Domestic and Family Violence Death Review and Advisory Board

Procedural Guidelines

2016-19

Queensland's reform program to end domestic and family violence

Queensland Government

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Acknowledgements

The *Domestic and Family Violence Death Review and Advisory Board Procedural Guidelines 2016-19* is informed by the collective knowledge and experiences of the many domestic and family violence, and child, death review processes that operate for the purposes of reducing the prevalence of these types of deaths.

The Board acknowledges the work of these teams in informing the development of this death review process and guidelines, particularly the:

- Queensland Domestic and Family Violence Death Review Advisory Group
- Ontario Domestic Violence Death Review Committee
- Virginia Domestic Violence Advisory Committee and Teams
- Australian Domestic and Family Violence Death Review Network.

Foreword

The Queensland Government is taking action to end domestic and family violence with the new *Domestic and Family Violence Prevention Strategy 2016-2026* which aims to drive change across all sectors of the Queensland community.

It sets the direction for collaborative partnerships between government, community and other sectors, outlining a shared vision and core principles to guide action. It also places the safety of victims and their children at the heart of all efforts to address and prevent domestic and family violence, and outlines how we will both support victims and their children, and engage with those responsible for the violence.

In Queensland approximately 45 per cent of all homicides occur within a domestic or family relationship. Between 1 January 2006 and 31 December 2015 this equated to 236 women, men and children killed by a family member, or by a person in which they were, or had been, in an intimate partner relationship with. Women continue to be overrepresented as victims in intimate partner homicides, while over 80 per cent of all offenders in these cases are male. In the vast majority of these deaths a previous history of violence and abuse was identifiable, as were opportunities for intervention by services and agencies prior to the death.

At a national and state level, governments have renewed their commitment to preventing domestic and family violence related deaths through a greater examination of the events preceding the death to inform service and practice improvements across sectors. The Second Action Plan of the *National Plan to Reduce Violence against Women and their Children 2010-2022* committed to driving continuous improvement in systems through reviewing domestic and family violence-related deaths and child deaths.

At a state level the Queensland Government has established the Domestic and Family Violence Death Review and Advisory Board as part of the implementation of wide-reaching recommendations from the Special Taskforce on Domestic and Family Violence's Final Report (2015), *Not Now, Not Ever: Putting an End to Domestic Violence in Queensland.* The Queensland Government has allocated $2.067 million over four years to support the Board's establishment and to increase staffing of the Domestic and Family Violence Death Review Unit within the Coroners Court to improve the systemic review of these types of deaths.

However government cannot achieve change alone and it is only through our collective efforts that we can break this cycle of violence. Together we can learn from these tragedies and work towards ensuring that the system protects victims of domestic and family violence while holding perpetrators accountable, with the ultimate aim of preventing future deaths.

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

Our thoughts remain with those who have lost their lives to domestic and family violence, and our sympathies with the loved ones who are left behind, their lives forever changed by their loss.

Overview

Currently Queensland has a two-tiered domestic and family violence death review process consisting of:

- **Tier 1:** the *Domestic and Family Violence Death Review Unit* that assists Coroners in understanding the context and circumstances of these types of deaths
- **Tier 2:** the independent multidisciplinary *Domestic and Family Violence Death Review and Advisory Board*, (the Board) that is responsible for the systemic review of domestic and family violence deaths.

This document is intended to support the Board by outlining its role and function in accordance with the *Coroners Act 2003*, and discussing the domestic and family violence death case categorisation and review process in Queensland.

These guidelines should be read in conjunction with the *Coroners Act 2003* and *the Memorandum of Understanding between the Domestic and Family Violence Death Review and Advisory Board and State Coroner* (Administrative Arrangements).

Domestic and family violence death review mechanisms are based on the premise that these types of fatalities are rarely without warning. They are generally preceded by violent or abusive incidents indicating a heightened risk of future harm, as well as missed opportunities for agencies and individuals to intervene before the death. It is because of these indicators that these deaths are considered some of the most preventable. The lessons from these reviews have shown to be invaluable in informing the development of more effective interventions, improving the service system through recommendations for change and preventing future deaths in similar circumstances.

Although there are many different types of domestic and family violence death review mechanisms, most have a number of shared principles and underlying philosophies.[1] Fatality review mechanisms all share the aim of improving a community's response to domestic and family violence by identifying systemic shortcomings and opportunities to prevent future deaths.

Fatality reviews do not assign blame to any agency or individual's action or inaction prior to the death, nor do they seek to reinvestigate a case. Engendering a culture of open-mindedness and non-defensiveness towards the review process encourages an in-depth analysis of the key issues, and the responses of services and systems prior to the death, and enhances the flow of information amongst relevant team members.

While conducting case reviews it is important to remember that the perpetrator is responsible for the violence. Fatality review focus on improving systemic responses to domestic and family violence, but the perpetrator, not the system, must be recognised as the cause of the problem. Similarly, it is important for fatality reviews to shift a focus away from victim blaming, and the actions of victims in response to their experiences of violence, and reorientate a focus to the response of the service system and community to domestic and family violence. Death review processes across jurisdictions consistently encompass most, if not all of the following steps (Figure 1).

[1] Virginia Department of Health (2009) Fatality and Intimate Partner Violence Fatality Review Team Protocol and Resource Manual, 3rd ed. Office of the Chief Medical Examiner

Figure 1: Steps of a death review process

Step 1	**Case identification**	This requires the development of a surveillance and monitoring system of relevant reportable death categories (i.e. homicide, suicide, murder-suicide) to capture those deaths that may meet the criteria for review.
Step 2	**Data collection**	Relevant case information is uploaded into a database, with a case file started for each death.
Step 3	**Triaging**	A determination is made, based on a preliminary review of available information what action should be taken on a file, or what additional information is required to inform the review process.
Step 4	**Case preparation**	Information is gathered in relation to the death within the format relevant to the review process.
Step 5	**Review**	The team reviews a case, and may require further information, action or follow up.
Step 6	**Development of recommendations**	Consideration is given to the circumstances of the case and ways to address systemic issues identified through making recommendations for change.
Step 7	**Compilation of review outcomes**	Results are compiled by a coordinator based on the discussions of the review team, including identified issues and recommendations.
Step 8	**Database management**	Data from the reviews after they have been completed is uploaded into the database.
Step 9	**Data analysis and research**	Data collected through the review process is aggregated and analysed to identify trends and issues across cases, and generally contextualised within relevant research. This data is may also be made publicly available through Annual Reports with accompanying case summaries and recommendations.
Step 10	**Monitoring of recommendations**	The implementation of recommendations is monitored across agencies, generally by the death review team, and is often reported publicly as a means to hold agencies accountable for implementation.

Section 1

Roles and responsibilities

This section outlines the investigation and review process for domestic and family violence related deaths in Queensland and considers the different roles and responsibilities of:

- *coroners* in their investigation of reportable deaths, to determine the identity of the deceased, how, when and where they died and their consideration of ways to prevent similar deaths from occurring in the future
- the *Domestic and Family Violence Death Review Unit* that assists coroners in understanding the context and circumstances of these types of deaths, and that provides secretariat support to the Domestic and Family Violence Death Review and Advisory Board
- the *Domestic and Family Violence Death Review and Advisory Board*, that is responsible for systemic reviews of domestic and family violence deaths to identify systemic issues and to make recommendations to improve systems, practices and procedures.

Role of the coroner

Under the *Coroners Act 2003* coroners are responsible for investigating reportable deaths that occur in Queensland. A 'reportable death' includes deaths that:

- were violent or unnatural, such as accidents, homicides, suicides or drug overdoses
- were sudden or happened in suspicious circumstances
- occurred in custody or care or as a result of police operations.

It also includes 'health care related deaths' which represent a substantial proportion of cases that proceed to inquest.[2]

There are seven coroners in Queensland: the State Coroner who oversees and coordinates the Queensland coronial system, the Deputy State Coroner and five regional coroners.

Pursuant to section 45 of the *Coroners Act 2003*, when a death is reported the coroner must investigate a death to find out the identity of the deceased person, when and where they died, how they died and the medical cause of death.

[2] Medical deaths refers to deaths where the person would not have died at the time of their death if the health care had not been provided or where a failure to provide health care contributes to a person dying where they would not have if they had have received the health care.

For matters that proceed to inquest, as prescribed in section 46, a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future.

The coronial investigation

A coronial investigation may take months or years depending on the context and circumstances of the death, and whether expert advice and assistance is required to assist the coroner in their investigation.

The coroner controls and coordinates each step of the investigation and police are required to assist with these investigations (as outlined in Figure 2).[3]

Figure 2: Steps of a coronial investigation

Step 1	The death is reported to the coroner, usually by police who will have attended the scene and obtained some initial information about the death from family members, friends and witnesses. Police are required to prepare an initial report (called a Form 1) for the coroner.
Step 2	Police arrange for the government contracted funeral director to take the deceased to a mortuary.
Step 3	The coroner requires the deceased person to be formally identified before they can be released to the family for the funeral. The coroner will order a partial or full autopsy to be conducted to help find out how and why the person died.
Step 4	Police assist the coroner to investigate the death. After considering the Form 1 the coroner may ask police to conduct further investigations. This might include obtaining medical records and taking further statements from witnesses.
Step 5	Once the autopsy is complete and the coroner is satisfied that it is not necessary to retain the body for further examination or tests, the deceased can be released for the family for burial or cremation.
Step 6	The coroner has wide powers of investigation and can request additional reports, statements or information about the death. Additional information may be obtained from investigators, police, doctors, engineers, workplace health and safety inspectors, mining inspectors, or other witnesses, such as families and friends of the deceased person.
Step 7	Once the coroner has completed these enquiries they will consider whether to hold an inquest into the death. Interested parties, such as family members, can also request that the coroner hold an inquest.
Step 8	At the end of the investigation the coroner must make written findings and they are required to include, where possible, the identity of the deceased and when, where and how they died and what caused them to die.

[3] Under s.794(2) of the *Police Powers and Responsibilities Act* (Qld) police are required to comply with every reasonable and lawful request, or direction, of a coroner.

Inquests

The *Coroners Act 2003* provides for both mandatory inquests such as deaths in custody and certain deaths in care, as well as discretionary inquests, where a coroner may decide to hold an inquest if they believe it is in the public interest to do so.

When an inquest is held, the coroner may make recommendations about broader issues connected with the death which are aimed at preventing similar deaths from occurring in the future.

For example, the coroner might make recommendations about improving hospital procedures, safety standards or road signage. During the inquest the coroner can receive expert evidence on which to base such recommendations.

Despite the common perception that many reportable deaths proceed to inquest, inquests are held into only a small percentage of the total number of deaths reported to coroners each year. Coroners also cannot hold an inquest into a particular death where criminal proceedings are ongoing.

Domestic and family violence related deaths represent only a very small proportion of the total number of reportable deaths in Queensland each year.

For example, in 2013-14 4,682 deaths were reported to the Coroners Court of Queensland, and only 62 were identified as potentially domestic and family violence related (including homicides, suicides and other relevant deaths).

The Domestic and Family Violence Death Review Unit

The Domestic and Family Violence Death Review Unit (the Unit) was established in 2011 and is embedded within the Coroners Court of Queensland. The Unit assists coroners by ensuring that information about the broader context within which the death occurred is gathered and examined.

The Unit also assists in the identification of systemic shortcomings and, for matters that proceed to inquest, informs the development of preventative recommendations as required.

Being based in the Coroners Court, the Unit has the capacity to review both open cases (cases which are currently subject to coronial investigation) and closed cases (cases where the coronial investigation has been finalised).

The Unit also maintains a dataset of all homicides that have occurred within an intimate partner or family relationship in Queensland since 2006 to assist in the monitoring and identification of any patterns or trends in these types of deaths.

The scope of the Unit was expanded in 2014 as part of the implementation of recommendations from the Child Protection Commission of Inquiry (2013), to include additional resourcing to assist coroners in their investigations of child deaths where there has been contact with the child protection system prior to the death.

In 2015, as part of the 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',* the Unit received additional resourcing to fulfil its functions and support the Domestic and Family Violence Death Review and Advisory Board. Following the establishment of the Board the Unit is required to support both coroners with their investigations into relevant reportable deaths, and the Board in the performance of its statutory functions.

Where applicable the Unit will also provide secretariat support to the Board, be tasked by the Board with further information-gathering to inform its systemic review function, and compile reports for the Board's consideration as required.

The Domestic and Family Violence Death Review and Advisory Board

In its *Not Now, Not Ever* report, the Special Taskforce on Domestic and Family Violence recognised that while the Unit played a valuable role with respect to providing advice and assistance to coroners regarding their investigation of domestic and family violence related deaths, that there was a need for a comprehensive review structure to look at the system as a whole. While coroners consider the systemic failures that may have occurred prior to the death, inquests are only held for a small proportion of these deaths and coroners are required to consider each death in isolation.

