actual or intended) recorded in these cases.

For cases involving culturally and linguistically diverse homicide deceased, there was a higher prevalence of prior attempts by the perpetrator to isolate the victim (71.4%) and child custody or access disputes (35.7%).

²⁴⁶ Meyer, S. (2016). *Indigenous Women's Experiences of Domestic and Family Violence and its Impact on Relation, Housing Stability and Parenting*. Presented at the annual Australian and New Zealand Society of Criminology (ANZSOC) conference, Hobart, 2016.

Table 24: Prevalence of risk factors, Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse, and other intimate partner homicides, 2011 to 2017

	Aboriginal and Torres Strait Islander	Culturally and linguistically diverse	Other
History of violence outside of the family by perpetrator	86.7%	21.4%	36.7%
History of domestic violence (current relationship)	86.7%	78.6%	81.6%
Prior threats to kill victim	53.3%	50.0%	40.8%
Prior threats with a weapon	53.3%	28.6%	12.2%
Prior assault with a weapon	60.0%	14.3%	10.2%
Prior threats to commit suicide by perpetrator	20.0%	28.6%	36.7%
Prior suicide attempts by perpetrator	20.0%	14.3%	26.5%
Prior attempts to isolate the victim	33.3%	71.4%	40.8%
Controlled most or all of victim's daily activities	46.7%	42.9%	34.7%
Prior hostage-taking and/or forcible confinement	40.0%	21.4%	20.4%
Prior forced sexual acts and/or assaults during sex	20.0%	7.1%	16.3%
Child custody or access disputes	0.0%	35.7%	20.4%
Prior destruction or deprivation of victim's property	13.3%	42.9%	28.6%
Prior violence against family pets	6.7%	14.3%	16.3%
Prior assault on victim while pregnant	13.3%	21.4%	16.3%
Choked/strangled victim in past	33.3%	21.4%	30.6%
Perpetrator was abused and/or witnessed DV as a child	13.3%	14.3%	10.2%
Escalation of violence	40.0%	35.7%	34.7%
Obsessive behaviour displayed by perpetrator	33.3%	42.9%	40.8%
Perpetrator unemployed	80.0%	28.6%	38.8%
Victim and perpetrator living common-law	86.7%	35.7%	46.9%
Presence of step children in the home	40.0%	0.0%	20.4%
Extreme minimisation and/or denial of spousal assault history	40.0%	28.6%	24.5%
Actual or pending separation	6.7%	71.4%	73.5%
Excessive alcohol and/or drug use by perpetrator	93.3%	21.4%	49.0%
Depression – in the opinion of family/friend/acquaintance	0.0%	35.7%	24.5%
Depression – professionally diagnose	13.3%	14.3%	24.5%
Other mental health or psychiatric problems – perpetrator	33.3%	35.7%	22.4%
Access to or possession of any firearms	6.7%	14.3%	18.4%
New partner in victim's life	13.3%	35.7%	34.7%
Failure to comply with authority	86.7%	14.3%	32.7%
Perpetrator exposed to/witnessed suicidal behaviour in family of origin	0.0%	0.0%	6.1%
After risk assessment, perpetrator had access to victim	20.0%	7.1%	10.2%
Youth of couple	0.0%	7.1%	8.2%
Sexual jealousy	80.0%	42.9%	49.0%
Misogynistic attitudes – perpetrator	20.0%	21.4%	12.2%
Age disparity of couple	20.0%	7.1%	14.3%
Victim's intuitive sense of fear of perpetrator	53.3%	64.3%	46.9%
Perpetrator threatened and/or harmed children	26.7%	21.4%	22.4

Co-occurring lethality risk indicators

Among the 78 cases of intimate partner homicide analysed, the number of risk factors identified ranged from one to 27, with an average of 11.8 per case. More than 11 risk factors were identified in 55.1% of cases (Table 25).

Table 25: Number of lethality risk factors per case, 2011 to 2017

Risk factors	Number of cases	Percent
Nil	0	0.0%
1 to 3 factors	10	12.8%
4 to 6 factors	13	16.7%
7 to 10 factors	12	15.4%
11 to 19 factors	31	39.7%
20 or more factors	12	15.4%

Risk factors clearly do not occur in isolation. To understand the complex interplay of such factors, further analysis was conducted, with a focus on some of the key risk indicators that are commonly associated with a heightened risk of lethal harm.²⁴⁷

Of note, where non-lethal strangulation was present there was an average of 18.1 lethality indicators; where non-lethal strangulation was not recorded there were just 9.1. This is suggestive of a heightened risk in those relationships where an act of non-lethal strangulation has occurred, which is well-established in current research.

Presence of non-lethal strangulation was also associated with increased levels of: sexual jealousy; prior threats to kill the victim; prior suicide threats; prior hostage taking and/or forcible confinement; prior assault during pregnancy; an escalation of violence; excessive substance use; a failure to comply with authority; and, a victim's intuitive sense of fear of the perpetrator.

Where sexual jealousy was reported, there were on average 16.3 lethality risk indicators, but where this was absent there were just 6.5. The presence of sexual jealousy was found to be associated with increased levels of: obsessive behaviour displayed by perpetrator; failure to comply with authority; history of violence outside the family by perpetrator; an escalation of violence; and, controlled all or most of victim's daily activities.²⁴⁸

Unlike non-lethal strangulation and sexual jealousy, there were fewer differences between cases that featured separation and those that did not. There were, however, slightly more risk factors in those where actual or pending separation was recorded (13.1 compared with 9.7). In cases characterised by separation, there were increased frequencies of: prior property damage; a new partner in the victim's life; an escalation of violence; prior attempts to isolate the victim; child custody or access disputes; and, victim's intuitive sense of fear of perpetrator.

²⁴⁷ Data tables of this analysis are available in Appendix C.

²⁴⁸ Other notable elevations were recorded for: prior assault with a weapon; prior suicide threats and attempts; prior attempts to isolate the victim; prior hostage-taking or forcible confinement; prior forced sexual acts or assaults during sex; prior destruction of property; choked / strangled the victim in the past; excessive drug and alcohol use; professional diagnosed depression (perpetrator); access / possession of firearms; a new partner in the victim's life; a victim's intuitive sense of fear.

Non-lethal strangulation

As reported by the Board in its 2016-17 Annual Report, there has been an increased focus on non-lethal strangulation in Queensland.

Queensland was the first Australian jurisdiction to introduce non-lethal strangulation in a domestic violence context as a stand-alone offence.²⁴⁹

In 2017-18, there were 834 strangulation offences lodged in Magistrates Courts throughout Queensland, with over 1700 offences lodged to date.²⁵⁰ Of those who have been convicted of strangulation offences, the vast majority have had a sentence of imprisonment imposed.²⁵¹

Nevertheless, despite this progress, the Board considers that more needs to be done to identify and respond to non-lethal strangulation. This was recently highlighted at the Inquest into the death of Tracy Beale, who died as a result of neck compression after a physical altercation with her partner.²⁵²

Magistrate David O'Connell ultimately recommended that a review of current legislative provisions²⁵³ be undertaken, in consultation with both legal and medical experts, to ensure that the wording of the offence captures all relevant circumstances. The Board is supportive of such a legislative review, as this remains a key area of focus throughout the case review process.

As identified in cases reviewed by the Board in this reporting period, there are still issues in service responses when non-lethal strangulation occurs.

In one particular case after a near-fatal assault, attending paramedics and police focused on transporting the perpetrator to hospital for mental health treatment. They were dismissive of the physical impact of this near lethal strangulation episode (including the victim losing consciousness for a period of time). Action was only taken when the victim later disclosed this episode of non-lethal strangulation to specialist service providers, who encouraged her to go to an emergency department and re-present to police.

In its 2016-17 Annual Report, the Board recommended mandatory training for all staff who may come into contact with victims and their children, or perpetrators of domestic and family violence. Within this, it was recommended that specialist non-lethal strangulation training be delivered to accident and emergency departments to assist in the recognition of the signs of this type of violence, and in the collation of forensic information to inform criminal prosecution.

The Queensland Government has accepted this recommendation in part, citing the publication of a toolkit of resources to support the recognition and response of health professionals to domestic and family violence.²⁵⁴ These resources, however, do not cover non-lethal strangulation in any detail.

Accordingly, the Board believes that this issue has not been adequately addressed to date, and is reinforcing the need for such training within this report, and the expansion of this recommendation to other services who may be in a position to respond.

Recommendation 5:

That Queensland Health and the Queensland Police Service examine the role of clinical forensic evidence in securing convictions for non-lethal strangulation within a domestic and family violence context, with a view to identifying opportunities for improvement and standardisation in processes.

Recommendation 6:

That Queensland Health explore opportunities to increase public health clinicians' (including ambulance officers, accident and emergency staff, drug and alcohol services, mental health clinicians) knowledge of the signs of, and appropriate responses to, non-lethal strangulation within a domestic and family violence context.

This should include an evaluation of the current Queensland Health training modules (i.e. Understanding domestic and family violence, Clinical response to domestic and family violence) to ensure they include relevant information to assist health practitioners identify and respond to non-lethal strangulation.

Recommendation 7:

That the Queensland Police Service evaluate their existing training in relation to domestic and family violence to increase frontline responding officers' knowledge of the signs of, and appropriate responses to, non-lethal strangulation.

Recommendation 8:

That Queensland Health explore data-linking opportunities with other relevant departments to improve the evidence base regarding the ongoing health impacts of non-lethal strangulation.

Recommendation 9:

That the Royal Australian College of General Practitioners explore opportunities to increase general practitioners' knowledge of the signs of, and appropriate responses to, non-lethal strangulation within a domestic and family violence context, inclusive of appropriate referral pathways.

249 Section 315A of the *Criminal Code Act 1899* was introduced on 5 May 2016.

250 Courts data: <https://www.courts.qld.gov.au/court-users/researchers-and-public/stats> Accessed 4 September 2018.

251 420 of the approximate 440 defendants who have been convicted received a penalty of imprisonment – Courts data. <https://www.courts.qld.gov.au/court-users/researchers-and-public/stats> Accessed: 4 September 2018.

252 https://www.courts.qld.gov.au/_data/assets/pdf_file/0017/561212/cif-beale-ta-20180328.pdf

253 That is, section 315A of the *Criminal Code 1899*.

254 Queensland Health. (2017). *Understanding Domestic and Family Violence*. Brisbane: Author. https://www.health.qld.gov.au/_data/assets/pdf_file/0025/465154/understanding-dfv-booklet.PDF

Lethality indicators in family homicides

As discussed in Chapter 3, homicides in a family relationship appear to vary considerably from intimate partner homicides, with coercive controlling behaviours less prevalent among family homicides.

As an exploratory comparison, a sub-sample of 15 homicides²⁵⁵ in a family relationship between 2009 and 2015 had the Ontario Domestic Violence Death Review Committee intimate partner homicide lethality risk indicator coding system applied to them.²⁵⁶

As expected, a range of factors associated with intimate partner homicides were not observed in the family homicides (Table 26). For example, there were limited reports of sexual jealousy, controlling behaviours, and non-lethal strangulation.

The most prevalent risk factors were largely perpetrator characteristics (e.g. problem substance use, mental health issues, and suicide attempts) with less emphasis on the dynamics within the index relationship/s. This demonstrates the need for further research to better understand family violence, and the underlying patterns of risk and harm.

With respect to current research regarding assessing risk within parent/child family relationships, it is clear that where domestic and family violence is present in the relationship, risk assessment tools are unable to distinguish between cases where a mother only or a mother and her children are at risk. As such, it has been recommended that where tools do identify the mother to be at risk of lethal harm, the same level of risk should be extended to the child/ren.^{257,258}

While some risks are recognised as shared between mother and children, others are distinct and thus require a child-specific focus.²⁵⁹ For example, children are considered to be at elevated risk where the perpetrator has previously made threats to kill them, reinforcing the need for such threats to be taken seriously.

Due to the commonalities in risk indicators between filicide and intimate partner homicide in the context of domestic violence,²⁶⁰ and given that risk assessment of fatal harm to children is rarely undertaken, there has also been a call for close coordination among family and other courts to ensure that safety planning for a parent in these circumstances extends to children as well.²⁶¹

In recognition of these issues, a recent evaluation of the family violence risk assessment and management framework in Victoria has recommended a taskforce be convened to examine existing risk assessment practices for children.²⁶²

Significantly, research indicates that a history of parental suicidality and mental illness are independent risk factors for filicide, with a call for filicide prevention initiatives to focus on better identifying, and responding to these characteristics.²⁶³

This has implications for the way in which suicide risk assessments are currently conducted, within the context of domestic and family violence. In a number of cases reviewed by the Board the father expressed suicidal ideation, but cited the children as a protective factor against suicide. While practitioners appeared to see this as a positive with the presumption that the father would stay alive for his child/ren, in some circumstances this was also indicative of a sense of ownership or a potential warning sign; in that the father may harm or kill his children if he decides to take his own life.

One particular tool has been developed (the screening and assessment framework developed for family relationship centres) in Australia,²⁶⁴ which outlines possible indicators for child homicide-suicide, inclusive of prior threats by a perpetrator to harm themselves or others if the partner leaves, as well as other indicators of coercive control and physical violence.²⁶⁵

255 This included ten cases where the deceased was a child and five where the deceased was an adult.

256 This is a preliminary review of risks in family relationships. Data collection and reporting for this cohort will be enhanced moving forward to capture a larger sub-sample.

257 Hamilton, L., Jaffe, P., & Campbell, M. (2013). Assessing children's risk for homicide in the context of domestic violence. *Journal of Family Violence*, 28(2), 179-189.

258 Olszowy, L., Jaffe, P., Campbell, M., & Hamilton, L.A. (2013). Effectiveness of risk assessment tools in differentiating child homicides from other domestic homicides. *Journal of Child Custody*, 10(2), 185-206.

259 McCulloch, J., Maher, J., Fitz-Gibbon, L., Segrave, M., & Roffee, J. (2016). *Review of the Family Violence Risk Assessment and Risk Management Framework (CRAF)*. Monash University.

260 Such as a history of domestic and family violence, separation, mental illness, history of suicide attempts, substance abuse - Lysell, H., Runeson, B., Lichtenstein, P., & Langstrom, N. (2014). Risk factors for filicide and homicide: 36-year national matched cohort study. *The Journal of Clinical Psychiatry*, 75(2), 127-132; Craig, M. (2004). Perinatal risk factors for neonaticide and infant homicide: can we identify those at risk? *Journal of the Royal Society of Medicine*, 97, 57-61.

261 Jaffe, P.G., Campbell, M., Olszowy, L., & Hamilton, L.H.A. (2014). Paternal filicide in the context of domestic violence: Challenges in risk assessment and risk management for community and justice professionals. *Child Abuse Review*, 23, 142-153.

262 Recommendation 19 of the *Review of the Family Violence Risk Assessment and Risk Management Framework*, Monash University. Available online: https://arts.monash.edu/gender-and-family-violence/wp-content/uploads/sites/11/2017/11/SOSS_CRAF_Final_Report_links.pdf

263 Lysell, H., Runeson, B., Lichtenstein, P., & Langstrom, N. (2014). Risk factors for filicide and homicide: 36-year national matched cohort study. *The Journal of Clinical Psychiatry*, 75(2), 127-132.

264 Commonwealth Government. (2006). *Screening and Assessment in the Family Relationships Centres and Family Relationship Advice Line: Practice Framework Space and Guidelines*. Canberra: Australian Catholic University.

265 Adopted from Johnson, C.H. (2005). *Come with Daddy: Child Murder-Suicide after Family Breakdown*. Perth: University of Western Australia Press.

Table 26: Lethality risk factors, family homicides and intimate partner homicides, 2009 to 2017

	Family homicides	Intimate partner homicides
History of violence outside of the family by perpetrator	20.0%	43.6%
History of domestic violence (current relationship)	73.3%	82.1%
Prior threats to kill victim	26.7%	44.9%
Prior threats with a weapon	13.3%	23.1%
Prior assault with a weapon	6.7%	20.5%
Prior threats to commit suicide by perpetrator	33.3%	32.1%
Prior suicide attempts by perpetrator	0	23.1%
Prior attempts to isolate the victim	20.0%	44.9%
Controlled most or all of victim's daily activities	13.3%	38.5%
Prior hostage-taking and/or forcible confinement	13.3%	24.4%
Prior forced sexual acts and/or assaults during sex	6.7%	15.4%
Child custody or access disputes	40.0%	19.2%
Prior destruction or deprivation of victim's property	6.7%	28.2%
Prior violence against family pets	6.7%	14.1%
Prior assault on victim while pregnant	6.7%	16.7%
Choked/strangled victim in past	6.7%	29.5%
Perpetrator was abused and/or witnessed DV as a child	0	11.5%
Escalation of violence	26.7%	35.9%
Obsessive behaviour displayed by perpetrator	26.7%	39.7%
Perpetrator unemployed	66.7%	44.9%
Victim and perpetrator living common-law	20.0%	52.6%
Presence of step children in the home	13.3%	20.5%
Extreme minimisation and/or denial of spousal assault history	0	28.2%
Actual or pending separation	20.0%	60.3%
Excessive alcohol and/or drug use by perpetrator	53.3%	52.6%
Depression – in the opinion of family/friend/acquaintance	46.7%	21.8%
Depression – professionally diagnosed	46.7%	20.5%
Other mental health or psychiatric problems – perpetrator	33.3%	26.9%
Access to or possession of any firearms	20.0%	15.4%
New partner in victim's life	0	30.8%
Failure to comply with authority	6.7%	39.7%
Perpetrator exposed to/witnessed suicidal behaviour in family of origin	13.3%	3.8%
After risk assessment, perpetrator had access to victim	13.3%	11.5%
Youth of couple	6.7%	6.4%
Sexual jealousy	13.3%	53.8%
Misogynistic attitudes – perpetrator	6.7%	15.4%
Age disparity of couple	6.7%	14.1%
Victim's intuitive sense of fear of perpetrator	33.3%	51.3%
Perpetrator threatened and/or harmed children	33.3%	23.1%

Chapter 8: Responding to presenting and underlying needs

Key findings

- » Perpetrators were identified as experiencing mental health problems in almost all cases considered by the Board, with half having recent or ongoing contact with mental health service providers within two years of the death.
- » The Board acknowledges current reforms within the public mental health system that are aimed at improving responses to people living with a mental illness and enhancing the safety of carers and families.
- » It is clear, however, that generalist mental health workers may require further specialised training and support to effectively respond to domestic and family violence.
- » There was evidence of collusion in some cases where private practitioners failed to challenge disclosures from a perpetrator about their use of physical and coercive controlling violence.
- » The Board considers that there is a clear and pressing need for improvements in this area.

This chapter considers health system responses to people experiencing domestic and family violence, focusing on two issues identified by the Board, specifically:

- » the intersection between domestic and family violence, problematic substance use and mental health problems; and
- » responses by private practitioners to perpetrators of domestic and family violence.

The Board discussed the complex intersections between mental illness, problematic substance use and violence victimisation and/or perpetration in depth in its 2016-17 Annual Report. As such these issues are not explored in detail within this report, outside of noting that the vast majority of people living with a mental illness do not use violence.

In a number of the cases reviewed it was noted that victims and/or perpetrators experienced a range of complex mental health problems and/or problematic substance use issues that impeded service engagement, intervention and treatment effectiveness.

In six cases reviewed by the Board, there were examples of limited efforts by clinicians to address co-occurring mental health issues and/or problematic substance use for the perpetrator of violence. In some of these cases, mental health services appeared reluctant or unwilling to address ongoing alcohol and drug use, even when it was known to be associated with a deterioration in the client's mental health and was noted in files as increasing their risk of future violence.

Perhaps the most significant example of this was when a treating team became aware that a client (and ultimate homicide offender) had used cannabis after he screened positive to this substance, which was in contravention of the conditions of his Forensic Order. The client originally tried to dismiss this test as passive inhalation and then alleged that his son had secretly added cannabis to his tobacco. He ultimately disclosed that he was using drugs to cope with the stressors he was experiencing at home, which included abuse by his son and other family members.

The treating team did not implement strategies to address the contravention of the order (such as by increasing routine drug screening). Clinicians also did not appear to explore the consumer's allegations of abuse at subsequent presentations, although he continued to report experiencing stressors associated with his experiences as a victim of family violence.

This homicide offender also disclosed excessive alcohol consumption (which was prohibited on his order and in contravention of his treatment regime) some two months before the death. Of note, the pathology report found alcohol was present at the time of death.

Responding to dual diagnosis

Dual-diagnosis is a term used to describe co-occurring diagnoses of two or more types of mental illness/es and drug related disorder/s. Dual diagnosis is often associated with poorer treatment outcomes, severe illness and high service use; and it is recognised that people with dual diagnosis may have a higher level of risk for suicide, self-harm, aggression and violence.²⁶⁶

Research shows this cohort is the norm rather than the exception, with evidence suggesting that the prevalence of dual diagnosis ranges from 50 to 70% in mental health settings, and 40 to 80% in alcohol and other drug treatment settings.²⁶⁷ It is, therefore, incumbent upon clinicians to respond in an integrated manner and to avoid treating one issue in isolation of the other/s.

