

Domestic and Family Violence
Death Review and Advisory Board



Domestic and Family Violence Death Review and Advisory Board

Annual Report 2024–25



Queensland
Government

Domestic and Family Violence Death Review and Advisory Board



Queensland
Government

Secretariat

Level 3, Brisbane Magistrates Court
363 George Street, BRISBANE QLD 4000
GPO Box 1649 BRISBANE QLD 4001
Email: DFVDRAB.Secretariat@justice.qld.gov.au

Our Reference: 7494285
Contact: Patricia Wagner
Telephone: 07 3738 7092

09 September 2025

The Honourable Deb Frecklington MP
Attorney-General and Minister for Justice
Minister for Integrity
GPO Box 149
Brisbane QLD 4001
By email: attorney.general@ministerial.qld.gov.au

Dear Minister

In accordance with the requirements of section 91ZB of the *Coroners Act 2003*, I am pleased to present the Domestic and Family Violence Death Review and Advisory Board Annual Report for the year ended 30 June 2025.

This report outlines the activities undertaken by the Board throughout this reporting period to fulfil its legislative functions.

Yours sincerely

Stephanie Gallagher
Deputy State Coroner
Chairperson
Domestic and Family Violence Death Review and Advisory Board

Encl.: Domestic and Family Violence Death Review and Advisory Board Annual Report 2024–25
(PDF file)



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

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

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

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

All enquiries regarding this document should be directed in the first instance to the Secretariat, GPO Box 1649, Brisbane, QLD, 4001, or by email: DFVDRAB.Secretariat@justice.qld.gov.au

© Domestic and Family Violence Death Review and Advisory Board, Brisbane, 2025.

Suggested citation:

Domestic and Family Violence Death Review and Advisory Board (2025) *2024–25 Annual Report*, www.coronerscourt.qld.gov.au/dfvdrab/annual-reports-and-government-responses.

Copyright permissions

This publication may be copied, distributed, displayed, downloaded, and otherwise freely dealt with for any personal or non-commercial purpose, on the condition that proper acknowledgement is included on all uses.

About this report

This Annual 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* (Qld) (the Act), which provides 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.



The content of this report may be distressing and confronting for readers. Please be mindful of the impact of this content and seek support as required. A list of relevant support services is provided below.

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.

We recognise and celebrate the unique and continuing position of Aboriginal and Torres Strait Islander peoples in Australia's history, culture, and future, and acknowledge their ongoing strength, resilience, and wisdom. We are working to translate this recognition into fair, safe and inclusive practices, policies, and services for Aboriginal and Torres Strait Islander peoples.

Caution: Aboriginal and Torres Strait Islander peoples should be aware this report contains information about Aboriginal deceased persons and Torres Strait Islander deceased persons. People may find parts of this content confronting or distressing. Recommended support services include: 13YARN (13 92 76) for Aboriginal and Torres Strait Islander peoples, 1800RESPECT (1800 737 732) and Lifeline (13 11 14).

Support services

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 are asked to engage in investigations and other proceedings to seek justice.

The Board acknowledges the strength of these families and stands in solidarity with them in the hope, one day, no Queenslanders 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 change. 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 phone number for police, fire fighters or ambulance 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. www.police.qld.gov.au/domestic-violence.
- » **DVConnect Womensline** is a 24-hour crisis support line for anyone who identifies as female being impacted by domestic and family violence. If you identify as gender-diverse you can call the helpline you feel most comfortable with. DVConnect Womensline 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. If you identify as gender-diverse you can call the helpline you feel most comfortable with. DVConnect Mensline is contactable on **1800 600 636** or via www.dvconnect.org.
- » **1800RESPECT** is the 24-hour national domestic, family, and sexual violence counselling, information, and support service. 1800RESPECT is contactable on **1800 737 732**, SMS on **0458 737 732**, or via www.1800respect.org.au.