The Taskforce recommended that in consultation with key domestic violence stakeholders, the Queensland Government immediately establish an independent domestic and family violence death Review board, consisting of multi-disciplinary experts, to:

a) Identify common systemic failures, gaps or issues and make recommendations to improve systems, practices and procedures
b) report regularly to the oversight body on these findings and recommendations[4]
c) be supported by, and draw upon, the information and resources of the Domestic and Family Violence Death Review Unit.[5]

The Taskforce recommended that the Board be focused on system improvement and accountability, be comprised of multi-disciplinary experts from relevant fields, and have the capacity to report findings of systemic failures and make recommendations for improvement. The Taskforce identified that the Board would require support from the Domestic and Family Violence Death Review Unit, and should have the capacity to access information from government and non-government agencies.[6]

The Domestic and Family Violence Death Review and Advisory Board (the Board) is responsible for the systemic review of domestic and family violence deaths that have occurred in Queensland, with its

[4] This was originally intended to be every six months, however consultation as part of the implementation of this recommendation revealed that every 12 months would likely improve outcomes for the Board
5 Special Taskforce on Domestic and Family Violence in Queensland. (2015). *Not Now, Not Ever*, Recommendation 8, p 19.
[6] Not Now, Not Ever, pp 114-115

role and function outlined within the *Coroners Act 2003*. The Board has a range of statutory functions including to:

- analyse data and apply research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland and to carry out, or engage other persons to carry out, research to prevent or reduce the likelihood of these types of deaths

- use data, research findings and expert reports to compile systemic reports into domestic and family violence deaths, including identifying key learnings and elements of good practice in the prevention of domestic and family violence deaths in Queensland

- make recommendations to the Minister about improvements to legislation, policies, practices, services, training, resources and communication to prevent or reduce the likelihood of domestic and family violence deaths in Queensland, and to monitor the implementation of these recommendations.

In reviewing deaths, the function of the Board is to identify systemic issues, not to investigate the circumstances of an individual death. Consequently, in practice, when the Board reviews deaths it will rely on the information that is gathered by a coroner's investigation, predominantly through case review reports and chronologies completed by the Unit in the first instance.

It is intended that the Board will review these types of deaths collectively across cases and will consider common themes and issues that occur in different types of deaths, for example: murder suicides, Aboriginal and Torres Strait Islander family violence related deaths, intimate partner homicides, suicides of perpetrators of domestic and family violence, or deaths where there has been recent contact with different systems or services.

The Board has the statutory authority to gather further information should it consider it necessary to do so. Further information regarding the Board's function, responsibilities and scope is outlined in Section 4: Governance.

Fatality reviews can reveal trends and may lead to changes to the system that could prevent future deaths.
They may also enhance any prevention and intervention programs aimed at reducing deaths related to domestic and family violence.[7]

[7] Websdale, N. Reviewing Domestic Violence Deaths, NIJ Journal, Issue No. 250

Section 2

Case identification and selection

'Domestic and family violence related deaths' include homicides and murder-suicides which have occurred within a domestic and family relationship, bystander homicides, and perpetrator or victim suicides where there is a known history of domestic and family violence. For the purposes of the Board's function, the definition of a 'domestic and family violence death' is outlined within the *Coroner's Act 2003* (the Act).[8]

Identifying these cases is not always simple, particularly for suicides where the link between the death and domestic and family violence is not clear or there are a range of other contributing factors or precipitating events. The definitions and processes for the identification of relevant deaths are discussed in this section.

Definition of a 'domestic and family violence death'

The term 'domestic and family violence death' is defined in section 91B of the *Coroners Act 2003* to include the death of a person caused by a person (the second person) if both people were, or had been, in a relevant relationship that involved domestic and family violence.

For the purposes of the Board's function, the Act defines domestic and family violence deaths as the death of a person caused by a second person if:

- the deceased person was or had been in a relevant relationship with the perpetrator that involved domestic and family violence
- at the time of death, the deceased person was in a relevant relationship with a person who was or had been in a relationship with the perpetrator that involved domestic and family violence
- at the time of death, the perpetrator mistakenly believed the deceased person was in a relevant relationship with a person who was or had been in a relevant relationship with the perpetrator that involved domestic and family violence
- at the time of death, the deceased person was a witness to, or present at, or attempted to intervene in domestic and family violence between the perpetrator and the person who had been in a relationship with the perpetrator (or mistakenly believed was in a relevant relationship with the perpetrator).

A domestic and family violence death also includes a suicide or suspected suicide if the person was or had been in a relevant relationship with another person that involved domestic and family violence. The term 'relevant relationship' is defined in section 13 of the *Domestic and Family Violence Protection Act 2012* and includes an intimate personal relationship, family relationship or informal care relationship.

[8] *Coroners Act 2003* (Qld), s 91B

Specifically, an intimate personal relationship is:

(a) a spousal relationship; or
(b) an engagement relationship, or
(c) a couple relationship.[9]

A spousal relationship includes:

(a) a current or former spouse of the person; and
(b) a parent, or former parent, of a child of the person.[10]

An engagement relationship exists between two persons if the persons are, or were, engaged to be married to each other, including a betrothal under cultural or religious tradition.[11]

A couple relationship exists between two people if the persons have, or had, a relationship as a couple, with consideration given to the degree of trust between the persons, and the level of each person's dependence on, and commitment to the other person. It also includes consideration of the length of the relationship, the frequency of contact and degree of intimacy between the persons. It does not exist merely because two persons date, or dated each other on a number of occasions.[12]

A family relationship exists between two persons it 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 to 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-brother, mother-in-law or aunt-in-law.[13]

An informal care relationship exists between two persons if one of them is or was dependent on the other person (the carer) for help in an activity of daily living. It specifically excludes those circumstances in which the assistance is provided under a commercial arrangement.

The term 'domestic and family violence' is defined by section 8 of the *Domestic and Family Violence Protection Act 2012* and 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.[14]

[9] *Domestic and Family Violence Protection Act* (Qld), s 14
[10] *Domestic and Family Violence Protection Act* (Qld), s 15
[11] *Domestic and Family Violence Protection Act* (Qld), s 17
[12] *Domestic and Family Violence Protection Act* (Qld), s 18
[13] *Domestic and Family Violence Protection Act* (Qld), s 19
[14] *Domestic and Family Violence Protection Act* (Qld), s 8(1)

This may include, but not be limited to:

(a) causing personal injury to a person or threatening to do so
(b) coercing a person to engage in sexual activity or attempting to do so
(c) damaging a person's property or threatening to do so
(d) depriving a person of the person's liberty or threatening to do so
(e) threatening a person with the death or injury of the person, a child of the person or someone else
(f) threatening to commit suicide or self-harm so as to torment, intimidate or frighten the person to whom the behaviour is directed
(g) causing or threatening to cause the death of, or injury to, an animal whether or not the animal belongs to the person to whom the behaviour is directed so as to control, dominate or coerce the person
(h) unauthorised surveillance of a person
(i) unlawfully stalking a person.[15]

Case selection

While these deaths are statistically relatively rare, a domestic and family violence related death is a sentinel event that can be used to identify systemic shortcomings and enhance our understandings of potential risks to others.

A death review team's capacity to identify systemic shortcomings and potential risks is enhanced with the number of cases that are reviewed, and it is important to recognise, and build upon, this collective knowledge.

An initial step, and a key consideration of all death review teams, is determining which cases will be reviewed. This is influenced by such factors as the total number of deaths in the jurisdiction, the manner and cause of death, the capacity to access relevant case information, the frequency of team meetings and the capacity of the team.[16]

While the *Coroners Act 2003* outlines the definition of a 'domestic and family violence death' and is sufficiently broad to allow the Board to consider a range of different deaths, operationally it is not always a simple process to identify those matters that will be subject to review.

As outlined within the State Coroner's Guidelines, the Unit uses a broader definition of a 'domestic and family violence related death' to ensure that cases are proactively identified and considered by the Unit for review. This definition includes:

- homicides or murder suicides which have occurred within the context of an intimate partner, family or informal care relationship as defined by the *Domestic and Family Violence Protection Act 2012*

- 'bystander homicides' such as 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

[15] *Domestic and Family Violence Protection Act* (Qld), s 8(2)
[16] National Centre for Child Death Review (2005) A *Program Manual for Child Death Review: Strategies to Better Understand Why Children Die and Taking Action to Prevent Child Deaths*. The Michigan Public Health Institute

- child suicides or homicides where there was a history of domestic violence between the child's parents or caregivers or an intimate partner of one

- suicides of a victim or perpetrator of domestic and family violence where there is a clear link between the suicide and history of domestic and family violence, such as an incident of violence within close proximity of the death.

Coroners may also refer any death they consider as domestic and family violence related to the Unit for review.

In the experience of the Unit, considering deaths in clusters that share similar characteristics enables a more comprehensive analysis of key issues and themes.

There are three different categories of domestic and family violence related deaths which are grouped based on the relationship between the deceased and offender, and the type of death, specifically:

1. **Domestic and family violence related homicides** which include: intimate partner homicides, homicides in a family relationship,[17] bystander homicides and filicides.[18]

2. **Domestic and family violence related suicides** which include: perpetrator suicides, suicides of victims of domestic and family violence, and child suicides where there has been a previous history of domestic and family violence between the parents or primary caregivers.

3. **Murder suicides which occur within a domestic and family violence context** and that share similar characteristics with both domestic and family violence related homicides and suicides.

Further, in some cases a victim of domestic and family violence may kill the primary perpetrator of the violence, and records may indicate that both parties engaged in acts of violence on various occasions. Therefore for the purposes of the review process the following definitions apply:

- **deceased:** the person/s who died
- **offender:** the person whose actions, or inaction, caused the person (the deceased) to die
- **victim:** the person who was the primary victim of the domestic and family violence in the relationship and the person most in need of protection
- **perpetrator:** the person who was the primary aggressor in the relationship prior to the death and who used violence within the relationship to control the victim.

Cases excluded from the review process include homicides and suicides that have occurred within a domestic or family relationship but where it is not possible to establish a prior history of domestic and family violence and there are other clear precipitating events or causal circumstances.

[17] Excluding filicides which generally have a unique set of characteristics in comparison to situations, for example, in which a brother murders another brother and there had been incidents of violence between them previously.
[18] These types of deaths are often the most difficult to ascertain the true circumstances of the event, and may be subject to lengthy police and coronial investigations which aim to gather enough information to prosecute a family member in relevant circumstances. Autopsy reports are often delayed due to the complexity of the pathologist's consideration in relation to cause of death or other factors.

When conducting a review into a domestic and family violence related death, the principles of the *Domestic and Family Violence Protection Act 2012* are considered with respect to any agency's action or inaction prior to the death.

These principles are:

- the safety, protection and well-being of people who fear or experience domestic and family violence, including children, are paramount
- that people who fear or experience domestic and family violence, including their children, should be treated with respect and disruption to their lives minimised
- perpetrators of domestic and family violence should be held accountable for their use of violence and its impact on other people, and if possible provided with an opportunity to change
- if people have characteristics that may make them particularly vulnerable to domestic violence, any response to this domestic violence should take into account these characteristics. Vulnerable persons include women, children, Aboriginal and Torres Strait Islanders, people from culturally or linguistically diverse backgrounds, people with a disability, and people who are lesbian, gay, bisexual, transgender or intersex.

Domestic and family violence related homicides

As a standing member of the Australian Domestic and Family Violence Death Review Network, the Unit adopts the national definition of a domestic and family violence related homicide.[19]

The definition of 'homicide' adopted by the Network is broader than the legal definition of the term. 'Homicide', as it is defined by the Network, includes all circumstances in which an individual's intentional 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.

The Network's Consensus Statement also recognises that not all homicides that occur within a domestic or family relationship are, upon analysis, 'domestic and family violence related' as there may be other factors which determine the fatal incident such as the offender experiencing an acute mental health episode or assisted suicide.

These types of deaths do not feature many of the characteristics that define domestic and/or family violence relationships, such as controlling, threatening or coercive behaviour, having previously caused the other person to feel fear, or evidence of past physical, sexual, emotional, psychological or financial abuse.

[19] The full Australian Domestic and Family Violence Death Review Network Homicide Consensus Statement is attached in Appendix A.

To assess homicides as domestic and family violence related, the Unit uses the following case categorisation process:

Figure 3: Homicide categorisation process

Level 1	No indicators of domestic and family violence can be identified and other contributing factors such as an acute psychotic episode are identifiable.
Level 2	There is some evidence of previous domestic and family violence between the deceased and/or perpetrator or some history of domestic and family violence in previous relationships.
Level 3	Clear history of domestic and family violence between the deceased and/or perpetrator, or a known history of multiple incidents of domestic and family violence in previous relationships.
Level 4	Significant history of domestic and family violence between the deceased and/perpetrator, from both a criminal justice and non-criminal justice system perspective.
Level 5	Extreme history of domestic and family violence between the deceased and/or perpetrator, significant precipitating events suggesting this death was potentially imminent and there was recent system contact or missed opportunities for intervention in immediate proximity to the death.

The Unit will conduct a preliminary review of a suspected domestic and family violence related death to ascertain whether it meets criteria for a review. For those cases identified as 'Level 1' the matter is monitored but not actively reviewed. Once the coronial investigation has progressed further and all evidence has been received the material is reviewed and uploaded into the Unit's statistical database.

No further action is taken by the Unit on these files, given they do not meet the definition of a domestic and family violence death.

In practice these represent a very small percentage of deaths that come to the attention of the Unit. While it is the case that there may have been elements of domestic and family violence within this relationship that went undetected by service providers, or family, friends and other witnesses, in the absence of any identifiable domestic and family violence, and the presence of other clear motivating factors, these cases are difficult to analyse and review with respect to the consideration of any missed opportunities for intervention or opportunities to prevent future deaths. This is because they do not exhibit the patterns of behaviour, or help seeking, generally identifiable in domestic and family violence related deaths.

Domestic and family violence related suicides

In contrast to domestic and family violence related homicides, it is not always possible to establish a clear causal link between the deceased person's experience of domestic and family violence (as either a victim or perpetrator) and their suicide.