A focus on integrated care from a clinical perspective recognises not only the individual issues arising from mental illness and drug disorders, but seeks to contextualise responses within the broader psychosocial circumstances and needs of the individual. This has been shown to improve clinical outcomes and reduce the risk of harm (to self or others).

While the relationship between mental illness and violence perpetration is complex, it is salient to note that research suggests depression is the most common diagnosis in homicide-suicides²⁶⁸, and around three in 10 homicide-suicide perpetrators had contact with mental health services prior to the deaths.²⁶⁹

In 18 of the 20 cases reviewed by the Board, perpetrator mental health concerns were noted, including eight cases where this was formally diagnosed. In nine cases, the perpetrator had recent and/or ongoing contact with mental health service providers (either private practitioners or through the public health system) in the year prior to the death. In at least two cases, records indicate that the offender had disclosed homicidal ideation or threats towards their current partner or family members, as well as serious acts of abuse, during treatment.

In one case considered by the Board, the perpetrator (and homicide offender) engaged with multiple mental health providers in the months prior to the homicide. Less than a month before the death, he pleaded with a psychologist to see him claiming he was *dangerous*, but was told no appointments were available for another month and advised to re-engage with his psychiatrist in the interim.

The week before, the same perpetrator had been hospitalised after a suicide attempt where he made disclosures about *explosive relationships* and repeated violence towards his current partner (the homicide deceased). On this occasion, the perpetrator was assessed as having personality disorder traits in the context of situational crises, but no major mental illness. Anger management issues were identified and clinicians proposed strategies to address this, including to set *firm limits on behaviour* and a *low stimulus environment*. However, these were ultimately inadequate in addressing his abusive behaviours.

As outlined in the previous chapter, evidence of formal risk assessment processes undertaken by health practitioners were lacking in these cases.

Efforts to enhance training to include more focus on educating clinicians about assessing their clients' risk of harm to others is likely to improve the support provided to consumers, carers and families.²⁷⁰

This is consistent with one of the key findings of the Sentinel Events Review Final Report relating to family engagement. The review noted poor communication during all phases of care (assessment, treatment and discharge planning), and found no documented evidence of information provided to families/carers about the consumers' risk to others.

The review also found that too much responsibility was placed on the consumer's family or carer to help manage relapse symptoms, with little evidence of mental health services staff working with families to inform them of the relationship between mental illness and violence, or to provide strategies to assist in managing violent behaviour and addressing the safety of the family or carer.²⁷¹

This issue was apparent in several cases reviewed by the Board. In one case, a victim (and homicide deceased) was relied upon to provide care and support to a perpetrator (and homicide offender) after he nominated her as his allied person and was discharged by the treating team into her care. This occurred despite the episode leading to the perpetrator's hospitalisation including acts of abuse against her.

In five cases reviewed by the Board, there were indicators that family members and partners who were carers/support persons for those experiencing mental health problems were not aware of the extent of the mental illness or any potential risks.

266 Queensland Health 2010, Queensland Health Dual Diagnosis Clinical Guidelines, Queensland Health, Brisbane.

267 Queensland Health 2003, Strategic plan for people with a dual diagnosis (mental health and alcohol and other drug problems), Queensland Health, Brisbane.

268 Queensland Health 2010, Queensland Health Dual Diagnosis Clinical Guidelines, Queensland Health, Brisbane.

269 McPhedran, S., Eriksson, L., and Mazerolle, P. (2014). To prevent murder suicide we need to better understand offenders. The Conversation, online at: <http://theconversation.com/to-prevent-murder-suicide-we-need-to-better-understand-offenders-31561>

270 The Mental Health Sentinel Events Review made recommendations that support this finding, namely: Recommendation 22 – Implement a three level violence risk assessment framework; Recommendation 46 – Consistent with the recommended phased model of risk assessment and management, all clinicians require training in principles of risk assessment of people with mental illnesses. This knowledge is necessary to complete the risk assessment screening required for all consumers. Senior clinicians require training in risk assessment and management necessary to enable them to undertake the level two risk assessments using and interpreting validated risk assessment measures; Recommendation 47 – Training in violence risk assessment, including the administration and interpretation of validated violence risk assessment measures, needs to strengthen formulation skill development and capability to ensure recommendations and care planning meet the consumer's needs rather than being passively identified in documents; Recommendation 48 – provide training and supervision specific to identification of risk factors of violence to ensure appropriate escalation processes are included where indicated; Recommendation 49 – Provide training and supervision specific to recovery principles, and the dignity of risk (i.e. the realisation that all people including consumers carry with them some degree of risk and the important factor is how they manage that risk), to ensure treatment plans assist with firstly stabilising the consumer's presentation and working towards recovery which includes addressing violence risk factors; and, Recommendation 50 – Provide training on consumer confidentiality and release of information so that information sharing between the forensic mental health services, other service providers and family/carers allows for open discourse on risk and discovery of important factors to be considered in care planning.

271 This is particularly pertinent given that the Sentinel Events Review Final Report noted research that suggests that while most people with a serious mental illness do not engage in acts of violence, and are in fact more likely to be victims of violence than perpetrators, there is a statistically and clinically significant link between psychosis and violence. Chloe, J.Y., Teplin, L.A., & Abram, K.M. (2008). Perpetration of violence, violent victimisation, and severe mental illness: Balancing public health concerns. *Psychiatric Services*, 59(2), 153-164. A number of factors have been found to increase the likelihood that someone with a serious mental illness will engage in acts of violence, for example: problematic substance use; personality dysfunction; antisocial attitudes; instability in major areas of life; active symptoms of mental illness; and, a lack of compliance with medication and treatment orders.

A series of recommendations in relation to family engagement were made within the Sentinel Events Review Final Report. Of note, recommendation 12²⁷² relates to more information being provided to family members about the potential risks of being exposed to violence by their loved one and possible risk mitigation strategies.²⁷³

However, the recommendations fail to adequately take into account the importance of assessing a person's capacity to meaningfully support their family member or loved one, particularly in cases of domestic and family violence.

This was evident in one case where a man's adult daughter was his primary carer. She would often minimise her father's symptoms and appeared unaware of any potential risk of harm to her or her child. The records indicate she was noted to be 'bossy' and abusive towards other family members and was listed as a respondent on a protection order at the time of the deaths, with a sibling as the aggrieved and the client (who was ultimately the homicide offender) as a named person on the order.

While the reforms associated with the Sentinel Events Review²⁷⁴ are a critical step towards improving the public health system response, it is clear from the cases reviewed by the Board that contact with private health care providers is also common.

Relevant recommendations from this review do not extend to the private sector and there is a need to enhance responses to perpetrators and victims in this setting.

Responding to perpetrators of violence

In 11 of 20 cases, the primary perpetrator was in contact with private health practitioners (i.e. GP, psychologist) prior to the death/s. Victims were also in contact with private health care providers in six cases.²⁷⁵

In a number of the cases where the perpetrator had contact with private health practitioners, they disclosed that they were responsible for serious abuse (such as sexual assault or threats to harm/kill), or disclosed other indicators of domestic and family violence.

This included:

- » exhibiting extreme possessiveness and jealousy in the context of what was described as low self-esteem and trust issues;
- » misogynistic attitudes towards women and a pattern of manipulation in intimate partner relationships;
- » controlling behaviours, including where perpetrator's voiced disapproval of who their estranged partners were communicating with;
- » the use of children to maintain ongoing monitoring of an estranged partner post-separation; and
- » monitoring the victim's movements post-separation.

In these cases, there was no evidence that the private practitioners undertook any formal or informal screening or risk assessment for domestic and family violence in their sessions.

This was the case even in the presence of clear indicators and disclosures of domestic and family violence, referrals for (at times self-disclosed) *anger management issues*, or in one case, when a client who presented with difficulties adjusting to a relationship separation disclosed they were a respondent on a protection order.

²⁷² Families/carers are to be informed of potential risks to their safety, provided with support and strategies on how to mitigate risks, and given clear advice on how to maintain their own safety in crisis and ongoing situations, including information about available support including support external to mental health services

²⁷³ Engagement with families is to occur at initial contact with the consumer and throughout the consumer's episode of care, consistent with the *National Standards for Mental Health Services 2010* and reflective of a tripartite model involving the consumer, clinician and the family/carer.

²⁷⁴ Queensland Health accepted in principle all recommendations from the Sentinel Event review, acknowledging that some will require further consideration to determine the best course of action, resourcing and budget requirements. Queensland Health. (2016). *Queensland Health Response to the Final Report – When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services*. Brisbane: Author The Queensland Health response to the recommendations will reportedly achieve: (a) Improved outcomes for those persons with a mental illness who pose a risk of harm to others, (b) Greater involvement, engagement, support and safety for families and others who may be at risk of violence, and (c) A clinical workforce that is empowered by knowledge, skills, specialist support and services to be able to assist consumers to address their very complex needs and achieve better outcomes in their recovery.

²⁷⁵ By comparison, primary perpetrators and victims were in contact with public health services in 15 cases and 10 cases respectively.

In one case, the clinical notes indicate a perpetrator disclosed to his psychologist that *his relationship with wife more strained, recent incident with police*, but was noted to regret the incident and that *he has to live with it*. There is nothing to indicate that this disclosure was challenged or explored further, or that any consideration was given to potential safety risks to the client's spouse.

In its 2016-17 Annual Report, the Board recommended that the Department of Health implement processes for mandatory screening for domestic and family violence perpetration within all Queensland Health and government funded mental health and alcohol and other drug services.²⁷⁶

The Queensland Government accepted this recommendation in part, referencing the publication of toolkits for health professionals which includes identification of domestic and family violence through a 'sensitive inquiry model'.

Evidence from case reviews considered in this reporting period suggest that screening for domestic and family violence perpetration should also be extended to other private practitioners including psychologists, psychiatrists and counsellors.

Work is currently underway nationally to improve responses in this area, including through enhancements to the national accreditation standards for health practitioners that aim to improve the recognition of, and response to, domestic and family violence.²⁷⁷

In a recent Consultation Paper on a review of current accreditation arrangements, AHPRA and the National Boards invited stakeholders to comment on how accreditation can best respond to domestic and family violence as a health priority. Consultations closed in mid-May 2018 and publication of the final report is imminent.

The Board awaits the outcomes of this review, to consider whether there are opportunities to further strengthen responses in this area.

It is important to acknowledge that working with perpetrators of domestic and family violence is inherently complex and requires a nuanced approach. While establishing rapport and a therapeutic relationship is crucial, it is imperative that conscious efforts are made to avoid colluding with the perpetrator.

Collusion occurs when there is an acceptance of a perpetrator's minimisation, denial or victim-blaming without challenge, and empathy towards the perpetrator is exhibited but not towards the victim of domestic and family violence.

While some practitioners may possess personal beliefs or attitudes that may condone or minimise the use of violence against victims²⁷⁸, it is generally accepted that most practitioners have positive intentions when working with perpetrators of violence. Practitioners may however lack the skills to identify disclosures to be domestic and family violence, or respond without affecting the therapeutic relationship.

In hindsight, there were clear examples of collusion in several cases considered by the Board, most notably in one case where a psychologist minimised the perpetrator's use of violence and provided letters of support which denied there was any risk to the victim.

This psychologist recommended that the perpetrator should have complete access to the victim and children despite disclosures of serious violence (including alleged sexual assault). Records indicate that this psychologist did not undertake any formalised risk assessment to inform his clinical judgement on this point.

It is, however, also important to note that utilising a confrontational approach with perpetrators may have negative outcomes with treatment resistant populations and may inadvertently increase the risk to victims.²⁷⁹ As such, a balanced approach is required by practitioners when working with perpetrators to challenge denial and minimisation of violent behaviours while building a therapeutic alliance.²⁸⁰

Working with perpetrators may be complicated by a range of individual, organisational and situational characteristics. For example, due to (traditionally) a lack of specific training around domestic and family violence in undergraduate or postgraduate programs, there may be a general lack of understanding of how to work with perpetrators of violence (which itself is also an emerging area of practice).²⁸¹

Notably, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) recently conducted a survey, which revealed that half of psychiatrists surveyed received two hours or less of training in relation to domestic and family violence and that they have inadequate knowledge of referral resources (including perpetrator programs).²⁸²

276 Recommendation 7 of the Domestic and Family Violence Death Review and Advisory Board. (2017). *Annual Report 2016-17*. Brisbane: Author.

277 Specifically relevant recommendations include (a) that the Health Practitioner Regulation Boards of Australia require specific skill sets pertaining to recognition of and appropriate intervention for domestic and family violence and child harm be included in accreditation standards submitted by Accreditation Agencies under the National Law (Recommendation 60) (b) that Health Practitioner Regulation Boards of Australia work with appropriate accreditation bodies and colleges to enable professional development on recognising and intervening appropriately in DFV to be considered suitable for Continuing Professional Development recognition (Recommendation 61) (c) that consideration be given to including skill sets and professional development on recognising and responding to child harm into accreditation standards and professional development programs (Recommendation 62). In July 2015, the then Queensland Minister for Health and Minister for Ambulance Service, the Honourable Cameron Dick MP, raised the issues at the COAG Health Council. Jurisdictions agreed that the recommendations be forwarded to the Australian Health Practitioner Regulation Agency (AHPRA) and the 14 National Health Practitioner Regulation Boards (the National Boards) for noting and consideration.

278 For example, research has shown that laypeople can be influenced by biased and inaccurate reporting in media stories regarding intimate partner homicide, even among those who have strong anti-violence against women attitudes. This research demonstrates that readers may begin to tolerate and accept intimate partner homicide in certain contexts including by empathising with the offender, not holding them to account, justifying and accepting the crime as logical, and blaming the deceased for her own murder. Post, L.A., Raile, A.N.W., Zeoli, A.M., Taylor, R., Smith, P.K., Dziura, J.D., & Biroscak, B.J. (2015). Domestic violence homicide: validating a scale to measure implicit collusion with murder. *Health Sciences Research*, 2, 1-8.

279 Alexander, P.C. (2007). *Stages of change and the group treatment of batterers*. As cited in: Sewell, E.S., Renes, S., & Dahl, H. (2016). *Considerations when Implementing Trauma-informed Care into Male Domestic Violence Offenders' Intervention Programs*. Fairbanks, AK: University of Alaska Fairbanks.

280 Iwi, K., & Newman, C. (2015). *Domestic Violence: Engaging with perpetrators of domestic violence: Practical techniques for early intervention*. London: Jessica Kingsley Publishers.

281 Cameron, P. 2016. *Expanding early interventions in family violence in Victoria*, Domestic Violence Victoria. Available online: http://dvvic.org.au/_wordpress/wp-content/uploads/2017/02/Early-Intervention-Report-FINAL-8-DEC.pdf

282 Unpublished study presented at the RANZCP Annual Congress in Auckland 13-17 May 2018. Reported in newsGP on 16 May 2018 <https://www.racgp.org.au/newsGP/Professional/Study-shows-psychiatrists-missing-vital-training-t>

It is critical that service providers, through education, ongoing training, professional supervision and clear guidelines, are able to recognise and exclude biases from practice.

In the RANZCP survey, one-fifth of psychiatrists reported difficulty in supporting a patient who stays in an abusive relationship. About one in 10 reported feeling that they did not have the necessary skills to discuss domestic and family violence with victims, particularly those from different cultural backgrounds.

Complicating this issue further, is that perpetrators can be masterful manipulators and are highly competent in image management.²⁸³ They may engage in a range of behaviours that ultimately aim to get a practitioner to 'take sides' by insinuating that the partner is 'crazy', a drug user, an unreliable parent and bad partner.

For example, in one of the cases, the step-father (and homicide offender) was seeing a mental health practitioner shortly before the death, during a period of relationship separation from his former spouse (and victim) who was residing with her daughter (from a previous relationship) at the time.

The perpetrator blamed the relationship separation on his step-daughter (and homicide deceased), alleging that a pertinent issue behind the separation was his former spouse's support and poor discipline of his step-daughter, who he described to the clinician as having consorted with drug dealers, experiencing numerous failed relationships and multiple abortions. He then suggested the step-daughter required psychological assessment.

The mental health practitioner ultimately concluded that, based on the reports provided by this perpetrator, the step-daughter had significant personal and inter-personal problems which she was unwilling to seek help for. The practitioner also determined that the step-daughter's influence had the potential to unravel the perpetrator's therapeutic progress. It appears no identifiable collateral information was gathered from other family members which may have identified the step-father as the perpetrator.

In another case reviewed by the Board, a psychologist cancelled joint relationship counselling sessions between the couple and transferred the perpetrator (and homicide offender) to individual counselling sessions at a different location after he disclosed a lack of remorse for his abusive actions and the psychologist felt she could no longer guarantee the safety of the victim (and homicide deceased). The perpetrator disclosed he felt like he had been 'singled out as the monster in all of this' and he ultimately disengaged from the service.

While the psychologist in this instance demonstrated positive actions through cancelling couple therapy out of safety concerns, there is no evidence that they reported these concerns to police or any other service that may have been able to appropriately intervene.

While the *National Outcome Standards for Perpetrator Interventions*²⁸⁴ provide limited practical advice for practitioners, they highlight that mental health practitioners and generalist services have an important role to play in responding to domestic and family violence. The National Outcome Standards identify that, although these services may not be directly or solely responsible for addressing the perpetrator's violence, practitioners should still seek to maintain victim safety by engaging with a perpetrator to address other associated issues that can amplify the impact of their violence or affect their readiness to change.²⁸⁵

As part of a broad review of existing practice standards and guidelines, the DCSYW is currently overseeing re-development of perpetrator intervention standards in Queensland, which are expected to be finalised by 2019.²⁸⁶ However, these practice standards are designed to support the delivery of perpetrator intervention programs and are not intended to guide how agencies should engage with perpetrators more broadly.

283 Rakovec-Felser, Z. 2014. Domestic Violence and Abuse in Intimate Relationship from Public Health Perspective, *Health Psychology Research*, 2(3). Available online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4768593/>

284 Commonwealth of Australia (Department of Social Services). (2015). *National Outcome Standards for Perpetrator Interventions*. Canberra: Author.

285 Commonwealth of Australia (Department of Social Services). (2015). *National Outcome Standards for Perpetrator Interventions*. Canberra: Author.

286 As well as perpetrator standards, DCSYW will also include services that deliver: support for victims, including case management, counselling, and court-based support; and, support for children and young people, including those at risk of future use of violence.

There are clear opportunities to ensure other services have access to resources to assist them in responding to perpetrators.

The Domestic Violence Resource Centre Victoria and No to Violence²⁸⁷ have developed a guide to assist practitioners engaging with men in relation to their use of domestic and family violence.²⁸⁸ This tip sheet highlights that the safety of victims remains paramount and that attempts to minimise, blame, excuse or justify the perpetrator's use of violence must be challenged through the encouragement of self-exploration and re-evaluation of their behaviour. The guidelines also reinforce that an accusatory style may lead to resistance, shame and disengagement which may in turn increase the risks to the victim.

The Royal Australian College of General Practitioners (RACGP) has recently published a research paper to describe how GPs can identify and respond to men who use violence in their relationships. This includes the need to be aware of perpetrators attempts to collude with a GPs personal attitudes and beliefs, and to be wary of men minimising their responsibility, blaming the victim, and underreporting the extent of the violence.²⁸⁹

Recommendation 10:

That the Queensland Government funds the development of a training package or module for professionals from generalist services (e.g. mental health services, child safety services, psychologists, general practitioners, alcohol and other drug treatment services). This should focus on how to respond to perpetrators, maintain the safety of victims and their children, and align with the National Outcome Standards for Perpetrator Intervention Programs.

This training package/module should be made available to all organisations, services and agencies who may come into contact with perpetrators of domestic and family violence.

²⁸⁷ No to Violence (NTV) is a peak body for organisations and individuals working with men to end their violence and abuse towards family members in Victoria and New South Wales.
<http://www.ntv.org.au/>

²⁸⁸ Available at: <http://www.thelookout.org.au/sites/default/files/tips-for-engaging-men-who-use-family-violence.pdf>

²⁸⁹ Hegarty, K., Forsdike-Young, K., Tarzia, L., Schweitzer, R., & Vlasis, R. (2016). Identifying and responding to men who use violence in their intimate relationships. *Australian Family Physician*, 45, 176-181.

Chapter 9: Crisis supports and responses

Key findings

- » The circumstances of these deaths highlighted a clear need for agile, agency safety planning, inclusive of both victims and perpetrators and informed by robust risk assessment processes.
- » Further, there were multiple cases where couples continued to reside together post-separation due to financial restrictions or a lack of alternative accommodation. This increased the risk of further harm to the victims and their children and highlights the ongoing need for accessible and affordable housing for victims seeking to separate from abusive relationships.
- » There is increasing investment in this area through 'safe at home' strategies, which are intended to improve safety and prevent homelessness for victims of domestic and family violence, and complement existing refuge and specialist homeless services.
- » There was also a lack of victim advocacy even when victims were consistently engaged with specialist services. This meant that victims were largely responsible for managing their own safety, including navigating complex referral and support pathways.
- » Service navigators have emerged in health settings to reduce barriers to care for individuals with complex needs. This is being trialled in Victoria for victims of domestic and family violence. The Board is interested to see whether this intensive support model improves outcomes for victims of domestic and family violence.

This chapter discusses service responses in periods of acute crisis or high risk and the role specialist services play in coordinating support for a victim in crisis. This includes their role in safety planning, advocacy and facilitating access to crisis accommodation.