- » **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 national crisis support line for mob who are feeling overwhelmed or having difficulty coping. Lifeline-trained Aboriginal and Torres Strait Islander Crisis Supporters provide yarning opportunities 24 hours, 7 days a week and can be contacted on **13 92 76** or via www.13yarn.org.au.
- » **Diverse Voices** supports the LGBTIQASB+ community experiencing domestic, family, or sexual violence, or are using violence toward a partner. For more information, or to make an appointment contact Diverse Voices on **07 3111 6729**, Monday to Friday from 9am – 4pm or support@divo.org.au. Diverse Voices also works alongside QLife to provide anonymous LGBTI peer support and referral for people wanting to talk about a range of issues including sexuality, identity, gender, bodies, feelings or relationships. Diverse Voices can be contacted on **1800 184 527** between 3pm and Midnight 365 days or via www.diversevoices.org.au.
- » **Rainbow Sexual, Domestic and Family Violence Helpline** is a 24-hour telephone counselling and referral service for anyone from the LGBTQ+ community who has experienced sexual, domestic or family violence. This service also assists those who support the LGBTQ+ community (family, friends and professionals). Rainbow Sexual, Domestic and Family Violence Hotline can be contacted on **1800 497 212**.
- » **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.
- » **Beyond Blue** provides mental health information, support, and hope nationally 24-hours a day. Beyond Blue can be contacted on **1300 22 4636** or via www.beyondblue.org.au/get-support.

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 (QHVSQ)** is a community support group which offers 24-hour support, personal advocacy and education to all people affected by homicides in Queensland. QHVSQ 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 peoples 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 providing 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.au.

- 
- » **Aboriginal and Torres Strait Islander Community Health Services** provide health and wellbeing services and programs for Aboriginal and Torres Strait Islander peoples. To access culturally appropriate health services through your local Aboriginal and Torres Strait Islander Community Health Service check www.qaihc.com.au/about/our-members.

For guidance regarding responsible reporting on DFV-related homicides:

- » **Queensland Government's Domestic and Family Violence Media Guide** provides information for journalists about responsible reporting of domestic and family violence at www.justice.qld.gov.au/community-engagement/media/dfv-media-guide.
- » **Our Watch** national media guidelines provide tips and information to ensure reporting does not further harm victim-survivors and is part of the solution to DFV. www.ourwatch.org.au/media-reporting/resources/guidelines-for-reporting.
- » **Mindframe** have developed guidelines for safe reporting in relation to substance use, suicide and mental illness for journalists which are available at www.mindframe.org.au.

Chair's message

This Annual Report outlines the work of the Domestic and Family Violence Death Review and Advisory Board (the Board) throughout 2024–25, which is the second year I have chaired the Board. The victims of domestic and family violence (DFV) remain at the centre of the Board's work. Their deaths have a devastating impact on the families, friends and communities who grieve their loss. The Board's statutory mandate is to identify systemic failures, gaps, and issues, and to recommend improvements to systems, practices, and procedures to prevent like deaths in the future.

This year, the Board undertook a case review of 16 DFV-related events where there was evidence of wilful fire-setting. The 16 events resulted in the deaths of 22 people.

Although such deaths are statistically rare, each DFV-related death provided an opportunity to identify systemic shortcomings and enhance our understanding of relevant risk factors. Accordingly, this report has been informed by findings from previous Annual Reports published by the Board, as well as data from the Queensland DFV-related Homicide and Suicide Databases.

The case review identified issues for consideration with a view to seeking to minimise risks of fire-related harm and enhance safety for primary victims (PVs), their families and the community. Fire-related threats and violence can be used as a tool of control by persons using violence (PUVs). Our case review identified fire-related threats and harm often take place in an environment of coercive control and may be used by PUVs to instil fear among PVs. Threats to kill and threats of wilful fire-setting have been recognised as significant risk factors for serious harm in this case review. Service providers, including health practitioners, identifying the source of suspicious burn injuries, may assist in providing appropriate supports to PVs to prevent the escalation of DFV through risk assessments and safety planning. Education about burns first aid for bystanders and the community, as well as education regarding fire safety and actions to take in the event of a fire, may minimise fire-related harm and injury and enhance community awareness.