Suicide is the act of intentionally killing oneself. For a coroner to make a finding of suicide they have to consider two elements based on the available evidence: that the deceased intentionally performed the action that directly led to their death, but also that they understood that their death was a likely consequence of the action. This may include considering the deceased's capacity at the time that the action was taken, for example whether they were particularly intoxicated or had a mental health condition which impaired their capacity to be able to reasonably foresee the consequences of their action.

The relationship between suicide and domestic and family violence is complex, with the deceased potentially being the victim, perpetrator or witness of interpersonal violence.

Being the victim of domestic and family violence is significantly associated with suicidal behaviours, including completed suicide. Research indicates that intimate partner violence is a significant risk factor for suicidality in female victims, with some evidence suggesting that women who have been abused by their intimate partners are almost four times more likely to express suicidal ideation compared to women in the general population.[20]

Likewise, perpetrators of domestic violence are also at increased risk of suicidal behaviours, though this relationship is not well understood. Suicide by a perpetrator can also accompany intimate partner homicide in some cases. Domestic violence history is also an indicator of familicide-suicide. Exposure to domestic and family violence in childhood is a significant risk factor for suicide among children and young people[21] and persists into adulthood.[22] The greater the severity of domestic and family violence, the greater the risk of suicide.[23]

To determine ways in which to categorise and review domestic violence related suicides, the Unit has explored issues surrounding the capacity to identify a suicide as domestic or family violence related when there are often a diverse range of other risk or contributory factors present. Following a review of a number of suicides that include a history of domestic violence, the most common interrelated factors identified by the Unit in this cluster of deaths included:

- mental health issues such as depression, anxiety and post-traumatic stress disorder
- drug and/or alcohol abuse
- relationship breakdown
- financial crises
- situational crises.

There are also a substantial number of cases that come to the attention of the Unit of suicide and murder-suicide of men with a history of perpetrating domestic or family violence that had occurred in the context of legal intervention, such as being issued with a notice to appear or a protection order. For those cases that are referred to the Unit, an assessment of the death is made based on available witness statements and the information gathered via QPRIME, to ascertain whether there has been a

[20] Taft, A (2003) 'Promoting Women's Mental Health: The Challenges of Intimate/Domestic Violence Against Women', *Australian Domestic and Family Violence Clearinghouse Issues Paper* (8) UNSW, Sydney.
[21] Fleming, T.M., Merry, S.N., Robinson, E.M., Denny, S.J., & Watson, P.D. (2007). Self-reported suicide attempts and associated risk and protective factors among secondary school students in New Zealand. *Australian and New Zealand Journal of Psychiatry, 41,* 213-221.
[22] Rajalin, M., Hirvikoski, T., & Jokinen, J. (2013). Family history of suicide and exposure to interpersonal violence in childhood predict suicide in male suicide attempters. *Journal of Affective Disorders, 148,* 92-97.
[23] McLaughlin, J., O'Carroll, R.E., & O'Connor, R.C. (2012). Intimate partner abuse and suicidality: a systemic review. *Clinical Psychology Review, 32,* 677-689.

police-recorded history of domestic or family violence. A recommendation is then made to the investigating coroner about whether or not the case should be progressed for further investigation and review. The Unit uses the following case categorisation process for domestic and family violence related suicides.

Figure 4: Suicide case categorisation process

Level 1	As all suspected suicides are monitored routinely to identify those that are potentially domestic and family violence related, level 1 cases are those in which there is no identifiable history of domestic and family violence.
Level 2	Some previous history of domestic and family violence however no recent incident identifiable and very clear evidence of other causative and complex factors. For example, mental health issues such as depression, anxiety and post-traumatic stress disorder (PTSD), drug and/or alcohol abuse, relationship breakdown, financial crises and/or situational crises.
Level 3	Recent domestic and family violence incident (as the victim or perpetrator) and/or extensive history of domestic or family violence, with the absence of more salient risk factors/triggers. For example, no history of mental health or other situational crisis.
Level 4	Very clear proximate relationship between suicide and history of domestic and family violence, as well as recent systemic contact or missed opportunities for intervention. For example, domestic or family violence is indicated in a suicide note, or the deceased disclosed to a friend/family member their intent to suicide due to domestic or family violence, or the deceased sought support from services related to domestic and family violence.

Suicides identified as Level 1 and 2 comprise the vast majority of cases assessed by the Unit. They are noted but not reviewed by the Unit as the circumstances are complex and no direct link can be identified between the deceased's experience of domestic and family violence and the suicide.

A full overview of the case review process for domestic and family suicides is outlined in Section 3.

Section 3

Case reviews

The Unit has established processes to assist coroners in their review of domestic and family violence related deaths which are intended to align with the broader coronial investigation and case management process, and for homicides, the police investigation into the criminal elements of the death.

It is important to remember that the purpose of the coronial investigation is to determine who the deceased person is, how the person died, when the person died, where the person died and what caused the person to die. The consideration by a coroner of whether a particular death may have been preventable is in addition to these other determinations, and is of specific relevance when a coroner is considering whether it may be in the public interest to hold an inquest.

To inform this decision-making process, coroners may consider whether there were any systemic shortcomings or missed opportunities for intervention prior to the death, and whether these issues may have been addressed by legislation, policy or practice changes since the death occurred.

This means that the involvement of the Unit with individual cases that have been identified as 'domestic and family violence related' may differ depending upon a variety of factors, including at what stage of the coronial investigation a case is referred for review, or the complexity of broader issues in the case.

Preliminary review

To identify relevant deaths the Unit routinely monitors all reportable deaths in Queensland to identify those that may be domestic and family violence related.

Once a relevant case is identified, information is gathered, with the assistance of a dedicated Detective Senior Sergeant attached to the Unit, regarding any known police history of domestic and family violence between the victim and/or perpetrator, including from previous relationships.

The availability of records at this stage is relatively limited and will be based primarily on the Form 1: Police Report to Coroner and, where there has been contact with police prior to the death in relation to domestic and family violence for either the victim and/or perpetrator, police records relating to this history (including in previous relationships) or any known history of violence (e.g. convictions for assault or grievous bodily harm).

For a significant proportion of domestic and family violence related deaths that occur within an intimate partner or family relationship there may have been no prior contact with police in relation to domestic and family violence by either the deceased and/or the offender.

This should not however be considered a reliable indicator that there was no history of abuse within this relationship. It is often the case that victims have accessed support and assistance from health or social services, or from informal support networks such as family, friends or colleagues, in response to their experiences of violence.

In recognition of this, and to assist the coroner in their investigations, the Queensland Police Service Operational Procedures Manual contains provisions to guide police investigations of domestic and family violence related deaths.[24]

This may include, but not be limited to, gathering the following information:

- previous history of domestic or family violence between the victim and offender or with their former partners
- status of the relationship at the time of the death
- history of suicide threats or attempts
- drug or alcohol abuse or any known mental health issues
- factors related to the incident such as separation, a new partner, financial problems, custody issues or an upcoming court appearance
- history of stalking or obsessive behaviour
- previous threats to kill (including against children or other family members).

Witness statements and other records obtained during police investigations are invaluable in providing context regarding the history of the relationship between the victim and the perpetrator.

For homicides where the deceased has had contact with the police within reasonable proximity of the death, the investigating officer may also be required to complete a 'Homicide Audit' for the coroner in collaboration with the District Domestic and Family Violence Coordinator.

This audit considers any contact that the deceased or offender had with police prior to the death in relation to the domestic and family violence, and whether this contact was appropriate within the context of any relevant policies and procedures in place at the time. If it is determined that a deceased or offender had contact with a service in relation to their experiences of domestic and family violence, then the Unit will recommend to the coroner that records of this this be obtained in the majority of cases.

[24] Queensland Police Service. (2016). Operational Procedures Manual, Chapter 8 – Coronial Matters, Issue 50, https://www.police.qld.gov.au/corporatedocs/OperationalPolicies/opm.htm

This may include records from:

- Hospital and Health Services (emergency department records for trauma and abuse related admissions, mental health, alcohol and other drug treatment services, or maternity admissions)
- Queensland Ambulance Service
- general practitioners or health care providers who the deceased or offender are known to have contact with
- Queensland Corrective Services (including Probation and Parole)
- domestic and family violence specialist support services
- Department of Communities, Child Safety and Disability Services
- Department of Education and Training
- other relevant agencies.

Final review

Approximately eight to twelve months after the death, once there is sufficient information available, the Unit will provide a review to assist coroners to identify any issues warranting further investigation.

Based on analysis of this information, for domestic and family violence related homicides and suicides which are identified as level 2 by the Unit's categorisation process, any further review may be considered of limited benefit as there are no identifiable missed opportunities for intervention within reasonable proximity to the death and no additional avenues for investigation. Advice will be provided to the coroner accordingly and these matters will then be closed within the Unit, with relevant information uploaded into the Unit's statistical database.

For Level 3, 4 or 5 cases, after all relevant records have been received, the Unit will provide a final review to the coroner which provides a comprehensive analysis of:

- the context and circumstances of the death, including any relevant precipitating events
- the recorded history of domestic and family violence between the deceased and/or offender, including in previous relationships
- the identifiable contact that the deceased and/or offender may have had with different services, including the appropriateness and adequacy of this response considering relevant legislation, policies and procedures current at the time of service provision
- a range of broader issues relevant to the case (for example a victim's use of violence or reluctance to report violence, or the presence of a range of intimate partner lethality risk factors).[25]

As with other coronial investigations, timeframes for the completion of a review by the Unit can be dependent on the receipt of information from external agencies, and a final review can only be completed once these records have been received. In addition to material gathered during the preliminary review phase, information at this stage includes the brief of evidence for homicides or the

[25] Most research in relation to lethality risk factors have been in relation to intimate partner homicides and as such it is difficult to extend these factors to other types of deaths (i.e. deaths within a family violence relationship). A copy of the Domestic and Family Violence Death Review Unit Coding Form, based on that utilised by the Ontario Domestic and Family Violence Death Review Committee is available in the appendices.

coronial file for other types of deaths (e.g. for suicides, murder-suicides or deaths in custody or police operations).

The brief of evidence contains information gathered by police in the course of their criminal investigation into a homicide for the purposes of the prosecution of the offender. As such it is provided to coroners after the police investigation has been finalised, and generally after a committal hearing has been held.

If agency records have been requested during the preliminary stages of the coronial investigation, then these records are likely to be available at this time and used to inform the review. For child deaths that have been identified as domestic or family violence related, where there has been recent prior contact with the child protection system, a Service and Practice Review from the Department of Communities, Child Safety and Disability Services, and a Child Death Review Panel Report, may also be available. Once completed these reviews will be provided to the Board, together with other reviews of deaths in similar circumstances, to enable the consideration of relevant systemic issues across related deaths.

Section 4

Governance

This section outlines the functions of the Domestic and Family Violence Death Review and Advisory Board (the Board) and the relationship between the Board and the Coroners Court of Queensland.

Establishment of the Board

The Special Taskforce on Domestic and Family Violence in Queensland (the Taskforce) was established in 2014 to examine Queensland's domestic and family violence support systems and make recommendations to the Queensland Government on how the system could be improved and how to prevent domestic and family violence from occurring in the future.

In their final report, *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* (the Taskforce Report), the Taskforce recommended the establishment of an independent board of multi-disciplinary experts to identify common systemic failures, gaps or issues in domestic and family violence deaths and make recommendations to improve systems, practices and procedures.[26]

The Queensland Government accepted all of the Taskforce's recommendations and the Board was established in late 2015 by the *Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015*.

The Board is required to:

- identify preventative measures to reduce the likelihood of domestic and family violence related 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 domestic and family violence deaths occur, and
- make recommendations to the Minister for implementation by government and non-government entities to prevent or reduce the likelihood of domestic and family violence deaths.[27]

[26] Special Taskforce on Domestic and Family Violence in Queensland. (2015). *Not Now, Not Ever*, Recommendation 8, p 19.
[27] *Coroners Act 2003* (Qld), *s* 91

Functions of the Board

The Board must act independently and in the public interest in fulfilling its statutory functions.[28] The Board's functions are to:

- review domestic and family violence deaths in Queensland, including deaths that occurred before the Board's establishment, and deaths that are still being investigated under the *Coroners Act 2003*[29]
- analyse data and apply research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland
- carry out, or engage other persons to carry out, research to prevent or reduce the likelihood of domestic and family violence deaths
- use data, research findings and expert reports to compile systemic reports into domestic and family violence deaths, including identifying key learnings and elements of good practice
- make and monitor the implementation of recommendations to the Minister about improvements to legislation, policies, practices, services, training, resources and communication for implementation by government and non-government entities to prevent or reduce the likelihood of domestic and family violence deaths in Queensland.

Systemic review function

In undertaking a review, the Board must consider the following matters:

- the events leading up to each death
- any interaction with, and the effectiveness of, any support or other services provided to the deceased person and/or the person who caused the death
- the general availability of services
- failures in systems or services that may have contributed to, or failed to prevent, the death.[30]

It is not a function of the Board to carry out an investigation of a death.[31] Although the Board may examine individual case reports, this will only be for the purposes of its systemic review function.

It is intended that the Board will consider these types of deaths collectively across cases, to identify common themes and issues for different types of deaths, such as perpetrator suicides, or for certain vulnerable populations, such as Aboriginal and Torres Strait Islander people.