One of the most confronting findings of this report is that despite services operating for the most part as they are required in legislation, practice and policy (as outlined in Chapter 6), where help was sought by victims in the immediate period preceding their death, they were unsuccessful in preventing the fatal outcome.

Safety planning

In six cases considered by the Board, there was evidence that safety planning was undertaken by specialist services or other services in contact with the victim. Where this occurred, there were examples of positive practice, particularly when plans were developed collaboratively with the victim.

In one particular example, the specialist service implemented an immediate safety action plan to ensure the safe relocation of a victim's children when it became apparent that the perpetrator's whereabouts was unknown after an early discharge from a period of hospitalisation. Specialist services in contact with the victim in another case endeavoured to review the safety plan at every contact, highlighting the importance of dynamic and ongoing risk assessment and management processes.

Practitioners who develop safety plans with victims of domestic and family violence should seek to obtain a comprehensive understanding of the unique risks each client faces to inform the development of that client's safety plan.²⁹⁰

Research indicates that effective safety planning should have a number of common elements, including that:

- » victim safety should be the top priority;
- » victims should be empowered to make decisions for themselves in their own best interests;
- » clear specific strategies are required;
- » safety planning should form part of an ongoing process and may require amendment as emerging risks arise;
- » they should be based on collaboration within and across agencies; and
- » they should consider the unique circumstances of the individual.²⁹¹

In a number of cases reviewed by the Board, there was evidence that safety planning was undertaken in isolation and without consultation with other agencies who were working with the victims and perpetrators.

In one particular case, there was an apparent lack of meaningful information exchange within a service where the perpetrator (and homicide offender) was enrolled in a men's behaviour change program and the victim (and homicide deceased) was receiving counselling and support.

²⁹⁰ Murray, C.E., Horton, G.E., Johnson, C.H., Notestine, L., Garr, B., Marsh, A., Flasch, P., & Doom, E.B. (2015). Domestic violence service providers' perceptions of safety planning: A focus group study. *Journal of Family Violence*, 30, 381-392.

²⁹¹ Murray, C.E., Horton, G.E., Johnson, C.H., Notestine, L., Garr, B., Marsh, A., Flasch, P., & Doom, E.B. (2015). Domestic violence service providers' perceptions of safety planning: A focus group study. *Journal of Family Violence*, 30, 381-392.

With the benefit of hindsight, there is a sense of futility with some of the actions recommended in this case, such as to *find a safe place within the home to call for help* and to *keep her car locked at all times when driving*. With the focus entirely on the victim, there were no corresponding plans to monitor the perpetrator even though he was concurrently engaged with the same service.

This highlights the need for collaborative safety planning to be undertaken informed by robust risk assessment processes, which considers how all agencies can work to keep the victim safe while holding a perpetrator to account.

Crisis or alternative accommodation

In multiple cases, couples continued living together post-separation due to financial restrictions and a lack of alternative arrangements, leading to a heightened risk of harm for the victims and their children.

These cases highlight some of the practical and financial barriers victims face in obtaining safe and stable accommodation when they try to escape a violent relationship.

Recently, the Queensland Government has enacted a range of reforms following the Special Taskforce report to improve housing stability for victims of domestic and family violence. These reforms aim to improve accessibility and affordability of housing for female victims and their children in recognition that this is a key contributor to homelessness.²⁹²

Further, the DCSYW, in partnership with the Department of Housing and Public Works, recently commissioned the Nous Group to undertake an evaluation of the domestic and family violence 72-hour shelter and mobile support services established in Brisbane and Townsville. The *Specialist Homelessness Services Summative Evaluation Report*, which is not yet publically available, identifies that specialist mobile support provided to women temporarily accommodated in motels can provide an immediate and flexible response that is not necessarily more disruptive to a client's journey than placement through shelter accommodation. These services can also be provided to women who may be living temporarily with family or friends, in other temporary accommodation or in their own homes before they are ready to leave.

However, meeting the individual requirements of victims and their families remains an ongoing challenge, highlighting the need for a range of flexible options in addressing this issue.

For example, one victim was supported to safely move interstate to escape her violent partner, although she later moved back to be near her family. The same victim was moved to a motel on a previous occasion and received outreach services from a specialist service while there, which was received positively. However, upon identifying that she had a male friend visit the premises she was told by the specialist service that the agency would withdraw their support if she had visitors again.

In another case, accommodation was offered to the victim (and homicide deceased), however, she had a large family and the small apartment would likely have been unsuitable over the longer term. Similarly, she had also been residing with a friend at one point, however, this subsequently fell through and she returned to live in the home she had previously shared with the perpetrator (and homicide offender).

Although discussions about alternative accommodation or refuges were apparent in six cases, there was nothing recorded on file to indicate safety upgrades were considered or discussed.

This may have been because the victims had expressed an intent to move, the perpetrator was still residing on the property, or other alternative accommodation options were being sought at the time of service contact.

While this may have been the case, it ultimately meant that the victim was unprotected and in two of these six cases, she was killed in the family home.

ANROWS recently undertook a national mapping and meta-evaluation project outlining key features of effective 'safe at home' programs that aim to enhance safety and prevent homelessness for women and their children who have experienced domestic and family violence.²⁹³

This research identified that 'safe at home' strategies are not intended to supplant refuges or specialist homelessness services, but to complement these and to provide a safe option for women who refuse to uproot their lives by fleeing the family home.

The four pillars of effective 'safe at home' responses are:

- » maximising women's safety – using a combination of criminal justice responses including proactive policing, safety alarms, home security upgrades, and legal provisions to keep the perpetrator from the home;
- » preventing homelessness – including ensuring women are informed about their housing options before crisis, and providing support for women to maintain their housing afterwards;
- » that they occur within the context of an integrated response involving partnerships between local services; and
- » that they focus on enhancing women's economic security.

It is critical that specialist services follow these principles when developing safety plans for victims who remain within a shared residence, or when perpetrators know where they are residing.

²⁹² Relevant actions undertaken to alleviate housing stress and homelessness for women and their children escaping violence include: (a) Automated bond loan approvals for clients experiencing domestic and family violence who have verified their circumstances. (b) Improvements to the Housing Needs Assessment tool to help the government more easily identify women and children affected by domestic and family violence. (c) Clarification with Domestic and Family Violence Specialist Homelessness Services that clients experiencing domestic and family violence can expect to receive a range of support from Housing Service Centres in relation to bond loans and rental grants; Rent Connect services; social housing assistance; and, tenants and management of social housing tenancies. (d) Development and distribution of information to Housing Service Centre staff that details and clarifies housing assistance available for clients impacted by domestic and family violence. (e) Engaging with Housing Service Centre staff to strengthen knowledge and understanding of the assistance and available support services to ensure that appropriate and timely referrals can be made when needed.

²⁹³ Breckenridge, J., Chung, D., Spinney, A., & Zufferey, C. (2016). *National Mapping and Meta-evaluation Outlining Key Features of Effective "Safe at Home" Programs that Enhance Safety and Prevent Homelessness for Women and their Children who have Experienced Domestic and Family Violence: Research report*. ANROWS: Sydney.

Client advocacy

In its case discussions, the Board identified that instances of quality service response were apparent, and there had been some noticeable improvements in service delivery and interagency collaboration over time. This, unfortunately, appeared to be sporadic and only involved some of the agencies working with the victim and/or perpetrator.

Indeed, one victim expressed feeling overwhelmed and confused by the (lack of) service response, stating that she felt that she was *in the dark* and that *no-one is helping her*.

In another case, the victim disengaged from the specialist service around the same time as her case worker took a period of long-term leave. When the service tried to re-contact the victim some nine months later, after police notified them that she was at high risk of harm, she demonstrated limited interest in engaging. This was likely also influenced by her partner's criminal affiliations and her associated fear of these connections.

Continuity in case managers may assist in this respect, as it can help to establish rapport and trust between a client and practitioner, which can improve service engagement and effectiveness. There are also challenges associated with the transition of case management responsibilities between workers which need to be carefully managed to maintain client rapport and engagement.

While continuity of care may be important, it is not always feasible when people go on leave or move to other positions. Accordingly, agencies should encourage a victim to feel that the entire service is working towards their protection, not just one worker. This is crucial as some of the key agencies that work with victims of violence, their children, and perpetrators have traditionally high staff turnover (e.g. child safety services and probation and parole).

In the cases reviewed by the Board within this reporting period, a lack of advocacy on behalf of the victims was apparent over time, even where they were engaged with specialist services. This meant that responsibility was placed on them to manage their own safety and attempt to negotiate referral and support pathways. While agencies may focus on victim empowerment, this should not be to the detriment of their safety as they need support to navigate a complex system, while (possibly) still being subjected to continued abuse.

As outlined in the *Practice Standards for Working with Women Affected by Domestic and Family Violence*²⁹⁴, advocacy is an essential component of crisis intervention and is one of 10 principles of effective practice in working with victims of domestic and family violence.

Advocacy provides a collaborative means by which victims are supported to navigate service systems effectively. Workers advocate (with consent) on behalf of the victim with other stakeholders, and also at a systems level by advocating for system change. Advocacy also seeks to empower victims to identify their rights and advocate for their own needs, and the needs of their children. This is particularly relevant in complex cases where a victim's prior history of trauma and abuse may impede meaningful engagement with a service.

One victim, in particular, was subjected to violence within multiple intimate partner and family relationships, commencing in adolescence and continuing into adulthood. She demonstrated a refusal to engage with any sort of counselling or support, and instead, would self-medicate with illicit drugs as a means to cope with her trauma. Where she had contact with emergency services in relation to domestic violence, she demonstrated a reluctance to engage and rapidly disengaged where contact did occur in periods of crisis.

When responding to these types of clients, alternative models of outreach and support may be needed, which requires service delivery frameworks to be flexible and agile. In this respect, a lot can be learnt from the way in which other sectors or jurisdictions have sought to meet the needs of clients with multiple or complex needs.

The emergence of 'navigators' as a strategy to reduce barriers to care in health settings²⁹⁵ is a framework that has the potential to be embedded in contemporary integrated service responses to domestic and family violence.

Such models of service delivery already exist to some extent in other international jurisdictions including, for example, in the United Kingdom where an independent domestic violence advocate model provides intensive advocacy and support to clients over the short to medium term to put victims on the path to long-term safety and recovery.²⁹⁶

This navigation delivery model is designed to achieve enhanced client outcomes by linking individuals with a lead professional who acts as a guide to navigate the complexities of multiple service providers on the clients' behalf. The navigator works with the client over the longer term, from crisis through to recovery, to identify safety and support needs, coordinate tailored responses, and address underlying challenges to recovery, stability and wellbeing.

The role of the navigator demands more than short-term crisis intervention. It requires the provision of tailored, proactive and often intensive individual work with clients and is intended to address service fragmentation and inefficiencies. Navigators also aim to make it easier and less traumatic for clients to seek and receive support.

294 Queensland Government. *Practice Standards for Working with Women Affected by Domestic and Family Violence*. Available online: <https://publications.qld.gov.au/storage/f/2014-10-21T04%3A36%3A34.176Z/practice-standards.pdf>

295 Navigators are now firmly positioned in clinical care settings throughout Queensland as a strategy to overcome barriers to care. Nurse navigators, for instance, have been positioned throughout various hospital and health services since 2015 to help patients with complex health needs successfully transition home through their hospital and community health journey. The principles of this model of care have also been adopted in some culturally and linguistically diverse regional areas where patient navigators are employed to assist patients who have difficulties in understanding the health care system to identify their health needs and link them to appropriate care in their community. An evaluation of this model ultimately concluded that it was successful in building bridges within the community to improve health literacy and empower local families from a culturally and linguistically diverse background.

296 Coy, M. & Kelly, L. n.d. *An evaluation of four London independent domestic violence advocacy schemes*. London Metropolitan University. Available online: <https://cwasu.org/wp-content/uploads/2016/07/IDVA-Main-Report1.pdf>

As a key recommendation of the Royal Commission,²⁹⁷ navigator delivery models are currently being introduced across Victoria as part of the establishment of a network of Support and Safety Hubs²⁹⁸.

The Hubs are intended to offer visible entry points into community-based services or interventions for individuals experiencing family violence, perpetrators of family violence, and families who need support with the care, wellbeing and development of children and young people.

In Queensland, as part of the integrated service response trials, victims and perpetrators receive support or intervention from a lead or primary case manager situated within a non-government organisation.

The case manager or lead professional has responsibility for ensuring the family or individual family member receives the right mix of services, in the right order and at the right time.

The worker acts as a single point of contact when a range of services are involved with that family or family member and an integrated response is required. They are also required to negotiate client access to services (in accordance with client support/safety needs), continually assess and monitor risk (to facilitate the safety and wellbeing of all family members), and collaborate with all identified service providers.

This is intended to:

- » ensure collaborative case management and service delivery;
- » prevent overlap or duplication of service delivery; and
- » enable the provision of a realistic and holistic intervention tailored to the needs of the family.

The lead case manager for a client will vary according to the case-specific considerations, such as which services the client is engaged with (if any) and the agency or professional that client has a trusting (or established relationship with).

The Board looks forward to the evaluation of the integrated service response trials to consider whether these case managers improve outcomes for victims, and is particularly interested to see whether the model in Victoria enhances victim safety and engagement.

The Board considers these more intensive support models would be of significant benefit to those clients who have complex needs (such as problematic substance use or mental health problems) and/or significant past histories of trauma and abuse, who may be reluctant to engage with services.²⁹⁹

²⁹⁷ <http://www.rcfv.com.au/Report-Recommendations>

²⁹⁸ Clients will also have access to highly skilled professionals with expertise in family violence, family support services, and perpetrator interventions who will take on the role as navigators to 'guide individuals through the system, advocate for them and empower them to choose the supports they need.' They will also be closely linked to intake, assessment and planning processes, as well as supporting ongoing risk assessment, safety planning and achievement of outcomes. Hub practitioners will further be supported by service system navigators whose role is to establish and maintain interagency connections across local service networks (i.e. trouble shooting and brokering service outcomes, identifying service gaps and working with the governance structure to effect change), as opposed to the direct provision of support to clients. Victoria State Government. *Ending Family Violence: Victoria's Plan for Change*. Available online: [https://www.vic.gov.au/system/user_files/Documents/fv/160803.10%2010%20Year%20Plan%20Booklet%20\(Online\).pdf](https://www.vic.gov.au/system/user_files/Documents/fv/160803.10%2010%20Year%20Plan%20Booklet%20(Online).pdf)

²⁹⁹ As outlined in the 2016-17 Annual Report by the Board a reluctance to engage by victims was noted as a significant barrier to the provision of meaningful support, particularly over the longer term.

Chapter 10: Enforcement, safety and protection

Key findings

- » In this reporting period, the Board focused on perpetrator accountability and service responses to high risk and recidivist perpetrators of domestic and family violence.
- » The Board commissioned researchers to conduct a review of criminal justice responses to domestic and family violence. This review focused on four areas: police, courts, corrections, and multi-agency interventions. A key finding from this report was the lack of robust evidence in the Australian setting of what works to reduce recidivism.
- » In five cases considered by the Board, perpetrators had been referred to men's behaviour change programs to address their abusive behaviours. However, issues with program availability, accessibility and appropriateness were identified.
- » Online delivery of perpetrator programs has been trialled in some locations in Australia and overseas. Although there is not yet a robust evidence-base for this approach as an independent intervention, there may be benefits in exploring this modality to complement other face-to-face interventions.
- » Providing motivational support to perpetrators prior to and while engaged in perpetrator intervention programs has also been identified as an area of promising practice.
- » Mechanisms to monitor high risk domestic and family violence offenders have been enacted in some jurisdictions, through enhancing legislative powers that initially focused on high risk sexual offenders.
- » This approach is resource intensive and relies upon robust risk assessment processes to determine which offenders are at risk of recidivism. There are also difficulties in applying such a regime to domestic and family violence, given the known underreporting of this type of violence.

This chapter considers criminal justice system responses to domestic and family violence, intervention programs for perpetrators of domestic and family violence, and other options that are used to increase monitoring and surveillance of high risk offenders.

Perhaps the most challenging part of this discussion is that in the cases reviewed by the Board, only nine perpetrators had a criminal conviction for a domestic and family violence offence or a contravention of a domestic violence protection order despite an often extensive abuse history.³⁰⁰ It is also clear that some victims had experienced abuse over many years prior to the first episode of violence being reported to formal services.

In 18 of the 20 cases, this abuse manifested as non-physical coercive controlling behaviours such as obsessiveness, sexual proprietariness or adherence to rigid gender roles. In 15 cases, the primary victim of violence had also experienced extensive physical abuse including sexual assaults (forced sex) and violent assaults.

For example, one victim was subjected to significant levels of physical and sexual violence during (and subsequent to the cessation of) her relationship. Despite considerable injuries, including a suspected cracked skull, and forced sex on a daily basis while pregnant, there are no indicators that this victim reported these episodes of violence until the immediate period preceding the death.

A lack of formal reporting makes it difficult for agencies to identify an underlying pattern of abusive behaviour. Even when a report is made, without sufficient exploration service providers may have a false perception of a person's safety based on the fact that it appears to be a 'one off' (a false negative).³⁰¹

Similarly, a presumption that all victims may have experienced extensive abuse prior to their initial presentation may be equally problematic as it can overwhelm an already stretched service system and lead to a false perception of risk level (a false positive).

This issue highlights the need to equip service providers with the necessary skills to explore disclosures of abuse by both victims and perpetrators, and to take a more holistic approach to understanding a client's presenting and underlying support needs.

³⁰⁰ This included five who had convictions for domestic violence offences, and seven who had convictions for breaching the protection order. An additional perpetrator had been given a fine, but no convictions recorded, for contravening the conditions of the order.

³⁰¹ For example, in one case, while police had notified child safety services that they considered the victim of violence to be at high risk of harm, child safety assessed the matter as a Child Concern Report based on the lack of prior departmental or police contact in relation to domestic and family violence; the perpetrator's current help-seeking efforts to source mental health support; the victim's intention to leave the relationship; the lack of evidence to suggest the children were direct witnesses to any violence or that the perpetrator had made threats to harm the children; and no reasonable suspicion of parental behaviour which would indicate an unacceptable risk of harm.

Much of the focus of the Board's discussions in relation to criminal justice system responses to date has focused on elements of a system that is designed to hold perpetrators to account.

The difficulties in pursuing criminal charges within cases of domestic and family violence has been discussed often by the Board, as it impacts on the capacity of services to respond. This includes identified issues with victims being recorded as unwilling to pursue criminal charges, make statements, or seeking to withdraw charges.

To ensure greater consideration of these issues was undertaken, under section 91D of the Act, the Board commissioned UQ to complete a systematic review of criminal justice responses to domestic and family violence.³⁰² This research sought to address two specific areas of focus:

- » identifying best practice approaches for working with high risk and/or recidivist perpetrators of domestic and family violence; and
- » identifying barriers to victim engagement with the criminal justice system and strategies to improve engagement with these processes.

The research methodology utilised by UQ focused on the highest quality research that met stringent inclusion criteria. As a result, this does not include all available research, but features those studies which robustly assessed the effectiveness of criminal justice interventions for domestic and family violence.

One of the most significant findings of this report was the paucity of evidence within an Australian setting of 'what works' for people experiencing domestic and family violence engaged with the criminal justice system. An extension of this is a lack of understanding of the effectiveness of these interventions for Aboriginal and Torres Strait Islander people, who are more likely to be victims of violence and to also come into contact with the criminal justice system.

While the absence of robust research highlights the importance of extending upon our current evidence in this area, this should not be taken to mean that interventions or programs do not work. Instead, the report findings provide an indication of where gaps are and where promising opportunities present themselves.

Generally speaking, relevant findings of this report include that:

- » there is little evidence to support mandatory arrest policies, and there is a potential for significant unintended consequences, particularly for vulnerable and minority populations (e.g. Aboriginal and Torres Strait Islander people, women);
- » a decision to arrest by police reduced the chances of subsequent re-victimisation;
- » body worn cameras have a positive impact on the collection of evidence for domestic and family violence occurrences and subsequent court outcomes;
- » legal advocacy in criminal and civil settings resulted in positive results for victims (e.g. greater social support, reduced likelihood of further victimisation);
- » a criminal conviction for domestic and family violence significantly reduced the likelihood of recidivism;
- » some court-based interventions may have positive outcomes for victims in terms of engagement and support;
- » motivational work in conjunction with intervention programs reduces the risk of recidivism;
- » highly violent offenders in the community who are engaged in a perpetrator intervention program may be less likely to re-offend, and if they do, it is less likely to be a violent offence;
- » second responder programs, where victim-advocates make proactive contact with victims shortly after police contact may enhance victims' experiences of the criminal justice system and encourage subsequent police contact;
- » there is some (mixed) evidence of positive benefits for collaborative multi-agency teams in terms of increased prosecution, treatment completion and referrals to specialist services; and
- » victims of severe physical violence find protection orders to be more effective than victims experiencing lower level intensity violence.

³⁰² Mazerolle, L., Eggins, E., Sydes, M., Hine, L., McEwan, J., Norrie, G., & Somerville, A. (2018). *Criminal Justice Responses to Domestic and Family Violence. A rapid review of the evaluation literature Final Report*. Brisbane: University of Queensland.