The case review accentuated the intersection between mental health conditions, alcohol and substance use and fire-related violence in the context of DFV. Escalating risk assessments and safety planning when significant risk factors are present may help minimise harm by providing appropriate supports to PVs and their families. Pending and actual separation from a relationship have been identified as risk factors for fire-related violence. Evidence of pre-planning of wilful fire-setting and violence was identified in a few of the deaths reviewed. In cases where the pre-planning of wilful fire-setting was present, there was also evidence of bystander awareness of threats to harm or kill, stressing the importance of appropriate supports for bystanders of DFV. Persistent data gaps relating to wilful fire-setting in the context of DFV have been identified, underlining the need for further research on the prevalence and impacts of fire-related violence to inform policy and practice.



The Board has continued to monitor the implementation of its 80 previous recommendations. It has also reflected on how improved framing of recommendations and supporting evidence can assist lead agencies to effectively implement the changes needed to prevent DFV-related deaths in Queensland.

There have been a few changes to the Board's membership this year, including in relation to government members following a change in role. The following members have resigned their positions:

- Assistant Commissioner Christopher Jory resigned from the Board in October 2024. Assistant Commissioner Jory made significant contributions to its work since his commencement in February 2024. I extend my best wishes to him in his new role as Assistant Commissioner of the Ethical Standards Command at the Queensland Police Service and express my gratitude for his dedication while serving on the Board.
- Ms Belinda Drew resigned from the Board in December 2024. Ms Drew made important contributions to the Board's work during her membership which commenced in July 2024. I extend my best wishes to her in her new role as the Director-General of the Department of Families, Seniors, Disability Services and Child Safety, and express my gratitude to her for her dedication while serving on the Board.
- Ms Kristina Deveson resigned from the Board in February 2025. Ms Deveson joined the Board in March 2022 and made considerable contributions to its work during her tenure. I extend my best wishes to her in her new role as Assistant Director-General of the Magistrates Court Service and express my appreciation for her commitment while serving on the Board.
- Professor Molly Dragiewicz from the Griffith University School of Criminology and Criminal Justice resigned from the Board in March 2025. Professor Dragiewicz joined the Board in March 2020 and, in sharing her research and data expertise, made a substantial contribution to its work during her membership. I express my appreciation to Professor Dragiewicz for her expertise and commitment while serving on the Board.

I welcome Dr Meegan Crawford, Chief Practitioner with Department of Families, Seniors, Disability Services and Child Safety, Queensland Police Service Assistant Commissioner Katherine Innes, Dr Anne Butcher, AASW Accredited Mental Health Social Worker, and Ms Kirsten Firman, Manager, Youth and Family Services for South Burnett CTC, who were appointed as members of the Board this year. Their experience and insight complement that of existing members as we work together to continue to enhance the value of the Board and honour the voices of those who have died from DFV.

The Board continues to be supported by the dedicated members of the Domestic and Family Violence Death Review Unit (DFVDRU) in the Coroners Court of Queensland. I wish to formally recognise their work and express my appreciation.

This year the Board sought additional expertise to inform our case review, and I wish to recognise the support of Professor Heather Douglas, Associate Professor Kristin Diemer and Ms Charlotte Hock from the University of Melbourne. I would also like to recognise the support of Queensland Fire Department Assistant Commissioners Neil Francis and Kevin Reading who provided their expertise during the Board's case review meetings. Additionally, I would like to thank Queensland Corrective Services Assistant Commissioner Sarah Hyde, Dr Elizabeth Vujcich from Metro North Hospital and Health Service, and Superintendent Michael Ede from the Queensland Police Service who supported the Board with the review of DFV-related homicide cases involving wilful fire-setting this year.

I would like to recognise the communities impacted by Tropical Cyclone Alfred and spotlight the tireless work of emergency response organisations and community members in their preparation and response efforts throughout the weather event. I acknowledge the impacts of Tropical Cyclone Alfred on the planning and preparation of our Board meetings and thank Board members for their flexibility during this time.

I am honoured to chair the Board as it continues to work towards meaningful systemic change for DFV victim-survivors and Queensland communities.