Relationship with the Coroners Court of Queensland

The Board is established under the *Coroners Act 2003* with the authority to undertake independent, timely and systemic reviews of domestic and family violence deaths in Queensland.[32]

Accordingly, it is intended that the Board will have the benefit of sharing the resources and expertise of the Domestic and Family Violence Death Review Unit, that will fulfil the Secretariat function for the

[28] *Coroners Act 2003* (Qld), *s* 91H
[29] The Board may perform its functions in relation to the death of a person who dies outside of Queensland if it is a reportable death mentioned in section 8(2)(b)
[30] *Coroners Act 2003* (Qld), s 91E
[31] *Coroners Act 2003* (Qld), s 91D(3)
[32] *Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015*, Explanatory notes, page 3

Board, and be responsible for ensuring data and information is shared in a timely and appropriate manner with both the Board and the coroners.

Independence and separation

The Board consists of multidisciplinary experts drawing on the research and data capabilities of the Unit, and other independently sourced research and advice, to identify preventative measures to reduce the likelihood of domestic and family violence deaths occurring in Queensland.

The Board may carry out a review even though the death is, or may be, the subject of a coronial investigation and this review is independent of, and separate to, any coronial investigation.[33] The Board has the legislative power to make recommendations to the Minister, based on its systemic reviews, for implementation by government and non-government organisations, whereas a coroner is only able to make recommendations for those cases that progress to inquest.

There are many examples of concurrent death review processes occurring, even though their scope may be different (e.g. a cross-agency child death review and an infant mortality team within a hospital). There can be significant benefits in combining resources, as it can lead to greater efficiency and effectiveness, while still retaining the independence of, and outcomes for, each review process or investigation.

To facilitate smooth coordination between the different processes it is useful to highlight what elements are shared and what are independent of each other. For the Queensland domestic and family violence death review process, case identification, data collection, database management and information gathering (as per Figure 1), are elements which can be shared, while the review of files by the Board and the investigation of the death by the Coroner, remain independent of, but run concurrently to, each other.

Preventative recommendations made by the Board will also need to be monitored differently to coronial recommendations, as a separate unit in the Department of Justice and Attorney General holds portfolio responsibility for the monitoring of all coronial recommendations, whereas the Board is required to monitor the implementation of any recommendations they make through their systemic review process.

To retain the independence of the Board, the State Coroner as Chairperson will not investigate any reportable domestic and family violence death subject to review by the Board; the matter will be referred to another coroner for investigation.

[33] *Coroners Act 2003* (Qld), s 91F

Practice Example

Queensland Child Death Review System

As a result of recommendations from the Child Protection Commission of Inquiry (2013) a new Child Case Review system was implemented in Queensland consisting of a two-tiered review process. This process was established in July 2014 with amendments to the *Child Protection Act 1999* (Qld).

Tier 1: Departmental Review (System and Practice Review)

A System and Practice Review is conducted when the Department of Communities, Child Safety and Disability Service becomes aware of the death (or serious physical injury) to a child who has been subject to departmental intervention within one year of the death or injury.

Depending on the complexity and apparent association between the death and department's decision making and associated practice, this review may be detailed, limited or brief. The intent of the review is to identify key learnings and opportunities to improve the provision of services to vulnerable children and young people in Queensland.

This review is examined by the internal System and Practice Review Committee, subsequently finalised and provided to the Child Death Case Review Panel, which consists of external experts, departmental senior officers and senior officers from other government departments with at least one member required to be an Aboriginal and Torres Strait Islander person.

Tier 2 – Independent Review (Child Death Case Review panel)

A Ministerially appointed panel is allocated cases based on themes and the areas of expertise of the panel members, and is provided copies of the System and Practice Reviews. The Child Death Case Review Panel meets and discusses the allocated cases. The Panel is required to consider areas of improvement with respect to these cases, and produce a report outlining their findings, which is subsequently provided to the department and Minister as required.

Secretariat services are provided by the department, assisting in ensuring a smooth flow of information between the two processes. While the purpose of both review processes is to facilitate ongoing learning and improvement in services provided by the department, and to promote accountability of the department, the Panel itself is independent of the Department.

Notably, for relevant reportable deaths, copies of both reports are required to be provided to the State Coroner for consideration by the investigating coroner, who are supported in their investigation of these cases by the Domestic and Family Violence Death Review Unit.

Access to, and the provision of, information

The *Coroners Act 2003* governs the Board's access to information and describes the circumstances and manner in which prescribed entities must provide relevant information to the Board to perform its functions.[34]

Under the Act the Board may enter into an arrangement with the State Coroner to facilitate the exchange of information between a coroner and the Board.[35]

[34] *Coroners Act 2003* (Qld), s 91Y
[35] *Coroners Act 2003* (Qld), s 91Z

This arrangement is required to include how and when the Board will be notified by a coroner that a reportable death is, or is likely to be, a domestic and family violence related death, how and when coronial investigation documents are provided to the Board and also how and when the Board gives coroners access to documents that are relevant to an investigation.

Information, research and analysis prepared by the Unit are available to the Board,[36] with case reviews and chronologies, as an initial overview of a case. It is not the intention for the Board to consider the circumstances of an individual death but instead to consider these deaths systemically.

Although the Board has the capacity to review open coronial matters to allow it to perform its functions in a timely and responsive manner, all relevant case information and service contact history must be provided by external departments and this can sometimes be delayed depending on the progression of any coronial or police investigation into an individual death.

The State Coroner is not authorised to release confidential information provided to a coroner, unless the chief executive of the entity who prepared the document agrees to the person having access to the document.

Access to information where criminal proceedings are underway

While the Board is empowered to consider matters in which criminal proceedings are ongoing, in practice it is important to acknowledge that information relevant to the Board's consideration is unlikely to be available until the police investigation is finalised and the brief of evidence provided to the Coroner.[37]

This is generally after the committal hearing has been held.

The brief of evidence contains a broad range of information about the death, including witness statements and records pertaining to the deceased and/or offender. It also forms the basis of a case review by the Unit and it is from this documentation that contact with systems and services prior to the death is identified and information from other sources is then gathered as required.

While coroners are kept informed of the status of criminal proceedings, the particulars of the investigation are generally withheld until a person is charged and subsequent proceedings are completed.

This process protects the integrity of ongoing investigations from the possibility of sensitive material being inadvertently released and impacting on the criminal proceeding. Furthermore, it protects the coroner's judicial independence.

Access to information from government agencies or other organisations

Section 91Y authorises the Board to access information it requires that is in the custody or under the control of a prescribed entity, with certain conditions.

[36] *Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015*, Explanatory notes
[37] *Coroners Act 2003* (Qld), s 91Y(5)

A prescribed entity is defined as any of the following:

- the chief executive of a department
- the Queensland Family and Child Commission
- the commissioner of the police service
- an entity that provides services to persons in relevant relationships if those persons are affected by domestic and family violence deaths
- an entity prescribed by regulation.[38]

The Board may, by written notice, request information within a stated time frame and is authorised to inspect documents and take copies unless there is a reasonable excuse for not disclosing the information.

The Secretariat is responsible for the coordination of these requests under the direction of the Chairperson, including ensuring the timely receipt of agency records as requested by the Board.

The Act identifies when a failure to comply can be reasonably excused, including (but not limited to) if the disclosure of information might incriminate an individual, is the subject of legal privilege, would endanger a person's life, or would prejudice a prosecution or another matter before a court.[39] The prescribed entity may comply in these circumstances by allowing the Board to inspect a document that with exempt information redacted.

Access to information from other jurisdictions

Coroners have broad powers under the *Coroners Act 2003* to access relevant information from interstate and Commonwealth entities, including courts where applicable.

If the Board considers it requires information from a Commonwealth or interstate agency that has not already been obtained as part of a coronial investigation, or cannot be obtained from the Board's counterpart in another state or territory, any request by the Board for information must comply with existing interstate and Commonwealth laws as relevant.

The Board may disclose information to other jurisdictions unless the disclosure would prejudice the investigation of a contravention, or possible contravention, of a law, or an investigation by a Coroner. The Board must consult the State Coroner about the proposed disclosure before disclosing coronial information.

Access to information from courts

Under the doctrine of the separation of powers, the judiciary operate independently of the legislative and executive arms of government. Consistent with this principle, the only mechanism for review of decisions made by courts is through current appeal processes. It would therefore not be appropriate for the Board to review decisions made by a court in individual cases or in relation to specific actions taken by a court.

It is recognised that the circumstances leading up to a domestic and family violence death may often involve an individual's interaction with courts, such as with the family law courts and Magistrates Courts.

[38] *Coroners Act 2003* (Qld), s 91Y(9)
[39] *Coroners Act 2003* (Qld), s 91Y

This broader context and circumstances may highlight potential issues with the current operation of the legal system suggesting a potential need for legislative or administrative reform.

Access to information from experts

An important function of the Board is the capacity to make recommendations to the Minister for implementation by government and non-government entities to prevent or reduce the likelihood of domestic and family violence deaths. The Board may also supplement the information provided by the Unit, by commissioning its own expert reports for example.

Statutory provisions enable the Board to engage persons with appropriate qualifications and experience to conduct research and prepare reports to help the Board perform its functions.[40]

Funding is available to engage experts subject to the approval of the State Coroner in his role of Chairperson. Remuneration for expert reports is in accordance with the Coroners Court of Queensland scale of fees, at the rate of $250.00 per hour.

Where the Board considers it necessary, requests for expert advice and assistance should be made to the Board Chairperson, with the Unit responsible for making the necessary arrangements with the nominated expert for this to occur.

Conflict of interest provisions are applicable when members seek to nominate the engagement of a particular expert.

Limitations to accessing information

The primary source of information for the review process is intended to be information gathered in the course of police and coronial investigations into an individual death and agency records by those services who may have had contact with a deceased and/or offender prior to a death.

Consequently substantial variability in the availability of records to inform a review exist, both in the capacity to accurately determine contact with services and systems prior to the death, the knowledge held by family and friends in relation to the deceased's experiences of domestic and family violence, or the quality of record keeping of relevant agencies. It is the nature of domestic and family violence that much occurs 'behind closed doors', with even close family and friends never being aware of the underlying dynamics of the relationship.

It is also the case that relevant information may not be disclosed to service providers, police or the courts by victims of domestic and family violence due to a myriad of reasons, including an unwillingness to engage with formal systems, a desire to remain in the relationship, or fear of retribution from a perpetrator. At a practical level such limitations restrict the scope and focus of a review into an individual death.

[40] *Coroners Act 2003* (Qld), s 91G

Membership

The Minister must appoint the State Coroner or the Deputy State Coroner as the Chairperson[41] of the Board, and not more than 11 other persons that the Minister considers appropriate.[42] The Minister may appoint a member of the Board to be the Deputy Chairperson.[43]

The Chairperson is responsible for leading and directing the activities of the Board to ensure it performs its functions appropriately. The Deputy Chairperson is required to act as the Chairperson when the Chairperson is absent from their duties or for another reason cannot perform the duties of the office.

The Minister must ensure that the membership comprises government and non-government members, reflects the diversity of the Queensland community and includes at least one member who is an Aboriginal or Torres Strait Islander.[44] The Minister must ensure that members have appropriate experience, knowledge or skills relevant to the Board's functions and in accordance with the Act's requirements.[45]

The Board's membership consists of six government representatives, in addition to the Chairperson, nominated by their Chief Executive because of their respective portfolio responsibilities and expertise.

Current members are as follows:

- Mr Terry Ryan, State Coroner (Chairperson)
- Assistant Commissioner Maurice Carless, State Crime Command, Queensland Police Service
- Dr Jeannette Young, Chief Health Officer and Deputy Director General, Prevention Division, Queensland Health
- Ms Tammy Williams, Commissioner, Queensland Family and Child Commission
- Dr Mark Rallings, Commissioner, Queensland Corrective Services
- Ms Barbara Shaw, Executive Director, Office for Women and Domestic and Family Violence Reform, Department of Communities, Child Safety and Disability Services
- Ms Natalie Parker, Director, Domestic and Family Violence Court Reform, Department of Justice and Attorney General.

A recruitment process was undertaken to seek nominations for non-government representatives for the Board. Selected based on their experience, knowledge and skills, non-government members are as follows:

- Dr Kathleen Baird, Senior Lecturer in Midwifery and Director of Education and Nursing, Griffith University (Deputy Chairperson)
- Dr Silke Meyer, Lecturer in Postgraduate Programs, (Domestic and Family Violence Practice), Centre for Domestic and Family Violence Research, Central Queensland University
- Ms Betty Taylor, Director, Betty Taylor Training and Consultancy
- Mr Mark Walters, Manager, DV Connect (Mensline)
- Ms Angela Lynch, Legal Reform and Community Legal Education Lawyer, Women's Legal Service Queensland.

[41] *Coroners Act 2003* (Qld), s 91K
[42] *Coroners Act 2003* (Qld), s 91J(b)
[43] *Coroners Act 2003* (Qld), s 91M
[44] *Coroners Act 2003* (Qld), s 91O
[45] *Coroners Act 2003* (Qld), s 91L

Terms of appointment

Members are appointed for the term of not more than three years, as stated in their instrument of appointment, and may be reappointed. Appointment of the current members commenced on 18 July 2016.

Remuneration

Section 91N provides that a member of the Board is to be paid remuneration and allowances as decided by the Minister.

A member who is a Queensland Government employee is not entitled to be paid remuneration for holding office as a member. For matters not provided for by this Act, a member holds office on the terms and conditions decided by the Minister.