Perpetrator Intervention Programs

In particular, the research conducted by UQ highlighted some important findings with respect to perpetrator intervention programs. Notably, it was identified that enhancing a perpetrator's motivation to change, through motivational interviewing prior to programs or running motivational work plans concurrently with program participation, may be beneficial with respect to treatment adherence and reducing recidivism.

The UQ report found inconclusive evidence of the effectiveness of perpetrator interventions. This included mixed results in terms of reducing future risk of recidivism for some programs, and negligible findings for anger management programs.

At a national level, ANROWS continues to drive reform in this area through a dedicated *Perpetrator Intervention Research Stream*, which is funded by the Commonwealth Government.

A total of 12 projects commenced in 2017, under four strategic research streams: system effectiveness, effectiveness of interventions, models to address diversity of perpetrators, and, interventions developed by, with and for Indigenous communities.³⁰³

In five cases considered by the Board, the perpetrator was referred to men's behaviour change programs to address their abusive behaviour. In one case, a perpetrator was issued a Voluntary Intervention Order requiring him to attend an intervention program in a regional area. The 16-week intensive intervention program was unavailable for several months so the perpetrator signed up to a less intensive (four week) program that focused on the impact of parental domestic and family violence on children. Upon exit, the practitioners considered that further work was required and unsuccessfully attempted to encourage the perpetrator to continue engagement.

In another case, the perpetrator attended three (of 24) sessions prior to being re-incarcerated for breaching his protection order, with no assessed reduction in risk across this period. The perpetrator reported that he had *never done anything like this before*, had been excluded from school at a young age, and was therefore not used to learning in a classroom type environment. He did not continue the intervention program in prison or after his release to the community.

This points to the need for perpetrator intervention programs to be flexible, accessible across settings, and in a modality that suits an individual's learning needs to enhance their effectiveness and ultimately keep victims and their children safe.

The UQ report also highlighted growing interest in the delivery of intervention programs online to treatment-resistant populations, which allows the ability to track participant progress, and ensure consistent and standardised delivery. These programs are also cost-effective as they require minimal staffing.

The UQ report, however, did not cite any examples of online perpetrator intervention programs and only referenced one found to be effective for victims.³⁰⁴

Recently, *Violence Free Families* in Victoria developed the Online Men's Behaviour Change Program, which requires participants to meet a facilitator online once a week for 14 weeks, with mandatory 'homework' activities between sessions. The program was developed to provide interventions for those who may not have access to face-to-face programs through their geographic location, being shift workers, or who may feel too ashamed to attend groups. Four trials were run and the program was evaluated by the University of Melbourne.³⁰⁵ Findings showed the online modality to be at least as safe and effective as face-to-face delivery, with indicators that safety outcomes for victims were sustained over time.

However, to date, the evidence is not definitive about the effectiveness of online programs in this area, with the peak body of perpetrator intervention programs in Victoria and New South Wales, No to Violence, recently issuing a position statement cautioning against the exclusive use of online modalities.³⁰⁶ They also identified the benefits that face-to-face programs have in assessing and immediately responding to dynamic risk, which is fundamental to safety and accountability in men's behavioural change programs.

Accordingly, it has been proposed that online engagement be used as only one component of a broader intervention approach, particularly where there is a lack of qualified facilitators in a regional or remote location, to increase the intensity of an intervention or to maintain engagement with perpetrators.³⁰⁷

Where program availability and accessibility remains an ongoing issue, the Board considers that the evidence is encouraging, and believes there may be benefit in exploring this issue further, with a view to expanding the suite of programs currently available. At the very least, an online program could be made available to those perpetrators who are on a waiting list for other existing programs as an initial step.

In an environment where supply cannot meet demand, with a lack of skilled facilitators in some areas of Queensland, there are potential opportunities to be progressive and innovative in this area. It is critical to note, however, that any online programs would have to include safeguards to ensure the safety of victims and their children. Therefore, it is envisioned that such an initiative could only be trialled where other services are concurrently providing intensive supports to the victim and their children.

While the evidence of alternative modalities, including online delivery, is still emerging, where appropriate safety measures are prioritised and services are engaged with the victim, the Board considers that efforts to develop this evidence-base should be considered.

303 More information about this work is available here: <https://www.anrows.org.au/research-program/perpetrator-interventions-research-program>

304 Gilbert, L., Goddard-Eckrich, D., Hunt, T., Ma, X., Chang, M., Rowe, J., & Shaw, S.A. (2016). Efficacy of a computerised intervention in HIV and intimate partner violence among substance-using women in community corrections: A randomised controlled trial. *American Journal of Public Health, 106*(7), 1278-1286.

305 Brown, T., & Flynn, C. (2016). *A Study of the Impact on Men and their Partners in the Short Term and in the Long Term of Attending Men's Behaviour Change Programs*. Melbourne: Violence Free Families.

306 No to Violence. (2018). *Position Statement: Online programs for men who use family violence*. Published online 27 February 2018. <https://www.ntv.org.au/wp-content/uploads/2018/02/Online-MBCP-Position-Paper-final-1.pdf>

307 Vlasis, R., Ridley, S., Green, D., & Chung, D. (2017). *Family and Domestic Violence Perpetrator Programs: Issues paper of current and emerging trends, developments and expectations*. Perth: Stopping Family Violence.

Recommendation 11:

That the Department of Child Safety, Youth and Women explore ways of supplementing men's behaviour change programs with initial and/or ongoing motivational work to support treatment adherence, reduction in recidivism risk, and improved safety for victims of domestic and family violence.

Recommendation 12:

That the Department of Child Safety, Youth and Women conducts a feasibility study about the use of online men's behaviour change programs.

This study should:

- » *focus on whether programs delivered in this modality are effective;*
- » *identify specific cohorts, contexts, and localities where this modality may be suitable (e.g. rural/remote, treatment-resistant perpetrators, young people);*
- » *be developed using the collective knowledge of experts in this area; and*
- » *be informed by, and adhere to, relevant best practice safety standards to ensure the protection of victims and their children remains a paramount priority.*

Given the clear pattern of repetitive perpetration for some offenders, including across current and former relationships, the Board considered how the system can monitor such offenders and reduce the likelihood of further episodes of violence. This builds upon previous findings of the Board during the last reporting period, which recommended a review to consider broadening the scope of the *Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004* to include other violent offences against children (e.g. manslaughter, torture) for the duration of reporting obligations.³⁰⁸

The Queensland Government has accepted this recommendation in principle and will consider broadening the scope of prescribed offences under the *Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004* to include violent offences against children.

Schemes for dealing with dangerous offenders are in place in all jurisdictions in Australia. For example, indefinite sentences³⁰⁹ are legislated for sexual and, in most cases, serious violent offending, and may be complemented by extended supervision in the community upon release from prison in all Australian jurisdictions.

In Queensland, an application for an indefinite sentence can only be made with the consent of the Attorney-General and cannot be made until an offender is convicted of a qualifying offence.³¹⁰

If a court, furnished with all relevant risk assessments and reports, can conclude that an offender is a serious danger to the community, an indefinite sentence can be issued. Currently, qualifying offences pertain to particularly serious offences (e.g. murder, manslaughter, rape, incest, indecent treatment of children), so application would only benefit domestic and family violence offences of comparable severity.

Post-custody offender management schemes are also in place overseas.

In Scotland, an indefinite sentencing scheme (the Order for Lifelong Restriction) incorporates a number of elements for offenders convicted of specified sexual or violent offences.³¹¹ This process is initiated by a risk assessment order which enables an offender to be remanded in custody to be assessed by an accredited assessor³¹², who will form an opinion as to the extent of risk the offender presents to the community.

This assessment is considered when a court issues an Order for Lifelong Restriction, and is also used to inform the development of a risk management plan that is reviewed annually. The process is overseen by the Risk Management Authority, which commissions and undertakes research about risk assessment and risk minimisation, accredits risk assessors, and publishes guidelines as to how to conduct risk assessments.

Supervision of high risk offenders

In 19 of the 20 cases reviewed by the Board, the perpetrators had a reported history of domestic and family violence that resulted in a protection order being issued (either in a current or former relationship).

Only seven perpetrators were ever charged with a domestic and family violence related offence. This excludes the 12 perpetrators who had ever been charged with a breach of a protection order (60%).

In total, five perpetrators were convicted of a domestic violence offence (not a contravention of the order). In one case, the perpetrator punched his former partner (the aggrieved) in the head when she went to his residence to collect their daughter's school uniform. This was after multiple breaches of the protection order were reported to police. The perpetrator was ultimately sentenced to nine months imprisonment for the assault and breaches of the protection order.

³⁰⁸ Recommendation 17 of the Domestic and Family Violence Death Review and Advisory Board. (2017). *Annual Report 2016-17*. Brisbane: Author.

³⁰⁹ As per section 162 of the *Penalties and Sentences Act 1992*, an indefinite sentence is a sentence of imprisonment for an indefinite term that must be reviewed under this part; and is to continue until a court orders that the indefinite term of imprisonment is discharged.

³¹⁰ A qualifying offence means an indictable offence against a provision of the Criminal Code 1899 mentioned in Schedule 2, or counselling, procuring or attempting to commit a relevant code provision (s162, *Penalties and Sentences Act 1992*). These offences include: murder, manslaughter, attempt to murder, unlawful striking causing death, torture, acts intended to cause grievous bodily harm and other malicious acts, as well as a range of child sexual offences and general sexual offences (e.g. rape, sexual assault). Part 10 of the *Penalties and Sentences Act 1992* pertains to indefinite sentences.

³¹¹ *Criminal Procedure (Scotland) Act 1995* and *Criminal Justice (Scotland) Act 2003*.

³¹² This includes obtaining information from a range of sources, face-to-face interviews with the offender, multi-disciplinary meetings with community, prison and hospital professionals involved in the management of the offender, and details of the previous criminal convictions and allegations.

In the United Kingdom, Multi-Agency Public Protection Arrangements (MAPPA) were established in 2001 to improve monitoring of sexual and violent offenders. MAPPA formalises and standardises interagency cooperation regarding the management of dangerous offenders³¹³ in every police district throughout England and Wales. An assessment of risk is undertaken for each MAPPA eligible offender, which informs the risk management response.³¹⁴

Evidence suggests that this process may positively contribute to managing offenders convicted of serious violent and sexual offences.³¹⁵ An analysis of MAPPA eligible offenders revealed that about one-quarter of violent offenders re-offended within one year, compared with 13% of sexual offenders. Since the introduction of the MAPPA, rates of serious re-offending among those identified to pose the highest risk fell from 29% to 16% in the year post-release.

Other schemes are operational in some jurisdictions in Australia, such as disproportionate sentencing schemes for serious repeat offenders.³¹⁶ This provision allows for a sentence in excess of what would normally be expected for a conviction of the nominated offence.

Continuing detention orders and extended supervision orders are also in operation in Queensland, as well as Victoria, New South Wales and Western Australia for high risk sexual offenders. Generally, for an order to be made, an offender must be assessed to be an unacceptable risk of committing a serious sexual offence if no such order were to be issued.

In 2013, NSW was the first jurisdiction in Australia to extend these types of legislative schemes to include high risk violent offenders.³¹⁷ This includes continuing detention orders (which require an offender to remain in custody at the completion of a term of imprisonment) and extended supervision orders (that is, obligations on an offender when released from custody which may include electronic monitoring and not residing in specific locations).³¹⁸ Conditions on an extended supervision order can include: electronic monitoring, restrictions on offender's movements, regular reporting, and participation in rehabilitation programs.

However, there has been concerns from the legal fraternity in relation to these legislative amendments.³¹⁹ At the fore is the challenge of adequately assessing for risk of violence in a diverse cohort of violent offenders where they may not share identifiable commonalities, including types of offending behaviours.

A review of the *Crimes (High Risk Offenders) Act 2006* was undertaken in 2016 by the NSW Department of Justice.³²⁰ The review concluded that the objectives of the Act remained valid and appropriate, but recommended some refinements to the framework. As a result, the scheme was modified in December 2017 to ensure the paramount priority is community safety, to have a stronger focus on reforming offenders, and to provide a stronger voice for victims and their families.³²¹

In Queensland, the *Dangerous Prisoner (Sexual Offender) Act (DPSOA) 2003* is in operation. This is a civil scheme which operates on the basis of 'balance of probabilities', as opposed to 'beyond reasonable doubt' as it is reliant on prediction of risk which is an inexact science. QCS manages offenders who have been placed on an order under DPSOA, including those in prison and the community.

Strategies utilised by QCS to manage these offenders include:

- » electronic monitoring;
- » restrictions on use of technology;
- » regular monitoring of phones and computers;
- » restrictions regarding where they can reside, and who they can reside with;
- » curfews;
- » high levels of supervision with trained case managers;
- » ongoing risk assessment; and
- » attendance at group-based programs and/or individual intervention.

Needless to say, this model is very resource intensive and has significant costs.

DPSOA legislation does not prevent an offender from entering a relationship, but offenders may be directed by QCS to provide information about their history of offending and supervision to any new partners to assist them to make an informed decision about their safety.

While an intensive case management process is provided, this framework focuses on managing, not responding to, risks. QCS relies on police to respond to apparent breaches, with concurrent resourcing implications for this agency.

313 Category 1 offenders are registered sexual offenders. Category 2 offenders are violent and other sexual offenders and includes offenders who are sentenced to 12 months or more imprisonment for a qualifying offence (e.g. manslaughter, kidnapping, threats to kill, wounding with intent to cause grievous bodily harm, strangulation, assault occasioning bodily harm). Category 3 offenders are 'other' dangerous offenders who do not qualify for the other two categories.

314 Level 1: Ordinary Agency Management. Most MAPPA eligible offenders are managed at this level, where the risk posed by the offender can be managed by one agency without actively or significantly involving other agencies. Information is shared between relevant agencies but without formal multi-agency meetings. Level 2: Active Multi-Agency Management: offenders are assessed as needing enhanced levels of supervision involving the coordination and cooperation of other agencies and requires multi-agency public protection meetings, but where the level of risk or complexity of risk management is not so great to require referral to level 3. Level 3: Active Multi-Agency Management: Used for the management of a small number of offenders assessed as being a high or very high risk of causing serious harm. These cases present risks that can only be managed by a plan that requires close cooperation at a senior level due to the complexity of the case and/or because of the unusual resource commitments it requires.

315 Bryant, S., Peck, M., & Lovbakke, J. (2015). *Reoffending Analysis of MAPPA Eligible Offenders*. London: Ministry of Justice.

316 Victoria, South Australia, Canada, United States of America.

317 *Crime (Serious Sex Offenders) Amendment Act 2013* extended the regime of post-sentence preventative detention and supervision to high risk violent offenders. As a result, the existent legislation was altered from *Crimes (Serious Sex Offenders) Act 2006* to *Crimes (High Risk Offenders) Act 2006*.

318 The process to gain either a continuing detention order or extended supervision order consists of: an application made by the Attorney-General to the Supreme Court; a preliminary hearing at the Supreme Court within 28 days of application; and, a substantive hearing in the Supreme Court

319 Tulich, T. (2015). Post-sentence preventative detention and extended supervision of high risk offenders in New South Wales. *University of New South Wales Law Journal*, 38(2), 823

320 NSW Department of Justice. (2017). *Review of the Crimes (High Risk Offenders) Act 2006 (NSW)*. Sydney: Author.

321 This is through providing advice to victims and their families when an offender is being considered for a CDO or ESO, and allowing victims to provide information to the court (in writing or orally) to ensure they are heard.

Risk assessment is a key component of this intensive surveillance and monitoring. Empirically validated, specialised actuarial and dynamic risk assessment tools for sexual offending are administered by trained staff, prior to an independent psychiatric assessment being conducted before a matter is referred, through Crown Law, to the Attorney-General for consideration. Matters are heard in the Supreme Court where an additional two independent psychiatric assessments are completed. These cases are reviewed annually.

The UQ report did not identify any research that substantiated a post-sentence supervision model as having an impact on perpetrator recidivism or victim safety. That is not to say that there is no research available regarding the efficacy of such a model, but that there have been no studies that meet the standards of a systematic review process.³²² This indicates that there is no research that has been identified that establishes causality in determining the impact of this model as an intervention.

Irrespective, it is considered unlikely that many of the cases reviewed by the Board, based on the available information that was known to service providers at the time of contact, would have been considered within the context of a long-term supervision order beyond a sentence.

This is because there was a paucity of formal records available to indicate that there was a pervasive history of violent offending, and that other sentencing options had not been trialled and found to be inadequate.

Within current sentencing guidelines, judicial officers must take into consideration a range of factors when determining an appropriate sentence, including that imprisonment be used as a last resort and that the preference is that an offender remain in the community.³²³

Outside of the DPSOA, the use of GPS technology for surveillance of serious offenders also has benefits, but is limited in terms of prevention. While electronic monitoring is useful for prosecution activities, it becomes less relevant if the perpetrator is permitted to reside in the house with the victim.

GPS technology may also provide a false sense of security to the community, as the effectiveness of electronic monitoring requires compliance on behalf of the offender (e.g. for charging devices, being contactable). It is also reliant on power, communications and GPS coverage, and a swift response to non-compliance by an offender.³²⁴

In response to a recommendation from the Special Taskforce,³²⁵ recent amendments to the *Bail Act 1980* now enable the court to impose a condition of bail that a defendant charged with domestic and family violence (or other offences) wear an electronic tracking device.³²⁶

ANROWS is currently conducting a project to consider the effectiveness and best practice principles for electronic monitoring of domestic and family violence perpetrators. The project, due for completion in late 2018, will identify whether electronic monitoring is effective in increasing victim safety, and if so, in what context. It will also seek to determine how to mitigate against risks of reoffending for those being electronically monitored.³²⁷



At least one of the perpetrators (and homicide offender) had a substantial history of general criminal offending, and was incarcerated after his parole order was suspended for a contravention of the protection order in place at the time. This offender served his full sentence in custody, as his application for parole was rejected. He was, therefore, not subject to monitoring in the community, as he would otherwise have been if he was released to parole.

As such, the Board gave consideration as to what action could be taken in these circumstances to ensure such offenders could be monitored post-release.

Notably, three cases subject to review were also flagged as high risk by police officers, who implemented a range of case management strategies to monitor and respond to these perpetrators in the community. This included: proactive engagement with the victims, referral of victims to specialist services and ongoing liaison with these services, regular reviews of police contacts, and taking action when they received intelligence about a perpetrator's new partner.

The QPS OPM includes provisions to encourage officers to implement case management strategies to proactively investigate and respond to domestic and family violence within their district, including for matters where there are repeat calls for services.

Given that police have existing capabilities to monitor high risk perpetrators of domestic and family violence, there may be opportunities to enhance their capacity to identify and respond to these cases, such as is occurring with the *Gold Coast Domestic and Family Violence Taskforce*, and the *Organised Crime Gangs Group State Crime Command Domestic and Family Violence Strategy*.

³²² The researchers utilised a hybrid approach that draw on traditional systematic review methodologies and also alternative review methodologies that permit expedited reviews of evaluation literature. Only the most rigorous studies, that is, systematic reviews, randomised control studies and strong quasi-experimental research, were included in this review.

³²³ Section 9(2(a)) of the *Penalties and Sentences Act 1992*.

³²⁴ For more information, see Orchiston, T. (2012). GPS Tracking and domestic violence offenders: Promise and pitfalls. Australian Domestic and Family Violence Clearinghouse newsletter 48, pp7-9.

³²⁵ The Queensland Government trials the use of GPS monitoring for high risk perpetrators of domestic and family violence.

³²⁶ Section 11(gB) of the *Bail Act (1980)*.

³²⁷ <https://www.anrows.org.au/node/1701> Accessed 7 September 2018

Chapter 11: Service integration and responsiveness

Key findings

- » Integrated service responses aim to cohesively build on each agency's collective efforts to improve victim safety and perpetrator accountability across the service system. They also seek to prevent secondary victimisation and victims from falling through the gaps.
- » This is particularly pertinent given that the Board identified a fragmented approach to service provision in the cases reviewed. Responses were generally reactive to crisis and services largely operated in isolation of one another.
- » A cohesive, integrated service response requires consideration of victim safety and perpetrator accountability through dynamic case management and risk planning processes. It should also take into account the safety and protection needs of any children in the relationship.
- » In the cases reviewed by the Board, about one-third of contacts with private health practitioners were considered inadequate, suggesting that further development is required for this workforce. Accordingly, the Board considers it integral that these care providers receive adequate training and supports.

While the previous three chapters have focused on elements of the service system, specifically health, specialist services, and criminal justice responses, it is clear from the cases reviewed by the Board that there is a need for all agencies to work together to prioritise the safety of victims and their children, at every contact point.

This chapter considers how agencies sought to work together in the cases reviewed by the Board, primarily through collaborative case management or referrals to other services. Specific issues identified by the Board included:

- » a lack of take-up of referrals;
- » a lack of continuity of care or support, with services continuing to work in silos to some extent, particularly where there were complex, intersecting issues or co-occurring needs;
- » information not being shared across agencies quickly; and
- » a reliance on self-reported information that was not corroborated through contact with other services.

In an attempt to reduce these types of issues, including victims 'falling through the gaps' or experiencing secondary victimisation by the services designed to protect them, there has been increasing focus on integrated service system responses to domestic and family violence.