Stephanie Gallagher
Deputy State Coroner

Acknowledgements

The Board respectfully acknowledges the victims of DFV whose lives are discussed in this report, alongside those who have lost a loved one to DFV. In addition to the victims whose experiences are discussed here, 2025 has seen further victims who have lost their lives in the context of wilful fire-setting and DFV. The Board respectfully acknowledges these victims and their families.

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

While DFV death review processes seek to bring together as much information as possible about the events leading up to a death, it is important to acknowledge no one agency or person has access to all available information prior to a death occurring. Reviews are conducted by the Board with the benefit of hindsight and, for this reason, it is necessary to share learnings from these reviews and effect systems change via those learnings.

During 2024–25, the Board was supported by expert advisors in its review of DFV-related homicides involving wilful fire-setting.

The Board would like to acknowledge the contributions of:

- Professor Heather Douglas AM, The University of Melbourne and Deputy Director ARC Centre of Excellence for the Elimination of Violence Against Women.
- Associate Professor Kristin Diemer, The University of Melbourne.
- Ms Charlotte Hock, The University of Melbourne.
- Assistant Commissioner Neil Francis, Queensland Fire Department.
- Assistant Commissioner Kevin Reading, Queensland Fire Department.
- Dr Elizabeth Vujcich, Queensland Health.
- Superintendent Michael Ede, Queensland Police Service.
- Assistant Commissioner Sarah Hyde, Queensland Corrective Services.
- Ms Victoria Van Houdt, Department of Families, Seniors, Disability Services and Child Safety.
- Coroner Ainslie Kirkegaard, Coroners Court of Queensland.

Board members

CURRENT

Ms Stephanie Gallagher

Deputy State Coroner of Queensland, Coroners Court of Queensland.

Chairperson

NON-GOVERNMENT MEMBERS

Ms Nadia Bromley

Chief Executive Officer, Women's Legal Service.

Deputy Chairperson

Ms Keryn Ruska

Legal Services Manager, IUIH Legal Service, Institute of Urban Indigenous Health.

Dr Brian Sullivan

Chief Executive Officer, Red Rose Foundation and Founder/Director, SICURA.

Mr Ben Bjarnesen

Founder and Managing Director, LGBTQ Domestic Violence Awareness Foundation.

Ms Aletia Twist

Chief Executive Officer, Mura Kosker Sorority Inc.

Dr Anne Butcher

AASW Accredited Mental Health Social Worker.

Ms Kirsten Firman

Manager, Community Services, South Burnett CTC.

GOVERNMENT MEMBERS

Mr Paul Stewart

Commissioner, Queensland Corrective Services.

Dr Julia De Boos

Staff Specialist – Hospital in the Home, Regional Forensic Coordinator, North West Hospital and Health Service, Queensland Health.

Ms Katherine Innes

Assistant Commissioner, Domestic Family Violence and Vulnerable Persons Command, Queensland Police Service.

Dr Meegan Crawford

Chief Practitioner

Department of Families, Seniors, Disability Services and Child Safety.

FORMER

Mr Christopher Jory

Assistant Commissioner, Domestic Family Violence and Vulnerable Persons Command, Queensland Police Service.

Ms Belinda Drew

Deputy Director-General, Women's Safety, and Victims and Community Support, Department of Justice and Attorney-General.

Ms Kristina Deveson

Assistant Director-General, Magistrates Courts Service, Department of Justice and Attorney-General.

Dr Molly Dragiewicz

Associate Professor, School of Criminology and Criminal Justice, Griffith University.

SECRETARIAT

Ms Patricia Wagner, A/Manager

Ms Cathy Paxton, Principal Researcher and Coordinator

Ms Milani Mudannayake, Project Officer
Domestic and Family Violence Death Review Unit,
Coroners Court of Queensland, Department of Justice.