Non-government members are paid a daily fee of $300. Where the Board meets six times or fewer per year, the Minister may pay daily fees of $500 for members.

In accordance with Queensland Public Service Remuneration Procedures all necessary and reasonable expenses incurred while travelling on business and attending meetings will be reimbursed in accordance with the following arrangements:

- economy class air travel is to be used
- motor vehicle allowances as varied from time to time by the Governor in Council
- domestic travelling and relieving expenses as varied from time to time by the Governor in Council.

Reporting

Annual report

The Board must provide an annual report to the Minister within three months after the end of each financial year in relation to the performance of its functions,[46] which includes information about the implementation of any of the Board's recommendations.

The Minister must table a copy of the report in the Legislative Assembly within one month of receiving it.[47]

In practice, the Secretariat is required to provide assistance to the Board in the collation of this report, in accordance with the specifications outlined by the Board.

Similar to Annual Reports collated by other death review committees this may include, but not be limited to:

- an overview of the Board's activities during the reporting period
- de-identified case reviews and statistics
- trends, systemic gaps and issues identified in the deaths reviewed in the preceding reporting period
- any recommendations made by the Board and the progress of their implementation.

This accords with other jurisdictions where the death review mechanism also reports annually, such as Western Australia and New Zealand.

[46] *Coroners Act 2003* (Qld), s 91ZB
[47] *Coroners Act 2003* (Qld), s 91ZB

Links to other jurisdictional teams' reports are provided in Section 5: Resources.

Systemic reports

The Board may prepare a systemic report:

- about its findings in relation to a review carried out by the Board, or to
- make recommendations to the Minister about any other matter likely to prevent or reduce domestic and family violence deaths.[48]

The Act prescribes requirements in the development of systemic reports, including processes in the event the Board proposes to include information adverse to a person or if the report includes information relating to a death still being investigated by a coroner.

The Board may make recommend that the Minister table the report in the Legislative Assembly, or not. In the event that the Board recommends that the systemic report is not tabled, the Minister may still table the report if satisfied that the public benefit in publishing the report outweighs other considerations.[49]

This provision allows for greater flexibility for the Board to report as it considers necessary, including to allow for more regular reports to be released in response to the identification of relevant trends, findings and issues.

The Secretariat is required to provide assistance with the completion of these reports, in accordance with the Board's specifications.

Monitoring recommendations made by the Board

The legislation gives the Board the power to monitor the implementation of recommendations made by the Board.

The Board will report directly to the Minister annually under section 91ZB in relation to progress made by other agencies to implement recommendations relevant to that agency.

These arrangements for the Board are consistent with the current approach to the monitoring of the implementation of coronial recommendations in Queensland.

In practice the Secretariat will communicate formally with relevant agencies regarding the implementation of these recommendations as part of the collation of the Annual Report, including, where applicable, seeking advice as to why recommendations were not adopted.

[48] *Coroners Act 2003* (Qld), s 91ZC
[49] *Coroners Act 2003* (Qld), s 91ZC

Board proceedings and business rules

Secretariat

The Unit provide secretariat and administrative support to the Board and can be contacted via:

Manager
Domestic and Family Violence Death Review Unit
Coroners Court of Queensland
Brisbane Magistrates Court
363 George St
BRISBANE QLD 4000

Postal: PO Box 1649
BRISBANE QLD 4000
Email: Coroner.DFVDRU@justice.qld.gov.au

The Secretariat is responsible for supporting the Board, under the direction of the Chairperson, and is responsible for:

- all administrative tasks associated with the functioning of the Board, including meeting arrangements, travel and remuneration of members
- ensuring the timely provision to the Board of coronial investigation documents in relation to domestic and family violence deaths, in accordance with the Administrative Arrangements
- the gathering of additional information, including records from relevant agencies and expert reports as required by the Board
- drafting reports or any other documentation as required by, and at the direction of, the Board
- any other duties nominated by the Board to assist it in fulfilling its functions in accordance with its statutory responsibilities.

Meeting schedule

The Board will meet no fewer than four times a year. The schedule for meetings will be determined at the first meeting and provided to members as an addendum to these guidelines. Noting that the Board may be required to meet more often, at a minimum and as much as practicable, the review process over a financial year may be structured as follows:

Case Review Meeting 1: Murder suicides and perpetrator suicides

Case Review Meeting 2: Intimate partner homicides, including bystander homicides

Case Review Meeting 3: Suicides of victims of domestic and family violence, including child suicides

Case Review Meeting 4: Vulnerable populations (Aboriginal and Torres Strait Islander people)

Case Review Meeting 5: Intimate partner homicides (female offenders) and homicides in a family relationship

Case Review Meeting 6: Homicides in a family relationship (filicides).

The Chairperson may call an additional meeting at any time, and must call a meeting if asked by at least three members.[50]

The Secretariat will make relevant case reviews and chronologies, clustered by death type, available to the Board for their consideration at least three weeks prior to the meeting.

Given the scope of deaths subject to a review, set meetings focusing on different types of deaths will provide an opportunity to consider these deaths systemically, and identify patterns and trends across cases.

It is anticipated that between five to seven reviews will be considered by the Board in each session.

Meeting preparation

Meetings are anticipated to last for at least a half day or as determined by the Board, depending on any outstanding business or administrative matters.

Board members are required to ensure they have the necessary time to consider the reviews prior to the meeting, as case reviews can be very detailed, and vary in complexity depending on the circumstances of the case.

If members have questions regarding aspects of an individual case review they are encouraged to contact the Secretariat to request any further information, clarification, or additional coronial records, prior to the meeting.

Attendance at meetings

Meetings will be held at the Brisbane Magistrates Court or another suitable location in the Brisbane CBD as determined by the Chairperson.

The Board may also hold meetings, or allow members to take part in meetings, by using any technology reasonably contemporaneous to allow continuous communication between persons taking part in the meeting.

Members are expected to attend all meetings, and in extenuating circumstances where they are unable to attend they are required to notify the Secretariat of their unavailability.

For those members who are unable to attend in person than they are requested to provide comments and feedback prior to the meeting for the consideration of other members.

[50] *Coroners Act 2003* (Qld), s 91S

Special advisors

In circumstances where a member is unable to attend in person, provision exists for them to nominate a suitably qualified individual to attend on their behalf and participate in discussions. The special advisor may be granted access to documentation relating to that meeting only, with the relevant confidentiality provisions applying to the special advisor with respect to Board documentation and discussions. Board members are required to ensure that special advisors are aware of their responsibilities in this regard.

The special advisor is prohibited from formally voting on any matters submitted for a vote.

Members who are seeking to send a special advisor to the meeting are required to notify the Chairperson, through the Secretariat, prior to the meeting.

Agenda preparation and meeting papers

Proposed agenda items and relevant papers should be provided to the Board Secretariat at least ten working days before a scheduled meeting. Case reviews will be provided three weeks prior to the meeting. Members will receive a copy of other agenda items and papers no later than five working days prior to the scheduled meeting.

Minutes

The Board must keep minutes of its meetings and a record of any decisions or resolutions of the Board.[51]

The Secretariat will maintain minutes and records, and distribute to members for their review and information following approval by the Chair. Board members should notify the Secretariat of any changes or errors which will be corrected out of session and resubmitted to members prior to the next scheduled meeting.

A meeting communique will be drafted by the Secretariat for the consideration and final endorsement of the Board within two weeks of each meeting, which outlines the outcome of the review process and any recommendations made by the Board.

Timely feedback is required from Board members to ensure any documentation is reflective of the Board's consideration of a case or a cluster of similar cases.

Confidentiality

It is acknowledged that members of the Board will have access to investigation material related to coronial investigations which are finalised, but also coronial, and criminal, investigations which are ongoing. In that regard, it is important that all Board members are aware of the sensitivity of the material, and the potential prejudice that could be caused to other investigations by external agencies if the material is used or re-distributed inappropriately.

It is acknowledged that Board members may on occasion require those assisting them to also have dealings with the material, to some extent. In that regard, Board members should try and limit the number of persons assisting them with this material, where possible to do so, and to ensure that those persons are aware of, and adhere to, the same confidentiality requirements.

[51] *Coroners Act 2003* (Qld), s 91W

This includes ensuring that any material, including electronic and hardcopy documentation, is appropriately secured at all times, and disposed of once the Board's consideration of the case is finalised.

For the purposes of the Board's functioning, confidential information is any information that:

- is not publicly available
- is in a form that identifies or may identify an individual
- was acquired by, or may be accessed by:
    - a person in the person's capacity as a member of the Board, or
    - a person engaged by the Board.[52]

All Board members or any person engaged to help in the performance of the Board's functions must not disclose confidential information to anyone else other than to the extent the disclosure is permitted by section 91ZD of the Coroners Act, including disclosures:

- in the performance of a function under this Act
- to the Commissioner of the Police Service in connection with a possible criminal offence
- to a Coroner to the extent it may relate to a reportable death
- to the Crime and Corruption Commission
- to the ombudsman about the death of a person to the extent it is relevant to the performance of the ombudsman's functions
- to the extent otherwise required or permitted under this Act or another Act.

Conflict of interest

In accordance with the Act,[53] members must disclose any direct or indirect interest in a matter being considered or about to be considered at a meeting of the Board, if that interest appears to raise a conflict with the proper performance of the member's duties.

Any perceived conflict of interest must be disclosed as soon as the potential conflict has come to the member's knowledge, and may or may not preclude them from deliberations or decision-making about the matter at hand. A register of interests will be maintained by the Secretariat, documenting the interest and any decisions made about the interest.

Media or public statements

The Chairperson of the Board is the appointed media spokesperson for all Board matters. Proactive media or public statements must be approved by a quorum of the Board.

Any media requests are to be directed to the Chairperson, through the Secretariat, in the first instance.

Quorum

A quorum for a meeting of the Board is at least half of the members.[54]

[52] *Coroners Act 2003* (Qld), s 91ZD
[53] *Coroners Act 2003* (Qld), s 91X
[54] *Coroners Act 2003* (Qld), s 91T

Resolutions

A resolution is a valid resolution of the Board even if it is not passed at a meeting of the Board if at least half the members give written agreement to the resolution and notice of the resolution is given to Board members within seven days.[55]

If the votes are equal, the member presiding has a casting vote.[56]

[55] *Coroners Act 2003* (Qld), s 91V(6)
[56] *Coroners Act 2003* (Qld), s 91V(5)

Section 5

Resources

Individual, family, community and cultural influences may operate to indirectly sanction domestic and family violence, may combine to restrain perpetrators from acting respectfully and non-violently[57] and may inhibit a victim from seeking safety.

System assessments

Most representatives on domestic and family violence fatality review teams work within their respective organisations towards improving the lives of individuals, families and communities.[58] Fatality review teams, however, require a shift in perception and broadening of perspective from an individual focus to a broader systems approach.

Knowing the service system, as well as the family, community, social and cultural environment in which the victim and perpetrator live in, is critical in completing an effective assessment.

For example, understanding the community they reside in is critical, as this environment influences a victim or perpetrator's engagement with the broader service system. Availability and accessibility of services in rural communities may limit a victim's capacity to seek, and obtain, support when and where they need it.

Further cultural barriers may prevent a victim seeking help, but they may also mean that when help is sought victims experience barriers to accessing services.

Every interaction with a service provider represents a supportive opportunity to secure safety for the victim, both immediately and on future occasions. A positive outcome from the intervention increases the likelihood that help will be sought again.

Conversely, collusion with a perpetrator's deflections, minimisations or victim-blaming by services contributes to inconsistent, incoherent and ineffective responses to men who use violence in their intimate partner or family relationships[59] and may serve to reinforce their use of violence within the relationship.

If initial attempts at reporting the violence are not responded to because service providers believe a perpetrator's version of events, this reduces future help-seeking by a victim by reinforcing that no-one is likely to believe them, or provide assistance even if help is sought.

[57] Department of Communities. Professional Practice Standards: working with men who perpetrate domestic and family violence, Queensland Government
[58] Sourced from Family and Intimate Partner Violence Fatality Review – Team Protocol and Resource Manual
[59] Department For Child Protection and Family Support (2015) Practice Standards for Perpetrator Intervention: Engaging and Responding to Men who are Perpetrators of Family and Domestic Violence, Perth Western Australia: Western Australian Government

In reviewing cases systemically it can be useful to consider the following issues:

- Are there any common trends and themes across the cases?
- Were there any barriers to help-seeking?
- What services were requested, received or refused by the victim or perpetrator?
- Should other agencies have been involved but were not?
- What information was available to responding agencies that informed their assessment and response to the victim or perpetrator?
- What was the degree of coordination among the agencies and community entities?

Developing recommendations

Exposure to domestic and family violence is a leading determinant of both physical and psychological health, with significant individual, community and social costs associated with domestic and family violence, and as such it is increasingly being recognised as a public health priority.

The high rates of recidivism amongst perpetrators of domestic and family violence, in particular, highlight the need for early intervention and prevention approaches to address this critical issue, and makes this social issue conducive to the adoption of a public health approach.

A public health approach to prevention focuses on addressing key risk factors or social determinants to address problems at a population level, instead of focusing on individuals, and includes the following steps:[60]

1. defining the problem
2. identifying risk and protective factors
3. developing and testing prevention strategies and programs
4. ensuring widespread adoption by disseminating the information.

Preventative strategies may be selective in that they target particular individuals or cohorts, or they may adopt a universal approach, such as whole of population community education initiatives.

There is no specific formula to guide how to construct preventative recommendations, other than ensuring they address issues or shortcomings apparent through the review process.

