Domestic and Family Violence Death Review and Advisory Board

Annual Report 2022–23

Queensland Government

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

We seek to ensure that domestic and family violence deaths do not go unnoticed, unexamined or forgotten.

Acknowledgment

We respect and honour Aboriginal and Torres Strait Islander Elders past, present and future. We acknowledge the stories, traditions and living cultures of Aboriginal peoples and Torres Strait Islander peoples on this land and commit to building a brighter future together.

Warning: Aboriginal and Torres Strait Islander peoples should be aware that this report contains information about Aboriginal deceased persons and Torres Strait Islander deceased persons.

About this report

This report has been prepared by the Domestic and Family Violence Death Review and Advisory Board (the Board) in accordance with section 91ZB(1) of the *Coroners Act 2003*, which outlines that the Board must, within three months of the end of the financial year, provide a report to the Minister in relation to the performance of the Board's functions during that financial year.

Under section 91ZB(2) of the Act the Annual Report must also include information about the progress made during the financial year to implement recommendations made by the Board during that year, or previous financial years.

Under section 91ZB(3) of the Act the Minister must table a copy of this report in the Queensland Parliament within one month of receiving it.

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

Seek help

Domestic and family violence has a profound and devastating impact on the community. The Board respectfully acknowledges and honours the victims of domestic and family violence, as well as the families and friends who have lost loved ones to acts of violence.

Families and friends must often navigate their own complex emotions and trauma as they search for answers to this tragedy, while also grieving for their loved ones.

At the same time as attending to funeral arrangements, family members are often required to manage the administrative tasks associated with the death of the loved one and asked to engage in investigations and other proceedings in order to seek justice.

A family's search for justice is often a long and difficult process, and the Board acknowledges that far too often, justice is not achieved.

The Board acknowledges the strength of these families and stands in solidarity with them in the hope that one day, no Queenslander will be impacted by acts of domestic and family violence.

The Board also acknowledges the significant efforts of those individuals, services and government agencies working across Queensland to prevent and respond to domestic and family violence. Responding to domestic and family violence is complex and multilayered. There are no simple solutions, and it will take time to enact the change we want to see. Until then, we acknowledge all persons working in pursuit of this shared goal.

If you, or someone you know, needs immediate help the following services are available to assist:

- **Triple Zero (000)** is a 24-hour emergency response call service to the police for anyone requiring assistance in life-threatening or time-critical emergency situations.
- **Policelink (131 444)** is a 24-hour service for non-urgent incidents, crimes or police inquiries.
- **DVConnect Womensline** is a 24-hour crisis support line for anyone who identifies as female being impacted by domestic and family violence. DVConnect is contactable on **1800 811 811** or via www.dvconnect.org.
- **DVConnect Mensline** operates between 9am and midnight, 7 days a week, and is a crisis support line for anyone who identifies as male who is experiencing or using domestic and family violence. DVConnect Mensline is contactable on **1800 600 636** or via www.dvconnect.org.
- **Lifeline** is a 24-hour telephone counselling and referral service and can be contacted on **13 11 14** or via www.lifeline.org.au.
- **13YARN** is a 24-hour telephone counselling and referral service run by Aboriginal and Torres Strait Islander peoples and can be contacted on **13 92 76** or via www.13yarn.org.au.
- **Kids Helpline** is a 24-hour free counselling service for children and young people (5–25 years of age) and can be contacted on **1800 55 1800** or via www.kidshelpline.com.au.
- **Suicide Call Back Service** can be contacted on **1300 659 467** or via www.suicidecallbackservice.org.au.
- **Beyondblue** can be contacted on **1300 22 4636** or via www.beyondblue.org.au.

If you, or someone you know, has lost a loved one to domestic and family violence, there is ongoing support available:

- **Queensland Homicide Victim Support Group (QHVSG)** is a community support group which offers 24-hour support, personal advocacy and education to all people affected by homicides in Queensland. QHVSG is contactable on **1800 774 744** or via www.qhvsg.org.au.
- **Queensland Indigenous Family Violence Legal Service (QIFVLS)** is a free legal service for Aboriginal or Torres Strait Islander people affected by family violence or sexual assault. If you, or your family, need legal support or more information, you can contact QIFVLS on **1800 887 700** or via www.qifvls.com.au.

» **Women's Legal Service Queensland (WLSQ)** is a community legal centre that provides free, statewide legal and social work help to Queensland women. WLSQ provides assistance in domestic violence, family law and sexual violence matters. Contact the statewide Legal Advice Helpline on **1800 957 957** or via www.wlsq.org.

If you identify as Aboriginal and Torres Strait Islander, please contact your local **Aboriginal and Torres Strait Islander Community Health Service** for culturally appropriate services.

The Queensland Government's **Domestic and Family Violence Media Guide** provides information for journalists about responsible reporting of domestic and family violence at https://www.publications.qld.gov.au/dataset/domestic-and-family-violence-prevention/resource/c9ed71ec-74e6-48b0-8894-e5de6d5cf290.

Guidelines for safe reporting in relation to substance use, suicide and mental illness for journalists are available at www.mindframe.org.au.

Outgoing chair's message

Seven years ago, the Special Taskforce on Domestic and Family Violence conducted a review into the domestic and family violence landscape in Queensland. The Taskforce recommended establishing a Domestic and Family Violence Death Review and Advisory Board (the Board) as part of its vision and strategy for addressing this form of violence.

While domestic and family violence-related deaths are statistically rare, the Queensland Government has previously recognised they provide critical opportunities to identify nuances, emerging trends, and opportunities for system-wide improvements.

As outgoing Chair, it has been my privilege to have overseen the establishment and development of the Board to what it is today—a leading mechanism in Queensland for supporting ongoing domestic and family violence reform and oversight.

The work of the Board is enabled by a group of multi-disciplinary experts from government agencies and non-government organisations, a Secretariat, and guest experts who are specialists in their field. It is because of their collective knowledge and experience that the Board has, and continues to, lead meaningful change.

The Board has reviewed more than 100 domestic and family violence deaths since its establishment in 2016. The Board examines case reviews, as well as data from the Queensland Domestic and Family Violence Homicide and Suicide Databases, for common systemic failures and gaps.

Years of knowledge, insight and learnings taken from domestic and family violence deaths have contributed to system and practice and procedural improvements.

I am particularly proud of the work of the Board in the following areas:

- calling for mandatory training to be delivered to Queensland Health staff who may come into contact with victims of domestic and family violence and persons using violence
- increasing awareness of the person most in need of protection where there are mutual allegations of violence and abuse, including a recommendation for commissioned research which has been actioned by Australia's National Research Organisation for Women's Safety (ANROWS)[1]
- ongoing examination of: bail for domestic and family violence breaches, coercive control, and police responses to domestic and family violence.

The Board has come a long way since its establishment and now plays a significant role in influencing reviews and inquiries into domestic and family violence, demonstrating its wide-reaching impact on domestic and family violence reform.

In March 2021, the Queensland Government announced the establishment of the Women's Safety and Justice Taskforce. The Taskforce conducted a wide-ranging review into the experiences of women across Queensland's criminal justice system, including consideration of how to best legislate against coercive control. The Taskforce acknowledged the contributions of the Board over the past six years and stated the Board's work contains a 'wealth of information about how domestic and family violence is being responded to across the service system and, importantly, where there are deficits that need to be addressed.'

In November 2022, the Commission of Inquiry into Queensland Police Service responses to domestic and family violence released its report. The Commission also acknowledged the work of the Board to consistently identify issues with the responses of police, courts, health, and child safety services in the lead up to domestic and family violence-related homicides and suicides. The work of the Board contributed to the comprehensive findings of the Commission.

[1] Australia's National Research Organisation for Women's Safety. (2020). *Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions* (Research to policy and practice, 23/2020). https://www.anrows.org.au/project/accurately-identifying-the-person-most-in-need-of-protection-in-domestic-and-family-violence-law/

The Commission further acknowledged its inquiry was informed by various coroners' findings about domestic and family violence-related deaths.

I also acknowledge and am appreciative of the work of the Board in informing coronial inquest findings into the tragic deaths of Doreen Langham and Hannah Clarke and her children Aaliyah, Laianah and Trey.

At the end of my tenure as Chair of the Board, I would like to thank the current Board, those supporting the Board in its important work, and former members whose impacts remain significant. I would like to acknowledge the work of the outgoing Board members, Dr Kathleen Baird, Ms Angela Lynch, Ms Rosemary O'Malley and Assistant Commissioner Brian Codd. Their contributions have been invaluable in helping to improve domestic and family violence service system responses. I would also like to recognise the commitment and dedication of the Domestic and Family Violence Death Review Unit who provide secretariat support for the Board.

Finally, I acknowledge and honour the victims of domestic and family violence and their families and friends. Their deaths are a tragic loss, and we should never stop working together to end domestic and family violence.

I welcome the new Chair and wish the Board well in its journey. This is a significant time for domestic, family and sexual violence reform In Queensland. However, I have no doubt that the Board will continue to uniquely contribute to this ongoing work, ensuring we do everything we can to prevent future deaths.

Terry Ryan

State Coroner

Incoming chair's message

I begin my tenure as Chair of the Domestic Family Violence, Death Review and Advisory Board at an interesting and significant time for domestic and family violence reform in Queensland.

Over the last two years, multiple reviews into domestic and family violence have resulted in more than 500 recommendations. The breadth and range of recommendations made across these reviews, including those from the Board and coronial findings, reflects the complexity of domestic and family violence and the community's increasing understanding of this insidious form of violence.

As a Board we find ourselves at an important point of reform. While recent reviews have culminated in wide ranging recommendations to guide Queensland's response to domestic and family violence, the journey does not stop here. Maintaining this momentum of change in domestic and family violence reform requires ongoing commitment and dedication.

The Board has demonstrated its influence in leading and contributing to Queensland's response to domestic and family violence since its establishment in 2016. The work of the Board in reviewing domestic and family violence deaths continues to be crucial in identifying systemic issues and making recommendations to improve systems, practices, and procedures.

This year's report builds on the Board's previous work. However, it stands apart from previously published reports in many ways, assessing the significant work that has been undertaken across Queensland's domestic and family violence landscape. Currently, the Queensland Government is leading the implementation of a comprehensive suite of reforms within the domestic, family and sexual violence service system.

In this year's annual report, the Board reflects on the extent to which implementation has progressed and where future change may still be required. In reflecting on these reforms, the Board turns its mind to how it may better utilise its functions to continue to drive system-wide improvements. The Board provides both a vehicle for accountability in the prevention of domestic and family violence deaths and for oversight of the impact of recommendations on system responses.

Always central to the Board's work are the victims of domestic and family violence. Their deaths are profoundly devastating for family members and the broader community. The Board's work must remain impactful, and this report reiterates the Board's commitment to learn from victims' stories to reduce the prevalence of domestic and family violence in our community and prevent future deaths. The annual report is only one way in which the Board fulfils its commitment.

Throughout the year the Board shares its findings in workshops and seminars to increase the community's awareness and understanding of this issue. This is work that the Board plans to increase over time.

In next year's annual report, the Board will respond to Recommendation 17 of the Women's Safety and Justice Taskforce, *Hear her voice – Report two – Women and girl's experience across the criminal justice system*. To inform this, the Board will undertake a review of past cases of domestic and family violence-related deaths involving sexual violence.

I farewell and thank State Coroner Terry Ryan for his work and leadership in overseeing the Board as Chair from 2016 to 2022 and acknowledge outgoing Board members whose journeys to making a difference in our community continue elsewhere. I welcome new members whose experiences and insights continue to enhance the value of the Board and its work.

It is my privilege as incoming Chair to oversee the functions of the Board as it creates a new path for system oversight and accountability in preventing and reducing domestic and family violence, and to honour the voices of Queensland's victims.

Stephanie Gallagher

Deputy State Coroner

About the Board

The Domestic and Family Violence Death Review and Advisory Board (the Board) was established in 2016 following Recommendation 8 of the *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland* report.[2]

The Board holds a unique position within the Queensland domestic and family violence sector as its functions are enshrined in legislation under Part 4A of the *Coroners Act 2003* (the Act).

The Board is responsible for the systemic review of domestic and family violence-related deaths that have occurred in Queensland. Its role and functions are outlined in the Act, and include to:

a) identify preventative measures to reduce the likelihood of domestic and family violence deaths in Queensland;

b) 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

c) make recommendations to the Minister for implementation by government entities and non-government entities to prevent or reduce the likelihood of domestic and family violence deaths.

In reviewing deaths, the function of the Board is to identify systemic issues, not to investigate the circumstances of an individual death. 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 victims of domestic and family violence and persons using violence, or deaths where there has been recent contact with different systems or services.

The Board looks to emerging issues and prevalent case types to decide what types of cases will be reviewed. When selecting cases for review, the Board prioritises cases where relevant information is available and there has been service system contact. This ensures the Board can examine service provision, interactions and information sharing between services and systems, and any missed opportunities for intervention to inform the development of preventative, system-focused recommendations.

The Board consists of representatives from both government and non-government organisations with expertise in domestic and family violence. Current Board members come from various expert backgrounds, including law enforcement, the criminal justice system, the healthcare sector, social services, and other public safety agencies.

Several members of the present Board have been involved since the Board's inception in 2016. Membership has evolved over the years to address changing and emerging issues that have been identified within the Queensland context. In some cases, external experts have been called to advise the Board on case reviews.