An effective integrated service response aims to ensure services are working together cohesively, with the intention of building on collective efforts to improve victim safety and perpetrator accountability.

Accordingly, service integration is promoted as an overarching mechanism for providing cohesive and comprehensive responses to victims of domestic and family violence. There are identified benefits to clients³²⁸ and service providers³²⁹ utilising integrated service response models.³³⁰

Key components of an integrated response model include that:

- » the framework sets shared intervention protocols and procedures, including common minimum standards and practice requirements;
- » there are cross-agency written agreements to define working relationships and accountability;
- » the model is supported by governance/steering committees; and
- » cross-sector training initiatives are established to ensure stakeholders comprehend the integrated response strategy and have a shared understanding of goals.

The model is, however, not without criticism, including that:

- » certain power imbalances between agencies (government and non-government) may arise in the policy development process, particularly when there is conflict between participating agencies around the purpose and goals of interventions;
- » the coordinated, collaborative and integrated nature of the framework may create privacy concerns for clients and discourage engagement;
- » implementing and sustaining the framework can be costly and there may be a scarcity of resources available; and
- » there has previously been a lack of performance monitoring and evaluation to ensure consistency and effectiveness.

³²⁸ For example, simplified coordinated response to multiple client needs particularly when they are one-stop shops; multiple entry points for intervention; and, minimisation of secondary victimisation

³²⁹ For example, cost effectiveness achieved through minimising duplication of services; formalised information sharing between services; potential up-skilling of workers across different issues; and, enhanced transparency and accountability between services and workers.

³³⁰ Breckenridge, J., Rees, S., Valentine, K., & Murray, S. (2015). *Meta-evaluation of Existing Interagency Partnerships, Collaboration, Coordination and/or Integrated Interventions and Service Responses to Violence Against Women: State of Knowledge paper*. Sydney: Australian National Research Organisation for Women's Safety.

To be effective, integrated responses to domestic and family violence need to involve both crisis and long-term counselling and support, safety planning, health and mental health services, criminal justice services, and where applicable, other relevant agencies such as housing and employment services. Integrated service responses also require all relevant services to be part of case management and decision making, inclusive of mental health services³³¹ and specialist services working with perpetrators of violence.

In recognition of the need for greater integration, the Special Taskforce report made several recommendations with respect to the development and implementation of integrated service response trials.³³²

Trial sites have subsequently been implemented in Logan/ Beenleigh, Mount Isa, and Cherbourg. High risk teams, which are a core component of the integrated service response approach, have been introduced at the trial sites, with additional sites³³³ commencing in 2017-18 and two³³⁴ further sites expected to commence in early 2019.³³⁵

Despite significant and ongoing improvements in certain areas across the state as part of the current reform agenda,³³⁶ the cases reviewed by the Board are indicative of a fragmented approach to service provision.

Further, in five cases reviewed by the Board, an integrated service response was known to be operating within the region at the time of the deaths.³³⁷ In one of these cases, this was not formalised, but in four, the integrated service response had been in place for many years. Despite this, there was limited evidence that services were working in an integrated way to meet the needs of the victim and the perpetrator.

While agencies were accessed or utilised by both victims and perpetrators, these entities often operated in isolation. Services were delivered separately to the victim and perpetrator, and while information may have been shared, there was limited evidence of collaborative case management and planning across agencies.

There was limited evidence of proactive follow up and, indeed, even where referrals were made, these would often be closed with no direct contact with the victim or perpetrator. Closure would occur generally because the service was unable to make contact or because the victim/perpetrator would state that they were no longer in need of support.

For those services responding to victims seeking support, a concurrent focus on perpetrator accountability was identified as a service gap in the cases reviewed by the Board. This finding has also been identified in some locations that have established integrated response models.³³⁸

For example, in one case reviewed by the Board, a specialist service initiated safety planning for the victim (and homicide deceased) on multiple occasions, inclusive of practical strategies to keep her and her family safe. At no point were corresponding plans developed to monitor the perpetrator in this case. Despite the perpetrator (and homicide offender) being identified as a high risk offender and subject to monitoring by police in relation to his criminal affiliations, there was no evidence that the police case management strategy was developed collaboratively with the specialist service.

In this respect, opportunities exist to broaden our understanding of perpetrator accountability and ensure that all services play their role in enforcing community standards with perpetrators and holding them to account for their abusive behaviours.

In this context, entities who may not be directly involved in the delivery of interventions can play a role in ensuring accountability through monitoring, surveillance or compliance. Regardless of whether attitudinal or behaviour change has been achieved, the perpetrator's visibility to these entities ensures risk and safety can be monitored, and fluctuations in risk more quickly identified, allowing services to intervene swiftly if necessary to prevent future violence.³³⁹

There is also potential to extend the role of integrated service responses to prevention activities and early intervention services, as they are well-placed to ensure robust responses to low to medium risk situations. This should assist in reducing these types of situations from escalating to one where there is an imminent risk of harm.

Of particular importance, given the findings in Chapter 4 pertaining to the impact of domestic and family violence on children, it is clear that agencies working with victims and perpetrators must have a corresponding focus on the safety of children. There was limited evidence in the cases reviewed that potential risks to children were meaningfully assessed or responded to.

331 As demonstrated in cases considered by the Board, 65.0% of perpetrators were involved with public mental health services prior to the deaths, signifying the importance for these services to be engaged in the process.

332 Recommendations 9, 74, 75, 76, 77, 78, 79, 80, 82 and 83 of the Special Taskforce on Domestic and Family Violence. (2015). *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland*. Brisbane: Author.

333 Brisbane, Ipswich and Cairns.

334 Mackay and Moreton Bay.

335 As part of the implementation of these reforms, the Australian National Research Organisation for Women's Safety (ANROWS) was commissioned to develop a suite of tools to support the integrated service response, including a common risk assessment framework and supporting documentation which are currently being trialled, but are not publically available. The integrated service response trial sites will undergo an evaluation by ANROWS.

336 As part of the Special Taskforce on Domestic and Family Violence reforms and the Domestic and Family Violence Prevention Strategy 2016-2016, integrated service response trials are underway in three locations: Logan/Beenleigh (urban location); Mount Isa (regional city location); and, Cherbourg (discrete Indigenous community location). The trial will be evaluated to inform and help guide the future direction for Queensland's integrated response to domestic and family violence.

337 These deaths did not occur in any of the current integrated service response trial sites associated with the Special Taskforce reforms. In only two cases was there identifiable contact with the key agencies participating in the integrated service response.

338 Humphreys, C., & Healey, L. (2017). *PATHways and Research Into Collaborative Inter-Agency practice: Collaborative work across the child protection and specialist domestic and family violence interface: Final report*. Sydney: ANROWS.

339 Commonwealth of Australia (Department of Social Services). (2015). *National Outcome Standards for Perpetrator Interventions*. Canberra: Author.

Primary health care provider's role as part of an integrated service response

It was apparent in 14 cases (70%) that either the victim or the perpetrator were engaged with private mental health practitioners or GPs prior to the death.

Of these cases, half had contact with GPs and two-fifths of perpetrators were in contact with psychologists in the two years preceding the deaths.

It is clear from these findings that private practitioners have a crucial role in the service system response to domestic and family violence. They play an important role as a gatekeeper to specialist services and also as a provider of ongoing support.

In one case, an integrated service response was operating in the area where a victim had recently relocated with her daughter following separation from her abusive husband. Although she did not have any contact with a specialist service at this time, a protection order had previously been established listing her as the aggrieved and her former partner as the respondent.

The victim sought help from a GP for her experiences of domestic and family violence as, by this time, due to the extent of the abuse she had experienced, she was unable to work. This victim requested that the GP assist her by providing a medical certificate for Centrelink citing that she was not fit to work due to stressors associated with trying to separate from her abusive relationship (including her relocation).

No substantive action was taken by this GP to refer the victim to any specialist support as a result of these disclosures of violence, and the GP was unwilling to provide a certificate despite obtaining the requisite records from the victim's former GP. These records documented a history of the victim's chronic health issues, including depression, and a history of the contextual circumstances surrounding her presentations. This included disclosures of childhood sexual abuse and increased stress associated with the chaotic home environment at the time.

This case demonstrates that GPs are often an initial and consistent point of contact for victims (and perpetrators) of violence, increasing the potential likelihood of relevant disclosures and associated opportunities to intervene. This is particularly pertinent given the increasing amount of research in relation to the pervasive health impacts of domestic and family violence.³⁴⁰

It is important that these opportunities for detection and response are maximised, and had a referral to a specialist service occurred on this occasion, it may have improved outcomes for this victim.

Further, perpetrators of violence rarely seek help from services directly for their violent behaviours and, if they do, this may be recorded as 'anger management issues'. This occurred in a number of cases reviewed by the Board, including one where the perpetrator disclosed to his GP anxiety and relationship stressors following a family violence episode involving his mother (which led to the issuing of a protection order against him). The GP cited 'anger management' as the presenting issue warranting further exploration by a psychologist and referred this perpetrator accordingly.

In another case, the perpetrator requested referral to a psychologist for anger management counselling, but, upon assessment by the practitioner, was told he did not have anger management issues, but instead more communication with his victims was needed.

These same victims (his former spouse and children) had endured significant abuse over a prolonged period of time from this perpetrator, including:

- » physical violence;
- » verbal abuse;
- » damage to property, including punching holes in the wall, doors and cupboard of the house;
- » psychological abuse, including threatening to restrict the children's access to their mother if they did not behave; and
- » threats to kill extended family.

Both of these cases may have benefited from a referral to a men's behaviour change program or other specialist supports. However, health practitioners may be reluctant to work collaboratively with other service providers because of concerns about client confidentiality with respect to disclosures of domestic and family violence.

This issue has been addressed with recent legislative amendments and, as outlined in the *Domestic and Family Violence Information Sharing Guidelines*, private practitioners (e.g. GP, psychologist) are able to provide information to prescribed entities (e.g. police, courts) and specialist services funded by government in situations where it will enhance those services' assessment of whether there is a serious threat to the life, health or safety of the victim.³⁴¹

Where it is reasonably believed that a serious threat exists, information may also flow from the prescribed entities and specialist services to private practitioners (and other service providers).

As demonstrated in Chapter 6, one-third of all contacts with private practitioners were identified as inadequate, suggesting that further training or support is required for this workforce.³⁴² It is also critical that efforts are made to improve referral pathways between these practitioners and specialist services.

This could include such strategies as locally led workforce development initiatives that bring mainstream care providers, specialist services, police and other agencies together to facilitate a shared understanding of community needs. This approach may also assist with the identification and clarification of each agency's roles and responsibilities in responding to both victims and perpetrators of domestic and family violence.

³⁴⁰ Hovane, V. & Cox, D. (2011). *Closing the Gap on Family Violence: Driving Prevention and Intervention through Health Policy*. Australian Domestic and Family Violence Clearinghouse. Issues Paper 21.

³⁴¹ Department of Communities, Child Safety and Disability Services. (2017). *Domestic and Family Violence Information Sharing Guidelines*. Brisbane: Queensland Government. <https://www.communities.qld.gov.au/resources/gateway/campaigns/end-violence/info-sharing-guidelines.pdf>

³⁴² This refers to only the cases reviewed within the 2017-18 reporting period by the Board.

Such initiatives should aim to develop greater connections between entities, with a view to strengthening local referral pathways and ensuring better support is provided over the long-term. It would also assist in creating opportunities to leverage off existing structures and activities.

Primary Health Networks (PHNs) act as locally led agents of change within Australia's health care system. Their role is to partner at a local level with clinicians, state and territory local hospital networks, local government, non-government organisations and the broader community to improve health outcomes and to make a person's experience through the system as smooth as possible.

This may involve a focus on reducing service gaps and duplication, engaging clinicians as enablers of change, encouraging a multidisciplinary approach to patient care, and other activities that aim to improve the health literacy of patients and the broader community.

A number of PHNs are already undertaking a range of initiatives with the aim of improving responses by primary health care providers to domestic and family violence.

For example, in late 2017, the Brisbane South PHN launched a front-line training program for primary health care providers in the region to assist in addressing domestic and family violence. They also funded a dedicated resource to provide support services to GPs who refer patients experiencing domestic and family violence. This resource aims to facilitate connections between general practices in the program and specialist services.³⁴³

While it is impossible to capture all activities underway across the state at a local level to respond to domestic and family violence, it is also acknowledged that there are similar training initiatives and partnerships underway at a local level in other PHNs across the state. This includes active promotion of the White Book³⁴⁴ to GPs, and those that aim to develop interagency partnerships.³⁴⁵

Recommendation 13:

That Primary Health Networks throughout Queensland play a leadership role in training and workforce development initiatives that seek to improve cross-agency responses to domestic and family violence within primary health care settings.

This should focus on enhancing local partnerships between specialist domestic and family violence support services, and primary health care providers.

³⁴³ See more here: http://bsphn.org.au/media_releases/new-dimension-addressing-domestic-family-violence/

³⁴⁴ Royal Australian College of General Practitioners. (2014). *Abuse and Violence: Working with our patients in general practice*. (4th edn). Melbourne: RACGP.

³⁴⁵ Such as within the Darling Downs and West Moreton Primary Health Network, the Domestic Violence Action Centre and University of South Queensland that aims to deliver domestic and family violence education to general practitioners and other primary health professionals.



Section 3

This section contains details regarding the remuneration of Board Members as per Queensland Government guidelines and reporting requirements (Appendix A). The data coding forms used by the Board to collate data in relation to lethality risk factors are also included (Appendix B), as are the co-occurring lethality risk indicators (Appendix C) and the common case characteristics identified in each of the cases (Appendix D), and a glossary of terms (Appendix E). The Government response to the 2017-17 Annual Report is also included (Appendix F).



Appendix A – Remuneration of the Board

Domestic and Family Violence Death Review and Advisory Board					
Act or instrument	<i>Coroners Act 2003</i>				
Functions	<i>Review domestic and family violence related deaths</i>				
Achievements	<i>In 2017-18, the Board met on eight occasions, including four case review meetings, three annual report preparation meetings that incorporated expert presentations, and one public forum which the findings of the 2016-17 Annual Report were presented.</i>				
Financial reporting	<i>The Board is audited as part of the Department of Justice and Attorney-General. Accounts are published in the annual report.</i>				
Remuneration					
Position	Name	Meetings/ sessions attendance	Approved annual, sessional or daily fee	Approved sub- committee fees if applicable	Actual fees received
Chair	Terry Ryan	8			
Deputy Chair	A/Prof Kathleen Baird	5	\$4500		\$3300
Member	Dr Silke Meyer	7	\$4500		\$4500
Member	Betty Taylor	5	\$4500		\$3600
Member	Mark Walters	5	\$4500		\$3300
Member	Angela Lynch	7	\$4500		\$3900
Member	Barbara Shaw	8			
Member	Tammy Williams	0			
Member	Natalie Parker	6			
Member	Dr Jeanette Young	4			
Member	Dr Peter Martin	2			
Member	Dr Maurice Carless ³⁴⁶	5			
No. scheduled meetings/sessions	Eight (inclusive of four case review meetings, three annual report planning meetings with presentations from expert speakers, and one public forum)				
Total out of pocket expenses	Nil reported				

³⁴⁶ Dr Martin was appointed to the Board in March 2018.

Appendix B – Intimate Partner Homicide Lethality Risk Factor Form

Perpetrator = The primary aggressor in the relationship

Victim = The primary target of the perpetrator's abusive/maltreating/violent actions

Risk factor	Descriptor
1. History of violence outside of the family by perpetrator	Any actual or attempted assault on any person who is not, or has not been, in an intimate relationship with the perpetrator. This could include friends, acquaintances, or strangers. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.).
2. History of domestic violence	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person who has been in, or is in, an intimate relationship with the perpetrator. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.). It could be as simple as a neighbour hearing the perpetrator screaming at the victim or include a co-worker noticing bruises consistent with physical abuse on the victim while at work.
3. Prior threats to kill victim	Any comment made to the victim, or others, that was intended to instil fear for the safety of the victim's life. These comments could have been delivered verbally, in the form of a letter, or left on an answering machine. Threats can range in degree of explicitness from 'I'm going to kill you' to 'You're going to pay for what you did' or 'If I can't have you, then nobody can' or 'I'm going to get you'.
4. Prior threats with a weapon	Any incident in which the perpetrator threatened to use a weapon (e.g., gun; knife; etc.) or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.) for the purpose of instilling fear in the victim. This threat could have been explicit (e.g., 'I'm going to shoot you' or 'I'm going to run you over with my car') or implicit (e.g., brandished a knife at the victim or commented 'I bought a gun today'). Note: This item is separate from threats using body parts (e.g., raising a fist).
5. Prior assault with a weapon	Any actual or attempted assault on the victim in which a weapon (e.g., gun; knife; etc.), or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.), was used. Note: This item is separate from violence inflicted using body parts (e.g., fists, feet, elbows, head, etc.).
6. Prior threats to commit suicide by perpetrator	Any recent (past 6 months) act or comment made by the perpetrator that was intended to convey the perpetrator's idea or intent of committing suicide, even if the act or comment was not taken seriously. These comments could have been made verbally, or delivered in letter format, or left on an answering machine. These comments can range from explicit (e.g., "If you ever leave me, then I'm going to kill myself" or "I can't live without you") to implicit ("The world would be better off without me"). Acts can include, for example, giving away prized possessions.
7. Prior suicide attempts by perpetrator	Any recent (past 6 months) suicidal behaviour (e.g., swallowing pills, holding a knife to one's throat, etc.), even if the behaviour was not taken seriously or did not require arrest, medical attention, or psychiatric committal. Behaviour can range in severity from superficially cutting the wrists to actually shooting or hanging oneself.
8. Prior attempts to isolate the victim	Any non-physical behaviour, whether successful or not, that was intended to keep the victim from associating with others. The perpetrator could have used various psychological tactics (e.g., guilt trips) to discourage the victim from associating with family, friends, or other acquaintances in the community (e.g., 'if you leave, then don't even think about coming back' or 'I never like it when your parents come over' or 'I'm leaving if you invite your friends here').
9. Controlled most or all of victim's daily activities	Any actual or attempted behaviour on the part of the perpetrator, whether successful or not, intended to exert full power over the victim. For example, when the victim was allowed in public, the perpetrator made her account for where she was at all times and who she was with. Another example could include not allowing the victim to have control over any finances (e.g., giving her an allowance, not letting get a job, etc.).

10. Prior hostage-taking and/or forcible confinement	Any actual or attempted behaviour, whether successful or not, in which the perpetrator physically attempted to limit the mobility of the victim. For example, any incidents of forcible confinement (e.g., locking the victim in a room) or not allowing the victim to use the telephone (e.g., unplugging the phone when the victim attempted to use it). Attempts to withhold access to transportation should also be included (e.g., taking or hiding car keys). The perpetrator may have used violence (e.g., grabbing; hitting; etc.) to gain compliance or may have been passive (e.g., stood in the way of an exit).
11. Prior forced sexual acts and/or assaults during sex	Any actual, attempted, or threatened behaviour, whether successful or not, used to engage the victim in sexual acts (of whatever kind) against the victim's will. Or any assault on the victim, of whatever kind (e.g., biting; scratching, punching, choking, etc.), during the course of any sexual act.
12. Child custody or access disputes	Any dispute in regards to the custody, contact, primary care or control of children, including formal legal proceedings or any third parties having knowledge of such arguments.
13. Prior destruction or deprivation of victim's property	Any incident in which the perpetrator intended to damage any form of property that was owned, or partially owned, by the victim or formerly owned by the perpetrator. This could include slashing the tires of the car that the victim uses. It could also include breaking windows or throwing items at a place of residence. Please include any incident, regardless of charges being laid or those resulting in convictions.
14. Prior violence against family pets	Any action directed toward a pet of the victim, or a former pet of the perpetrator, with the intention of causing distress to the victim or instilling fear in the victim. This could range in severity from killing the victim's pet to abducting it or torturing it. Do not confuse this factor with correcting a pet for its undesirable behaviour.
15. Prior assault on victim while pregnant	Any actual or attempted form physical violence, ranging in severity from a push or slap to the face, to punching or kicking the victim in the stomach. The key difference with this item is that the victim was pregnant at the time of the assault and the perpetrator was aware of this fact.
16. Choked/Strangled victim in the past	Any attempt (separate from the incident leading to death) to strangle the victim. The perpetrator could have used various things to accomplish this task (e.g., hands, arms, rope, etc.). Note: Do not include attempts to smother the victim (e.g., suffocation with a pillow).
17. Perpetrator was abused and/or witnessed domestic violence as a child	As a child/adolescent, the perpetrator was victimized and/or exposed to any actual, attempted, or threatened forms of family violence/abuse/maltreatment.
18. Escalation of violence	The abuse/maltreatment (physical; psychological; emotional; sexual; etc.) inflicted upon the victim by the perpetrator was increasing in frequency and/or severity. For example, this can be evidenced by more regular trips for medical attention or include an increase in complaints of abuse to/by family, friends, or other acquaintances.
19. Obsessive behaviour displayed by perpetrator	Any actions or behaviours by the perpetrator that indicate an intense preoccupation with the victim. For example, stalking behaviours, such as following the victim, spying on the victim, making repeated phone calls to the victim, or excessive gift giving, etc.
20. Perpetrator unemployed	Employed means having full-time or near full-time employment (including self-employment). Unemployed means experiencing frequent job changes or significant periods of lacking a source of income. Please consider government income assisted programs (e.g., O.D.S.P.; Worker's Compensation; E.I.; etc.) as unemployment.
21. Victim and perpetrator living common-law	The victim and perpetrator were cohabiting.
22. Presence of stepchildren in the home	Any child(ren) that is(are) not biologically related to the perpetrator.
23. Extreme minimisation and/or denial of spousal assault history	At some point the perpetrator was confronted, either by the victim, a family member, friend, or other acquaintance, and the perpetrator displayed an unwillingness to end assaultive behaviour or enter/comply with any form of treatment (e.g., batterer intervention programs). Or the perpetrator denied many or all past assaults, denied personal responsibility for the assaults (i.e., blamed the victim), or denied the serious consequences of the assault (e.g., she wasn't really hurt).