Contents

About this report.....	3
Support services	4
Chair’s message.....	7
Board members.....	11
Contents.....	12
Overview.....	14
Section One: Performance of the Board’s functions	15
About the Board.....	16
Section 91D(1)(a): Review domestic and family violence deaths.....	18
Section 91D(1)(b-d): Analyse data and research to identify trends and prevent deaths	18
Section 91D(1)(e): Make recommendations to the Minister	19
Section 91D(1)(f): Monitor the implementation of recommendations.....	19
Section Two: Case review: DFV-related homicides involving wilful fire-setting.....	21
Background and context	22
Introduction	22
Scan of current research and literature across jurisdictions	23
Brief media content analysis of DFV-related intimate partner homicides involving wilful fire-setting (2020–2022).....	26
Case review design.....	30
Findings and recommendations	36
<i>Data analysis.....</i>	<i>36</i>
<i>Systemic issue 1: Community awareness and appropriate supports for bystanders of DFV to support victims.....</i>	<i>49</i>
<i>Systemic issue 2: Availability of appropriate DFV services.....</i>	<i>52</i>
<i>Systemic issue 3: Adequate assessment of risk supporting safety planning.....</i>	<i>56</i>
<i>Systemic issue 4: Persistent data gaps and need for further research.....</i>	<i>60</i>
Conclusion.....	62
Section Three: Domestic and family violence-related homicides 2016–25.....	63
Identifying domestic and family violence-related homicides.....	64
Domestic and family violence-related homicides 2024–25	67
Domestic and family violence-related homicides 2020–25	73
Appendices.....	76
Appendix A: Remuneration of the Board.....	77



Appendix B: Australian Domestic and Family Violence Death Review Network Homicide Consensus Statement	78
Appendix C: Glossary of terms	84
Appendix D: Queensland Government Response to the Domestic and Family Violence Death Review and Advisory Board 2023–24 Annual Report	91

Overview

The 2024–25 Annual Report of the Domestic and Family Violence Death Review and Advisory Board comprises three sections:

- a) **Section One** describes the performance of the Board’s functions;
- b) **Section Two** reports on the content, findings and recommendations arising from the Board’s case review for 2024–25; and
- c) **Section Three** presents data about DFV-related homicides in Queensland between 1 July 2020 and 30 June 2025.

The 2024–25 Annual Report also includes several appendices, which include supporting information to the annual report.



This Annual Report contains content which may be distressing for readers. Please be mindful of the impact of this content and seek support as required. A list of relevant support services is provided at the front of this report.



Section One: Performance of the Board's functions

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.¹

The Board holds a unique position within the domestic and family violence (DFV) sector of Queensland with its functions enshrined in legislation under Part 4A of the *Coroners Act 2003* (Qld) (the Act).²

The Board is responsible for the systemic review of DFV-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 DFV deaths in Queensland;
- b) increase recognition of the impact of, and circumstances surrounding, DFV and gain a greater understanding of the context in which DFV 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 DFV deaths.

In reviewing DFV-related deaths, the role of the Board is not to investigate the circumstances of an individual death, but to identify systemic issues. It is intended the Board will review DFV-related deaths collectively across cases and will consider common themes and issues occurring across different types of deaths, such as homicide–suicide, Aboriginal and Torres Strait Islander family violence-related deaths, intimate partner homicides, suicides of victims of DFV and persons using violence, or deaths where there has been recent contact with different systems or services.

¹ Special Taskforce on Domestic and Family Violence (2015) *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland*. www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/533db62b-b2c9-43cc-a5ff-f9e1bc95c7c7/dfv-report-vol-one.pdf?ETag=c69c3ef47071a137ddbaedb49f7fe468.

² www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#pt.4A.

This section of the report outlines how the Board fulfilled the legislated functions, as outlined below, across the year.

Under section 91D(1) of the *Coroners Act 2003* (Qld), the Board has the following functions:

- (a) to review domestic and family violence deaths in Queensland.
- (b) to analyse data and apply research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland.
- (c) to carry out, or engage other persons to carry out, research to prevent or reduce the likelihood of domestic and family violence deaths.
- (d) to use data, research findings and expert reports to compile systemic reports into domestic and family violence deaths, including identifying key learnings and elements of good practice in the prevention and reduction in the likelihood of domestic and family violence deaths in Queensland.
- (e) to make recommendations to the Minister about improvements to legislation, policies, practices, services, training, resources and communication for implementation by government entities and non-government entities to prevent or reduce the likelihood of domestic and family violence deaths in Queensland.
- (f) to monitor the implementation of recommendations made under paragraph (e).