[2] Special Taskforce on Domestic and Family Violence (2015). *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland*. https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/533db62b-b2c9-43cc-a5ff-f9e1bc95c7c7/dfv-report-vol-one.pdf?ETag=c69c3ef47071a137ddbaedb49f7fe468

Board members

CURRENT

Ms Stephanie Gallagher
Deputy State Coroner of Queensland
Chairperson (appointed March 2023)

Ms Nadia Bromley
Non-government member
Chief Executive Officer, Women's Legal Service (appointed March 2023)

Ms Kristina Deveson
Acting Executive Director, Magistrates Court Services Queensland, Department of Justice and Attorney-General

Dr Molly Dragiewicz
Non-government member
Associate Professor, School of Criminology and Criminal Justice, Griffith University

Mr David Harmer
Senior Director, Strategic Policy and Legislation Branch, Queensland Health (appointed March 2023)

Ms Keryn Ruska
Non-government member
Principal Lawyer
IUIH Legal Service
Institute of Urban Indigenous Health (IUIH)

Dr Kylie Stephen
Assistant Director-General, Office for Women and Violence Prevention, Department of Justice and Attorney-General

Mr Paul Stewart
Commissioner, Queensland Corrective Services

Ms Betty Taylor
Non-government member
Director, Betty Taylor Training and Consultancy
Chief Executive Officer, Red Rose Foundation

FORMER

Mr Terry Ryan
State Coroner of Queensland
Outgoing Chairperson (to October 2022)

Dr Kathleen Baird
Deputy Chairperson
Professor of Midwifery; Director of Midwifery, Maternal and Child Research Centre
School of Nursing and Midwifery, Faculty of Health
University of Technology Sydney
Adjunct Professor, Griffith University (to October 2022)

Mr Brian Codd
Assistant Commissioner, Domestic, Family Violence and Vulnerable Persons Command
Queensland Police Service (to October 2022)

Ms Angela Lynch
Non-government member
Lawyer and Advocate
Queensland Sexual Assault Network (QSAN) (to October 2022)

Ms Rosemary O'Malley
Non-government member
Chief Executive Officer
Gold Coast Domestic Violence Prevention Centre (to October 2022)

SECRETARIAT

Domestic and Family Violence Death Review Unit
Coroners Court of Queensland

Contents

Overview

The 2022–23 Annual Report of the Domestic and Family Violence Death Review and Advisory Board comprises four sections:

- **Section 1** 'Influencing the landscape: Domestic and family violence reform in Queensland' discusses the recent domestic and family violence reforms in Queensland and contextualises the work of the Board.
- **Section 2** 'Current performance' reports on the progress made towards implementing the recommendations made by the Board since its establishment in 2016.
- **Section 3** 'Driving sustainable change' concludes the 2022–23 Annual Report by outlining the evolving role of the Board and its proposed focus for 2023–24.
- **Section 4** presents data about domestic and family violence-related deaths in intimate partner and family relationships in Queensland between 1 July 2017 and 30 June 2023.

The 2022–23 Annual Report also includes several appendices, which include supporting information to the annual report.

1. Influencing the landscape

Domestic and family violence reform in Queensland

This section discusses the Queensland domestic and family violence reform environment and contextualises the work of the Board.

This is the seventh Annual Report produced by the Board since its establishment in 2016. It is produced at a time of significant and ongoing reform across Queensland.

These reforms aim to prevent domestic and family violence-related deaths by improving legislation, policies and procedures, services, and systems to better protect victims and to keep persons using violence accountable. This ensures emerging issues are recognised early, new initiatives are proposed and options for updating and creating more sustainable approaches are put forward.

While domestic and family violence has only been on the social and policy agenda for around 50 years, there has been ongoing and extensive reform.

In 2015, the Special Taskforce on Domestic and Family Violence published its long-term vision for domestic and family violence reform in its report, *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland*.[3] Almost $1.3 billion has been invested in domestic and family violence reforms and initiatives since 2015.[4]

In the past two years alone, there have been several significant reviews which intersect with the Board's focus on preventing domestic and family violence deaths. Collectively, these reviews have made more than 500 recommendations.

The recommendations made have been far-reaching. Those with direct relevance to the mandate of the Board have sought to:

- raise community awareness and understanding of domestic and family violence
- improve primary prevention and service system responses with a particular focus on police, lawyers, judicial officers, forensic medical examiners, and the court
- develop, implement, and adequately fund consistent evidence-based, trauma-informed, and culturally informed domestic and family violence training tailored to stakeholders across the service system
- enhance interagency collaboration and coordination across the service system to keep people safe from domestic and family violence.

In addition to these reviews, there is significant ongoing activity at the national and state levels. This includes work undertaken to deliver on:

- the *National Plan to End Violence against Women and Children 2022–2032*[5]
- Target 13 of the *National Agreement on Closing the Gap* which commits to reducing the rate of all forms of family violence against Aboriginal and Torres Strait Islander women and children[6]
- the Queensland Government's *Fourth Action Plan 2022–23 to 2025–26* of its *Domestic and Family Violence Prevention Strategy 2016–2026*[7]
- the *Queensland Women's Strategy 2022–27*, including the Queensland Government's support of Wiyi Yani U Thangani and commitment to developing a Wiyi Yani U Thangani Action Plan.[8,9]

[3] Special Taskforce on Domestic and Family Violence (2015). *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland*. https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/533db62b-b2c9-43cc-a5ff-f9e1bc95c7c7/dfv-report-vol-one.pdf?ETag=c69c3ef47071a137ddbaedb49f7fe468

[4] Queensland Government (2022). *Action for victim-survivors of sexual violence*. https://statements.qld.gov.au/statements/96625

[5] Australian Government Department of Social Services (2022). *National Plan to End Violence Against Women and their Children*. https://www.dss.gov.au/the-national-plan-to-end-violence-against-women-and-children/the-national-plan-to-end-violence-against-women-and-children-2022-2032

[6] Closing the Gap (2022). *Closing the Gap: Targets and Outcomes*. https://www.closingthegap.gov.au/national-agreement/targets

[7] Queensland Government (2022). *Fourth action plan 2022–23 to 2025–26 of the Domestic and family violence prevention strategy*. https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/3b48a2e8-94ce-46c2-ad49-9aed3b3ac2d9/fourth-action-plan.pdf?ETag=d22784780bf2eaf1bfcc688f17d25eb7

[8] Queensland Government (2022). *Women's Strategy 2022–27*. https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/95357068-d24b-4565-a991-7b8be088ced9/queensland-womens-strategy-2022-27.pdf?ETag=c655247f0b2cb9f9295b45147ce05295

[9] Queensland Government (2022). *Statement of support for Wiyi Yani U Thangani (Women's Voices) report 2020*. https://humanrights.gov.au/our-work/aboriginal-and-torres-strait-islander-social-justice/publications/wiyi-yani-u-thangani

The Board itself has played an active role in contributing to and shaping ongoing reform in Queensland. The Board drives reform by identifying common systemic failures, gaps or issues and makes recommendations to improve systems, practices and procedures to prevent future domestic and family violence deaths. The Board's work also involves enhancing existing reform activities across Queensland, enabling the Board to amplify its impact.

Examples of the Board's role as a driving force behind reform over the last seven years are highlighted below. These examples show some of the wide-ranging influence the Board has had on Queensland's response to domestic and family violence to date:

- 2016–17: the Board made recommendations to complement and enhance current reforms associated with the Special Taskforce Report on Domestic and Family Violence, as well as other reform agendas relevant to the health, child protection, and criminal justice systems.
- 2017–18: the Board's report suggested there is a heightened risk of homicide in those relationships where an act of non-lethal strangulation has occurred. In recognition of this, and in response to the *Not Now, Not Ever* Report, the Government introduced a new offence of choking, suffocation, or strangulation in a domestic setting.
- 2018–19: the Board's recommendations aligned with the broader policy outlined in the Government's Third Action Plan (2019–20 to 2021–22) of the Queensland Government's *Domestic and Family Violence Prevention Strategy*, thereby supporting actions to be implemented under three foundational elements of reform: changing community attitudes and behaviours; integrating service responses; and strengthening justice system responses.
- 2019–20: the Government accepted the Board's calls for the development of a comprehensive, system-wide strategy for addressing all perpetrators of domestic and family violence and committed to developing a long-term framework to guide Queensland's response to persons using violence over coming years.
- 2020–21: the Board noted that its recommendations needed to complement the then forthcoming first report of the Women's Safety and Justice Taskforce (the Taskforce). Many of the Board's recommendations had direct links to the Taskforce's first report, as intended by the Board. The government committed to implementing these recommendations in tandem with its response to the work of the Taskforce.
- 2021–22: the Board's recommendations for this period were made in the context of significant reforms underway in response to the Taskforce's *Hear Her Voice* reports.

The Board recognises that the intensity of reform has rapidly increased in recent years as a result of multiple reviews. It applauds this renewed focus on domestic and family violence. The Board also acknowledges that an important part of reform is ensuring that recommendations deliver on their intended outcomes of preventing domestic and family violence and keeping victim-survivors safe.

The Board recognises that in the current domestic and family violence landscape, there is a potential risk that the bigger picture and intended outcomes of reform are overlooked. This may occur if the focus is on planning and implementing activities to respond to and manage the large volume of recommendations. A balanced and strategic approach is needed to achieve meaningful change. There is a further risk that agencies experience reform fatigue and this is addressed by the Board in section 2.

Monitoring the implementation of its recommendations is a function that will come into sharper focus as the Board seeks to critically analyse progress in this crowded reform environment, while keeping the needs and experiences of victim-survivors at the centre of reform.

Some of the recommendations from reviews build upon previous recommendations made by the Board. The following case study is an illustrative example. The Board continues to monitor the implementation of recommendations which have been expanded upon by subsequent reviews. As part of its monitoring function, the Board notes the importance of ensuring the initial intent of the recommendations are retained as associated reforms and initiatives are implemented.

The Board's influence on accurately identifying how best to respond to the person most in need of protection.

In its 2016–17 Annual Report, the Board reported that in just under half (44.4%) of all cases of female deaths subject to review, the woman had been identified as a respondent to a domestic and family violence (DFV) protection order on at least one occasion. Further, in nearly all the DFV-related deaths of Aboriginal and Torres Strait Islander peoples, the Board noted the deceased had been recorded as both respondent and aggrieved prior to their death.

Considering these findings, the Board highlighted the need for increased awareness of when, why, and how victims may use violence. It also noted the critical importance that the person most in need of protection, and the person most likely to inflict harm, are correctly identified at every point of contact with services who may be able to assist.

Consequently, the Board recommended research to identify how best to respond to the person most in need of protection where there are mutual allegations of violence and abuse (Recommendation 16).[10]

In 2020, in response to this recommendation, Australia's National Research Organisation for Women's Safety (ANROWS) completed this research. ANROWS published its final report, *Accurately identifying the "person most in need of protection" in domestic and family violence law,* in November 2020.[11] The report recommended the need for improved guidance for police to support identifying patterns of coercive control, and guidance for magistrates on how and when they can dismiss inappropriate applications and/or orders. It also recommended clarifying decision-making processes and accountability to address current ambiguity surrounding whether police or courts are responsible for determining the person most in need of protection.

The Board recommended the implementation of the ANROWS report's recommendations in its 2020–21 Annual Report. It also recommended extending this to consider potential legislative amendments to strengthen existing provisions under the *Domestic and Family Violence Protection Act 2012* designed to ensure the identification of the person most in need of protection in proceedings (Recommendation 2). This recommendation was accepted by the Queensland Government.

The Board has continued to monitor this recommendation, noting it has been further extended by the Taskforce in its first report, *Hear Her Voice – Report 1- Addressing Coercive Control and Domestic and Family Violence in Queensland* (2021).[12] In particular, the Board's recommendation is aligned with Recommendations 56, 67, and 68 of the Taskforce's first report. In response to these recommendations, the Queensland Government is progressing legislative amendments to the *Domestic and Family Violence Protection Act 2012* to ensure applications and cross applications for a domestic violence order are considered together, so that courts only make one domestic violence order which favours the person most in need of protection in the relationship, unless exceptional circumstances apply. It is further considering updating and developing guidance in DFV bench books on how to identify the person most in need of protection.

The also Board notes the Queensland Police Service (QPS) has addressed this recommendation through the development and implementation of a mandatory training program on coercive control. The program was rolled out in 2021–22 and provides guidance to QPS members regarding the accurate identification of the person most in need of protection in situations where there are mutual allegations.

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[10] Recommendation 16: *That the Queensland Government commission research which aims to identify how best to respond to the person most in need of protection, where there are mutual allegations of violence and abuse. This research should take into account the identification of potential training or education needs for service providers, across applicable sectors to better assist in the early identification of, and response to, victims who may use violence, particularly where they come to the attention of services during relevant civil proceedings for domestic and family violence protection orders*. See Domestic and Family Violence Death Review and Advisory Board (2017). *2016–17 Annual Report*. https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0003/723675/domestic-and-family-violence-death-review-and-advisory-board-annual-report-2016-17.pdf

[11] Australia's National Research Organisation for Women's Safety. (2020). *Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions* (Research to policy and practice, 23/2020). https://www.anrows.org.au/project/accurately-identifying-the-person-most-in-need-of-protection-in-domestic-and-family-violence-law/

[12] Women's Safety and Justice Taskforce (2021). *Hear Her Voice – Report 1 – Addressing Coercive Control and Domestic and Family Violence in Queensland*. https://www.womenstaskforce.qld.gov.au/publications

During its discussions, the Board noted that rather than adding to the list of recommendations, its unique value is in assisting with the effective implementation of broader reforms by using its system focus, expertise, and experience to:

1. ensure the victims' voices and experiences continue to be at the centre of reform
2. identify potential gaps in the reform environment, including opportunities to strengthen current activities
3. ensure there is a system focus, where agencies work collaboratively and are accountable for achieving intended reform outcomes.