Recommendations can apply to many agencies and professions, or can be very specific.

They are most effective when there is clear connection to a particular case, and they refer to an accountable agency (for example, a government department or peak body). Recommendations for action can address a range of areas including education and training, policy and legislation, practice, networks or collaboration, resources, funding and services.[61]

The Spectrum of Prevention, outlined in Figure 5, is used by some death review mechanisms to structure their consideration of preventative strategies.

[60] Walden, I. & Wall, L. (2014) *Reflecting on primary prevention of violence against women: the public health approach* Australian Centre for the Study of Sexual Assault: Commonwealth of Australia
[61] Virginia Department of Health (2009) Fatality and Intimate Partner Violence Fatality Review Team Protocol and Resource Manual, 3rd ed. Office of the Chief Medical Examiner

Figure 5: The Spectrum of Prevention[62]

Level of spectrum	Definition of level	Example
Level 1 **Strengthening Knowledge and skills**	Enhancing an individual's capacity to prevent a problem and promote safety	This can be achieved through strategies such as education, counselling and services that encourage individuals to change their behaviour
Level 2 **Promoting Community Education**	Reaching people with information and resources to promote health and safety	This helps support healthier behaviour and community norms, and can be achieved through media strategies.
Level 3 **Educating Providers**	Informing providers who will transmit skills and knowledge to others	This can be achieved through ensuring that those who provide training, advice or act as role models have the information, skills, capacity and motivation to effectively promote prevention.
Level 4 **Fostering Coalitions and Networks**	Bringing together groups and individuals to accomplish broader goals and greater impact.	This is effective because it extends beyond the capacity of an individual or an agency to accomplish a broad range of goals. Such goals may range from information sharing to community coordination of services
Level 5 **Changing Organisational Practices**	Adopting regulations and shaping norms to improve health and safety.	This includes focusing on changing and strengthening internal agency policies, regulations, practices and norms
Level 6 **Influencing Policy and Legislation**	Developing strategies to change laws and policies to influence outcomes.	Changing policy, legislation or regulatory frameworks can sometimes lead to the greatest improvements to prevention

The levels are not discrete, with action in one area potentially influencing or leading to action in another. For example, policy change (level 7) may lead to the need to train providers (level 3) or change organisational practice (level 5).

Research demonstrates that a combination of activities and strategies will be more effective than any single action. It is also the case that a recommendation is more likely to be adopted if it is within an agency's resources to do so, and there is some evidence of effectiveness.

[62] Cohen et.al. Sourced from Chamberlain, L. (2008) Bridging the gap: Bringing together intentional and unintentional injury prevention efforts to improve health and well-being. *Journal of Safety Research, 34,* 473-483. Sourced from *A Prevention Primer for Domestic Violence: Terminology, Tools and the Public Health Approach,* National Online Resource Centre on Violence Against Women

The most effective preventative recommendations are those that have proven efficacy, meaning they have been trialled, implemented and evaluated. Alternatively, they may have shown promise in addressing similar issues with a different population group or extend beyond existing practice.

Consideration of recommendations should also take into account such factors[63] as:

- **Effectiveness:** is this recommendation likely to prevent future deaths?
- **Cost:** how would this recommendation be funded and would the benefit of the recommendation outweigh the costs?
- **Implementation**: is this recommendation feasible and what resources would be needed to implement it?
- **Sustainability**: would this recommendation be effective over the long term, and who would coordinate this?
- **Community acceptance**: would there be resistance to the recommendation within the community and will it address the underlying issues?
- **Unintended consequences**: are there any negative consequences or risks associated with the implementation of this recommendation? Will it affect different vulnerable groups in different ways?

The latter should always be a salient consideration. For example, the introduction of mandatory arrest policies for domestic and family violence incidents within some American jurisdictions led to an increase in arrests of both parties, including female victims, and has disproportionally affected already marginalised populations.[64]

Emotional impact and self-care strategies

Conducting death reviews, and examining the circumstances of a person's life preceding the death, can be an emotionally draining and disturbing process.

It is important for Board members to be aware that everybody reacts differently to this process and to be mindful of the need for self-care strategies.

Self-care. Why is this important?

Much has been written about the impact on professionals of working with people who experience trauma. Terms such as compassion fatigue, vicarious traumatisation, secondary traumatisation, secondary stress disorder and burnout are commonly used in an attempt to label and define what happens, why it happens and how to adjust positively to these experiences.[65]

The experiencing of physical, emotional and psychological symptoms and changes is a very real and present consequence of working in the area of trauma, including being exposed to the trauma experienced by others through a death review process.

[63] National Centre for Child Death Review (2005) A Program Manual for Child Death Review, Michigan Public Health Institute

[64] Frye, V., Havilance, M. & Rajah (2007) Dual Arrest and Other Unintended Consequences of Mandatory Areest in New York City: A Brief Report. *Journal of Family Violence, 22*, 397-405; Hirschel, D., Buzawa, E., Pattavina, A. & Faggiani, D. (2008) Domestic Violence and Mandatory Arrest Laws: to what extent do they influence police arrest decisions, *The Journal of Criminal Law and Criminology*.

[65] National Clearinghouse on Family Violence. (2001). Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers. Health Canada. (p3)

Vicarious trauma is the term used in this context to describe the cumulative and built-upon memories obtained through listening to the stories of trauma, abuse and cruelty. This creates a permanent, subtle or marked change in the personal, political, spiritual and professional outlook of the individual. Vicarious trauma has a life-changing effect on individuals, ultimately affecting their view of the world and their relationships and connections to family, friends and community. Understanding and working with this type of trauma is both an individual and organisational challenge.[66]

How do we as individuals, who within our professional roles witness the traumas of others, remain healthy in body and mind? It is important to reflect on our own life experiences and how witnessing through case reviews or victim narratives that detail the trauma of others can trigger past personal trauma and impact on ourselves.

The principles surrounding self-care are transferable across situations we may face in all areas of our lives, not just in the work that we perform. Self-awareness regarding our own experiences is important in the development of boundaries and ongoing management of the impacts of witnessing trauma. Identifying when exposure to further information about a case or particular types of cases are likely to cause distress is important in order to protect oneself.

Seeking support, as well as taking time to reflect and restore, is critically important in order to meet the personal and professional need to remain healthy and balanced in order to sustain longevity in this challenging area of work.

Hindsight bias

Hindsight bias is the subjective tendency to consider an event to be more predictable after it has taken place than it was beforehand.[67] Hindsight bias can confound attempts to understand past events, and may be unavoidable to some extent when the outcome is known.

In the medico-legal landscape, for example, professionals consistently rate service delivery with adverse outcomes to be of a poorer standard than the identical service delivery when the outcomes are neutral.[68] That is, knowing the outcome can confound the views on the antecedents of the event in question.

With this in mind, when reviewing the involvement of stakeholders in fatality cases it is important to do so on the basis of what could have been known by those involved with the deceased or offenders *at the time of the death*.

In many cases, risk factors and indicators that are present in fatalities are also present in cases where no significant harm is caused, making it impossible to predict outcomes based on static factors.

[66] National Clearinghouse on Family Violence. (2001). Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers. Health Canada. (p4)
[67] Roese, N.J., & Vohs, K.D. (2012). Hindsight bias. *Perspectives on Psychological Science, 7,* 411-426.
[68] Hugh, T.B. & Tracy, G.D. (2002). Hindsight bias in medicolegal expert reports. *Medical Journal of Australia, 176,* 277-278.

Language

The choice and use of language used to describe those involved in domestic and family violence, and in fatal acts in death reviews, can influence the way each party is perceived. Despite the best intentions of those involved, there can be a tendency to misrepresent and minimise the context of the violence and it can reflect more positively for perpetrators and more negatively for victims.[69]

The service system may reinforce this misrepresentation, with the onus placed on the victim to enact changes to keep themselves and their children safe from a perpetrator, as opposed to requiring the perpetrator to be held responsible for their actions. Identifying acts of domestic and family violence as distinct and independent incidents prohibits a holistic understanding of the pattern of harm, and the impact of cumulative violence. Viewing domestic and family violence as an incident encourages an incident-focused response system, suggestive of there being a beginning and end to the 'incident'; however we know that this is often not the case with domestic and family violence.

International scholars have proposed the use of the term 'episode' to better describe the series of events characterising this type of violence.[70] 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.

The choice of language used can also distort the understanding of a violent episode, and blame and pathologise victims. Distorted language can misrepresent crucial information such as:

- the context within which the violence occurs
- the victim's resistance to the violence
- the perpetrator's anticipatory actions to stop resistance
- diminish the perpetrator's responsibility for their role in the violence
- the impact of the violence on the victim
- the nature and severity of the violence.[71]

[69] Wilson, D., Smith, R., Tolmie, J., & de Haan, I. (2015). Becoming better helpers: rethinking language to move beyond simplistic responses to women experiencing intimate partner violence. *Policy Quarterly, (11),* 25-31.
[70] Wilson et al. (2015)
[71] Coates, L. & Wade, A. (2007). Language and violence: analysis of four discursive operations. *Journal of Family Violence, 22*, 511-522; as cited in Wilston et al., 2015

Section 6

Relevant legislation and publications

Legislation

Legislation relevant to the performance of the Board's functions are below:

Coroners Act 2003
https://www.legislation.qld.gov.au/Bills/55PDF/2015/CoronersDFVAB15E.pdf

Domestic and Family Violence Protection Act 2012
http://www.legislation.qld.gov.au/LEGISLTN/ACTS/2012/12AC005.pdf

Publications

Documentation that relates to the evolution and implementation of the Queensland Domestic and Family Violence Death Review Process are as follows:

State Coroner's Guidelines
http://www.courts.qld.gov.au/courts/coroners-court/fact-sheets-and-publications

Special Taskforce on Domestic Violence Final Report 'Not Now, Not Ever' (2015)
http://www.qld.gov.au/community/getting-support-health-social-issue/dfv-read-report-recommendation/index.html

Report of the Domestic and Family Violence Death Review Panel (2010)
http://www.communities.qld.gov.au/resources/communityservices/violenceprevention/death-review-panel.pdf

Dying to be Heard (2008)
http://www.learningtoendabuse.ca/sites/default/files/Dying-to-be-heard-2008.pdf

Jurisdictional domestic and family violence death review mechanisms

Reports and publications related to Australian and New Zealand Domestic and Family Violence Death Review Mechanisms include:

Victorian Systemic Review of Family Violence Deaths
http://www.coronerscourt.vic.gov.au/home/coronial+investigation+process/family+violence+investigations/

New South Wales Domestic and Family Violence Death Review Team
http://www.coroners.justice.nsw.gov.au/Pages/Publications/dv_annual_reports.aspx

Western Australia Ombudsman Family Violence Fatality Review
http://www.ombudsman.wa.gov.au/Reviews/review_of_certain_deaths.htm

New Zealand Family Violence Death Review Committee
http://www.hqsc.govt.nz/our-programmes/mrc/fvdrc/

Section 7

Appendices

Appendix A

Australian Domestic and Family Violence Death Review Network Homicide Consensus Statement

Background and Purpose

Following the implementation of domestic and family violence death review mechanisms in several Australian jurisdictions, the Australian Domestic and Family Violence Death Review Network ("the Network") was established in March 2011.

The Network comprises representatives from each of the established Australian death review teams, namely:

- Domestic Violence Death Review Team (New South Wales);
- Domestic and Family Violence Death Review Unit (Queensland);
- Domestic and Family Violence Death Review (South Australia);
- Victorian Systemic Review of Family Violence Deaths;
- Review Team Ombudsman Western Australia.

The overarching goals of the Network are to, at a national level:

- improve knowledge regarding the frequency, nature and determinants of domestic and family violence deaths;
- identify practice and system changes that may improve outcomes for people affected by domestic and family violence and reduce these types of deaths;
- identify, collect, analyse and report data on domestic and family violence-related deaths; and
- analyse and compare domestic and family violence death review findings and recommendations.

These goals align with the *National Plan to Reduce Violence Against Women and their Children 2010-2022*.

Definitions

This Consensus Statement defines the inclusion criteria adopted by the Network for domestic and family violence homicide. While 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 abuse within an intimate or family relationship. Domestic and family violence behaviours include 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 and coercive control 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 Network is broader than the legal definition of the term. 'Homicide', as used by the Network, includes all circumstances in which an individual's

intentional 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.

Surveillance

The World Health Organization (2001) defines surveillance as:

> "… *systematic ongoing collection, collation and analysis of data and the timely dissemination of information to those who need to know so that action can be taken*."

Surveillance processes produce data that describe the frequency and nature of mortality and morbidity at the population level. This serves as a first step to the identification of risk factors to target preventive intervention. The Network applies these principles to ensure a consistent and standardised approach to data collection and analysis. To identify the target population and opportunities for intervention, surveillance of domestic and family violence homicide incidents is conducted both retrospectively and prospectively.

Categorisation

Identification and classification of domestic and family violence deaths is complex and needs to be conducted cautiously. The key considerations in this area are:

i) the case type;
ii) the role of human purpose in the event resulting in a death (intent);
iii) the relationship between the parties (i.e. the deceased-offender relationship); and
iv) the domestic and family violence context (i.e. whether or not the homicide occurred in a context of domestic and family violence).

Consideration 1: Case Type

Determination of case type (i.e. external cause, natural cause, unknown cause) is the first consideration for classification. An external cause death is any death caused, directly or indirectly, by an offender through the application of assaultive force or by criminal negligence. In cases where the cause of death is unknown, the death is monitored until further information is available.