Section 91D(1)(a): Review domestic and family violence deaths

In response to an emerging trend identified through a DFV-related homicide data analysis by the Domestic and Family Violence Death Review Unit (DFVDRU), and anecdotal evidence across the service system that deaths from wilful fire-setting and fire-related threats were increasing, the Board chose to undertake a review of DFV-related homicides involving wilful fire-setting. Detail of this case review, including the design, data analysis, findings, and recommendations for Government, are contained in Section Two of this Annual Report.

Section 91D(1)(b-d): Analyse data and research to identify trends and prevent deaths

The Board's data and research functions in 2024–25 complemented its review of DFV-related homicides involving wilful fire-setting. Section Two of this report provides a detailed analysis of data from the Board's case review.

To supplement the Board's extensive knowledge and expertise, the Board contracted research and content area experts from the University of Melbourne. On behalf of the Board, these academic experts – Professor Heather Douglas, Associate Professor Kristin Diemer and Ms Charlotte Hock – undertook a review of existing research and literature on fire-related injuries and fatalities in the context of DFV. The literature review highlighted there is limited Australian research available regarding DFV-related homicides involving wilful fire-setting. The Board intends to publish the literature review in full on its website in late 2025.

Literature review summary of findings: DFV and fire-related injuries and deaths

The literature review identified several areas requiring further research, or increased training and development:

Enhanced data collection can assist in identifying links between fire-related injuries and DFV as well as help better establish prevalence rates of fire-related violence. Enhanced data collection will also contribute to the national evidence base and promote further research in this area.

Additional data in this area may improve training and awareness among health professionals about DFV risk indicators, increase risk identification and improve responses to fire-related violence.

Fire-related violence is under reported and often not disclosed by DFV victim-survivors in health settings. There was also research that suggested while victim-survivors sought health services; they showed an increased rate of not attending a healthcare review. Further research is required into influences on decision-making for burn victims in health settings, and whether

victim-survivors leave before attending a healthcare review due to fear, coercive control or other circumstances.

A review of media guidelines for reporting fire-related violence and its impacts is required. Adherence to media guidelines for responsible reporting of DFV may reduce sensationalist depictions of fire-related violence and its capacity to influence copycat behaviours.

Further research is also required on risk indicators of fire-related violence and threats in the context of coercive control. Collaboration between the global burns' community, violence prevention organisations, and self-harm prevention organisations has been suggested as a means of raising awareness of fire-related violence and self-harm. By investing in research and data collection relating to fire-related violence in the context of DFV, increased safety planning, awareness campaigns and prevention initiatives can be implemented to enhance the safety of the community and minimise fire-related harm.³

Section 91D(1)(e): Make recommendations to the Minister

As a result of the activities in 2024–25 focusing on DFV-related homicides involving wilful fire-setting, the Board identified four findings resulting in four recommendations to the Minister. The recommendations are detailed in Section Two of this report.

Section 91D(1)(f): Monitor the implementation of recommendations

Each year the Board makes recommendations to the Attorney-General which are published in the Board's annual report. The recommendations are focussed on system reform to prevent and reduce domestic and family violence in Queensland. The Board monitors the status of its recommendations in accordance with section 91D(1)(f) of the Act. The Board is required to report on the implementation of recommendations as part of the review process. Monitoring implementation allows the Board to evaluate the effectiveness of its recommendations and assists in determining whether the intent of the recommendations have been considered throughout implementation processes. Additionally, it supports effective death review processes and provides accountability across the DFV reform landscape. Whole-of-government responses are provided in relation to the Board's recommendations, when initially accepted. The Board is then provided with periodic updates documenting the progress of implementation until recommendations are considered to have been implemented in full by Government. All recommendation updates are published on the Board's website.⁴

³ Domestic and Family Violence and Fire-Related Injuries and Deaths: Literature Review will be published on the Coroners Court of Queensland website in December 2025. www.coronerscourt.qld.gov.au/dfvdrab/reports-research-and-data.

