Domestic and Family Violence Death Review Unit

Research and Data Sharing Protocol

Purpose

The purpose of this document is to outline the process for agencies with relevant policy responsibilities to make requests for research and data held by the Domestic and Family Violence Death Review Unit.

Background

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 been shown to be invaluable in informing the development of more effective interventions, in improving the service system through recommendations for change and in preventing future deaths from occurring in similar circumstances.

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,* which 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,* which is responsible for the systemic reviews of domestic and family violence deaths.

Overview of the Domestic and Family Violence Death Review Unit

Established in 2011 in the Coroners Court of Queensland, the Domestic and Family Violence Death Review Unit (the Unit) assists Coroners in their investigations of relevant reportable deaths, 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.

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 an additional focus on assisting Coroners in their investigations of child deaths, where there has been prior contact with the child protection system.

In 2015 the *Special Taskforce on Domestic and Family Violence* released its Final Report *'Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland (2015)* which recognised the value of the Unit as being the only entity in Queensland who has access to such a detailed body of evidence regarding domestic and family violence deaths. However, the Taskforce expressed concern that the Unit did not appear to be adequately resourced to fulfil its function, nor did it have prominence with policy makers in government who could benefit from the results of the research conducted.

This was seen as a lost opportunity to better understand, and potentially prevent, domestic and family violence related deaths, particularly as a significant amount of the work of the Unit was not publicly released.

Consequently in their final report the Taskforce made the following recommendations with respect to the Queensland Domestic and Family Violence Death Review process, including that:

- the Queensland Government immediately considers an appropriate resourcing model for the Domestic and Family Violence Death Review Unit to ensure it can best perform its functions to enable policy makers to better understand and prevent domestic and family violence (Recommendation 6)
- that protocols be developed with the Domestic and Family Violence Death Review Unit to ensure that government departments with relevant policy development responsibilities have access to the research and resources available from the Unit (Recommendation 7)
- in consultation with key domestic violence stakeholders, the Queensland Government immediately establishes 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 every six months to the oversight body on these findings and recommendations
  (c) be supported by, and draw upon, the information and resources of the Domestic and Family Violence Death Review Unit (Recommendation 8).

Data and information

The Domestic and Family Violence Death Review Unit is responsible for the systemic surveillance and monitoring of relevant categories of reportable deaths (homicides, suicides and homicide-suicides), the collation of data and statistics, and undertaking research to inform the investigation and review of these deaths.

Information and data held by the Unit is generated throughout the review process to support Coroners in their investigation of a relevant reportable death, or the Board in fulfilling their systemic review function.

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.

Data is collated and analysed by the Unit as a coronial investigation progresses and more information becomes available. Consequently, while preliminary demographic data may be available shortly after the death has occurred (e.g. deceased's gender, the relationship to the alleged offender or type of death) it is not always possible to establish a history of domestic and family violence between the deceased and the offender, or the presence of any risk indicators prior to the death, until further information becomes available.

Additionally, while at the initial stages of an investigation it may appear that a death was caused by the action, or inaction, of another party, with the provision of further expert advice, a Coroner may make a determination that the death was related to other causal factors. Conversely, while a death may not have originally been considered to be a suicide or homicide, subsequent investigations may indicate that the death was non-accidental or a result of the involvement of a third party.

Because of this, the data held by the Unit undergoes a series of revisions over time and preliminary statistics (particularly within the last two years) may be subject to change pending the outcomes of the coronial investigation. External agencies need to be mindful of these limitations when submitting requests for data to the Unit, and in ensuring that any statistics are reported with the caveat that, as the data relates to both open and closed coronial cases, it may be subject to change pending the outcome of any further investigation.

This process of revision is not unique to domestic and family violence deaths, and is a process adopted by a range of agencies such as the Australian Bureau of Statistics[1] and the Australian Institute for Suicide Research and Prevention[2] (in relation to suspected or apparent suicides) or the National Drug and Alcohol Research Centre (in relation to suspected overdose fatalities).