A key strength of the Board is its enduring nature as a statutory body. While each of the reviews noted earlier in this section represented a significant piece of reform, these reviews often had a specific focus and were short-term in nature.

As the focus on domestic and family violence has increased, resulting in increased funding, policy reform, and community awareness in Queensland, the Board has observed its role has evolved to focus on the broader service system and to supporting ongoing reform. In section 3, the Board addresses how it plans to deliver these functions.

2. Current performance

Monitoring progress

This section reports on the implementation progress towards the recommendations made by the Board since its establishment in 2016.

The Board is empowered to make recommendations to the Minister to prevent or reduce the likelihood of domestic and family violence deaths.

Under section 91D(1)(f) of the Act, the Board is also required to monitor and report on the implementation of recommendations it has made as part of its review process. In practice, agencies provide both an initial whole-of-government response to all recommendations made by the Board, and then regular progress updates throughout implementation. All responses are published on the Board's webpage.

The capacity to monitor recommendations is key to ensuring an effective death review process. It supports accountability and informs consideration of the effectiveness and appropriateness of any recommendations the Board has made, including whether the identified issues have been addressed as intended.

The Government response to the Board's 2021–22 Annual Report was released on Friday 4 August 2023. All 10 recommendations were accepted (see Appendix B). Of the 75 recommendations made by the Board between 2016–17 and 2021–22, all but one has been accepted (in full, in part or in principle) by the Queensland Government.

Figure 1 shows implementation progress based on information provided to the Board in 2021–22.[13] It shows that 40 (53%) recommendations are complete, and 24 (32%) are in progress.

The Board's recommendations relate to multiple portfolio areas. While in some instances multiple secondary agencies were nominated to support the lead agency in delivering recommendations, most of the Board's recommendations have been directed towards the departments with responsibility for Child Safety Services, domestic and family violence reform and service delivery, women's safety, health and justice.[14]

The Board is required to direct its recommendations to the Minister, not non-government organisations. However, some recommendations have specifically named other entities as implementation partners, such as Primary Health Networks, the Queensland Sentencing Advisory Council, the Queensland Law Reform Commission and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Although these entities are not the responsible agency for reporting on implementation, they play an important role in the implementation of the Board's recommendations.

The Board will continue to consider how it can develop recommendations to influence the broader service system, including non-government organisations, within the context of undertaking case reviews.

The Board's recommendations have had a broad focus, with the majority aiming to enhance workforce development, enhance systems and processes, and enable greater service accessibility and availability (see Figure 2).

The Board's focus on these areas of reform reflects both the issues identified in its previous case reviews, as well as current activities underway across Queensland that can reasonably be considered to improve the way agencies and systems respond into the future (relevant to the issue identified).

[13] The Board did not receive an implementation update for 2022–23 before this report was finalised.

[14] Machinery of government changes have meant that the implementation of recommendations have been reported upon by different agencies over time.

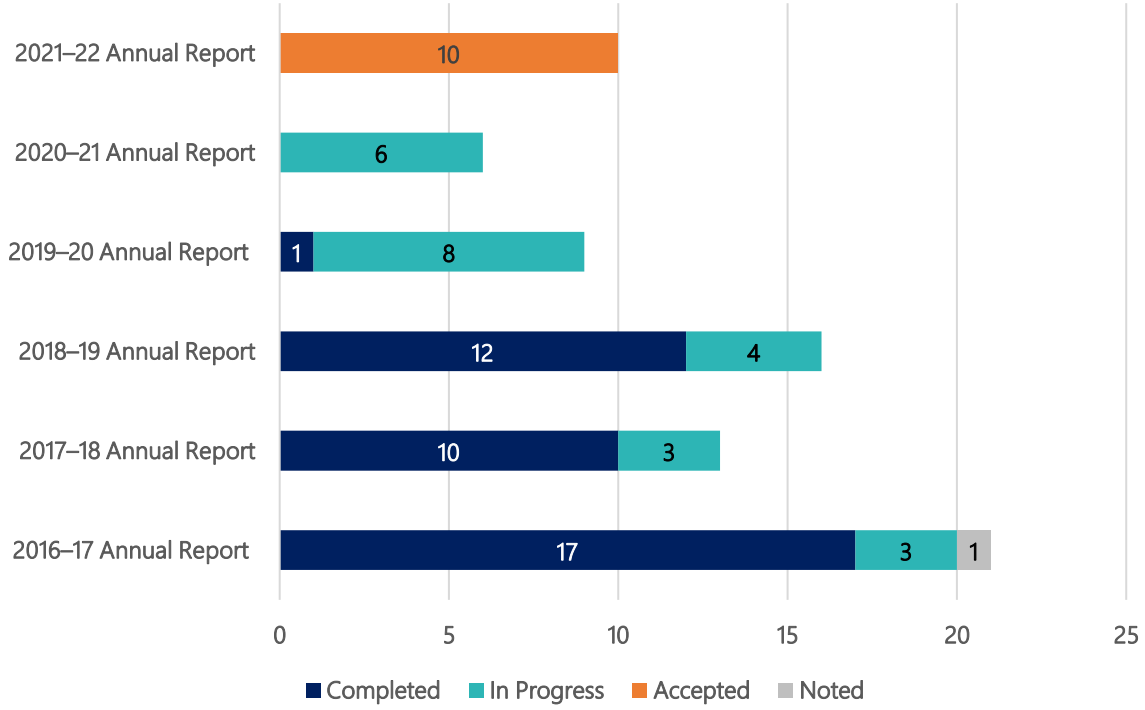

Figure 1: Implementation status of recommendations made by the Board between 2016–17 and 2021–22

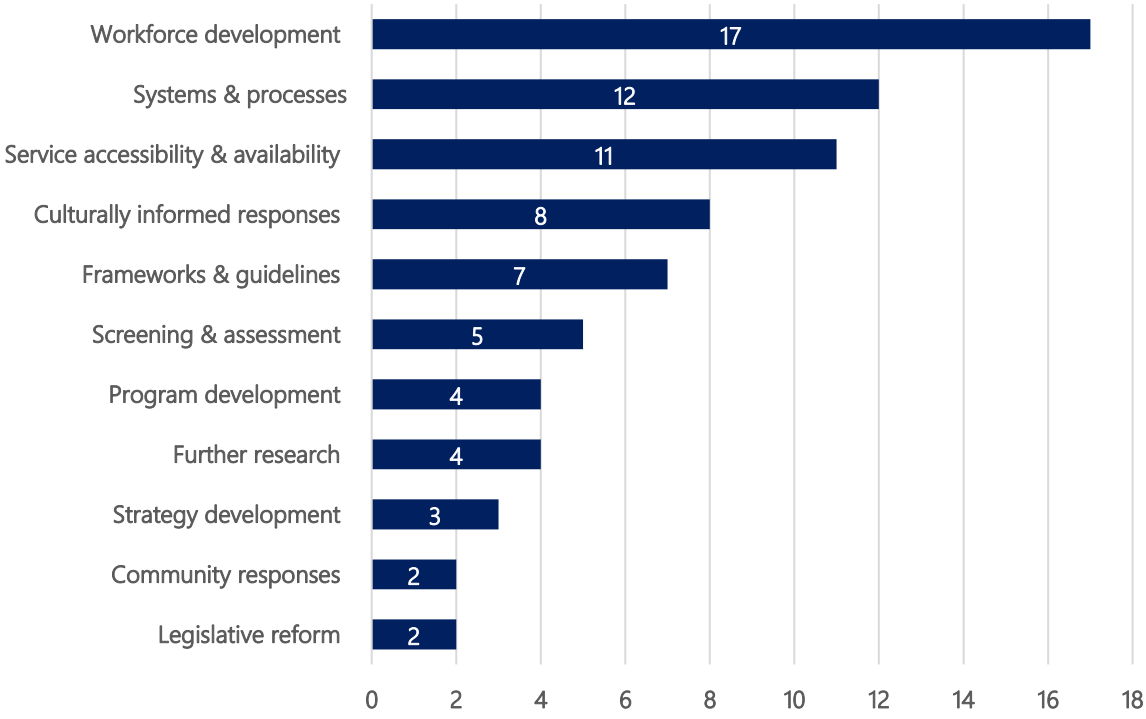

Figure 2: Focus of recommendations made by the Board between 2016–17 and 2021–22

In its 2021–22 Annual Report, the Board noted it was not clear in some reports provided by agencies what new actions had been taken to implement recommendations made in addition to work already underway.

The Board acknowledges that the implementation of recommendations and broader reform is a significant undertaking requiring time and commitment from lead agencies and stakeholders across the domestic and family violence sector.

The Board further acknowledges the significant scope of reform across the system and within Queensland's agencies. It is keenly aware of the risk of change fatigue likely to be experienced by those leading and delivering reform initiatives.

Whilst the Board notes the Queensland Government's commitment to preventing domestic and family violence, it maintains this work must remain a priority.

This demands that agencies manage the scope of reform through the effective integration of domestic and family violence prevention initiatives into strategic and operational plans, so that effort is well-directed and aligned.

The Board also acknowledges that with the renewed focus on reform, it is common practice for reviews to extend upon earlier recommendations.

The Board is eager to support agencies with implementation and identifying opportunities for collaboration, as part of monitoring the implementation of its recommendations.

The Board will also remain attuned to what is happening in the sector and utilise diverse communication approaches to engage both the sector and the community in its work. This is addressed further in section 3.

An example of progress towards the Board's recommendation to improve court support for victims of domestic and family violence is highlighted below.

This example illustrates the winding path of reform—subsequent reviews have extended upon the Board's 2016–17 recommendation to further improve court support services for victim-survivors of sexual violence. It further illustrates the significant time and commitment required across the domestic and family violence sector to achieve broader reform.

The Board's influence on court support liaison officers

In its 2016–17 Annual Report, the Board recommended that a program for specialised and consistent court support for victims of domestic and family violence in criminal proceedings be developed and funded by the Queensland Government (Recommendation 12).[15]

The Board acknowledged that interaction with the court system presented an opportunity to ensure additional, specialist services were afforded to both victims and persons using violence; noting there were several examples throughout the cases reviewed by the Board where judicial contact was clearly a source of distress for both parties, with limited evidence of support being provided in this context.

This recommendation was accepted in principle by the Queensland Government.

In 2019, the Department of Justice and Attorney-General and the then Department of Child Safety, Youth, and Women formed an interagency implementation team and undertook an exploration of existing and alternate court support options available for victims of domestic and family violence in criminal proceedings. In 2020, this interagency implementation team identified three potential service delivery models.

The reform environment has continued to evolve while the Queensland Government plans the implementation of improvements to court support for victims of domestic and family violence. In its second report, the Women's Safety and Justice Taskforce (the Taskforce) found that victim–survivors of sexual violence need more support to navigate the criminal justice system, from the moment they disclose the offence through the criminal justice process (if they choose this path) and beyond. The Taskforce found that the support available to help victim–survivors navigate the criminal justice system is patchy and uncoordinated, leaving most to navigate an unknown process alone with many left isolated and confused.

As a result, the Taskforce recommended the Queensland Government—in consultation with people with lived experience, Aboriginal and Torres Strait Islander peoples and services and legal system stakeholders—develop, fund, and implement a statewide model for the delivery of a professional victim advocacy service (Recommendation 9). These advocates would provide individualised, culturally safe, trauma-informed support to victims of sexual violence to help them navigate through the service and criminal justice systems and beyond.

This recommendation was supported by the Queensland Government. It has since been extended upon by the Queensland Legislative Assembly's Legal Affairs and Safety Committee (the Committee) in their 2023 inquiry into support provided to victims of crime.[16] The Committee recommended that the Queensland Government, in line with the Taskforce's recommendation, develop a pilot victim advocate service to support victims of crime to navigate through the criminal justice system.

[15] Recommendation 12: *A program for specialised and consistent court support for victims of domestic and family violence in criminal proceedings be developed and funded by the Queensland Government*. See Domestic and Family Violence Death Review and Advisory Board (2017). *2016–17 Annual Report*. https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0003/723675/domestic-and-family-violence-death-review-and-advisory-board-annual-report-2016-17.pdf

[16] Queensland Government (2023). Legal Affairs and Safety Committee – Report No. 48, 57th Parliament – *Inquiry into support provided to victims of crime*. https://documents.parliament.qld.gov.au/tp/2023/5723T648-B045.pdf

In addition to monitoring the implementation of the recommendations and producing an Annual Report, the Board, via the Domestic and Family Violence Death Review Unit, responds to requests from across the sector to deliver presentations to discuss the role and work of the Board in more detail.

Table 1 outlines the community awareness presentations delivered in the 2022–23 reporting period.

Table 1: 2022–23 community awareness sessions

Date	Agency/Organisation
20/06/2022	QPS High Risk Team presentation
13/07/2022	Red Rose Foundation High Risk High Harm Training
16/08/2022	Logan High Risk Team
14/09/2022	Centre for Women & Co – Logan Central
20/01/2023	High Risk Team Program Integration officers and High Risk Team Core Members
6/02/2023	Victims Assist
19/04/2023	WorkUp Qld
9/05/2023	Beenleigh/Logan Integrated Service Response

Given the sector's interest in discussing the Board's work and its findings in more detail, the Board will consider its communication strategies in 2023–24 to deliver on its purpose under s91A(b) of the Act to 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.