⁴ www.coronerscourt.qld.gov.au/dfvdrab/annual-reports-and-government-responses.



Since the Board's inception in 2016 it has made 80 recommendations, 79 of which have been accepted, accepted in part, or accepted in principle by Government. One recommendation from the 2016–17 Annual Report was noted. Of the 80 total recommendations, the Board has been advised 67 recommendations have been implemented, 7 recommendations are in the process of implementation by Government and the 5 recommendations from the 2023–24 Annual Report are awaiting an initial implementation update. The Government Response to the recommendations made in the 2023–24 Annual Report can be found in Appendix D.

Some of the key areas of reform, to which the Board's recommendations relate are workforce development, systems and processes, service accountability and availability, culturally informed responses and practice frameworks and guidelines. The Board will continue to monitor and evaluate the effectiveness of its recommendations in contributing to systematic reforms to prevent and reduce domestic and family violence in Queensland.



**Section Two: Case
review: DFV-
related homicides
involving wilful
fire-setting**



This Annual Report contains content which may be distressing for readers. Please be mindful of the impact of this content and seek support as required. A list of relevant support services is provided at the front of this report.

This section describes the focus of the Board’s work in 2024–25, the analysis of DFV-related homicides involving wilful fire-setting between 2009 and 2024. This is broken into three chapters:

- a) background and context of the Board’s case review;
- b) case review design including data sources, case inclusion criteria and case coding and analysis; and
- c) findings and recommendations arising from the case review.

Background and context

Several factors were considered in determining the focus of the Board in 2024–25, including the work undertaken by various taskforces, recent data, and existing research. After assessing several potential themes, the Board prioritised a case review of DFV-related homicide deaths involving wilful fire-setting.

In addition to the limited available research on this topic, the Board noted DFV service system stakeholder views there had been increased media attention on the use of fire to coerce, control and punish current or former intimate partners or family members.⁵ Some members of the DFV service sector have suggested this is due to an increase in the behaviour, while others caution media representations of DFV can be sensationalist and favour extreme, multiple fatality cases leading to a perception within the community these events are increasing or more common than they really are.⁶ The Board therefore concluded undertaking a case review of DFV-related homicides involving wilful fire-setting would yield unique insights into the DFV system.

Introduction

DFV-related homicides involving wilful fire-setting represent a particularly violent and devastating form of violence, often resulting in the deaths of family members, intimate partners, children, and sometimes bystanders, in addition to property destruction. There is limited understanding of the use of wilful fire-setting in the context of DFV.

⁵ Lelliott, J, and Wallis, R (2023) ‘Threats of fire in the context of domestic and family violence: views on prevalence, forms and contexts from service providers in Queensland’, *Current Issues in Criminal Justice*, 35(2), 234–248. <https://doi.org/10.1080/10345329.2022.2161844>.

⁶ Lelliott, J, Lim, P, and Lu, M (2021) ‘Dousing threats and the criminal law in Queensland: Do we need a new offence?’, *Alternative Law Journal*, 46(4), 282–287. <https://doi.org/10.1177/1037969X211029961>; Sutherland, G, McCormack, A, Pirkis, J, Vaughan, C, Dunne-Breen, M, Easteal, P, and Holland, K (2016) *Media representations of violence against women and their children: Final report* (ANROWS Horizons, 03/2016). Sydney: ANROWS. www.anrows.org.au/publication/media-representations-of-violence-against-women-and-their-children-final-report/.

Unlike other forms of lethal violence, wilful fire-setting can result in rapid, large-scale harm, particularly when victims are confined within homes or vehicles. Despite its lethality, threats or use of fire are not systematically recorded as a DFV-related risk, possibly leading to missed opportunities to provide safety planning or intervention.

This section outlines the case review undertaken by the Board, and explores the characteristics, risk factors and systemic challenges emphasised by reviewing DFV-related homicides involving wilful fire-setting.