24. Actual or pending separation	The partner wanted to end the relationship. Or the perpetrator was separated from the victim but wanted to renew the relationship. Or there was a sudden and/or recent separation. Or the victim had contacted a lawyer and was seeking a separation and/or divorce.
25. Excessive alcohol and/or drug use by perpetrator	Within the past year, and regardless of whether or not the perpetrator received treatment, substance abuse that appeared to be characteristic of the perpetrator's dependence on, and/or addiction to, the substance. An increase in the pattern of use and/or change of character or behaviour that is directly related to the alcohol and/or drug use can indicate excessive use by the perpetrator. For example, people described the perpetrator as constantly drunk or claim that they never saw him without a beer in his hand. This dependence on a particular substance may have impaired the perpetrator's health or social functioning (e.g., overdose, job loss, arrest, etc.). Please include comments by family, friend, and acquaintances that are indicative of annoyance or concern with a drinking or drug problem and any attempts to convince the perpetrator to terminate his substance use.
26. Depression – in the opinion of family/friend/acquaintance - perpetrator	In the opinion of any family, friends, or acquaintances, and regardless of whether or not the perpetrator received treatment, the perpetrator displayed symptoms characteristic of depression.
27. Depression – professionally diagnosed – perpetrator	A diagnosis of depression by any mental health professional (e.g., family doctor; psychiatrist; psychologist; nurse practitioner) with symptoms recognized by the DSM-IV, regardless of whether or not the perpetrator received treatment.
28. Other mental health or psychiatric problems – perpetrator	For example: psychosis; schizophrenia; bipolar disorder; mania; obsessive-compulsive disorder, etc.
29. Access to or possession of any firearms	The perpetrator stored firearms in his place of residence, place of employment, or in some other nearby location (e.g., friend's place of residence, or shooting gallery). Please include the perpetrator's purchase of any firearm within the past year, regardless of the reason for purchase.
30. New partner in victim's life	There was a new intimate partner in the victim's life or the perpetrator perceived there to be a new intimate partner in the victim's life
31. Failure to comply with authority – perpetrator	The perpetrator has violated any family, civil, or criminal court orders, conditional releases, community supervision orders, or 'No Contact' orders, etc. This includes bail, probation, or restraining orders, and bonds, etc.
32. Perpetrator exposed to/ witnessed suicidal behaviour in family of origin	As a(n) child/adolescent, the perpetrator was exposed to and/or witnessed any actual, attempted or threatened forms of suicidal behaviour in his family of origin. Or somebody close to the perpetrator (e.g., caregiver) attempted or committed suicide.
33. After risk assessment, perpetrator had access to victim	After a formal (e.g., performed by a forensic mental health professional before the court) or informal (e.g., performed by a victim services worker in a shelter) risk assessment was completed, the perpetrator still had access to the victim.
34. Youth of couple	Victim and perpetrator were between the ages of 15 and 24.
35. Sexual jealousy – perpetrator	The perpetrator continuously accuses the victim of infidelity, repeatedly interrogates the victim, searches for evidence, tests the victim's fidelity, and sometimes stalks the victim.
36. Misogynistic attitudes – perpetrator	Hating or having a strong prejudice against women. This attitude can be overtly expressed with hate statements, or can be more subtle with beliefs that women are only good for domestic work or that all women are 'whores'.
37. Age disparity of couple	Women in an intimate relationship with a partner who is significantly older or younger. The disparity is usually nine or more years
38. Victim's intuitive sense of fear of perpetrator	The victim is one that knows the perpetrator best and can accurately gauge his level of risk. If the women discloses to anyone her fear of the perpetrator harming herself or her children, for example statements such as, 'I fear for my life', 'I think he will hurt me', 'I need to protect my children', this is a definite indication of serious risk.
39. Perpetrator threatened and/or harmed children	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual; etc.) towards children in the family. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family; friends; neighbours; co-workers; counsellors; medical personnel, etc.).

Appendix C – Co-occurring lethality risk indicators

Table 27: Co-occurring lethality risk indicators, non-lethal strangulation

	Present (n=23)		Absent (n=55)	
History of violence outside of the family by perpetrator	15	65.2%	19	34.5%
History of domestic violence (current relationship)	23	100.0%	41	74.5%
Prior threats to kill victim	16	69.6%	19	34.5%
Prior threats with a weapon	7	30.4%	11	20.0%
Prior assault with a weapon	6	26.1%	10	18.2%
Prior threats to commit suicide by perpetrator	13	56.5%	12	21.8%
Prior suicide attempts by perpetrator	10	43.5%	8	14.5%
Prior attempts to isolate the victim	14	60.9%	21	38.2%
Controlled most or all of victim's daily activities	11	47.8%	19	34.5%
Prior hostage-taking and/or forcible confinement	11	47.8%	8	14.5%
Prior forced sexual acts and/or assaults during sex	8	34.8%	4	7.3%
Child custody or access disputes	7	30.4%	8	14.5%
Prior destruction or deprivation of victim's property	12	52.2%	10	18.2%
Prior violence against family pets	6	26.1%	5	9.1%
Prior assault on victim while pregnant	7	30.4%	6	10.9%
Choked/strangled victim in past	23	100.0%	-	0.0%
Perpetrator was abused and/or witnessed DV as a child	4	17.4%	5	9.1%
Escalation of violence	16	69.6%	12	21.8%
Obsessive behaviour displayed by perpetrator	10	43.5%	21	38.2%
Perpetrator unemployed	12	52.2%	23	41.8%
Victim and perpetrator living common-law	13	56.5%	28	50.9%
Presence of step children in the home	7	30.4%	9	16.4%
Extreme minimisation and/or denial of spousal assault history	12	52.2%	10	18.2%
Actual or pending separation	15	65.2%	32	58.2%
Excessive alcohol and/or drug use by perpetrator	18	78.3%	23	41.8%
Depression – in the opinion of family/friend/acquaintance	5	21.7%	12	21.8%
Depression – professionally diagnosed	7	30.4%	9	16.4%
Other mental health or psychiatric problems – perpetrator	10	43.5%	11	20.0%
Access to or possession of any firearms	5	21.7%	7	12.7%
New partner in victim's life	10	43.5%	14	25.5%
Failure to comply with authority	16	69.6%	15	27.3%
Perpetrator exposed to/witnessed suicidal behaviour in family of origin	2	8.7%	1	1.8%
After risk assessment, perpetrator had access to victim	5	21.7%	4	7.3%
Youth of couple	4	17.4%	1	1.8%
Sexual jealousy	19	82.6%	23	41.8%
Misogynistic attitudes – perpetrator	7	30.4%	5	9.1%
Age disparity of couple	4	17.4%	7	12.7%
Victim's intuitive sense of fear of perpetrator	20	87.0%	20	36.4%
Perpetrator threatened and/or harmed children	8	34.8%	10	18.2%
Average (range)	18.1	(7-27)	9.1	(1-25)

Table 28: Co-occurring lethality risk indicators with sexual jealousy

	Present (n=42)		Absent (n=36)	
History of violence outside of the family by perpetrator	27	64.3%	7	19.4%
History of domestic violence (current relationship)	41	97.6%	23	63.9%
Prior threats to kill victim	25	59.5%	10	27.8%
Prior threats with a weapon	14	33.3%	4	11.1%
Prior assault with a weapon	14	33.3%	2	5.6%
Prior threats to commit suicide by perpetrator	21	50.0%	4	11.1%
Prior suicide attempts by perpetrator	16	38.1%	2	5.6%
Prior attempts to isolate the victim	26	61.9%	9	25.0%
Controlled most or all of victim's daily activities	24	57.1%	6	16.7%
Prior hostage-taking and/or forcible confinement	14	33.3%	5	13.9%
Prior forced sexual acts and/or assaults during sex	10	23.8%	2	5.6%
Child custody or access disputes	11	26.2%	4	11.1%
Prior destruction or deprivation of victim's property	16	38.1%	6	16.7%
Prior violence against family pets	9	21.4%	2	5.6%
Prior assault on victim while pregnant	10	23.8%	3	8.3%
Choked/strangled victim in past	19	45.2%	4	11.1%
Perpetrator was abused and/or witnessed DV as a child	7	16.7%	2	5.6%
Escalation of violence	23	54.8%	5	13.9%
Obsessive behaviour displayed by perpetrator	26	61.9%	5	13.9%
Perpetrator unemployed	21	50.0%	14	38.9%
Victim and perpetrator living common-law	24	57.1%	17	47.2%
Presence of step children in the home	9	21.4%	7	19.4%
Extreme minimisation and/or denial of spousal assault history	16	38.1%	6	16.7%
Actual or pending separation	29	69.0%	18	50.0%
Excessive alcohol and/or drug use by perpetrator	27	64.3%	14	38.9%
Depression – in the opinion of family/friend/acquaintance	10	23.8%	7	19.4%
Depression – professionally diagnosed	14	33.3%	2	5.6%
Other mental health or psychiatric problems – perpetrator	16	38.1%	5	13.9%
Access to or possession of any firearms	12	28.6%	-	0.0%
New partner in victim's life	18	42.9%	6	16.7%
Failure to comply with authority	26	61.9%	5	13.9%
Perpetrator exposed to/witnessed suicidal behaviour in family of origin	3	7.1%	-	0.0%
After risk assessment, perpetrator had access to victim	8	19.0%	1	2.8%
Youth of couple	3	7.1%	2	5.6%
Sexual jealousy	42	100.0%	-	0.0%
Misogynistic attitudes – perpetrator	9	21.4%	3	8.3%
Age disparity of couple	8	19.0%	3	8.3%
Victim's intuitive sense of fear of perpetrator	29	69.0%	11	30.6%
Perpetrator threatened and/or harmed children	12	28.6%	6	16.7%
Average (range)	16.3	(3-27)	6.5	(1-17)

Table 29: Co-occurring lethality risk indicators with separation

	Present (n=47)		Absent (n=31)	
History of violence outside of the family by perpetrator	20	42.6%	14	45.2%
History of domestic violence (current relationship)	41	87.2%	23	74.2%
Prior threats to kill victim	22	46.8%	13	41.9%
Prior threats with a weapon	8	17.0%	10	32.3%
Prior assault with a weapon	5	10.6%	11	35.5%
Prior threats to commit suicide by perpetrator	18	38.3%	7	22.6%
Prior suicide attempts by perpetrator	13	27.7%	5	16.1%
Prior attempts to isolate the victim	25	53.2%	10	32.3%
Controlled most or all of victim's daily activities	20	42.6%	10	32.3%
Prior hostage-taking and/or forcible confinement	12	25.5%	7	22.6%
Prior forced sexual acts and/or assaults during sex	7	14.9%	5	16.1%
Child custody or access disputes	13	27.7%	2	6.5%
Prior destruction or deprivation of victim's property	18	38.3%	4	12.9%
Prior violence against family pets	8	17.0%	3	9.7%
Prior assault on victim while pregnant	9	19.1%	4	12.9%
Choked/strangled victim in past	15	31.9%	8	25.8%
Perpetrator was abused and/or witnessed DV as a child	7	14.9%	2	6.5%
Escalation of violence	21	44.7%	7	22.6%
Obsessive behaviour displayed by perpetrator	21	44.7%	10	32.3%
Perpetrator unemployed	20	42.6%	15	48.4%
Victim and perpetrator living common-law	23	48.9%	18	58.1%
Presence of step children in the home	9	19.1%	7	22.6%
Extreme minimisation and/or denial of spousal assault history	13	27.7%	9	29.0%
Actual or pending separation	47	100.0%	0	0.0%
Excessive alcohol and/or drug use by perpetrator	24	51.1%	17	54.8%
Depression – in the opinion of family/friend/acquaintance	11	23.4%	6	19.4%
Depression – professionally diagnosed	12	25.5%	4	12.9%
Other mental health or psychiatric problems – perpetrator	14	29.8%	7	22.6%
Access to or possession of any firearms	11	23.4%	1	3.2%
New partner in victim's life	19	40.4%	5	16.1%
Failure to comply with authority	18	38.3%	13	41.9%
Perpetrator exposed to/witnessed suicidal behaviour in family of origin	3	6.4%	0	0.0%
After risk assessment, perpetrator had access to victim	6	12.8%	3	9.7%
Youth of couple	4	8.5%	1	3.2%
Sexual jealousy	29	61.7%	13	41.9%
Misogynistic attitudes – perpetrator	7	14.9%	5	16.1%
Age disparity of couple	7	14.9%	4	12.9%
Victim's intuitive sense of fear of perpetrator	28	59.6%	12	38.7%
Perpetrator threatened and/or harmed children	12	25.5%	6	19.4%
Average (range)	13.1	(1-27)	9.7	(1-22)

Appendix D – Case characteristics

People from a culturally and linguistically diverse background

	Danielle and Yumi	Zara and Narinder	Malaya	Yasmin	Luka
Deceased Gender	Female	Female	Female	Female	Male
Offender Gender	Female	Male	Male	Male	N/A
Relevant Service Contact	Police, specialist services, primary health care practitioner, private mental health practitioner	Police	Police, Corrective Services, primary health care practitioner	Police, Corrective Services, Queensland Health, private mental health practitioner, private counsellor, specialist services	Police, Corrective Services, Ambulance, Queensland Health, Alcohol Tobacco and Other Drug Services, private mental health practitioner
Known to Family and friends	Yes	Yes	No	Yes	Yes
History with previous partners	No	No	Yes (perpetrator and victim)	Yes (perpetrator)	Yes – (perpetrator)
Relationship separation	Yes	Pending	Pending	Yes	Yes
Child custody concerns	No	No	No	Yes	No
Other history of offending	No	No	Yes	Yes	Yes
Problematic substance use (perpetrator)	Yes	Yes	No	Yes	Yes
Mental health concerns (perpetrator)	Yes	Yes	No	Yes	Yes
Protection order in place at time of death	No	No	Yes	Yes	Yes
Previous suicide attempt or threats	Yes	No	No	Yes	Yes
Other characteristics	Victim fears for safety and repetitive help-seeking around separation, and experiences of abuse.		Pending court proceedings; victim fears for safety.	Threats of legal action in relation to unborn child; suicidal and homicidal ideation (perpetrator); Victim fears for safety.	

Homicides in a family relationship

	Bradley, Maxine and Hayden	Nicholas	Kevin	Bronwyn	Jim
Deceased Gender	Female and Male	Male	Male	Female	Male
Offender Gender	Male	Male	Male	Male	Male
Relevant Service Contact	Police, Queensland Health	Police	Police, Queensland Health, primary health care practitioner	Police, primary health care practitioner, private mental health practitioner, Child Safety Services	Police, Courts, Corrective Services, primary health care practitioner
Known to Family and friends	Yes	Yes	Yes	Yes	No
History with previous partners	Yes (Bradley) Yes (Maxine)	Yes (Francis) No (Nicholas)	Yes (Kevin)	Yes (Graham) Yes (Bronwyn)	Yes
Other history of offending	Yes (Bradley)	Yes (Nicholas)	Yes (Kevin)	Yes	Yes
Problematic substance use (perpetrator)	Yes (Bradley)	Yes (Francis) Yes (Nicholas)	Yes (Kevin)	Yes	Yes
Mental health concerns (perpetrator)	Yes (Bradley)	Yes (Francis)	Yes	Yes	Yes
Protection order in place at time of death	Yes – Maxine (respondent), Bradley (named person)	Yes – between offender (respondent) and his partner	Yes – between Kevin (respondent) and partner	Yes – between offender (respondent) and his partner	Yes – between offender (respondent) and his mother
Previous suicide attempt or threats	Yes (Bradley)	Nicholas - Yes	Yes (Kevin)	Unknown	No
Other characteristics	Chaotic family environment; ongoing family stressors; pregnancy; prospect of loss of income.	Familial stressors.	Normalisation of violence.	Long history of violence within the broader familial network.	Release from prison on parole.

Homicide suicides

	Sam, Riley and Edward	Vivian and Harry	Sophie and Alexander	Brittany and Jeremy
Deceased Gender	Female and male	Female	Female	Female
Offender Gender	Male	Male	Male	Male
Relevant Service Contact	Police, Queensland Health, Mental Health, Courts, primary health care practitioner, Child Safety Services, specialist service	Police, Ambulance, Queensland Health, Mental Health, Corrective Services, Child Safety Services primary health care provider, specialist services and other support services	Police, Ambulance, Queensland Health, Mental Health, Courts, private mental health practitioner, Child Safety Services, support services	Police, Corrective Services, Mental Health, Prison Mental Health, specialist services and other support services, primary health care practitioner
Known to Family and friends	Yes	Yes	Yes	Yes
History with previous partners	No	Yes	Yes	Yes
Relationship separation	Yes	Yes	Yes	Yes
Child custody concerns	Yes	No	Yes	No
Other history of offending	No	No	No	Yes
Problematic substance use (perpetrator)	Yes	No	Yes	Yes
Mental health concerns (perpetrator)	Yes	Yes	Yes	Yes
Protection order in place at time of death	Yes	Yes	Yes	Yes
Previous suicide attempt or threats	Yes	Yes	Yes	Yes
Other characteristics	Familial stressors; cohabitation post separation; perpetrator threats to harm children; system abuse by perpetrator.	Familial stressors; release from prison on bail; perpetrator cessation of medication proximate to death.	Familial stressors; recent separation and relocation of victim.	Reconciliation after period of imprisonment; threat of sexual transmitted infection; outlaw motorcycle gang connections.

Male deceased (female perpetrated, and collateral homicides)

	Julian	Jonathon and Tiffany	Percy	Michael	Joshua	Edwin
Deceased Gender	Male	Male	Male	Male	Male	Male
Offender Gender	Female	Female	Female	Male	Male	Male
Relevant Service Contact	Police, Courts, Ambulance, Queensland Health, Child Safety Services, specialist services	Police, Corrective Services, Courts, Alcohol Tobacco and Other Drug Service, Queensland Health, Indigenous health service, other support service	Police, Courts, Ambulance, specialist service	Police, Corrective Services, Mental Health, Alcohol Tobacco and Other Drugs Service, Queensland Health	Police, Corrective Services, private mental health practitioner, Mental Health	Police, Courts, Legal Aid, Ambulance, Queensland Health, Child Safety Services, primary health care practitioner, private mental health practitioner
Known to Family and friends	Yes	Yes	No	Yes	Yes	Yes
History with previous partners	Yes	Yes	Yes	No	Yes	No
Relationship separation	Yes	Yes	Yes	Yes	Yes	Yes
Child custody concerns	No	No	No	Yes	Yes	Yes
Other history of offending	Yes	Yes	Yes	Yes	Yes	No
Problematic substance use (perpetrator)	Yes	Yes	Yes	Yes	Yes	No
Mental health concerns (perpetrator)	Yes	Yes	Yes	Yes	Yes	Yes
Protection order in place at time of death	No	Yes	No	Yes	Yes	Yes
Previous suicide attempt or threats	Yes	No	No	Yes	Yes	Yes
Other characteristics	Hostage taking; non-lethal strangulation; attempts to retrieve property; transience in accommodation; threats proximate to death.	Acute episode of violence including imminent threat; acute intoxication; transience in accommodation; non-lethal strangulation.		New partner for victim; perpetrator warrants for arrest and recent release from prison; perpetrator escalation of erratic behaviours; perpetrator homeless and uncontactable.	New partner for victim; recent release from prison; problematic substance use; child custody issues; recent rape and other serious offending.	Sexual assault; new partner (for victim); recent relocation of victim; escalation of violence.

Appendix E – Glossary of terms

Aggrieved: the person for whose benefit a domestic violence protection order or police protection notice is in force under the *Domestic and Family Violence Protection Act 2012*.

AIFS: Australian Institute for Family Studies.

ANROWS: Australian National Research Organisation for Women's Safety.

Board reviewed cases: this refers to the 20 cases featuring 30 domestic and family violence related deaths reviewed by the Board during the 2017-18 financial year.

COAG: Council of Australian Governments.

Coercive controlling violence: an ongoing and often relentless pattern of behaviour asserted by a perpetrator which is designed to induce various degrees of fear, intimidation and submission in a victim.³⁴⁷ This may include the use of tactics such as social isolation, belittling, humiliation, threatening behaviour, restricting resources and abuse of children, pets or relatives.

Collateral homicides: includes a person who may have been killed intervening in a domestic dispute or a new partner who is killed by their current partner's former abusive spouse.