3. Driving sustainable improvement

Future focus of the Board

This section outlines the evolving role of the Board and its focus for 2023–24.

With the significant ongoing reform discussed in sections 1 and 2, now more than ever it is critical that the Board pauses and reflects on its role in preventing or reducing the likelihood of domestic and family violence deaths.

In 2023–24 the Board will continue its ongoing work to analyse data and conduct research to identify patterns, trends and risk factors relating to domestic and family violence-related deaths in Queensland.

It will also continue to identify key lessons and good practice, making recommendations to the Minister to improve legislation, policies, practices, services, training, resources, and communication to prevent or reduce the likelihood of domestic and family violence-related deaths in Queensland.

In addition to its ongoing work, the Board will focus its case reviews on past cases involving sexual violence to build knowledge in this area. It will, however, continue to respond to emerging trends in case reviews and across the sector throughout the year.

Each of the Board's proposed areas of work for 2023–24 is described in further detail below.

The Board's upcoming work

In 2023–24, the Board will consider a range of matters to support the Board's influence. This will include, but is not limited to:

- A reflection on the Board's past work to identify strengths and areas for improvement. This may be complemented by a cross-jurisdictional review of how other bodies like the Board are operating to understand how the Board is performing and to identify new and emerging good practice for the Board to consider.
- The development of strategies to improve the Board's communication of findings. This will involve defining needs of distinct audiences and determining the appropriate messages from the Board (and channels through which these should be communicated). Success will be evidenced by the number of citations of the Board's annual reports, research, and data in academic research and by other jurisdictions seeking to prevent or reduce the likelihood of domestic and family violence deaths. A summary of citations of the Board's existing work is included in Appendix C.
- A detailed review of Queensland data about domestic and family violence-related deaths that occurred in an intimate partner or family relationships between 2017 and 2023.

As outlined in sections 1 and 2, the Board acknowledges the need to take a systems view of reform to best address failings and drive improvement. The Board plans to deliver on this in 2023–24 through the following activities:

- Development of the 2023–24 Annual Report and review of implementation progress updates by lead agencies. This will include developing recommendations to improve how sexual violence in the context of domestic and family violence is being responded to across the service and criminal justice systems (see 'Sexual violence case reviews' below).
- A review of previous recommendations made by the Board which have been adapted or extended by various inquiries to ensure the intent of the Board's original recommendations are being fully implemented and the intended service improvements are realised. Further, the review will confirm whether recommendations have been strengthened and improved upon, rather than simply superseded.
- The Board will further review recommendations and implementation progress to identify patterns and trends and seek to understand which recommendations have been successful and why. This could inform whether certain areas of reform are more difficult than others to achieve or whether there are inherent difficulties in certain sections of service delivery.
- The Board will also explore how relationships with agencies could be strengthened to ensure more effective collaboration. This includes consideration of developing more streamlined reporting practices and understanding how new Board recommendations can complement or bolster work underway in agencies and organisations.

Sexual violence case reviews

In its 2020–21 Annual Report, the Board noted that prior forced sexual acts and assaults during sex are recognised lethality indicators (a warning sign or predictor of harm) in relationships characterised by domestic and family violence. The Board found that in the 92 intimate partner homicides that occurred in Queensland between 2011 and 2018, more than 15% included evidence of this lethality indicator. It also found that sexual jealousy was evident in 49% of reviewed cases of intimate partner homicides in Queensland and was among the most prevalent lethality risk indicators. The Board noted a high level of service contact was found in both intimate partner homicides (76%) and domestic and family violence suicides (89%).[17]

The Board reported on the devastating impacts of sexual abuse on victims. This group is more likely to experience depression and show higher rates of suicidal behaviour.[18] Those exposed to intimate partner sexual violence are also at heightened risk of homicide.[19]

Drawing on the Board's findings, the Taskforce's second report identified the need for greater service system leadership and coordination.[20] In particular, the Taskforce noted the need to better understand how sexual violence in the context of domestic and family violence is being responded to across the service and criminal justice systems.

The Taskforce also acknowledged the Board's finding that trauma awareness and trauma-informed practice is needed across the service system to better respond to victims' needs.

In its second report, the Taskforce noted just over a third (35%) of victims of sexual assault in Queensland in 2020 were recorded as family and domestic violence-related assaults. The Taskforce, drawing from its first report, *Hear Her Voice – Report 1 – Addressing Coercive Control and Domestic and Family Violence in Queensland*, also noted that perpetrators of domestic and family violence frequently use sexual violence to intimidate, control and harm women.[21]

As such, the Taskforce acknowledged that it is likely that the number of reports received about sexual violence in intimate partner relationships does not reflect the full picture.

Acknowledging the Board's knowledge and expertise in examining the circumstances of domestic and family violence deaths, the Taskforce recommended the Board undertake a focused review of cases involving sexual violence to further enhance understanding in this area.[22]

The Board will undertake and report on this review in the 2023–24 Annual Report. The primary objective of the review is to further develop the evidence base, identify systemic and practice issues, and improve responses. This will involve identifying cases involving sexual violence to be reviewed, alongside a review of recent literature and cross-jurisdictional practice to inform the development of recommendations.

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[17] Domestic and Family Violence Death Review and Advisory Board (2021). *2020-21 Annual Report*. https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0007/723679/domestic-and-family-violence-death-review-and-advisory-board-annual-report-2020-21.pdf

[18] Australia's National Research Organisation for Women's Safety (2019). *Intimate Partner Sexual Violence: Research Synthesis* (2nd Ed). https://www.anrows.org.au/publication/intimate-partner-sexual-violence-research-synthesis/

[19] Australia's National Research Organisation for Women's Safety (2019). *Intimate Partner Sexual Violence: Research Synthesis* (2nd Ed). https://www.anrows.org.au/publication/intimate-partner-sexual-violence-research-synthesis/

[20] Women's Safety and Justice Taskforce (2022). *Hear Her Voice: Report 2, Volume 1.* https://www.womenstaskforce.qld.gov.au/__data/assets/pdf_file/0008/723842/Hear-her-voice-Report-2-Volume-1.pdf

[21] Women's Safety and Justice Taskforce (2021). *Hear Her Voice: Report 1, Volume 1.* https://www.womenstaskforce.qld.gov.au/__data/assets/pdf_file/0013/700600/volume-1-exectutive-summary-and-introduction.pdf

[22] Recommendation 17: *The State Coroner as Chair of the Domestic and Family Violence Death Review and Advisory Board (the Board) consider the Board undertaking a one-off specific topic review of relevant past cases of domestic and family violence related deaths involving sexual violence, to examine and report matters within the Board's purpose and functions related to sexual violence within the context of domestic and family violence*. See, Women's Safety and Justice Taskforce (2022). *Hear Her Voice: Report 2, Volume 1.* https://www.womenstaskforce.qld.gov.au/__data/assets/pdf_file/0008/723842/Hear-her-voice-Report-2-Volume-1.pdf

4. Domestic and family violence-related deaths in an intimate partner or family relationship 2017–23

Intimate partner deaths were identified by reviewing deaths flagged as 'domestic violence related' and/or 'interpersonal violence/apparent homicide' in the Coronial Case Management System against the Australian Domestic and Family Violence Death Review Network Homicide Consensus Statement (see Appendix D). Additional deaths identified by the Queensland Police Service Coronial Support Unit were also reviewed against the Consensus Statement.

These processes resulted in the identification of 16 deaths that occurred in an intimate partner or family relationship in Queensland in 2022–23.[23] The Board acknowledges that each of these deaths impacts the families, loved ones, colleagues and communities of the women, children and men killed.

The term 'deaths' is used rather than 'homicides' in this section in recognition that, for many cases reported here, criminal proceedings are incomplete. The term 'alleged' or 'allegedly' appears in this section for a similar reason. While this term has been applied globally, the Board acknowledges that the criminal justice process has been finalised for many matters and the outcomes are settled. The purpose of this qualification is to allow a comprehensive discussion of all deaths and encompass all material which has informed the work of the Board.

Domestic and family violence-related deaths in an intimate partner or family relationship 2022–23

Table 2 describes the domestic and family violence-related deaths in an intimate partner or family relationship that occurred in 2022–23.[24]

Table 2: Intimate partner and family relationship deaths (2022–23), N = 16

Intimate partner
There were 9 domestic and family violence-related deaths in an intimate partner relationship, including: • 3 females in their 40s • 2 females in their late teens • A female in her 20s • A female in her 50s • A female in her 60s • A male in his 30s
Family relationship
There were 7 domestic and family violence-related deaths in a family relationship, including: • A female in her 40s • A female in her 50s • A female in her 70s • A pre-teen male • A male in his 20s • A male in his 50s • A male in his 60s

[23] It is acknowledged that as police and coronial investigations continue, additional cases may be identified for inclusion, and some cases may be excluded as more information becomes available (e.g., from agency records, witness statements and police briefs of evidence). This data was correct based on the information available as of 31 July 2023.

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

Domestic and family violence-related deaths in an intimate partner or family relationship 2017–23

Between 1 July 2017 and 30 June 2023, there were 123 domestic and family violence-related deaths that occurred in an intimate partner or family relationship in Queensland. As shown in Figure 3, of these 123 deaths, 64 occurred in intimate partner relationships and 59 were family relationships.

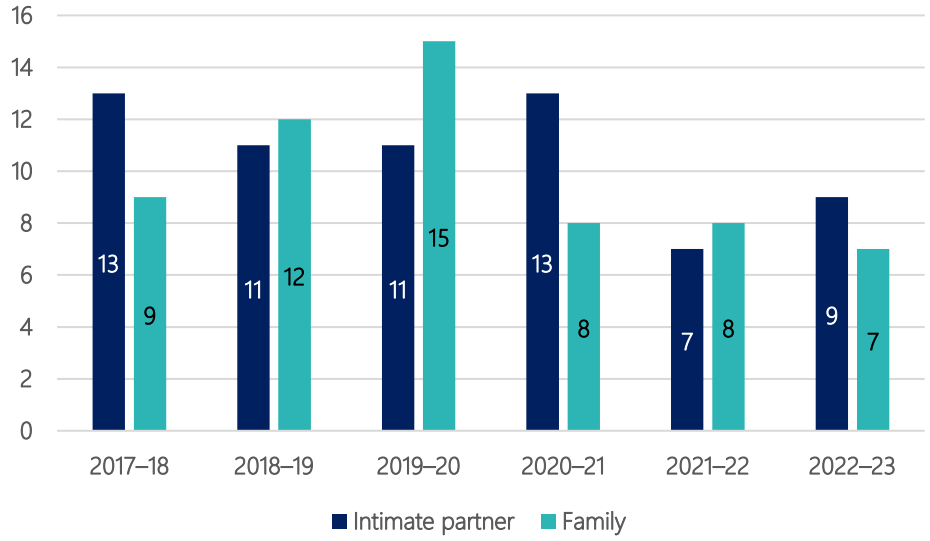


Figure 3: Domestic and family violence-related deaths in an intimate partner or family relationship (1 July 2017 to 30 June 2023), N = 123

Of the domestic and family violence-related deaths that occurred in a family relationship, 47% (28 of 59 cases) involved the death of one or more children. These children were all allegedly killed by a family member or caregiver (filicide). Of this number, 54% (15 of 28 cases) involved the death of a male child/ren and 46% (13 of 28 cases) involved the death of a female child/ren.

The remaining 31 family relationship deaths involved the deaths of adults who were allegedly killed by adult family members. Most adults allegedly killed by a family member were killed by their son (48%) or brother (16%), but some were killed by their nephew (10%), mother (6%), brother-in-law, daughter, ex-son-in-law, son-in-law, mother's partner or stepson (3% each).

Males continue to be over-represented as offenders in domestic and family violence-related deaths in intimate partner and family relationships. As shown in Figure 4 below, of the 123 deaths that occurred between 1 July 2017 and 30 June 2023, the alleged homicide offender was male in 68% of cases (86 of 127), and female in only 32% of cases (41 of 127).[25]

For intimate partner deaths, the alleged homicide offender was male in 65% of cases (44 of 68) and the alleged homicide offender was female in 35% of cases (24 of 68).

For deaths in a family relationship, the alleged homicide offender was male in 71% of cases (42 of 59) and the alleged homicide offender was female in 29% of cases (17 of 58).

[25] There are a total of 127 alleged homicide offenders. This is because in one family relationship homicide, there were two people (one male and one female) charged with homicide offences, and three intimate partner homicides where multiple offenders were charged (in two cases, there were two homicide offenders [one male and one female] and in one case there were three homicide offenders [one male and two females]).

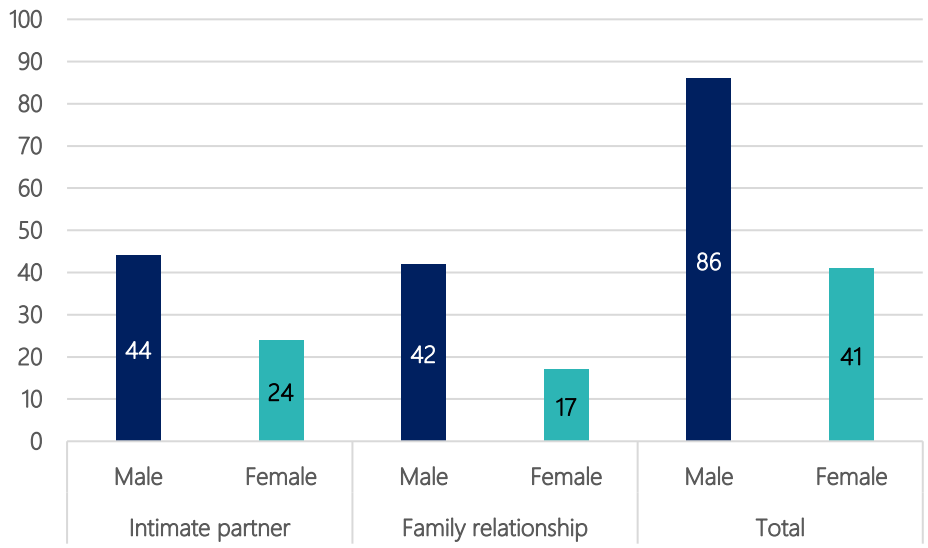


Figure 4: Sex of alleged homicide offenders in domestic and family violence-related deaths in intimate partner and family relationships (1 July 2017 to 30 June 2023), N = 127

The youngest person who died as a result of a domestic and family violence-related death in a family relationship was less than one year old, and the oldest person was 82 years old. The youngest person who died as a result of a domestic and family violence-related death in an intimate partner relationship was 16 years old, and the oldest was 82 years old (see Figure 5).