Case Type	Definition	Inclusion
External Cause	Any death resulting directly or indirectly from environmental events or circumstances that cause injury, poisoning and / or other adverse effect.	Yes
Unexplained Cause	Deaths for which it is unable to be determined whether it was an external or natural cause.	No
Natural Cause	Any death due to underlying natural causes. Includes chronic illness due to long-term alcohol abuse / smoking.	No

Consideration 2: Intent

The second consideration is to establish the role of human purpose in the event resulting in the external cause death. In accordance with the WHO International Classification of Disease (ICD-10), the intent is coded according to the following categories.

Intent	Definition	Inclusion
Assault[72]	Injury from an act of violence where physical force by one or more persons is used with the intent of causing harm, injury, or death to another person; or an intentional poisoning by another person. This category includes intended and unintended victims of violent acts (e.g. innocent bystanders).	Yes
Complications of Medical or Surgical Care	Death which occurred due to medical misadventure, accidents or reactions in the administration of medical or surgical care drugs or medication.	No
Intentional Self-Harm	Injury or poisoning resulting from a deliberate violent act inflicted on oneself with the intent to take one's own life or with the intent to harm oneself.	No
Legal Intervention/ Operations of War	Death which occurred due to injuries that were inflicted by police or other law-enforcing agents (including military on duty), in the course of arresting or attempting to arrest lawbreakers, suppressing disturbances, maintaining order or other legal action.	Yes (only where DV context present)
Still Enquiring	Death under investigation whereby the intent or case type is not immediately clear based on the level of information available.	No
Undetermined Intent	Events where available information is insufficient to enable a person to make a distinction between unintentional, intentional self-harm and assault.	No
Unintentional	Injury or poisoning that is not inflicted by deliberate means (that is, not on purpose). This category includes those injuries and poisonings described as unintended or "accidental", regardless of whether the injury was inflicted by oneself or by another person.	No
Unlikely to be Known	Upon case completion, the coroner was unable to determine whether the death was due to Natural or External causes, therefore unable to make a determination on intent.	No

Consideration 3: Relationship

The third consideration for classification is whether a domestic or familial relationship existed between the deceased and the offender. The Network recognises the various state and federal legislative instruments that define and address deceased-offender relationship.

In particular, it is acknowledged that the member jurisdictions operate within the following legislative frameworks:

- *Coroners Act 2009* (NSW);

[72] Mortality classification systems refer to 'homicide' as 'assault'.

- *Domestic and Family Violence Protection Act 2012* (QLD);
- *Family Violence Protection Act 2008* (Vic); and
- *Intervention Orders (Prevention of Abuse) Act 2009* (SA);
- *Restraining Orders Act 1997* (WA) *and Parliamentary Commissioner Act 1971* (WA).

Each review team recognizes current or former intimate partners (heterosexual and homosexual), family members (adults and children), and kin, as relevant relationships. To standardise the inclusion and categorisation of relationship type, the following definitions are adopted by the Network.

Relationship Type	**Definition**	**Inclusion**
Intimate[73]	Individuals who are or have been in an intimate relationship (sexual or non-sexual).	Yes
Relative[74]	Individuals, including children, related by blood, a domestic partnership or adoption.	Yes
Aboriginal and/or Torres Strait Islander kinship relationships	A person who under Aboriginal and/or Torres Strait Islander culture is considered the person's kin.	Yes
No relationship	There is no intimate or familial relationship between the individuals.	Yes (only where DV context present)
Unknown	Relationship is unknown.	No

Consideration 4: Domestic and Family Violence Context

Having determined that a homicide has occurred and that a domestic relationship exists between the deceased and offender, the final consideration for classification is whether the homicide occurred in a domestic or family violence context. Deaths that fulfill these criteria are defined as domestic and family violence homicides and are subject to review by each jurisdiction.

Each jurisdiction can also review deaths where no direct domestic relationship exists between the deceased and offender but the death nonetheless occurs in a context of domestic and family violence. For example, this might include a bystander who is killed intervening in a domestic dispute or a new partner killed by their current partner's former abusive spouse.

Similarly, the Network recognises that the existence of an intimate or familial relationship between a deceased and offender does not, in itself, constitute a domestic and family violence homicide. In these deaths, other situational factors determine the fatal incident, such as the offender experiencing an acute mental health episode. These deaths do not feature many of the characteristics known to define domestic and family violence, such as controlling, threatening or coercive behaviour; having previously caused the other person to feel fear; or evidence of past physical, sexual or other abuse

[73] This includes current and former intimate relationships irrespective of the gender of the individuals.
[74] This includes formal and informal family-like relationships, and explicitly includes extended family-like relationships that are recognised within that individual's cultural group.

Domestic and Family Violence Death Review Unit Homicide Coding Form

Occurrence Number of Death	
Deceased name	
Offender name	
Year Death Occurred	
Date Death Occurred	
Incident Classification	Homicide ☐ Murder/Suicide ☐
Single/Multiple Deaths	Single ☐ Multiple ☐
Evidence of Domestic and Family Violence	Yes ☐ No ☐ Unknown ☐
Deceased domestic or family violence Status	Victim ☐ Perpetrator ☐ Both ☐ Unknown ☐
Cause of Death	Asphyxiation ☐ Stab wound ☐ Smoke inhalation ☐ Assault ☐ Gunshot wound ☐ Motor vehicle ☐ Suffocation ☐ Neglect ☐ Malnutrition ☐ Drowning ☐ Explosion ☐ Poison ☐ Other ☐
Weapon/means used	Axe ☐ Firearm ☐ Motor vehicle ☐ Blunt weapon ☐ Hands ☐ Tomahawk ☐ Smothered ☐ Neglect ☐ Body ☐ Knife ☐ Other ☐

Relationship Classification	Intimate Partner Homicide ☐ Family Violence ☐ Bystander (Family) ☐ Bystander (Intimate Partner) ☐
Bystander	Yes ☐ No ☐
Incident Suburb	
Postcode	
Aboriginal and/or Torres Strait Islander Status deceased	No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Unknown ☐
Aboriginal and/or Torres Strait Islander Status offender	No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Unknown ☐
Ethnicity Deceased	
Sex Deceased	Male ☐ Female ☐
Sex Perpetrator	Male ☐ Female ☐
Age Deceased	
Age category of Deceased	< 5 years ☐ 6 to 12 years ☐ 13 to 17 years ☐ 18 to 24 years ☐ 18 to 25 years ☐ 26 to 35 years ☐ 36 to 45 years ☐ 46 to 55 years ☐ 56 to 65 years ☐ 65 years + ☐
Age Perpetrator	
Age category of Perpetrator	Under 18 years ☐ 18 to 24 years ☐ 26 to 35 years ☐ 36 to 45 years ☐ 46 to 55 years ☐ 56 to 65 years ☐ 65 years + ☐

Employment Status Deceased	Unknown ☐ Employed ☐ Unemployed ☐ Recently Unemployed ☐ Retired ☐ Student ☐
Employment Status Perpetrator	Unknown ☐ Employed ☐ Unemployed ☐ Recently Unemployed ☐ Retired ☐ Student ☐
Disability Deceased	Physical ☐ Intellectual ☐ Both Physical and Intellectual ☐ Unknown ☐ NA ☐
Disability Perpetrator	Physical ☐ Intellectual ☐ Both Physical and Intellectual ☐ Unknown ☐ NA ☐
Relationship Status *Tick if **NA*** ☐	Married ☐ Arranged Marriage Married and separated ☐ Divorced ☐ Resided together as a couple ☐ Biological parents of a child ☐ Engaged or were engaged ☐ Betrothed or were betrothed under cultural or religious tradition ☐ Dating ☐ Dated and lives enmeshed ☐ Had dated and lives no longer enmeshed ☐ Relative to deceased Informal Care relationship ☐ Previous informal care relationship ☐ Bystander ☐ Other:_____ ☐
Relative Status of the deceased *Tick if **NA*** ☐	Adult child over 18 years ☐ Aunt ☐ Boyfriend of perpetrator's ex-defacto ☐ Boyfriend of perpetrator's ex-girlfriend ☐ Brother ☐ Brother-in-Law ☐ Cousin ☐ Daughter ☐

	Defacto ☐ Defacto Partner with Defendant's Father ☐ Defacto Partner with Defendant's Mother ☐ Defacto Step-Daughter ☐ Defacto Step-Father ☐ Defacto Step-Mother ☐ Defacto Step-Son ☐ Engaged ☐ Ex-Brother-in-Law ☐ Ex-Daughter-in-Law ☐ Ex-Husband ☐ Ex-Sister-in-Law ☐ Ex-Son-in-Law ☐ Ex-Wife☐ Father-in-Law ☐ Girlfriend of perpetrator's ex-defacto ☐ Girlfriend of perpetrator's ex-girlfriend ☐ Granddaughter ☐ Grandfather ☐ Grandparent Grandmother ☐ Grandson ☐ Half-Brother ☐ Half-Sister ☐ Kin Relation ☐ Mother-in-Law ☐ Nephew ☐ Niece ☐ Parent ☐ Sibling ☐ Sister ☐ Sister-in-Law ☐ Son ☐ Step-Child Daughter ☐ Step-Parent ☐ Step-Son ☐ Uncle ☐ Other:_____ ☐
Duration of the relationship/family relationship	Less than 12 months ☐ 1-2 years ☐ 3-4 years ☐ 5-10 years ☐ More than 10 years ☐
Female pregnant/infant ***NA** [if deceased male]* ☐	Not pregnant/no infant ☐ Pregnant ☐ Infant < 12 months ☐ Pregnant and infant < 12 months ☐ Unknown ☐

Social /or Geographical Isolation	Not isolated ☐ Socially isolated ☐ Geographically isolated ☐ Socially and Geographically isolated ☐ Unknown ☐
Place of Incident	Deceased residence ☐ Partner/ ex-partner's residence ☐ Deceased and partner/ex-partner's residence ☐ Public location ☐ Private Residence ☐ Other:_____ ☐
Impending Separation of Intimate relationship	No separation ☐ Intent to separate 2 months ☐ Intent to separate 6 months ☐ Intent to separate greater than 6 months ☐ Actual Separation 2 months ☐ Actual separation 6 months ☐ Actual separation greater than 6 months ☐ Unknown ☐ NA ☐
Deceased mental health	No mental health ☐ Mental health diagnosed ☐ Mental health symptoms but not diagnosed ☐
Deceased Mental Health Classification *Tick if **NA*** ☐	
Perpetrator mental health	No mental health ☐ Mental health diagnosed ☐ Mental health symptoms but not diagnosed ☐
Perpetrator Mental Health Classification *Tick if **NA*** ☐	
Deceased substance abuse history	No ☐ Alcohol ☐ Illicit drugs ☐ Alcohol and Illicit drugs ☐ Prescription drugs ☐ Inhalants ☐ Unknown ☐

Deceased substance abuse at time of death	No ☐ Alcohol ☐ Illicit drugs ☐ Alcohol and Illicit drugs ☐ Prescription drugs ☐ Inhalants ☐ Unknown ☐
Autopsy traces of alcohol or drugs	No ☐ Alcohol ☐ Illicit drugs ☐ Alcohol and Illicit drugs ☐ Prescription drugs ☐ Inhalants ☐ Unknown ☐
Perpetrator substance abuse history	No ☐ Alcohol ☐ Illicit drugs ☐ Alcohol and Illicit drugs ☐ Prescription drugs ☐ Inhalants ☐ Unknown ☐
Perpetrator substance abuse at time of death	No ☐ Alcohol ☐ Illicit drugs ☐ Alcohol and Illicit drugs ☐ Prescription drugs ☐ Inhalants ☐ Unknown ☐
Deceased Previous suicide ideation	No ☐ Yes < 6 months ☐ Yes 6- 12 months ☐ Yes > 12 months ☐ Unknown ☐
Deceased Previous suicide attempt	No ☐ Yes < 6 months ☐ Yes 6- 12 months ☐ Yes > 12 months ☐ Unknown ☐
Perpetrator Previous suicide ideation	No ☐ Yes < 6 months ☐ Yes 6- 12 months ☐ Yes > 12 months ☐ Unknown ☐

Perpetrator Previous suicide attempt	No ☐ Yes < 6 months ☐ Yes 6- 12 months ☐ Yes > 12 months ☐ Unknown ☐
History of domestic or family violence involving the deceased & Perpetrator	Yes ☐ No ☐ Unknown ☐
Type of domestic or family violence *Tick if **NA*** ☐	Physical ☐ Psychological/emotional ☐ Verbal ☐ Economic ☐ Violence towards children ☐ Abuse of pets ☐ Unknown ☐ Other:_____ ☐
Escalation of family /or domestic violence *Tick if **NA*** ☐	Constant ☐ Escalated ☐ De-escalated ☐ Unknown ☐
Stalking of deceased by perpetrator	Yes ☐ No ☐ Unknown ☐
Perpetrator obsessive/jealous towards deceased	Yes ☐ No ☐ Unknown ☐
Perpetrator controlling behaviour towards deceased	Yes ☐ No ☐ Unknown ☐
Exposure of children to prior DFV	Yes ☐ No ☐ Unknown ☐
DV order /or application involving the deceased	Yes ☐ No ☐
If yes, occurrence number: *Tick if **NA*** ☐	
If yes, was the deceased the aggrieved or respondent *Tick if **NA*** ☐	Aggrieved ☐ Respondent ☐ Aggrieved and Respondent ☐ Cross-Application ☐