The release of preliminary statistics allows for a more timely identification of any emerging trends and issues in these types of deaths, and potentially the implementation of preventative strategies that aim to reduce the occurrence of future deaths.

While the Unit reviews suicides identified as domestic and family violence related, 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. As such, the methodology for the systemic identification and analysis for these types of deaths is more complex, and not as statistically robust as that related to homicides.

The Unit is currently exploring ways, with relevant partner agencies, to more effectively report on data in relation to suicides where there is a known prior history of domestic and family violence, and the context and circumstances of the death are such that the history can reasonably be considered a proximate or contributory factor to the death, to better inform research and policy responses in this area.

[1] This process was implemented to address concerns regarding the under-reporting of suicides, more information can be found here: http://www.aph.gov.au/~/media/wopapub/senate/committee/clac_ctte/completed_inquiries/2008_10/suicide/report/c03_pdf.ashx

[2] The development of the interim Queensland Suicide Register enables AISRAP to provide more current data in relation to these types of deaths, more effectively track emerging trends and issues, as well as inform policy, practice and prevention responses.

Definitions

Outlined within the State Coroners Guidelines, the Unit uses a broad definition of a *'domestic and family violence related death'* to ensure that cases are proactively identified and considered by the Unit for review. The definition includes:

- homicides or homicide-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
- 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.

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. The definition of 'homicide' adopted by the Network is broader than the legal definition of the term. 'Homicide', as 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 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.

The Australian Domestic and Family Violence Death Review Network is currently developing a national minimum data set of intimate partner homicides, and domestic and family violence related deaths, to increase knowledge regarding the context and circumstances of these types of deaths at a national level.

Requests for information

The Unit is responsible for the provision of advice and assistance to Coroners in their investigations of relevant reportable deaths, and in providing information and support to the Domestic and Family Violence Death Review and Advisory Board to help it fulfil its systemic review function.

It is because of this supportive function that the release of data, information and research generated by the Unit is subject to the consideration and approval of either the State Coroner or the Board.

Under the *Coroners Act 2003,* the State Coroner is responsible for approving the release of any data or information held in relation to the coronial jurisdiction, including information held by the Unit. In addition to oversight of data requests, access to investigation documents may also be granted by the State Coroner to genuine researchers under section 53 of the Act. More information about these provisions can be found on the Coroners Court of Queensland website.

Requests cannot be made to the Unit in relation to the progress of a coronial investigation. However, coronial findings are publicly available for matters that proceed to inquest, or for those cases where a coroner has made a determination to publish the findings of their investigation as they consider it in the public interest to do so, even when they have decided not to hold an inquest. These findings can be found here. The issues considered by a coroner throughout their investigation, including domestic violence, are identifiable in the key words related to each case.

Provisions also exist in the Administrative Arrangements between the Board and the State Coroner for the Board to provide government agencies with relevant portfolio responsibilities with access to research and resources generated through the review process. The Board is also required to report to the Minister annually in relation to the performance of its functions, including information about the implementation of any of the Board's recommendations, with a view to these reports being made publicly available. Information and reports relevant to the Board can be found here.

While requests for data can be made to the Unit, approval for the release of this information will be based on the purpose of the request, and whether the data will be used to inform changes in policy or practice that aim to prevent or reduce domestic and family violence related deaths from occurring in the future.

Requests for data or information held by the Unit should be submitted to the Manager here: Coroner.DFVDRU@justice.qld.gov.au

For agencies who are interested in being proactively informed of published findings made by coroners in relation to relevant reportable deaths or reports released by the Board, a request to be included on a mailing list can also be submitted to the above email address.

Approval for inclusion on the mailing list will only be granted to representatives from government agencies, academics or non-government organisations with relevant portfolio responsibilities, and not to individuals with a private interest in this area. The Unit will not respond to enquiries from private individuals, or media entities, as they are required to submit requests through established Department of Justice and Attorney-General processes.