Almost 40% of persons who died as a result of a domestic and family violence-related death in an intimate partner relationship were aged 45–49 years (n = 14, 22%) or 50–54 years (n = 10, 16%) at the time of their death. For deaths in a family relationship, the most common age group of those who died were children aged less than four years (n = 22, 38%).

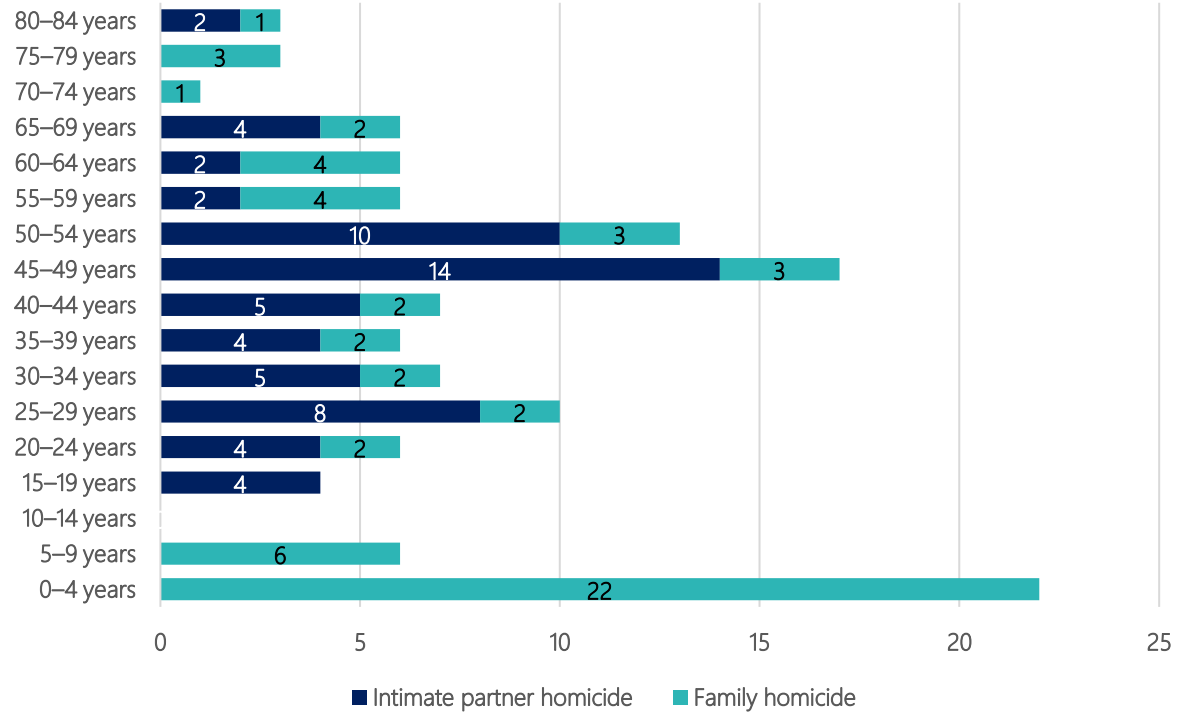


Figure 5: Age group of deceased persons who died as a result of domestic and family violence-related deaths in intimate partner or family relationships (1 July 2017 to 30 June 2023), N = 123

The cultural background of the deceased was known for 92% (59 of 64 cases) of domestic and family violence-related deaths in intimate partner relationships and 95% (56 of 59 cases) of deaths in family relationships between 1 July 2017 and 30 June 2023. Percentages in Table 3 use cases where cultural background was known as the denominator.

One quarter (25%) of deceased persons in domestic and family violence-related deaths in intimate partner and family relationships identified as Aboriginal and/or Torres Strait Islander. A smaller percentage were from culturally and linguistically diverse backgrounds (12% of intimate partner deaths; 7% of family relationship deaths).

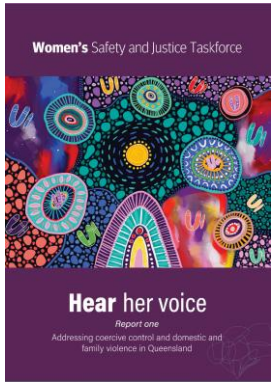
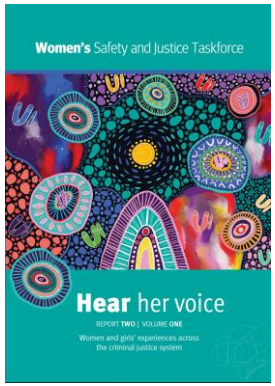
Table 3: Cultural background of deceased persons in domestic and family violence-related deaths in intimate partner and family relationships (1 July 2017 to 30 June 2023), N = 123

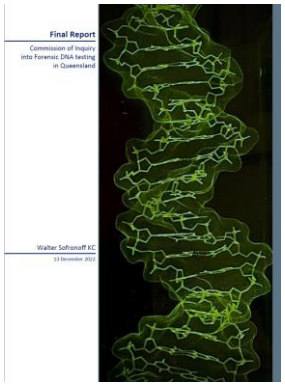
	Intimate partner	Family relationship	Total
Aboriginal	13 (22%)	11 (20%)	24 (21%)
Torres Strait Islander	2 (3%)	3 (5%)	5 (4%)
Aboriginal and Torres Strait Islander	0	0	0
Culturally and linguistically diverse	7 (12%)	4 (7%)	10 (10%)
Non-Indigenous and non-culturally and linguistically diverse	37 (63%)	38 (68%)	75 (65%)
Unknown	5	3	8
Total	**64**	**59**	**123**

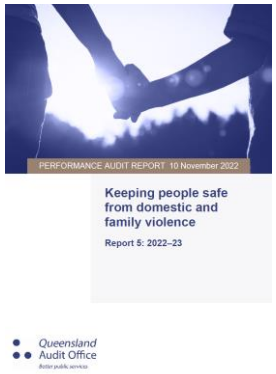
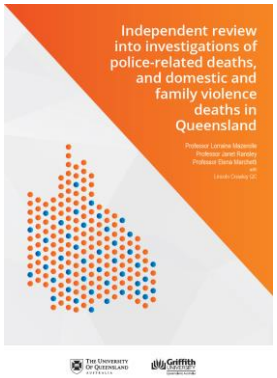
Appendices

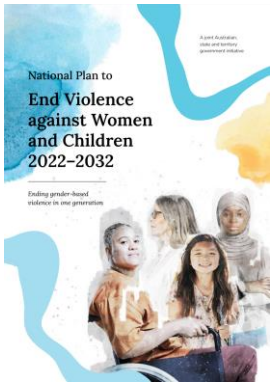
Appendix A: Recent reports reflecting reform across the domestic and family violence system

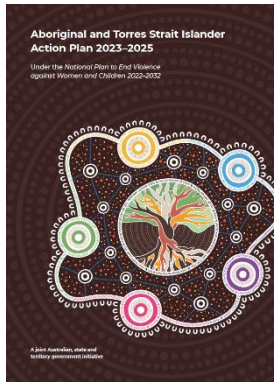
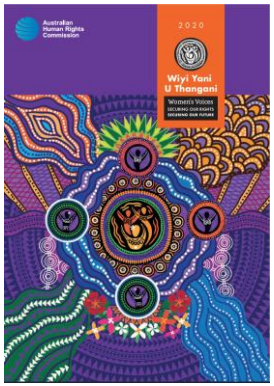
Table A: Summary of recent reports reflecting reform across the domestic and family violence system in Queensland

#	Cover thumbnail	Report title	Summary
WOMEN'S SAFETY AND JUSTICE TASKFORCE			
1		Women's Safety and Justice Taskforce (2021). Hear Her Voice – Report 1 – Addressing Coercive Control and Domestic and Family Violence in Queensland https://www.womenstaskforce.qld.gov.au/publications	The Taskforce's First Report (2021) examined and reviewed coercive control and considered whether there was a need to create a new criminal offence. This report identified multiple opportunities to enhance responses to domestic and family violence in Queensland and made 89 recommendations which seek to: • raise community awareness and understanding of domestic and family violence • improve primary prevention and service system responses with a particular focus on police, lawyers, judicial officers, and the court • hold persons using violence (PUV) accountable to stop the violence • progress immediate and longer-term legislative reforms addressing coercive control.
2		Women's Safety and Justice Taskforce (2022). Hear Her Voice – Report 2 – Women and girls' experience across the criminal justice system https://www.womenstaskforce.qld.gov.au/publications	The Taskforce's Second Report (2022) considered opportunities to improve outcomes for women and girls who have experienced sexual violence and or have contact with the criminal justice system (as both victims and PUV). In this report, the Taskforce made a further 188 recommendations. That report explores intersections between domestic, family, and sexual violence further, including: • community attitudes to sexual violence and consent, and barriers to reporting • responses to, and support for, victim–survivors within the criminal justice system • the quality, accessibility, and use of forensic evidence within legal proceedings.

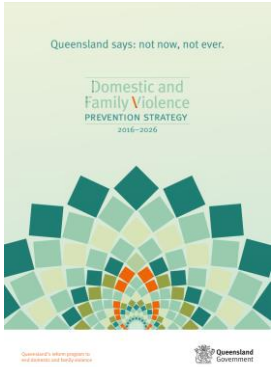
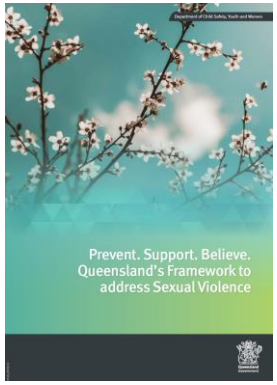
#	Cover thumbnail	Report title	Summary
COMMISSIONS OF INQUIRY			
3		The Commission of Inquiry into Queensland Police Service responses to domestic and family violence (2022). A Call for Change https://www.qpsdfvinquiry.qld.gov.au/about/report.aspx	The Commission reported on its findings in November 2022 in *A Call for Change*. The report made 78 recommendations and identified which recommendations should receive the highest priority. The four highest priority recommendations include those that seek to: • build the capacity of the QPS to measure demand for domestic and family violence responses and to respond accordingly • strengthen the understanding and skills of QPS members through robust and regular training • embed partnerships with the Domestic and Family Violence Advisory Group and First Nations Reference Group • establish an independent Police Integrity Unit to create the necessary cultural shift within the QPS.
4		The Commission of Inquiry into Forensic DNA Testing in Queensland (2022). Final Report https://www.dnainquiry.qld.gov.au/	The Commission reported on its findings in December 2022. The report made 123 recommendations which seek to improve and ensure public confidence in the collection, testing and analysis of DNA in the criminal justice context in Queensland. This included specific recommendations of relevance to the Board which seek to ensure: • all health practitioners who conduct forensic medical examinations complete appropriate training and continued professional development • participants in the criminal justice system understand the meaning of forensic DNA test results.

#	Cover thumbnail	Report title	Summary
OTHER REVIEWS			
5		Queensland Audit Office (2022). Keeping people safe from domestic and family violence https://www.qao.qld.gov.au/reports-resources/reports-parliament/keeping-people-safe-domestic-family-violence	The Queensland Audit Office examined how effectively state public sector entities keep people safe from domestic and family violence, prevent it from occurring, and rehabilitate perpetrators to minimise re-offending. The Auditor-General reported on their findings in November 2022 in *Keeping people safe from domestic and family violence*. In most cases, the audit concluded that relevant public sector entities and service providers help keep people safe from domestic violence. However, it also noted the entities are under pressure and not always as effective as they should be, which can lead to unacceptable and even tragic consequences. The report made 21 recommendations. Many are aimed at enhancing responses, training, case management, interagency coordination, and preventing domestic and family violence. The report also made recommendations to better support young people and tackle intergenerational violence.
6		Mazerolle, L., Ransley, J., Marchetti, E., Crowley, L., Colbert, P., & Gilmour, J. (2022). Independent review into investigations of police-related deaths, and domestic and family violence deaths in Queensland https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/1bba8624-50e4-4026-8cf1-7750ac1d42f3/review-investigations-police-related-dfv-deaths-qld-report.pdf?ETag=3789658251df7d4365f7f30b091bf2a9	In November 2021, arising from Recommendation 2 of the State Coroner's Inquest into the death of Cindy Leigh Miller, the Queensland Government commissioned an independent review of the current arrangements for the investigation of police-related deaths. The final report, *Independent review into the investigations of police-related deaths and domestic and family violence deaths in Queensland,* was delivered in July 2022. The report made 12 recommendations; 7 relate to investigative mechanisms for deaths in police custody and during police operations, and 5 relate to investigative mechanisms for DFV deaths with prior police contact.