Collusion: the conscious or unconscious collaboration of two or more individuals to protect those engaged in unethical or illegal practices. This can involve friends, family or service systems, and can include the justification or minimisation of abusive behaviours, blaming the victim, and failing to intervene when violence is detected.

CRAF: the Queensland Common Risk Assessment Framework is a coordinated approach designed to assist practitioners and the specialised domestic violence workforce to undertake effective risk identification, assessment and management through the use of a structured tool which combines professional judgement, the assessment of risk by the person experiencing violence and evidence-based risk factors.

Cross-orders: where two protection orders have been made by the same court or by different courts, and a person named as a respondent in one of the protection orders (the first protection order) is named as the aggrieved in the other protection order (the second protection order).

Deceased: the person/s who died.

DCSYW: Department of Child Safety, Youth and Women.

DFVPA 2012: *Domestic and Family Violence Protection Act 2012*.

Domestic and family violence: as defined by section 8 of the *Domestic and Family Violence Protection Act 2012*, domestic and family violence means behaviour by a person (the first person) towards another person (the second person) with whom the first person is in a relevant relationship that: (a) is physically or sexually abusive; or (b) is emotionally or psychologically abusive; or (c) is economically abusive; or (d) is threatening; or (e) is coercive; or (f) in any other way controls or dominates the second person and causes the second person to fear for their safety or wellbeing, or that of someone else.

Domestic and family violence homicide: Queensland uses a nationally consistent definition of a 'domestic and family violence homicide' as outlined within the Australian Domestic and Family Violence Death Review Network 'Homicide Consensus Statement'. This recognises that although there is no universally agreed definition of the behaviours that comprise domestic and family violence, in Australia, it includes a spectrum of physical and non-physical behaviours including physical assault, sexual assault, threats, intimidation, psychological and emotional abuse, social isolation and economic deprivation. Primarily, domestic and family violence is predicated upon inequitable relationship dynamics in which one person exerts power over another. This accords with the definition of family violence contained in the *Family Law Act 1975* (Cth), which is adopted by the Network. The definition of homicide adopted by the National Network is broader than the legal definition of the term, and includes all circumstances in which an individual's act, or failure to act, resulted in the death of another person, regardless of whether the circumstances were such as to contravene provisions of the criminal law.

DV-PAF: the Domestic and Family Violence Protective Assessment Framework is a decision making framework employed by the Queensland Police Service to assist officers in assessing the protective needs of an aggrieved person and determining the required response. This is based on the identification of risk factors and an assessment of the aggrieved's level of fear.

Domestic and family violence related contact: contact with an agency where the individual (perpetrator or victim) a) made disclosures regarding violence in a relevant relationship, b) presented with observable consequences of domestic and family violence (e.g. assault related injuries at a hospital), or c) had previously reported domestic and family violence was occurring or had occurred, and contact with this agency was ongoing.

³⁴⁷ Johnson, M.P. (2008). *A Typology of Domestic Violence: Intimate terrorism, violent resistance and situational violence*. Boston, USA: University Press of New England.

Economic abuse: behaviour by a person that is coercive, deceptive or unreasonably controls another person without the second person's consent in a way that denies economic or financial autonomy, or by withholding or threatening to withhold financial support necessary for meeting reasonable living expenses if the first person is predominantly or entirely dependent on the first person financially.

ED: Emergency Department.

Emotional or psychological abuse: behaviour by a person towards another person that torments, intimidates, harasses or is offensive to the other person.

Episodes of violence: describes the series of events characterising domestic and family violence. Referring to episodes of violence allows practitioners to consider the repetitive nature of violence perpetration and victimisation, exposing the ongoing vulnerabilities of victims and cumulative risk that perpetrators pose both within, and across, relationships.

Exposed to domestic violence: a child is exposed to domestic and family violence if the child sees or hears domestic violence or otherwise experiences the effects of domestic and family violence.

Family violence: in this report, this term is used to describe the complex phenomenon of violence that occurs between members of a family relationship. As defined by the *Domestic and Family Violence Protection Act 2012*, a family relationship exists between two persons if one of them is, or was, the relative of the other. A relative of a person is someone who is ordinarily understood to be, or have been, connected to the person by blood or marriage and may include: a child, step-child, parent, step-parent, sibling, grandparent, aunt, nephew, cousin, half-sibling, mother-in-law or aunt-in-law. In this report, this is distinct from the term that is commonly used when referring to violence that occurs within Aboriginal and Torres Strait Islander families and communities.

False negative: when trying to utilise a risk assessment tool to predict if an individual will offend, and the tool incorrectly predicts the individual will not be violent, when in fact they are at risk of doing so. This can result in a victim being exposed to risk of harm. Lowering the threshold of false negatives may lead to an increase in false positives.

False positive: when trying to utilise an assessment tool to predict if an individual will offend, and the tool incorrectly predicts the individual will be violent, when in fact they are not at risk of doing so. This can result in the individual being subject to a risk mitigation strategy that may impinge their civil liberties. Lowering the threshold of false positives may lead to an increase in false negatives, and risks to victims.

Filicide: the killing of children by parents (including step-parents).

Generalist services: services not specifically designed for, but in the course of their business, may be required to respond to issues associated with domestic and family violence (e.g. health, mental health, criminal justice, child safety, psychologists, general practitioners, and alcohol and other drug treatment services).

GP: General Practitioner.

High Risk Teams: seek to support the delivery of coordinated, consistent and timely responses to prevent serious harm or death in cases where victims and their children are assessed as being at high risk. Participating agencies across the service system will work together to enhance victim safety, monitor the high risk posed by the perpetrator, and implement strategies which seek to hold the perpetrator to account through appropriate information sharing, comprehensive risk assessment and informed safety planning, and increased agency accountability. There are many different models for high risk teams. In Queensland, the funded High Risk Teams form part of the integrated service response trials that are part of reforms associated with the Special Taskforce report.

Homicide event: an incident resulting in the unlawful killing of a person.

Index relationship: this refers to the relevant relationship between the primary perpetrator and primary victim in which domestic and family violence was prevalent, and may not necessarily describe the homicide offender-deceased relationship. For example, the index relationship for a man who was killed (the homicide deceased) by his new spouse's former abusive partner (homicide offender) would be the former intimate partner relationship between the homicide offender and his former spouse; not between the deceased and the offender.

Integrated service response: this is an innovative approach that ensures coordination of services and supports across government, non-government and other community organisations. The aim of an integrated service response is to have all relevant services work together in a timely, structured, collaborative way to ensure people affected by domestic and family violence receive quality and consistent support.

Intimate partner relationship: individuals who are, or have been, in an intimate relationship (sexual or non-sexual), irrespective of the gender of the individuals.

Lethality risk indicators: domestic and family violence death review processes are based on the premise that there have been warning signs and key indicators or predictors of harm prior to the death. These indicators, such as a noted escalation in violence, non-lethal strangulation or real or impending separation, have been found to be associated with an increased risk of harm in relationships characterised by domestic and family violence. For the purposes of this report, data on lethality risk indicators is gathered using the Ontario Domestic Violence Death Review Committee's coding form.

Mental Health Sentinel Events Review (Sentinel Event Review): the Mental Health Sentinel Events Review Committee was established to review recent fatal events involving people with mental health issues in Queensland. The review provided expertise and leadership in public mental health care and forensic mental health care that balanced best practice care with operational practicality. The Sentinel Event Review provides high level guidance for clinicians, administrators and policymakers on opportunities to improve the identification and quality of care for severely mentally ill consumers while simultaneously considering public safety.³⁴⁸

National Outcome Standards for Perpetrator Interventions: were developed by the Australian Commonwealth, state and territory governments and endorsed by the Council of Australian Governments on 11 December 2015, and aim to inform interventions to reduce re-offending, to better understand the nature of perpetration against high risk groups, to evaluate existing program models, and to determine the characteristics of effective perpetrator intervention programs.

Not Now, Not Ever report: the Special Taskforce on Domestic and Family Violence published a final report titled *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland* in February 2015. This report made 140 recommendations to inform the development of a long term vision and strategy for Government and the community to rid the state of this form of violence.

Offender: the person whose actions, or inaction, caused the person (the deceased) to die.

Perpetrator: the person who was identified as the aggressor in the relationship prior to the death and who used abusive tactics within the relationship to control the victim. Within the context of this report, a perpetrator may be the homicide offender, homicide deceased, suicide deceased or surviving perpetrator.

Perpetrator Interventions: typically refer to specific programs (e.g. behaviour change programs) for perpetrators of domestic and family violence. These interventions generally seek to change men's attitudes, beliefs and behaviour in order to prevent them from engaging in violence in the future.³⁴⁹

Primary Health Networks (PHN): a national initiative which operates across Queensland to increase the efficiency of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time.

Primary perpetrator: this is defined as the person most responsible for violence in the relevant relationship that preceded the domestic and family violence death. This could be the homicide offender, homicide deceased, suicide deceased, or surviving perpetrator.

Primary victim: this is the person who was subjected to domestic and family violence in a relevant relationship to the homicide event. This could be the homicide deceased, homicide offender, or surviving victim.

Private health practitioner: general practitioners, psychologist, psychiatrist etc.

Protection order: as defined by Part 3 of the *Domestic and Family Violence Protection Act 2012*, a domestic violence protection order is an official document issued by the court that stipulates conditions imposed against a respondent with the intent to stop threats or acts of domestic and family violence.

QCS: Queensland Corrective Services.

QH: Queensland Health.

QPS: Queensland Police Service.

QPS OPM: the Queensland Police Service Operational Procedures Manual outlines general policies and procedures in relation to operational matters of the Queensland Police Service.

Queensland Child Protection Commission of Inquiry (the Carmody Review): led by the Honourable Tim Carmody QC, this inquiry was established in 2012 to review the entire child protection system and to deliver a roadmap for a new system for supporting families and protecting children. The final report, *Taking Responsibility: A roadmap for Queensland child protection*³⁵⁰, released in 2013, outlined 121 recommendations to government to reform the child protection system; 116 of these recommendations were accepted fully and the remaining five were accepted in principle.

Queensland Domestic and Family Violence Homicide dataset: a dataset of all homicides that have occurred in Queensland within an intimate partner or family relationship since 2006. This is maintained by the Domestic and Family Violence Death Review Unit within the Coroners Court of Queensland, and is used to assist in the monitoring and identification of any patterns or trends in these types of deaths.

³⁴⁸ Mental Health Sentinel Events Review Committee. (2016). *When Mental Health Care Meets Risk: A Queensland sentinel events review into homicide and public sector mental health services*. Brisbane: Queensland Health.

³⁴⁹ Mackay, E., Gibson, A., Lam, H., & Beecham, D. (2015). Perpetrator interventions in Australia: Part one – literature review. Landscapes, Nov 2015. Sydney: Australian National Research Organisation for Women's Safety.

³⁵⁰ Queensland Child Protection Commission of Inquiry. (2013). *Taking Responsibility: A roadmap for Queensland Child Protection*. Brisbane: Author.

Queensland Domestic and Family Violence Suicide dataset: a database of all suicides that have occurred in the context of recent or ongoing domestic and family violence. This dataset is maintained by the Domestic and Family Violence Death Review Unit within the Coroners Court of Queensland, and holds data from all apparent suicide deaths with a clear nexus with domestic and family violence since 1 July 2015.

Relative: individuals, including children, related by blood, a domestic partnership or adoption. This includes family-like relationships and explicitly includes extended family-like relationships that are recognised within that individual's cultural group. This includes: a child, step-child, parent, step-parent, sibling, grandparent, aunt, nephew, cousin, half-brother, or mother-in-law.

Relevant relationship: as defined by section 13 of the DFVPA 2012, a relevant relationship includes an intimate partner relationship, family relationship or informal care relationship.

Reporting period: 2017-18 financial year.

Respondent: a person against whom a domestic violence protection order or a police protection notice is in force or may be in force made under the DFVPA 2012.

Risk assessment: a comprehensive evaluation that seeks to gather information to determine the level of risk and the likelihood and severity of future violence. Levels of risk should be continually reviewed through a process of ongoing monitoring and assessment.

Risk management: an approach to respond to and reduce the risk of violence. Risk management strategies should include safety planning, ongoing risk assessment, plans to address the needs of victims through relevant services (e.g. legal, counselling), and liaison between services utilising appropriate information sharing processes.³⁵¹

Risk screening: a routine process to determine if domestic and family violence occurs to inform further actions, including referral and intervention.

Safety planning: a safety plan assists a victim to identify and recognise their safety needs and plan for emergency situations. Safety plans can be developed to assist a victim to escape the violent situation, or to remain with the person who has abused them. In either case, the aim of the safety plan is to assist the victim to stay or to leave as safely as possible.

Sexual Jealousy: is a type of jealousy evoked in response to an actual or perceived threat of sexual infidelity.

Special Taskforce on Domestic and Family Violence (the Special Taskforce): was established on 10 September 2014 to define the domestic and family violence landscape in Queensland and make recommendations to inform the development of a long term vision and strategy for Government and the community to rid the state of this form of violence. The Special Taskforce's Final Report, *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland*, which made 140 recommendations, was submitted to the Queensland Premier on 28 February 2015.

Specialist services: services designed to provide frontline support and resources to individuals affected by domestic and family violence (e.g. victim services, women's refuges, perpetrator intervention programs).

Systems abuse: the ongoing use of systems to continue to abuse victims by a perpetrator, typically after a relationship separation (e.g. child custody matters through Family Law Court).

The Act: within the context of this report refers to the *Coroners Act 2003*.

The National Plan to Reduce Violence against Women and their Children 2010-2022 (the National Plan): explains what the Commonwealth, state and territory governments, in partnership with the community, are doing to reduce violence against women and their children in Australia. The National Plan focuses on two main types of violent crimes impacting on women, specifically domestic and family violence and sexual assault, and seeks to support initiatives that enhance prevention and early intervention, victim support and perpetrator accountability.

Victim: the person who was identified as the victim of the domestic and family violence in the relationship and the person most in need of protection. Within the context of this report, the victim may be the homicide offender, the homicide deceased, the suicide deceased or surviving victim.

Victorian Royal Commission into Family Violence (the Royal Commission): was established on 22 February 2015 to examine how to effectively prevent family violence, improve early intervention, support victims, make perpetrators accountable, better coordinate community and government responses, and evaluate and measure strategies, frameworks, policies, programs and services. The final report, which made 227 recommendations, was submitted to the Victorian Government House on 29 March 2016.

Violent resistance: where one partner becomes controlling and violent, the other partner may respond with violence in self-defence. Within this typology, the violent resister does not engage in controlling behaviours.

³⁵¹ Department of Human Services. (2012). *Family Violence: Risk assessment and risk management framework and practice guides 1-3*. Melbourne: Author.

Appendix F – Government’s Response to the Domestic and Family Violence Death Review and Advisory Board 2016-17 Annual Report

The Domestic and Family Violence Death Review and Advisory Board (the Board) was established as part of the Queensland Government’s implementation of recommendations from the Special Taskforce on Domestic and Family Violence Final Report - *‘Not Now, Not Ever’ Putting an end to domestic and family violence in Queensland* (2015).

The Board is established under the *Coroners Act 2003* to review domestic and family violence deaths to identify common systemic failures, gaps or issues; and make recommendations to improve systems, practices and procedures to prevent future domestic and family violence deaths.

The Board’s first report, the 2016-17 Annual Report, contained **21 recommendations**.

The Government broadly supports the intent of the Board’s recommendations, which cumulatively aim to prevent future deaths through improving the accessibility, availability and responsiveness of health, justice and community support services.

The Board’s recommendations cut across four key areas:

- » suicide risk screening in specialist services;
- » strengthening our systems;
- » earlier detection and targeted intervention; and
- » changing the response to domestic and family violence in Aboriginal and Torres Strait Islander People.

The Board makes a number of recommendations to complement and enhance current reforms associated with implementing recommendations in the Special Taskforce Report on Domestic and Family Violence; as well other reform agendas relevant to the child protection, health and criminal justice systems.

Many of the recommendations made by the Board are already underway. Of the recommendations directed towards improving the systems that service victims and perpetrators of domestic and family violence – whether health, justice or community support – the Government has initiatives underway that meet the intent of all of these recommendations.

The Report acknowledges the important reforms the Government has already undertaken; including legislative reform which has seen the introduction of a circumstance of aggravation of domestic and family violence to be applied to all applicable criminal offences and the introduction of the specialist domestic and family violence courts.

In the 2017-18 State Budget, the Palaszczuk Government invested \$69.5 million over four years in specialist domestic and family violence courts, building on the success of the Southport specialist court trial. The Southport specialist domestic and family violence court is now a permanent court and specialist courts are being rolled out to four other locations including Beenleigh, Townsville, Mount Isa and Palm Island.

These specialist courts put clients at the centre of court services and provide wrap-around multi-agency supports. The approach is multi-disciplinary and collaborative, and provides a framework for co-ordinated services – all working together – to help people experiencing domestic and family violence navigate the justice system and get the support that they need. In the 2018-19 Budget, a further \$8.052 million over four years has been committed to ensure that the Townsville domestic and family violence court, with circuits to Mount Isa and Palm Island, is funded to deal with criminal and civil domestic and family violence matters.

The Government will develop a suicide prevention framework for implementation within domestic and family violence women’s shelters. A number of trials such as the Integrated Service Response sites are also currently underway as well as other initiatives to improve information sharing between agencies such as the Queensland Police Service and the Department of Child Safety, Youth and Women to improve frontline responses to women and children at risk.

The Government will also continue implementing initiatives that work towards improving domestic and family violence proficiency, bridging the gap between domestic and family violence and child safety policy and practice.

The Government acknowledges the Board’s call for change to respond to Aboriginal and Torres Strait Islander family violence, recognising the impact of dispossession, the breakdown of kinship networks, child removal policies and entrenched disadvantage, as well as intergenerational trauma and grief, on Aboriginal and Torres Strait Islander families and communities. The Government will explore options to build on existing initiatives under the Domestic and Family Violence Prevention Strategy 2016-26.

In 2018-19, more than \$11 million will be targeted at providing maternal, child health and family support services and programs. The Government will also develop a three year Queensland Aboriginal and Torres Strait Islander Maternity Services Action Plan to improve maternity services and responses to the needs of Aboriginal and Torres Strait Islander mothers and babies across Queensland.

Domestic and family violence impacts on all geographical regions of Queensland and all levels of our society. It is only through the rigorous analysis provided in this report, and the key learnings identified by the Board, we can implement the systemic changes required to protect lives in the future.