If DV order breach history, was the deceased the aggrieved or the respondent *Tick if **NA*** ☐	Aggrieved ☐ Respondent ☐ Aggrieved and respondent ☐ Cross-Application ☐
Previous calls for service to police in relation to domestic or family violence	Yes ☐ No ☐
Perpetrator breach history	Yes ☐ No ☐ NA ☐
Deceased Criminal Justice History	Yes ☐ No ☐
Perpetrator Criminal Justice History	Yes ☐ No ☐
Deceased had prior social services contact	Yes ☐ No ☐ Unknown ☐
If yes, name service/s: *Tick if **NA*** ☐	
Perpetrator had prior social services contact	Yes ☐ No ☐ Unknown ☐
If yes, name service/s: *Tick if **NA*** ☐	
Deceased had prior Government agency contact	Yes ☐ No ☐ Unknown ☐
If yes, name Government Agency/ies: *Tick if **NA*** ☐	
Perpetrator had prior Government agency contact	Yes ☐ No ☐ Unknown ☐
If yes, name Government Agency/ies: *Tick if **NA*** ☐	
Child Protection History(Children of deceased/and or perpetrator	Child Protection Notification ☐ Child Protection Investigation ☐ Child Protection Intervention ☐ Child Protection Order ☐

*Tick if **NA*** ☐	Unknown ☐
Child Protection History(if child deceased) *Tick if **NA*** ☐	Child Protection Notification ☐ Child Protection Investigation ☐ Child Protection Intervention ☐ Child Protection Order ☐ Unknown ☐
Incident Details:	

Domestic and Family Violence Death Review Unit Suicide Coding Form

Occurrence Number of Death	
Year Death Occurred	
Date Death Occurred	
Incident Classification	Suspected suicide ☐ Murder/Suicide ☐
Single/Multiple Deaths	Single ☐ Multiple ☐
Deceased domestic or family violence Status	Victim ☐ Perpetrator ☐ Both ☐
Cause of Death	
Weapon/means used	
Incident Suburb	
Postcode	
Aboriginal and/or Torres Strait Islander	No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Unknown ☐
Ethnicity	
Sex	
Age	
Age category	Under 17 years ☐ 18 to 25 years ☐ 26 to 35 years ☐ 36 to 45 years ☐ 46 to 55 years ☐ 56 to 65 years ☐ 65 years + ☐
Employment Status	Unknown ☐ Employed ☐ Unemployed ☐ Recently Unemployed ☐ Retired ☐ Student ☐

Disability	Physical ☐ Intellectual ☐ Both Physical and Intellectual ☐ Unknown ☐ NA ☐
Relationship status at time of death	Married ☐ Married and separated ☐ Divorced ☐ Reside with another as a couple ☐ Have resided with another as a couple ☐ Engaged ☐ Dating ☐ Informal Care relationship ☐ Other:_____ ☐
Duration of the relationship	Less than 12 months ☐ 1-2 years ☐ 3-4 years ☐ 5-10 years ☐ More than 10 years ☐
Deceased Female ****NA** [if deceased male]* ☐	Not pregnant/no infant ☐ Pregnant ☐ Infant < 12 months ☐ Pregnant and infant < 12 months ☐ Unknown ☐
Social /or Geographical Isolation	Not isolated ☐ Socially isolated ☐ Geographically isolated ☐ Socially and Geographically isolated ☐ Unknown ☐
Place of Incident	Deceased residence ☐ Partner/ ex-partner's residence ☐ Deceased and partner/ex-partner's residence ☐ Public location ☐ Other:_____ ☐
Impending Separation of Intimate relationship	No separation ☐ Intent to separate 2 months ☐ Intent to separate 6 months ☐ Intent to separate greater than 6 months ☐ Actual Separation 2 months ☐ Actual separation 6 months ☐ Actual separation greater than 6 months ☐ Unknown ☐ NA ☐

Deceased mental health	No mental health ☐ Mental health diagnosed ☐ Mental health symptoms but not diagnosed ☐
Mental Health Classification *Tick if* ***NA*** ☐	
Prescribed medication	Yes ☐ No ☐ Yes, but inconsistent taking of medication ☐ NA ☐
Deceased substance abuse history	No ☐ Alcohol ☐ Illicit drugs ☐ Alcohol and Illicit drugs ☐ Prescription drugs ☐ Inhalants ☐ Unknown ☐
Deceased substance abuse at time of death	No ☐ Alcohol ☐ Illicit drugs ☐ Alcohol and Illicit drugs ☐ Prescription drugs ☐ Inhalants ☐ Unknown ☐
Autopsy traces of alcohol or drugs	No ☐ Alcohol ☐ Illicit drugs ☐ Alcohol and Illicit drugs ☐ Prescription drugs ☐ Inhalants ☐ Unknown ☐
Previous suicide ideation	No ☐ Yes < 6 months ☐ Yes 6- 12 months ☐ Yes > 12 months ☐ Unknown ☐
Previous suicide attempt	No ☐ Yes < 6 months ☐ Yes 6- 12 months ☐ Yes > 12 months ☐ Unknown ☐
Number of previous suicide attempts *Tick if* ***NA*** ☐	
EEO History	Yes ☐ No ☐

If yes, most recent EEO *Tick if **NA*** ☐	< 1 month ☐ 1-6 months ☐ 6-12 months ☐ >12 months ☐ NA ☐
History of domestic or family violence involving the deceased	Yes ☐ No ☐ Unknown ☐
Type of domestic or family violence *Tick if **NA*** ☐	Physical ☐ Psychological/emotional ☐ Verbal ☐ Economic ☐ Violence towards children ☐ Abuse of pets ☐ Unknown ☐ Other:_____ ☐
Escalation of family /or domestic violence *Tick if **NA*** ☐	Constant ☐ Escalated ☐ De-escalated ☐ Unknown ☐
Evidence of Financial Problems	Yes ☐ No ☐ Unknown ☐
Evidence of Child Custody Issues	Yes ☐ No ☐ Unknown ☐
Evidence of a Situational Crisis	Yes ☐ No ☐ Unknown ☐
If Situational Crisis Evident, type: *Tick if **NA*** ☐	
Most recent court appearance:	NA ☐ < 1 week ☐ 1-2 weeks ☐ 2-4 weeks ☐ 1 month – 6 months ☐ >6 months ☐
Other crisis/factors that may have contributed to decision to suicide *Tick if **NA*** ☐	

Children exposed to domestic /or family violence	Yes ☐ No ☐ Unknown ☐ NA ☐
DV order /or application involving the deceased	Yes ☐ No ☐
If yes, occurrence number: *Tick if **NA*** ☐	
If yes, was the deceased the aggrieved or respondent *Tick if **NA*** ☐	Aggrieved ☐ Respondent ☐ Aggrieved and Respondent ☐
Previous calls for service to police in relation to domestic or family violence	Yes ☐ No ☐
DV order breach history	Yes ☐ No ☐ NA ☐
If DV order breach history, was the deceased the aggrieved or the respondent *Tick if **NA*** ☐	Aggrieved ☐ Respondent ☐ Aggrieved and respondent ☐
Criminal Justice History	Yes ☐ No ☐
Suicide Note	Yes ☐ No ☐
Deceased had prior social services contact	Yes ☐ No ☐ Unknown ☐
If yes, name service/s: *Tick if **NA*** ☐	
Deceased had prior Government agency contact	Yes ☐ No ☐ Unknown ☐
If yes, name Government Agency/ies: *Tick if **NA*** ☐	

Proximity of the most recent DFV incident/order/referral: *Tick if **NA*** ☐	
Child Protection History(Children of deceased/and or perpetrator *Tick if **NA*** ☐	
Incident Details:	

Appendix D

Intimate Partner Homicide Lethality Risk Factor Form

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, prior attempts of strangulation or real or impending separation, have been found to have been associated with an increased risk of harm in a relationship characterized by domestic and family violence.

Consequently they are often included in domestic and family violence assessment and screening tools by specialist and generalist services, with a view to enhancing responses to victims and their children.

The recognition of multiple risk factors within a relationship allows for a more comprehensive assessment of risk, safety planning and, potentially, the prevention of future deaths related to domestic and family violence.

Assessing and determining the severity of domestic and family violence within a relationship can assist services to identify and quantify the level of risk or danger; allocate resources; and assist victims to understand that they may be at a high risk of violence against them[75].

There is a need however for a more nuanced understanding of risk assessment processes, including differentiating between static and dynamic risk factors. While static risk factors which are historical in nature (such as prior assaults) are incapable of change, dynamic risk factors such as a perpetrator's excessive alcohol and other drug use may fluctuate over time. Factors that are capable of change need to be monitored, as they may change an overall assessment of harm at any point in time. More importantly they can also become a potential point of intervention for service providers to target to reduce risk within a relationship, potentially leading to more effective responses to a perpetrator's use of violence and abuse in a relationship.

While many international domestic and family violence death review mechanisms consider lethality risk factors as part of the review process, assessment tools vary in scope and focus. Currently the DFVDRU adopts the Ontario Domestic Violence Death Review Committee Coding Form as it provides a comprehensive list of 39 risk factors developed cumulatively over time from their reviews of intimate partner homicides.

Established in 2003 and embedded within the coronial jurisdiction, the purpose of this committee is to assist the Office of the Chief Coroner in their investigation and review of domestic violence related homicides, and to make recommendation to prevent deaths in the future. The scope of their review process is restricted to homicides which have occurred within a current or former intimate partner relationship; which, similar to most risk assessment processes, restricts the applicability of the risk factor coding process to only these types of relationships. There is limited research that explores the presence of risk within family relationships characterized by abuse, as the patterns of family violence within these relationships is often very different to patterns coercive controlling violence present in intimate partner relationships. In 75 per cent of cases reviewed by the Ontario Domestic Violence Death Review Committee from 2003 to 2012, seven or more lethality risk factors were present; indicating that these

[75] Roehl, J., O'Sullivan, C., Webster, D. & Campbell, J. (2005). *Intimate Partner Violence Risk Assessment Validation Study, Final Report.* National Criminal Justice Reference Service: U.S. Department of Justice

domestic homicides were predictable and may have been prevented with earlier recognition and action[76].

See more here:
http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/PublicationsandReports/DVDR/2012Report/DVDR_2012.html#b

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A= Evidence suggests that the risk factor was absent
P= Evidence suggests that the risk factor was present
Unk = Unknown

Risk Factors	Code (A,P, Unk)
1. History of violence outside of the family by perpetrator	
2. History of domestic violence	
3. Prior threats to kill victim	
4. Prior threats with a weapon	
5. Prior assault with a weapon	
6. Prior threats to commit suicide by perpetrator	
7. Prior suicide attempts by perpetrator* (if check #6 and/or #7 only count as one factor)	
8. Prior attempts to isolate the victim	
9. Controlled most or all of victim's daily activities	
10. Prior hostage-taking and/or forcible confinement	
11. Prior forced sexual acts and/or assaults during sex	
12. Child custody or access disputes	
13. Prior destruction or deprivation of victim's property	
14. Prior violence against family pets	
15. Prior assault on victim while pregnant	
16. Choked/Strangled victim in the past	
17. Perpetrator was abused and/or witnessed domestic violence as a child	
18. Escalation of violence	
19. Obsessive behaviour displayed by perpetrator	
20. Perpetrator unemployed	
21. Victim and perpetrator living common-law	
22. Presence of stepchildren in the home	
23. Extreme minimization and/or denial of spousal assault history	
24. Actual or pending separation	
25. Excessive alcohol and/or drug use by perpetrator	
26. Depression – in the opinion of family/friend/acquaintance - perpetrator	
27. Depression – professionally diagnosed – perpetrator (If check #26 and/or #27 only count as one factor)	
28. Other mental health or psychiatric problems – perpetrator	

[76] Office of the Chief Coroner (2014) *Domestic Violence Death Review Committee Annual Report*

29. Access to or possession of any firearms	
30. New partner in victim's life	
31. Failure to comply with authority – perpetrator	
32. Perpetrator exposed to/witnessed suicidal behaviour in family of origin	
33. After risk assessment, perpetrator had access to victim	
34. Youth of couple	
35. Sexual jealousy – perpetrator	
36. Misogynistic attitudes – perpetrator	
37. Age disparity of couple	
38. Victim's intuitive sense of fear of perpetrator	
39. Perpetrator threatened and/or harmed children	
Other factors that increased risk in this case? Specify:	

Risk Factor Descriptions

Perpetrator *= The primary aggressor in the relationship*
Victim *= The primary target of the perpetrator's abusive/maltreating/violent actions*

Risk Factor	Description
1	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	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; counselors; 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	Any comment made to the victim, or others, that was intended to instill 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	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	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	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	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	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	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	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	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	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	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	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	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	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	As a child/adolescent, the perpetrator was victimized and/or exposed to any actual, attempted, or threatened forms of family violence/abuse/maltreatment.
18	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	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	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	The victim and perpetrator were cohabiting.
22	Any child(ren) that is(are) not biologically related to the perpetrator.
23	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	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	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	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	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	For example: psychosis; schizophrenia; bipolar disorder; mania; obsessive-compulsive disorder, etc.
29	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	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	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	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 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	Victim and perpetrator were between the ages of 15 and 24.
35	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	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	Women in an intimate relationship with a partner who is significantly older or younger. The disparity is usually nine or more years
38	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	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; counselors; medical personnel, etc).