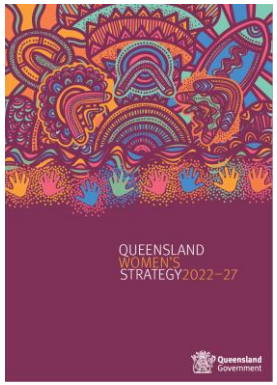
#	Cover thumbnail	Report title	Summary
NATIONAL PLANS & REVIEWS			
7		Australian Government Department of Social Services (2022). National Plan to End Violence against Women and Children https://www.dss.gov.au/women-programs-services-reducing-violence/the-national-plan-to-end-violence-against-women-and-children-2022-2032	On behalf of Queensland, the Attorney-General and Minister for Justice, Minister for Women and Minister for the Prevention of Domestic and Family Violence endorsed the *National Plan to End Violence against Women and Children 2022–2032* in October 2022 (National Plan). The National Plan is the overarching national policy framework that will guide actions towards ending violence against women and children over the next 10 years. An outcomes framework has been developed to support monitoring and reporting change over the life of the National Plan and provide governments across all jurisdictions with a shared vision and direction for change. See: https://www.dss.gov.au/sites/default/files/documents/08_2023/np-outcomes-framework.pdf
7a		Australian Government Department of Social Services (2023). First Action Plan 2023–2027 Under the National Plan to End Violence against Women and Children 2022–2032 https://www.dss.gov.au/sites/default/files/documents/08_2023/np-first-action-plan.pdf	The First Action Plan (2023–2027) provides a roadmap for the first 5-year effort towards achieving the vision of the National Plan. It sets out the initial scope of activities, areas for action and responsibility with respect to outcomes, and outlines how we will make the commitments set out in the National Plan a reality. Under this Action Plan, the Australian, state and territory governments commit to implementing 10 actions.

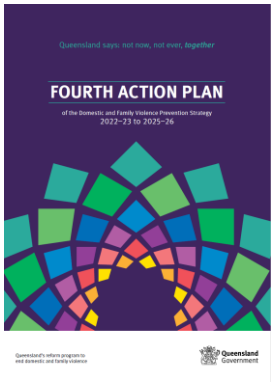
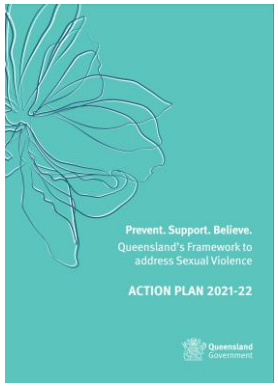
#	Cover thumbnail	Report title	Summary
NATIONAL PLANS & REVIEWS			
7b		Australian Government Department of Social Services (2023). Aboriginal and Torres Strait Islander Action Plan 2023–2025 Under the National Plan to End Violence against Women and Children 2022–2032 https://www.dss.gov.au/sites/default/files/documents/08_2023/np-atsi-action.pdf	A dedicated Aboriginal and Torres Strait Islander Action Plan will work alongside the First Action Plan. It has been developed in genuine partnership with the Aboriginal and Torres Strait Islander Advisory Council on family, domestic and sexual violence. The Aboriginal and Torres Strait Islander Action Plan has been developed in recognition of the disproportionately high rates of family, domestic and sexual violence that Aboriginal and Torres Strait Islander women experience. The Aboriginal and Torres Strait Islander Action Plan has been developed using a wealth of community, sector, and academic knowledge. Activities within the Action Plan acknowledge the unique underlying causes of violence against Aboriginal and Torres Strait peoples, such as the ongoing impacts of colonisation, intergenerational trauma, and systemic and institutional racism.
8		Queensland Government (2022). Statement of support for Wiyi Yani U Thangani (Women's Voices) report 2020 https://www.justice.qld.gov.au/about-us/services/women-violence-prevention/women/queensland-womens-strategy/wiyi-yani-u-thangani-qld	In October 2022, the Attorney-General and Minister for Justice, Minister for Women and Minister for the Prevention of Domestic and Family Violence, and Minister for Seniors and Disability Services and Minister for Aboriginal and Torres Strait Islander Partnerships, signed a statement of support of Wiyi Yani U Thangani. Wiyi Yani U Thangani is a watershed moment in ensuring the voices of First Nations women and girls are heard as part of the national conversation and outlines an ambitious and necessary First Nations female-led plan for structural change. The Queensland Government has committed to developing a Wiyi Yani U Thangani Action Plan to support this immense work in Queensland.

#	Cover thumbnail	Report title	Summary
NATIONAL PLANS & REVIEWS			
9		Closing the Gap (2022). Closing the Gap: Targets and Outcomes https://www.closingthegap.gov.au/national-agreement/targets	Implementation is ongoing as part of the *National Agreement on Closing the Gap* (National Agreement) with the Queensland Government working to overcome inequality experienced by Aboriginal and Torres Strait Islander people and achieve life outcomes equal to all Australians. Target 13 of the National Agreement specifically commits to ensuring the rate of all forms of family violence against Aboriginal and Torres Strait Islander women and children is reduced by at least 50% by 2031, as progress towards zero. The 2022 *Queensland Closing the Gap Annual Report* baselines this rate for Aboriginal and Torres Strait Islander women and children in Queensland as 6.4%. See: https://www.dsdsatsip.qld.gov.au/resources/dsdsatsip/work/atsip/reform-tracks-treaty/closing-gap/ctg-snapshot-2022.pdf

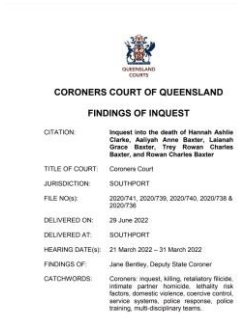
#	Cover thumbnail	Report title	Summary
QUEENSLAND STRATEGIES AND PLANS			
10		Queensland Government (2016). Domestic and family violence prevention strategy 2016–2026 https://www.justice.qld.gov.au/initiatives/end-domestic-family-violence/dfvp-strategy	The Queensland Government's *Domestic and Family Violence Prevention Strategy 2016–2026* is a vehicle to drive change across all sectors of the Queensland community. The strategy sets the direction for collaborative action to end DFV in Queensland, encouraging partnerships between the government, community, and business. It also outlines a shared vision and a set of principles to guide action across government and the community, including a staged 10-year plan on how we will get there. The Queensland Government is currently delivering action on this strategy through Fourth Action Plan 2022–23 to 2025–26 (see Report 13 below). This action plan builds on the significant work of Queensland's DFV reform program delivered under the: • First action plan 2015–16[26] • Second action plan 2016–19[27] • Third action plan 2019–20 to 2021–22.[28]
11		Queensland Government (2019). Prevent. Support. Believe. Queensland's framework to address sexual violence https://www.justice.qld.gov.au/about-us/services/women-violence-prevention/violence-prevention/sexual-violence-prevention/framework	*Prevent. Support. Believe. Queensland's Framework to address Sexual Violence* (the Framework) sets out Queensland's overarching approach to preventing and responding to all forms of sexual violence in Queensland, including sexual assault, sexual harassment, technology-facilitated sexual violence, child sexual abuse and youth sexual violence. It was released during Sexual Violence Awareness Month in October 2019. The vision, as outlined in the Framework, is for a Queensland where everyone lives free of the fear, threat, or experience of sexual violence. The Framework is organised around three priority areas for action—Prevention, Support and healing, and Accountability and justice—and identifies objectives and strategies for each priority area to guide our work.

[26] https://www.publications.qld.gov.au/dataset/not-now-not-ever/resource/dafdecff-2870-4bec-b5ab-d61795a2364a
[27] https://www.publications.qld.gov.au/dataset/not-now-not-ever/resource/c88b0334-a95a-4e1e-bd70-e841d9b8725d
[28] https://www.publications.qld.gov.au/dataset/not-now-not-ever/resource/20cf6cc3-42da-4553-ba15-f2dd3a2a393b

#	Cover thumbnail	Report title	Summary
QUEENSLAND STRATEGIES AND PLANS			
12		Queensland Government (2022). Women's Strategy 2022–27 https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/95357068-d24b-4565-a991-7b8be088ced9/queensland-womens-strategy-2022-27.pdf?ETag=c655247f0b2cb9f9295b45147ce05295	The *Queensland Women's Strategy 2022–27* outlines a vision to strengthen and support the rights of women and girls, with an emphasis on achieving gender equality in Queensland. The cornerstone of the Strategy is an acknowledgement that economic security is at the centre of gender equality and has a definitive impact on the ability of women and girls to achieve and thrive in all areas of their lives. The Strategy commits to elevating First Nations women and continuing ongoing reforms and implementation of new ideas to strengthen prevention of, and response to, violence against women in all places.

#	Cover thumbnail	Report title	Summary
QUEENSLAND ACTION PLANS			
13		Queensland Government (2022). Fourth action plan 2022–23 to 2025–26 of the Domestic and family violence prevention strategy https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/3b48a2e8-94ce-46c2-ad49-9aed3b3ac2d9/fourth-action-plan.pdf?ETag=d22784780bf2eaf1bfcc688f17d25eb7	Aligned to the National Plan and the National Agreement, the Queensland Government released the *Fourth Action Plan 2022–23 to 2025–26* of its *Domestic and Family Violence Prevention Strategy 2016–2026*, to prevent and respond to violence against women and girls. The Fourth Action Plan marks the last action plan to deliver on the Strategy. Its focus is to ensure momentum continues on work to end domestic and family violence in a conscientious, evidence-based and coordinated way. The Fourth Action Plan seeks to deliver: • increased awareness of, and appropriate responses to, all forms of domestic and family violence • culturally safe and trauma-informed responses that prioritise keeping people safe at all stages of their life and in key settings • domestic and family violence responses that are integrated, holistic, specific and effective • a reform agenda that identifies and addresses priorities in domestic and family violence responses • initiatives that actively address perpetrating behaviours and increase perpetrator accountability.
14		Queensland Government (2022). Prevent. Support. Believe. Queensland's Framework to address Sexual Violence Action Plan 2021–22 https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/2a3e1674-b3ee-406a-97f4-17c7b71cf81a/sexual-violence-action-plan-2021-22.pdf?%E2%80%8CETag=add79e034e0d3fb%E2%80%8C9711203ac6943e38b	The Queensland Government released the *Prevent. Support. Believe. Queensland's framework to address sexual violence—Action plan 2021–22* to support implementation of the Framework (see Report 11 above). This action plan outlines new and continuing initiatives the Queensland Government is undertaking to implement the Framework. This is a whole-of-government action plan, with agencies responsible for children, violence prevention, women, health, education, justice and youth justice, policing, corrections, housing, and disability services all committed to actions listed.

While there have been several coronial investigations into domestic and family violence-related deaths, these two inquests are highlighted as they resulted in recommendations to government, and their findings influenced other reform activities discussed in this report.

#	Cover thumbnail	Report title	Summary
INQUESTS			
15		Coroners Court of Queensland (2022). Inquest into the deaths of Doreen Gail Langham and Gary Matthew Hely https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0006/723372/cif-langham-and-hely.pdf	An inquest was held into the deaths of Doreen Gail Langham and Gary Matthew Hely. The inquest found that Mr Hely intended to kill Ms Langham by setting her home on fire on 21 February 2021. Mr Hely also died in the fire. The Coroner recommended that: • Queensland Police Service trial a specialist victim-centred police station in the Logan District staffed with multi-disciplinary teams who can provide an integrated response for domestic and family violence victims • a DFV specialist social worker be embedded at every police station in the Logan District for 12 months • the Queensland Police Service Operational Procedures Manual be amended so officers must view interstate records for all DFV matters.
16		Coroners Court of Queensland (2022). Inquest into the death of Hannah Ashlie Clarke, Aaliyah Anne Baxter, Laianah Grace Baxter, Trey Rowan Charles Baxter, and Rowan Charles Baxter https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0010/723664/cif-hannah-clarke-aaliyah-baxter-laianah-baxter-trey-baxter-and-rowan-baxter.pdf	An inquest into the deaths of Hannah Ashlie Clarke, Aaliyah Anne Baxter, Laianah Grace Baxter, Trey Rowan Charles Baxter, and Rowan Charles Baxter. The inquest found that Mr Baxter intended to kill Hannah and the children when he set their car alight. They all died as a result of injuries caused by the fire. He also died by self-inflicted stab wounds with burns a contributing factor. The Coroner recommended that: • Queensland Police Service implement 5-day face-to-face DFV training for specialist DFV officers • Queensland Police Service add a mandatory face-to-face DFV module to the annual training required of all officers • a trial of a multi-disciplinary specialist police station occur in Logan or Kirwan • the Queensland Government fund men's behaviour change programs in prisons and the community.

Appendix B: Queensland Government Response to the Domestic and Family Violence Death Review and Advisory Board 2021–22 Annual Report

The Queensland Government response to the Board's 2021–22 Annual Report was released on Friday 4 August 2023.[29]

The response noted that 'integration is critical across different services and systems that respond to DFV such as police, courts, child protection, alcohol and other drug services, mental health and suicide prevention as well as specialist DFV services. The Government's response to the Board's 2021–22 Annual Report recommendations will enhance implementation of significant reforms already underway across these services and systems.'

The response to each recommendation is summarised in the table below.