Government's Response to the Domestic and Family Violence Death Review and Advisory Board 2016-17 Annual Report

Recommendations	Lead Agency	Proposed response
<p>Recommendation 1 Targeted suicide prevention framework for Domestic and Family Violence (DFV) refuges</p> <p>That a targeted suicide prevention framework, which accounts for the detection of, and response to, vulnerable individuals should be developed and implemented within domestic and family violence refuges by the Department of Communities, Child Safety and Disability Services, in consultation with relevant experts and stakeholders.</p> <p>This framework should include:</p> <ul style="list-style-type: none"> a) the implementation of routine, evidence based, suicide risk screening at intake and provisions for timely reassessment during periods of acute crisis or elevated risk (e.g. following contact with a violent ex-partner) to ensure that responses are commensurate with risk b) referral pathways to relevant support services, and be used to inform a comprehensive safety and risk management plan for individual clients c) suicide awareness and risk management training for staff, as well as the introduction of standardised policies and procedures that aim to support appropriate storage of, and access to, medications in domestic violence refuges 	<p>Department of Child Safety, Youth and Women</p>	<p>Accept</p> <p>The Government will implement a staged approach to the development of a suicide prevention framework for implementation within domestic and family violence women's shelters and will contract an external provider to deliver initial suicide awareness and risk management training for shelter workers.</p>
<p>Recommendation 2 Mandatory training of QH staff</p> <p>That the Department of Health introduce mandatory training for staff who may come into contact with victims and their children or perpetrators of domestic and family violence.</p> <p>The training should be delivered to a standard (or level) that proficiency can be measured. This should cover:</p> <ul style="list-style-type: none"> a) risk screening, assessment and management processes b) enhancing understanding of risk factors c) comprehensive discharge planning and follow up care that takes into account the safety of both self and others, including appropriate referrals d) appropriate safe information sharing in accordance with Queensland Health guidelines e) specialist non-lethal strangulation training for accident and emergency departments that aims to assist in recognition of the signs of this type of violence but also in the collation of forensic information to inform the prosecution of any related criminal charges. 	<p>Queensland Health</p>	<p>Accept in part</p> <p>Queensland Health has published the Domestic and Family Violence Training resources to support clinicians – a toolkit of resources to support the recognition and response of health professionals to domestic and family violence.</p> <p>The toolkit and training address many of the areas raised, including risk screening, assessment, management, understanding risk factors, referral pathways, information sharing and information on non-lethal strangulation.</p> <p>The toolkit and resources are available online. The Department of Health will actively promote the completion of training, and support staff being afforded time to complete training.</p>

Recommendations	Lead Agency	Proposed response
<p>Recommendation 3 Enhancement of post-natal care</p> <p>That the Department of Health consider ways to enhance the delivery of post-natal care for all families with a focus on equipping them with the requisite skills to care for a newborn infant. The Department should also consider and incorporate intensive and robust maternity and post-natal support models of care for all high-risk and vulnerable families with a focus on continuity of care options (including midwives), the use of multidisciplinary teams to address broader support needs, and specific interventions and support for fathers.</p>	Queensland Health	<p>Accept in principle</p> <p>The Government supports this recommendation in principle, but notes the provision of specific interventions for high-risk families would need to be considered in the development of any new maternity and post-natal models of care in each Hospital and Health Service (HHS), as well as in state-wide plans and strategies.</p>
<p>Recommendation 4 Availability of culturally appropriate maternity and post-natal care for Aboriginal and Torres Strait Islander families</p> <p>That the Department of Health consider ways to ensure culturally appropriate maternity and post-natal care for Aboriginal and Torres Strait Islander families are available. This should include a focus on increasing and supporting a specialist workforce in this area, and the provision of outreach support services that aim to engage with hard to reach families.</p>	Queensland Health	<p>Accept in principle</p> <p>The Government is developing a three-year Queensland Aboriginal and Torres Strait Islander Maternity Services Action Plan to improve maternity services for Aboriginal and Torres Strait Islander mothers. The intent of the proposed Action Plan is to facilitate access to culturally appropriate and responsive maternal health services, while effectively co-ordinating the provision of targeted services that respond to the needs of Aboriginal and Torres Strait Islander mothers and their babies across Queensland.</p>
<p>Recommendation 5 Routine screening for DFV by obstetricians and gynaecologist</p> <p>That the Department of Health liaise with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to promote routine screening for domestic and family violence, and enhanced responses to high-risk and vulnerable families in private obstetrics and health facilities.</p>	Queensland Health	<p>Accept</p> <p>In response to Recommendation 54 of the Special Taskforce on Domestic and Family Violence Final Report, the Government commissioned an independent review of antenatal screening. Following this review, an expert reference group comprised of representatives from both public and private sector health services, Primary Health Networks and representatives from professional bodies including the Royal Australian and New Zealand College of Obstetricians and Gynaecologists developed an 'Antenatal screening for domestic and family violence guideline'.</p> <p>The Guidelines are currently being implemented.</p>

Recommendations	Lead Agency	Proposed response
<p>Recommendation 6 Priority alcohol and other drug treatment for high risk or vulnerable parents</p> <p>That the Queensland Government consider ways to improve access to, and availability of, priority alcohol and other drug treatment places for high risk or vulnerable parents who may have contact with the child protection system or be experiencing domestic and family violence. This should also take into account the practical supports that parents may need, such as free access to child-care, to encourage uptake with treatment services, and aim to ensure that services are informed around the intersection between domestic and family violence, trauma and substance use.</p>	<p>Queensland Health</p>	<p>Accept in principle</p> <p>Queensland Health and the Department of Child Safety, Youth and Women (DCSYW) are working together to support the Child Safety workforce engage with families impacted by substance misuse in the child protection system, specifically through the establishment of an Alcohol and Other Drug Clinical Practice Leader position based in DCSYW.</p> <p>DCSYW is currently commissioning a Domestic and Family Violence Workforce Capacity and Capability service. From late 2018-19, the service will deliver training that will assist in ensuring services are informed around the intersection between domestic and family violence, trauma and substance abuse.</p> <p>The Government has also committed to the creation of a new 42-bed Alcohol and Other Drug Residential Rehabilitation and Treatment Facilities. This facility will include two Family Units.</p> <p>'Action on Ice' – the Government's plan to address use and harms caused by crystal methamphetamine, also includes actions to support Queensland families involved in the child protection system, or experiencing domestic and family violence, to overcome substance abuse.</p>
<p>Recommendation 7 Routine mandatory DFV victim and perpetrator screening in mental health, alcohol and other drug services</p> <p>That the Department of Health implement processes for routine mandatory screening for domestic and family violence victimisation and perpetration, within all Queensland Health and government funded mental health, and alcohol and other drug services. These should be supported by clear local pathways to specialist support services and appropriate training on the intersection between domestic and family violence, mental health and substance use which accords with the National Outcome Standards for Perpetrator Interventions.</p>	<p>Queensland Health</p>	<p>Accept in part</p> <p>The Government's response to this recommendation is in line with the responses to recommendations 2 and 3. Queensland Health has published a toolkit of resources to support the recognition and response of health professionals to domestic and family violence. This includes identification of domestic and family violence through a sensitive inquiry model and how to respond appropriately.</p> <p>A project is currently underway to implement an integrated suite of clinical documentation for both mental health and alcohol and other drug services. The Advisory Group leading this work has identified the Mental Health Risk Screening Tool as suitable for use by the integrated sector with some changes made. Consideration will be given to whether this tool may require greater acknowledgement of factors contributing to domestic and family violence.</p>

Recommendations	Lead Agency	Proposed response
<p>Recommendation 8 Enhanced collaboration between mental health, drug and alcohol and specialist DFV services</p> <p>That the Queensland Government fund and facilitate cross professional training and relationship building between mental health, drug and alcohol, and specialist domestic and family violence services to enhance collaboration, shared understandings and information sharing.</p>	<p>Queensland Health; and Department of Child Safety, Youth and Women</p>	<p>Accept</p> <p>From late 2018-19, the Domestic and Family Violence Workforce Capacity and Capability service being commissioned by DCSYW will potentially assist in providing a professional development program to enhance collaboration, communication and understanding between mental health, drug and alcohol and specialist domestic and family violence services.</p> <p>DCSYW is proposing to participate in the STACY Project, an action research project being undertaken with the University of Melbourne focused on the concurrence of parental mental health and alcohol and other drug issues in families experiencing DFV, and building the capacity of practitioners working with such complexity.</p> <p>The Government is trialling a DFV Integrated Service Response in three locations and establishing High Risk Teams in 8 sites to ensure coordination of services and supports across government, non-government services and other community organisations for victims of domestic and family violence and their children.</p> <p>New DFV information sharing provisions under the <i>Domestic and Family Violence Protection Act 2012</i> were enacted in May 2017, with implementation supported by Information Sharing Guidelines and the roll-out of training in their use.</p> <p>Similarly, expanded information sharing provisions pursuant to the <i>Child Protection Reform Act 2017</i> will become operational later in 2018.</p>
<p>Recommendation 9 DFV awareness training of all registered practitioners</p> <p>That the Queensland Government liaise with peak professional bodies to recommend all registered practitioners who may come into contact with victims and their children or perpetrators of domestic and family violence, complete specialist domestic and family violence awareness training within one year of obtaining registration or membership and be required to complete ongoing refresher training to maintain their registration or membership. Training should include specific information pertaining to working with perpetrators in accordance with the National Outcome Standards for Perpetrator Interventions, as well as responding to victims of domestic and family violence.</p> <p>Peak professional bodies may include, but are not limited to, practitioners registered with the Australian Counselling Association, Australian Association of Psychologists, Australian Association of Social Workers, Royal Australian and New Zealand College of Psychiatrists and accredited relationship counsellors and mediators.</p>	<p>Department of Child Safety, Youth and Women; and Queensland Health</p>	<p>Accept</p> <p>The Queensland Government notes that this is an extension of the Government's implementation of recommendations of the Special Taskforce on Domestic and Family Violence Final Report which recommended awareness training.</p> <p>The Government will liaise with relevant peak bodies to recommend ongoing domestic and family violence awareness training for registered practitioners.</p> <p>From late 2018-19, the Domestic and Family Violence Workforce Capacity and Capability service being commissioned by DCSYW will potentially assist with delivery of training programs.</p>

Recommendations	Lead Agency	Proposed response
<p>Recommendation 10 DFV training of first responders</p> <p>That the Queensland Police Service continue to develop operational communiques and training targeted at first responding officers to domestic and family violence related occurrences, which aim to enhance understanding of the broader dynamics of domestic and family violence and the significance of certain risk indicators that may lead to a heightened risk of harm, such as those identified within this report.</p>	<p>Queensland Police Service</p>	<p>Accept</p> <p>The Government is committed to ongoing and continual improvement of training provided to QPS first responding officers.</p>
<p>Recommendation 11 Queensland Police Service access to DFV history of victims and perpetrators</p> <p>That the Queensland Police Service ensure that all first responding officers have timely access to electronically available, current, relevant and accurate information held across their data systems in relation to a prior history of domestic and family violence, for perpetrators and victims; in a format which aims to enhance but not disrupt, an operational response. This should be supported by the implementation of strategies that emphasise the importance of this information to call takers and frontline officers, and how to better take this information into account when responding to domestic and family violence related occurrences, particularly repeat calls for service.</p>	<p>Queensland Police Service</p>	<p>Accept</p> <p>The Queensland Police Service (QPS) ensures ongoing enhancements to Queensland Police Records and Information Management Exchange (QPRIME) system and its mobile frontline policing capability to aid effective operational responses to domestic and family violence incidents. Ongoing training also highlights the importance of quality and timely data to inform decisions of responding police.</p> <p>During 2018-19, the QPS will commence a trial of two Domestic and Family Violence Coordinators within the Brisbane Police Communications Centre for a period of six months. The trial aims to provide frontline officers with access to on-call dedicated specialist advice to assist them when responding to domestic and family violence incidents.</p>
<p>Recommendation 12 Court support for victims in criminal proceedings</p> <p>That a program for specialised and consistent court support for victims of domestic and family violence in criminal proceedings be developed and funded by the Queensland Government.</p>	<p>Department of Justice and Attorney-General; and</p> <p>Department of Child Safety, Youth and Women</p>	<p>Accept in principle</p> <p>Recommendation 132 of the Special Taskforce on Domestic and Family Violence Final Report relates to the inclusion of coordinating appropriate justice supports for victims of domestic and family violence exposed to criminal proceedings.</p> <p>Currently, Victim Assist Queensland (VAQ) provides specialist court support through their Victim Coordination Officer program and by funding Court Network's Victim Support Unit. Through these programs, in person court support is available in Ipswich, Brisbane, Rockhampton and Cairns with phone support available on the Sunshine Coast.</p> <p>Government will further consider service delivery models that will enable consistent court support for victims, involved in criminal proceedings across the state as well as explore opportunities to leverage off existing court support mechanisms in recognition of the importance of practical and emotional support. Specialist training for court support workers undertaking DFV work will also be explored.</p>

Recommendations	Lead Agency	Proposed response
<p>Recommendation 13 Strengthening guidelines re interviewing children in presence of alleged perpetrator</p> <p>That the Department of Communities, Child Safety and Disability Services, in investigating alleged harm to a child and assessing whether the child is in need of protection, review the appropriateness of conducting interviews with children and young people in front of persons alleged to have caused harm, particularly in the context of domestic and family violence; with a view to strengthening guidelines within the context of statutory obligations as to when this should not occur.</p>	<p>Department of Child Safety, Youth and Women</p>	<p>Accept</p> <p>Current Department of Child Safety, Youth and Women (DCSYW) practice provides that, prior to interviewing a child, Child Safety staff are to consider a number of factors, including whether interviewing the child in the presence of other people may reduce the likelihood of the child disclosing significant harm or risk of significant harm, especially if the person holds a position of authority in relation to the child.</p> <p>In exceptional circumstances, powers under the <i>Child Protection Act 1999</i> may be used to contact and interview a child at their school or other place of education without the parents' consent or without the parents having prior knowledge of the interview.</p> <p>DCSYW will consider how existing guidelines and staff training can be strengthened to address this recommendation.</p> <p>DCSYW is also implementing a range of initiatives that work towards bridging the gap between domestic and family violence and child safety policy and practice, and improving domestic and family violence proficiency, including:</p> <ul style="list-style-type: none"> » Safe and Together training » Specialist Domestic and Family Violence workers in Family and Child Connect and Intensive Family Services » Walking with Dads and Caring Dads programs. <p>In addition, DCSYW and Queensland Police Service (QPS) officers undertake joint training on interviewing, and are trialling three joint investigations teams and a Child Safety Officer team out-posted to QPS Headquarters.</p>
<p>Recommendation 14 Identification of persons experiencing DFV</p> <p>That the Department of Health develop a mechanism to assist practitioners to identify persons experiencing domestic and family violence or high-risk families who have presented to the service previously; and to better take into account previous presentations to enhance future responses.</p>	<p>Queensland Health</p>	<p>Accept in principle</p> <p>Clinicians currently undertake a level of 'previous history' inquiry with clients as part of assessment processes, which are a mechanism to assist practitioners to identify possible patterns of domestic and family violence presentations.</p> <p>The Domestic and Family Violence training developed by Queensland Health also captures the intention of this recommendation – through the elements of sensitive inquiry and identification of risk factors.</p> <p>In the 2018-19 financial year, there will be funding provided to two more HHSs to fund health representatives on the Caboolture and Mackay DFV High-Risk Teams.</p>

Recommendations	Lead Agency	Proposed response
<p>Recommendation 15 Consideration of a warning flag in QPRIME to identify child at risk of harm</p> <p>That the Queensland Police Service implement a process within Queensland Police Records and Information Management Exchange (QPRIME) and across the Service which includes consideration of a warning flag, to assist frontline officers to identify when a child may be at risk of harm and to inform their investigations at any calls for service.</p>	<p>Queensland Police Service</p>	<p>Accept</p> <p>Queensland Police Records and Information Management Exchange (QPRIME) currently provides capability for a particular person or address to be flagged. However, while a flag may alert an officer to a child at risk of harm, there is potential that overreliance on such a flag may cause officers not to consider child harm issues when they attend residences which are not flagged on QPRIME.</p> <p>Queensland Police Service will continue to focus on improving the capability of officers responding to child harm and to build awareness across the Service of the child harm reporting process.</p>
<p>Recommendation 16 Person most in need of protection research</p> <p>That the Queensland Government commission research which aims to identify how best to respond to the person most in need of protection where there are mutual allegations of violence and abuse. This research should take into account the identification of potential training or education needs for service providers across applicable sectors to better assist in the early identification of, and response to, victims who may use violence particularly where they come to the attention of services during relevant civil proceedings for domestic and family violence protection orders.</p>	<p>Department of Child Safety, Youth and Women</p>	<p>Accept</p> <p>The Government will consult with Australia's National Research Organisation for Women's Safety (ANROWS) and the Queensland Government Statistician's Office Crime Research Reference Committee to build on the existing research and evidence base. Research findings will be shared with relevant Government agencies or service providers to better assist in the early identification of, and response to victims.</p>
<p>Recommendation 17 Access to information regarding past offending</p> <p>That the Queensland Government consider opportunities to strengthen legislative, policy and practice requirements within Child Safety Services and the Queensland Police Service to enable each agency to have timely access to relevant information about past offending conduct including charge and conviction information from Queensland and other jurisdictions when undertaking their respective and joint investigative functions and powers. This should include, but not be limited to, a review of prescribed offences within the Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004, to consider the appropriateness of broadening the scope to other violent offences against children (e.g. manslaughter or torture) for the duration of reporting obligations, and the feasibility of broadening access to the National Child Offender System to Child Safety Services.</p>	<p>Queensland Police Service; and Department of Child Safety, Youth and Women</p>	<p>Accept in principle</p> <p>The Department of Child Safety, Youth and Women (DCSYW) currently receives relevant police information on persons with child sex offending history through information sharing provisions under the <i>Child Protection Act 1999</i> and the <i>Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004</i> (CPOR Act). On this basis, the Government considers there is no discernible benefit to broadening access to the National Child Offender System to DCSYW.</p> <p>Queensland Police Service (QPS) and DCSYW will continue to share relevant information under the existing information sharing framework in the Domestic and Family Violence Protection Act 2012 for the purposes of assessing and managing DFV threats, including sharing information about past convictions for a domestic violence offence.</p> <p>From March 2018, DCSYW and QPS have been running an information sharing trial which will see four Child Safety Officers placed in QPS headquarters to assist with information sharing requests from Child Safety to QPS. This is intended to streamline information sharing and ensure that information is targeted to the purpose for which it is requested.</p> <p>The Government will consider broadening the scope of prescribed offences under the CPOR Act to include violent offences against children.</p>

Recommendations	Lead Agency	Proposed response
<p>Recommendation 18 Offending Reporter guidelines for prosecutors</p> <p>That the Director of Public Prosecutions and the Queensland Police Service develop guidelines and educational resources with regard to the <i>Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004</i> to ensure that prosecutors have the necessary knowledge to make applications for an Offender Reporting Order as a matter of course for serious offences against children that are not prescribed offences, even if they do not proceed to trial by virtue of a guilty plea.</p>	<p>Director of Public Prosecutions; and Queensland Police Service</p>	<p>Accept</p> <p>The Queensland Police Service (QPS) Child Protection Offender Registry is collaborating with the Office of the Director of Public Prosecutions (ODPP) (legal training unit) to develop a video recorded information training session, which outlines the application of offender reporting orders and prohibition orders under the <i>Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004</i>. The recorded training session will be provided to ODPP for delivery to its staff.</p>
<p>Recommendation 19 Review of supports and referral pathways of employers</p> <p>That the Queensland Government review existing responses that provide support, practical advice and referral pathways for families and friends concerned about loved ones who may be at risk of domestic and family violence, and employers who identify that their staff may be experiencing domestic and family violence, in order to ensure the state-wide availability and accessibility of dedicated supports in this area.</p>	<p>Department of Child Safety, Youth and Women</p>	<p>Accept</p> <p>The Government is reviewing the existing responses and pathways (including non-government support services sector) to consider appropriateness and whether there is a need for alternative supports.</p> <p>Over the past three years, the Department of Child Safety, Youth and Women (DCSYW) has commissioned a state-wide network of Family and Child Connect Services, extra family intervention services, and Indigenous Family Well-being Services. These services are linking with specialist domestic and family violence services and receiving referrals (including self-referrals) for families where domestic and family violence is an issue.</p> <p>DCSYW is developing a new 'digital self-service' website to act as a central place for information about domestic and family violence. This website will be a resource for victims, perpetrators, friends and family, employers and the general public. It will draw together the wealth of information and resources currently available across multiple government and non-government websites and make information readily and easily accessible.</p> <p>This work will complement the provision of Referral Pathways for employers by the Public Service Commission's work delivered under the Queensland Government's implementation of recommendations of the Special Taskforce on Domestic and Family Violence Final Report.</p> <p>Additionally, the Government has released the Domestic and Family Violence Prevention Engagement and Communication Strategy which includes a Bystander awareness campaign.</p>

Recommendations	Lead Agency	Proposed response
<p>Recommendation 20 Aboriginal and Torres Strait Islander family violence strategy</p> <p>That the Queensland Government, in partnership with community Elders and other recognised experts, develop a specific Aboriginal and Torres Strait Islander family violence strategy as a matter of urgent priority.</p> <p>This work should be informed by the Queensland Government’s Supporting Families Changing Futures reforms, Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2039 and Changing Tracks: An action plan for Aboriginal and Torres Strait Islander children and families (2017-2019).</p> <p>The strategy should:</p> <ol style="list-style-type: none"> be led and implemented by Elders and the community be informed by evidence and account for the various drivers perpetuating family violence focus on cultural strengths and family-centred services and programs recognise and seek to address the unique construct, challenges and co-morbidities of this type of violence have an urban focus as well as addressing the needs of regional and discrete communities complement broader domestic and family violence strategies and others of relevance including health, justice, education and child protection strategies where appropriate embed trauma-informed approaches that recognise historical and contemporary issues include a tertiary response but provide equal focus and investment on primary prevention and early intervention include primary prevention strategies for Aboriginal and Torres Strait Islander children which should be developed in consultation with young people to ensure their needs are met be sustainably and sufficiently funded, noting the cost benefit to be accrued through reducing the burden on resource intensive services such as emergency departments and child safety services include allied, wrap-around services to support the development and implementation of the strategy be formally monitored and independently evaluated using culturally appropriate outcome measures, methodologies and providers. This should include a strong focus on building the evidence base and data around what works in this area be publicly reported at regular intervals to increase accountability. This should include tracking the investment to ascertain whether it is proportionate to the current investment in crisis response. be supported by a governance body to oversee a co-design approach to the development and implementation of this strategy. 	<p>Department of Child Safety, Youth and Women; and</p> <p>Department of Aboriginal and Torres Strait Islander Partnerships Accept in principle</p>	<p>Accept in principle</p> <p>The Government acknowledges the Board’s call for change to respond to Aboriginal and Torres Strait Islander family violence, recognising the impact of dispossession, the breakdown of kinship networks, child removal policies and entrenched disadvantage, as well as intergenerational trauma and grief, on Aboriginal and Torres Strait Islander families and communities.</p> <p>The Government is exploring options for progressing this recommendation in partnership with stakeholders, building on existing initiatives under the Domestic and Family Violence Prevention Strategy 2016-26 such as Community Justice Group enhancements and Integrated Service Response Trials.</p>

Recommendations	Lead Agency	Proposed response
<p>Recommendation 21 Extended culturally informed family responsive alcohol and other drug treatment options</p> <p>That the Queensland Government extend upon culturally informed, family responsive alcohol and other drug treatment options, to ensure they include options for residential treatment or outpatient support and provide ongoing care as part of the treatment program.</p>	<p>Not applicable.</p>	<p>Noted.</p> <p>The Government notes this recommendation given that predominantly drug and alcohol treatment services are funded by the Commonwealth Government through primary health care and targeted Aboriginal and Torres Strait Islander Health funding initiatives.</p>

Domestic and Family Violence
Death Review and Advisory Board

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