RECOMMENDATION	GOVERNMENT RESPONSE
Recommendation 1 That the Queensland Government commission research in relation to formal and informal help-seeking behaviours by people affected by domestic and family violence in intimate partner relationships, and the key influences in decisions to contact particular services, including perceptions about which services are the most helpful.	**Accept** Australia's National Research Organisation for Women's Safety (ANROWS) released the second report from their project *"Transforming responses to intimate partner and sexual violence: Listening to the voices of victims, perpetrators and services"* in December 2022. This research is a comprehensive overview of help-seeking behaviours and barriers to help-seeking across Australia. The Queensland Government will utilise this research to inform future policy and program development and consider whether additional research is required. **Lead agency:** Department of Justice and Attorney-General
Recommendation 2 That the Queensland Government, in implementing recommendation 9 from the Women's Safety and Justice Taskforce relating to the plan for the primary prevention of violence against women, provide visible resources for family and friends to obtain information and support. This might be modelled on Ontario's Neighbours, Friends and Families campaign, recognising that many victims of domestic violence tell someone in their informal network about the violence before approaching service providers.	**Accept** Informed by the development of the primary prevention plan in response to recommendation 9 of the Taskforce's Report One, the Queensland Government will identify and pursue opportunities to develop and distribute resources to support bystanders such as family members and friends to appropriately respond to disclosures of domestic and family violence. This will include consideration of opportunities to build on existing resources aimed at supporting members of the community to respond safely and appropriately to people experiencing domestic and family violence. **Lead agency:** Department of Justice and Attorney-General

[29] See: https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0006/779406/government-response-2021-2022-annual-report.pdf

RECOMMENDATION	GOVERNMENT RESPONSE
Recommendation 3 That in the roll out of High-Risk Teams and Integrated Service Responses, practice guidelines and protocols emphasise the need for safety planning based on the specific role that each agency can play in supporting effective safety planning, rather than locating responsibility for safety planning solely with victim-survivors.	**Accept** The Queensland Government will continue to strengthen safety management. This includes ensuring agencies are working across the integrated service response to provide wrap-around, holistic services to protect the victim-survivor and enact interventions to prevent the person using violence from further perpetrating violence. Government and sector stakeholders will be guided on good practice safety management through ongoing implementation of the revised Common Risk and Safety Framework. Good practice approaches will be embedded in the Integrated Service System Training Strategy. The development of a new perpetrator-centric risk assessment tool (in response to recommendations 21 and 29 of the Taskforce Report One) will help to ensure the perpetrator is held accountable for their behaviour. **Lead agency:** Department of Justice and Attorney-General
Recommendation 4 That in implementing recommendation 64 from the Women's Safety and Justice Taskforce relating to the admissibility of expert evidence about domestic and family violence, the Queensland Government give consideration to the need for the accreditation of private practitioners, such as psychologists, working within the domestic and family violence system, particularly those completing reports for court proceedings.	**Accept** Legislative amendments to the *Evidence Act 1977* (Evidence Act) to allow for relevant expert evidence of DFV in criminal proceedings were included in the Domestic and Family Violence Protection (Combatting Coercive Control) and Other Legislation Amendment Act 2023 (DFVP Amendment Act). The DFVP Amendment Act was passed by Queensland Parliament on 22 February 2023 and commenced on 1 August 2023. The relevant section of the DFVP Amendment Act states that *"For this section, an expert on the subject of domestic violence includes a person who can demonstrate specialised knowledge, gained by training, study or experience, of a matter that may constitute evidence of domestic violence"*. This is consistent with the common law position on the admissibility of expert evidence. It is noted that, as part of criminal proceedings, there is scope for parties to cross-examine an expert witness, including the ability to submit that a particular expert does not have the necessary level of knowledge, training, study or experience. The Queensland Government will monitor whether there is a need for accreditation, after the amendments have been operationalised. **Lead agency:** Department of Justice and Attorney-General

RECOMMENDATION	GOVERNMENT RESPONSE
Recommendation 5 That in implementing recommendation 22 from the Women's Safety and Justice Taskforce relating to the practice framework and tools for Child Safety staff to work to support victims of domestic and family violence to care protectively for their children and to hold perpetrators to account, the Queensland Government notes that the Board has identified that a significant onus can be placed on mothers to protect their children from domestic and family violence. The Board recommends that the Queensland Government prioritises research on how services can safely intervene when children are identified as high risk, particularly where they have ongoing contact with perpetrators, and that this research informs the Strengthening Families Protecting Children Framework for Practice and the Safe and Together Program.	**Accept** The Queensland Government will continue to implement and embed the Safe and Together model, which aims to address domestic and family violence in the child protection context, and the Strengthening Families Protecting Children Framework for Practice (Framework for Practice) across the state. This will include providing staff with improved and ongoing training and tools to support adult victims of domestic and family violence to care protectively for their children, enhance recognition of children as victims of domestic and family violence in their own right, and increased emphasis on holding perpetrators accountable for their use of violence. Future work to implement recommendation 22 of the Women's Safety and Justice Taskforce includes reviewing existing practice support, tools and resources, with a view to ensuring adequate consideration for: • Ensuring children are safe and supported • Perpetrator accountability • Victim safety • Aboriginal and Torres Strait Islander inclusion and leadership • Intersections between mental health and drug and alcohol misuse. The Department of Child Safety, Seniors and Disability Services will also work with Leneen Forde Chair of Child Protection Research at Griffith University, Dr Silke Meyer, a recognised DFV expert, to ensure contemporary understanding of DFV and perpetrator behaviour is influencing child protection policy, procedures and practice. **Lead agency:** Department of Child Safety, Seniors and Disability Services

RECOMMENDATION	GOVERNMENT RESPONSE
Recommendation 6 That in implementing recommendation 24 from the Women's Safety and Justice Taskforce relating to evidence based and trauma-informed ongoing training and education, the Queensland Government considers the establishment of an independent funded training body to develop and deliver ongoing training and education.	**Accept** The Queensland Government is developing an evidence-based and trauma-informed DFV training and change management framework in response to recommendation 23 of the Taskforce Report One. The Queensland Government is also exploring options to best implement and embed training and education for all frontline and other relevant staff across government, as well as funded nongovernment agency staff effectively and efficiently in response to recommendation 24 of the Taskforce Report One. In exploring implementation options, the Queensland Government will explore if an independent funded training body is required and appropriate to develop and deliver ongoing training and education in line with the Framework, once it has been finalised. **Lead agency:** Department of Justice and Attorney-General
Recommendation 7 That in implementing recommendation 23 from the Women's Safety and Justice Taskforce relating to the development of a consistent, evidence-based and trauma informed framework to support training and education, the Queensland Government considers the importance of understanding, recognising and responding to escalation in risk.	**Accept** The Queensland Government commits to including guidance around understanding, recognising and responding to escalation of risk for victim-survivors of domestic and family violence, including children and young people, in the Domestic and Family Violence Training and Change Management Framework. The development of a whole of system Domestic and Family Violence Training and Change Management Framework relates to Taskforce Recommendation 23 Report One. In response to this recommendation, the Queensland Government is developing an evidence informed, culturally appropriate Training Framework to promote consistency in content and delivery of domestic and family violence training across government and community agencies. The Training Framework will address the issue of coercive control and support trauma informed service delivery. **Lead agency:** Department of Justice and Attorney-General
Recommendation 8 That the Queensland Government review the implementation of the Suicide Prevention Framework for working with people impacted by domestic and family violence with a view to strengthening and enhancing its use across specialist domestic and family violence services.	**Accept** The Queensland Government will work with DFV sector stakeholders to strengthen and enhance a whole of system approach to addressing suicide risk in DFV responses. The implementation of the Suicide Prevention Framework will be reviewed with a view to exploring options for increasing its awareness and consistent use. **Lead agency:** Department of Justice and Attorney-General **Supporting agency:** Queensland Health

RECOMMENDATION	GOVERNMENT RESPONSE
Recommendation 9 That in implementing recommendation 18 of the Women's Safety and Justice Taskforce relating to the further rollout of High Risk Teams, the Queensland Government ensure High Risk Teams are able to meet the needs of Aboriginal and Torres Strait Islander people, including by considering an enhanced and formal role for Aboriginal and Torres Strait Islander organisations.	**Accept** The Queensland Government supports the need to improve the cultural capability of High Risk Teams (HRTs) to ensure they better serve the needs of diverse communities. In implementing Recommendation 18 of the Taskforce's Report One, the Queensland Government continues to roll out integrated service system responses and will establish new HRTs in three locations. A key element of all new HRTs will be the addition of a First Nations Cultural Advisor role to provide culturally informed and culturally appropriate responses for Aboriginal and Torres Strait Islander people affected by DFV. The First Nations Cultural Advisors will work closely with the Positive Relationship Cultural Connectors (employed by Department of Treaty, Aboriginal and Torres Strait Islander Partnerships, Communities and the Arts) to enhance the cultural capability of the HRT and integrated service responses more broadly. **Lead agency:** Department of Justice and Attorney-General **Supporting agency:** Department of Treaty, Aboriginal and Torres Strait Islander Partnerships, Communities and the Arts
Recommendation 10 That the Queensland Government continue to support and establish High Risk Teams (HRTs) across the State, and that agencies involved in the HRTs continue to enhance integration, protocols, assessments and responses to hold perpetrators to account and to support victim-survivors.	**Accept** The Queensland Government has committed to establishing three new HRTs over four years from 2022–23 to 2025–26. The Integrated Service Systems Oversight Committee (ISSOC), the multi-agency governance group responsible for overseeing and strengthening integrated service responses, will continue to explore and enact options for enhancing integration, protocols, assessments and responses to hold persons using violence to account and to better support victim-survivors. **Lead agency:** Department of Justice and Attorney-General **Supporting agency:** Queensland Police Service

Appendix C: Domestic and Family Violence Death Review and Advisory Board citations

In addition to many of the reports and reviews noted in section 1 (Influencing the landscape), the Board's previous annual reports and research has been used in academic research into domestic and family violence and to support other jurisdictions seeking to prevent or reduce the likelihood of domestic and family violence deaths. This includes, but is not limited to:

2021–22 Annual Report

- Meyer, S., Helps, N., & Fitz-Gibbon, K. (2023). Domestic and family violence perpetrator screening and risk assessment in Queensland: Current practice and future opportunities. *Trends and Issues in Crime and Criminal Justice* [Electronic Resource], (660), 1–18. https://search.informit.org/doi/10.3316/informit.882135090247619
- The Commission of Inquiry into Queensland Police Service responses to domestic and family violence – A Call for Change (2022). https://www.qpsdfvinquiry.qld.gov.au/about/report.aspx

2020–21 Annual Report

- Mazerolle, L., Ransley, J., Marchetti, E., Crowley, L., Colbert, P., & Gilmour, J. (2022). *Independent review into investigations of police-related deaths, and domestic and family violence deaths in Queensland*. https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/1bba8624-50e4-4026-8cf1-7750ac1d42f3/review-investigations-police-related-dfv-deaths-qld-report.pdf?ETag=3789658251df7d4365f7f30b091bf2a9
- The Commission of Inquiry into Queensland Police Service responses to domestic and family violence – A Call for Change (2022). https://www.qpsdfvinquiry.qld.gov.au/about/report.aspx
- Women's Safety and Justice Taskforce (2022). *Hear Her Voice: Report 2, Volume 1*. https://www.womenstaskforce.qld.gov.au/__data/assets/pdf_file/0008/723842/Hear-her-voice-Report-2-Volume-1.pdf.
- Women's Safety and Justice Taskforce (2021). *Hear Her Voice: Report 1, Volume 1*. https://www.womenstaskforce.qld.gov.au/__data/assets/pdf_file/0013/700600/volume-1-exectutive-summary-and-introduction.pdf

2019–20 Annual Report

- Ombudsman Western Australia (2022). *Investigation into family and domestic violence and suicide*. https://www.ombudsman.wa.gov.au/Publications/Reports/FDV-Suicide-2022-Volume-1-Ombudsman-Foreword-and-Executive-Summary.pdf
- Queensland Audit Office. (2022). *Keeping people safe from domestic and family violence*. https://www.qao.qld.gov.au/reports-resources/reports-parliament/keeping-people-safe-domestic-family-violence
- The Commission of Inquiry into Queensland Police Service responses to domestic and family violence – A Call for Change (2022). https://www.qpsdfvinquiry.qld.gov.au/about/report.aspx
- Women's Safety and Justice Taskforce (2021). *Hear Her Voice: Report 1, Volume 1*. https://www.womenstaskforce.qld.gov.au/__data/assets/pdf_file/0013/700600/volume-1-exectutive-summary-and-introduction.pdf

2018–19 Annual Report

- Australian Domestic and Family Violence Death Review Network, & Australia's National Research Organisation for Women's Safety. (2022). *Australian Domestic and Family Violence Death Review Network Data Report: Intimate partner violence homicides 2010–2018* (2nd ed.; Research report 03/2022). https://www.anrows.org.au/publication/australian-domestic-and-family-violence-death-review-network-data-report-intimate-partner-violence-homicides-2010-2018/

- Dragiewicz, M., Woodlock, D., Salter, M. et al. (2022). "What's Mum's password?": Australian mothers' perceptions of children's involvement in technology-facilitated coercive control. *Journal of Family Violence*, 37, 137–149. https://doi.org/10.1007/s10896-021-00283-4
- Meyer, S., Atienzar-Prieto, M., Fitz-Gibbon, K., & Moore, S. (2023). *Missing Figures: The Role of Domestic and Family Violence in Youth Suicide – Current State of Knowledge Report*. https://research-repository.griffith.edu.au/handle/10072/422436
- Queensland Audit Office. (2022). *Keeping people safe from domestic and family violence*. https://www.qao.qld.gov.au/reports-resources/reports-parliament/keeping-people-safe-domestic-family-violence
- The Commission of Inquiry into Queensland Police Service responses to domestic and family violence – A Call for Change (2022). https://www.qpsdfvinquiry.qld.gov.au/about/report.aspx

2017–18 Annual report

- Boxall, H., & Lawler, S. (2021). How does domestic violence escalate over time? *Trends and Issues in Crime and Criminal Justice* [Electronic Resource], 626, 1–17. https://search.informit.org/doi/10.3316/informit.935878265546402
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Appendix D: 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
- Family Violence Death Review Unit (Northern Territory).

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[30]
- 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 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".[31]

[30] See: https://www.anrows.org.au/project/australian-domestic-and-family-violence-death-review-network-national-data-update/
[31] Adopting the definition in Last, J (ed). (2001). *A Dictionary of Epidemiology (4th ed).* Oxford: Oxford University Press.

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)
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 a PUV 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*	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

* Mortality classification systems refer to 'homicide' as 'assault.'

Consideration 3: Relationship

The third consideration for classification is whether a domestic or familial relationship existed between the deceased and the PUV. 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)
- *Domestic and Family Violence Protection Act 2012* (Qld)
- *Family Violence Protection Act 2008* (Vic)
- *Intervention Orders (Prevention of Abuse) Act 2009* (SA)
- *Restraining Orders Act 1997* (WA) and *Parliamentary Commissioner Act 1971* (WA)
- *Domestic and Family Violence Act 2007* (NT).

Each review team recognises 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**	Individuals who are or have been in an intimate relationship (sexual or non-sexual).	Yes
Relative***	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

** This includes current and former intimate relationships irrespective of the gender of the individuals.

*** This includes formal and informal family-like relationships, and explicitly includes extended family-like relationships that are recognised within that individual's cultural group.

Consideration 4: Domestic and family violence context

Having determined that a homicide has occurred and that a domestic relationship exists between the deceased and PUV, the final consideration for classification is whether the homicide occurred in a domestic or family violence context. Deaths that fulfil 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 PUV 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 PUV does not, in itself, constitute a domestic and family violence homicide. In these deaths, other situational factors determine the fatal incident, such as the PUV 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.

Appendix E: Remuneration of the Board

Domestic and Family Violence Death Review and Advisory Board					
Act or instrument	*Coroners Act 2003*				
Functions	Review domestic and family violence deaths				
Achievements	In 2022–23, the Board met on two occasions. An annual report planning meeting was held on 5 August 2022. The appointments of Board members ceased on 31 October 2022, and the new Board was appointed in late March 2023. Individual meetings were held with Board members to discuss the purpose and function of the Board ahead of a work program planning meeting on 29 June 2023. The delay between appointments of previous Board members ceasing and appointment of new members meant it was not possible to schedule a case review meeting in 2022–23.				
Financial reporting	The Board is audited as part of the Department of Justice and Attorney-General. Accounts are published in the annual report.				
Remuneration					
Position	Name	Meetings/ sessions attendance	Approved annual fee	Approved sub-committee fees if applicable	Actual fees received[32]
Chair	Terry Ryan[33]	2			
Chair	Stephanie Gallagher[34]	1			
Deputy Chair	A/Prof Kathleen Baird[35]	1	$4,500		$300
Member	Betty Taylor	2	$4,500		$300
Member	Rosemary O'Malley[36]	1	$4,500		$300
Member	Angela Lynch[37]	1	$4,500		$300
Member	Nadia Bromley[38]	1	$4,500		
Member	A/Prof Molly Dragiewicz	2	$4,500		$300
Member	Keryn Ruska	1	$4,500		$300
Member	Kristina Deveson	1			
Member	Dr Kylie Stephen	2			
Member	Brian Codd[39]	1			
Member	Paul Stewart	2			
Observer	Tricia Mattias[40]	1			
No. scheduled meetings/sessions	Two (2)				
Total out of pocket expenses	$0				

[32] Payments for the 29 June 2023 meeting were not processed in 2022–23. These will be reflected in remuneration expenses for 2023–24.
[33] State Coroner Terry Ryan's appointment ceased in October 2022.
[34] Deputy State Coroner Stephanie Gallagher was appointed to the Board in March 2023.
[35] Associate Professor Kathleen Baird's appointment ceased in October 2022.
[36] Rosemary O'Malley's appointment ceased in October 2022.
[37] Angela Lynch's appointment ceased in October 2022.
[38] Nadia Bromley was appointed to the Board in March 2023.
[39] Assistant Commissioner Brian Codd's appointment ceased in October 2022.
[40] David Harmer was appointed to the Board in March 2023 but subsequently left Queensland Health. Tricia Mattias attended the 29 June 2023 Board meeting on behalf of Queensland Health.

Appendix F: Glossary of terms

Aggrieved: the person for whose benefit a domestic violence protection order, or Police Protection Notice, is in force under the *Domestic and Family Violence Protection Act 2012* (Qld).

ANROWS: Australian National Research Organisation for Women's Safety.

Apparent suicide: in Queensland, only an investigating coroner can determine that a death is a suicide after considering all the information they have gathered as part of their investigation. Until a coroner has made their findings, these deaths are referred to as 'suspected' or 'apparent' suicides.

Coercive control: an ongoing pattern of behaviour asserted by a PUV that is designed to induce various degrees of fear, intimidation, and submission in a victim.[41] This may include the use of tactics such as social isolation, belittling, humiliation, threatening behaviour, restricting resources and physical abuse of the victim, children, pets, or relatives. Coercive control also includes acts of physical and sexual violence.

Deceased: the person/s who died.

DFVPA 2012: *Domestic and Family Violence Protection Act 2012 (Qld)*.

Domestic and family violence: as defined by section 8 of the *Domestic and Family Violence Protection Act 2012*, means behaviour by a person (the first person) towards another person (the second person) with whom the first person is in a relevant relationship that: (a) is physically or sexually abusive; or (b) is emotionally or psychologically abusive; or (c) is economically abusive; or (d) is threatening; or (e) is coercive; or (f) in any other way controls or dominates the second person and causes the second person to fear for their safety or wellbeing, or that of someone else.

Domestic and family violence homicide: Queensland uses a nationally consistent definition of a 'domestic and family violence homicide' as outlined within the Australian Domestic and Family Violence Death Review Network 'Homicide Consensus Statement' that recognises that although there is no universally agreed definition of the behaviours that comprise domestic and family violence, in Australia it includes a spectrum of physical and non-physical behaviours including physical assault, sexual assault, threats, intimidation, psychological and emotional abuse, social isolation and economic deprivation.

Primarily, domestic and family violence is predicated upon inequitable relationship dynamics in which one person exerts power over another. This accords with the definition of family violence contained in the *Family Law Act 1975* (Cth), which is adopted by the Network. The definition of homicide adopted by the National Network is broader than the legal definition of the term, and includes all circumstances in which an individual's act, or failure to act, resulted in the death of another person, regardless of whether the circumstances were such as to contravene provisions of the criminal law.

Emotional or psychological abuse: behaviour by a person towards another person that torments, intimidates, harasses or is offensive to the other person.

Episodes of violence: describes the series of events characterising this type of violence. Referring to episodes of violence (e.g. as opposed to 'incidents') allows practitioners to consider the repetitive nature of violence perpetration and victimisation, exposing the ongoing vulnerabilities of victims and cumulative risk that PUV pose both within, and across, relationships.

Filicide: the killing of a child/ren by a parent or caregiver who was under the age of 18 years at the time that they died.

[41] Johnson, M. (2008). *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance and Situational Violence*. Boston: University Press of New England.

Financial abuse: behaviour by a person that is coercive, deceptive, or unreasonably controls another person without the second person's consent in a way that denies economic or financial autonomy, or by withholding or threatening to withhold financial support necessary for meeting reasonable living expenses if the first person is predominantly or entirely dependent on the first person financially.

High Risk Teams: seek to support the delivery of coordinated, consistent and timely responses to prevent serious harm or death in cases where victims and their children are assessed as being at high risk. Participating agencies across the service system will work together to enhance victim safety, monitor the high risk posed by the PUV, and implement strategies that seek to hold the PUV to account through appropriate information sharing, comprehensive risk assessment and informed safety planning, and increased agency accountability. In Queensland, the funded High-Risk Teams form part of the Integrated Service Response trials associated with reforms arising from the final report of the *Special Taskforce on Domestic and Family Violence in Queensland* titled *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland* (2015).

Homicide event: an event resulting in the unlawful killing of a person.

Integrated Service Response: refers to the strategic sharing arrangements and the intensive management of cases using common protocols, consistent risk assessment frameworks, and information sharing to support the actions of frontline workers. This also includes the coordination and collaboration of government and non-government agencies to deliver holistic service responses, more efficient pathways through the service system, and coordination of service delivery between agencies. For the purposes of this report, 'Integrated Service Response' refers to the specific approach taken in Queensland as recommended by the Women's Safety and Justice Taskforce.

Intimate partner relationship: individuals who are or have been in an intimate relationship (sexual or non-sexual), irrespective of the genders of the individuals.

Lethality risk indicators: domestic and family violence death review processes are based on the premise that there have been warning signs, and key indicators or predictors of harm, prior to the death. These indicators, such as a noted escalation in violence, non-lethal strangulation or real or impending separation, have been found to have been associated with an increased risk of harm in relationships characterised by domestic and family violence.

Homicide offender: the person whose actions, or inaction, caused the person (the deceased) to die, also known as person using violence.

PUV (person using violence): the person who was the primary aggressor in the relationship prior to the death and who used abusive tactics to control the victim.

PUV interventions: typically refers to specific programs (e.g. behaviour change programs) for PUV of domestic and family violence. These interventions generally seek to change men's attitudes, beliefs, and behaviour to prevent them from engaging in violence in the future.[42]

Person most in need of protection: the *Domestic and Family Violence Protection Act 2012* (Qld) requires that consideration be given to the person most in need of protection in circumstances where there are mutual allegations of violence.

Police Protection Notice: section 101 of the *Domestic and Family Violence Protection Act 2012* (Qld) enables a police officer to make a Police Protection Notice (PPN) if certain conditions are met. A PPN may be made when police attend a location where domestic and family violence is occurring or has occurred. A PPN requires the respondent to be of good behaviour towards the aggrieved and may include other conditions stopping the respondent from having contact with the aggrieved. A PPN is taken to be an application for a protection order made by a police officer.

[42] Mackay, E, Gibson, A, Lam, H & Beecham, D. (2015). 'Perpetrator Interventions in Australia: Part One – Literature Review'. *Landscapes: State of Knowledge Papers.* https://d2rn9gno7zhxqg.cloudfront.net/wp-content/uploads/2019/02/19024727/Landscapes-Perpetrators-Part-ONE.pdf.

Primary victim: this is the person who was subjected to domestic and family violence in a relevant relationship prior to the homicide event. This could be the homicide deceased, homicide offender, homicide–suicide offender/deceased, and surviving victim.

Protection order: as defined by Part 3 of the *Domestic and Family Violence Protection Act 2012* (Qld), a domestic violence protection order is an official document issued by the court that stipulates conditions imposed against a respondent with the intent to stop threats or acts of domestic and family violence.

Relative: individuals, including children, related by blood, a domestic partnership or adoption. This includes family-like relationships and explicitly includes extended family-like relationships that are recognised within that individual's cultural group. This includes: a child, stepchild, parent, step-parent, sibling, grandparent, aunt, nephew, cousin, half-brother, or mother-in-law.

Relevant relationship: as defined by section 13 of the DFVPA 2012, includes an intimate partner relationship, family relationship or informal care relationship.

Respondent: a person against whom a domestic violence protection order, or a police protection notice, is in force or may be made under the DFVPA 2012.

Risk assessment: a comprehensive evaluation that seeks to gather information to determine the level of risk and the likelihood and severity of future violence. Levels of risk should be continually reviewed through a process of ongoing monitoring and assessment.

Risk management: an approach to respond to and reduce the risk of violence. Risk management strategies should include safety planning, ongoing risk assessment, plans to address the needs of victims through relevant services (e.g. legal, counselling) and liaison between services utilising appropriate information sharing processes.

Safety planning: a safety plan assists a victim to identify and recognise her safety needs and plan for emergency situations. Safety plans can be developed to assist a woman to escape the violent situation, or to remain with the person who has abused her. In either case, the aim of the safety plan is to assist the victim to stay, or to leave, as safely as possible.

Service system: a term used to refer to all services and agencies that play a role in identifying and responding to domestic and family violence including health and mental health services, child protective services, police, corrections, court services, housing services and domestic and family violence services.

Sexual jealousy: is a type of jealousy evoked in response to an actual or perceived threat of sexual infidelity.

Special Taskforce on Domestic and Family Violence in Queensland (the Special Taskforce): established on 10 September 2014 to define the domestic and family violence landscape in Queensland and make recommendations to inform the development of a long-term vision and strategy to stop domestic and family violence, the Special Taskforce's Final Report, *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland* (2015), made 140 recommendations that have now been implemented.

Specialist domestic and family violence services: services designed to provide frontline support and resources to individuals affected by domestic and family violence (e.g. victim services, women's refuges, PUV intervention programs).

Victim: the person who was the primary victim of domestic and family violence in the relationship and the person most in need of protection.

Women's Safety and Justice Taskforce (the Taskforce): was established as an independent, consultative taskforce by the Queensland Government to examine: coercive control and review the need for a specific offence of domestic violence and the experience of women across the criminal justice system. The Taskforce has reported twice—in 2021 and 2022.