Scan of current research and literature across jurisdictions

To inform the Board’s case review, content area experts from the University of Melbourne – Professor Heather Douglas, Associate Professor Kristin Diemer and Ms Charlotte Hock – undertook a review of existing research and literature on fire-related injuries and fatalities in the context of DFV. A summary of the review is below, and the full paper will be published on the Board’s website in late 2025.⁷

Data and reporting of fire-related violence

- a) there is a paucity of data regarding fire-related injury and death in Australia;
- b) fire-related violence in the context of DFV is under-reported;
- c) burn injuries misattributed as accidental rather than DFV-related may contribute to the underreporting of fire-related injuries due to DFV;
- d) barriers to disclosure of fire-related injuries in the context of DFV include person using violence (PUV) accompanying burn victim to hospital, and primary victims (PVs) not disclosing DFV due to fear, coercive control, or other circumstances;
- e) follow-up discussions with PVs post hospital admission have led to the reclassification of fire-related injuries as being due to DFV in international contexts; and
- f) gaps in training and awareness of risk indicators among health professionals may also contribute to the misclassification of the causes of fire-related injury and death in the context of DFV.

Victim attributes

- a) women are more likely to be PVs of fire-related injuries from suspected violence than men,⁸

⁷ ‘Domestic and Family Violence and Fire-Related Injuries and Deaths: Literature Review’ will be published on the Coroners Court of Queensland website in December 2025. www.coronerscourt.qld.gov.au/dfvdrab/reports-research-and-data.

⁸ There are a number of studies highlighting the gendered-nature of fire-related injuries: NSW Death Review and Family Violence Review Network annual reports from 2019–2023 reveal that in 2021 to 2023, five women and one man died by fire-related death, www.coroners.nsw.gov.au/documents/reports/2019-2021_DVDRT_Report.pdf. A recent study analysed data from the Burns Registry of Australia and New Zealand, focusing on women over 18 years admitted to burn centres between 2009 and 2022. Of 6,262 women meeting the study criteria, 2.5% reported burns from suspected violence—Singer Y, Tracy L, Malic C, Martin L, Gabbe B, and Douglas H (2025) ‘Burn violence against women in Australia: The tip of the iceberg from Australian burn centres.’ *Journal of Burn Care and Research*, Advance online publication. <https://doi.org/10.1093/jbcr/iraf081>.

	<ul style="list-style-type: none"> b) First Nations women and younger women have a greater likelihood of being PVs of fire-related injuries from suspected violence; c) people residing in remote, very remote and lower socioeconomic areas have higher instances of fire-related violence in the context of DFV; and d) PVs may experience an environment of coercive control prior to fire-related threats being made, with threats of fire-related violence occurring in the context of escalating DFV.
Offender attributes	<ul style="list-style-type: none"> a) current or former partners of PVs are the primary perpetrators of fire-related violence, followed by family members; and b) male PUVs may use fire to intimidate and maintain control over PVs, which may be part of a broader pattern of coercive control.
Impact of fire-related violence	<p>When compared to women who reported accidental burns, women who were PVs of fire-related violence:</p> <ul style="list-style-type: none"> a) had more severe injuries and higher mortality rates; b) had higher instances of flame burns, burns using accelerants, head injuries, injuries to the front of their body and more severe burns over a higher total body surface area; c) had more severe petrol burns, required longer periods of hospitalisation, required escharotomies and had more admissions to intensive care units than male victims with assault-related burns; and d) were less likely to be discharged home when they sustained burn injuries from suspected violence.
Potential impacts of media reporting	<ul style="list-style-type: none"> a) media reporting into high profile cases involving the use of fire in the context of DFV may contribute to perceptions of copycat behaviours used by PUVs to instil fear in victims; b) fire-related threats and acts spotlighted in the media may be used by PUVs as a tactic of control; c) the risk of copycat events may be reduced with adherence to media guidelines pertaining to responsible reporting and sensationalised depictions of fire-related violence; and d) further research is required regarding fire-related threats and death to understand the potential impacts of media reporting on fire-related violence.

**Prevention and
management of
fire-related
violence**

- a) several tentative risk indicators of fire-related violence, including impending or actual separation, mental health issues and substance misuse were identified;
- b) risk identification and management through collaboration and targeted prevention strategies is an important way to approach and address fire-related violence;
- c) collaboration between fire and rescue services, police and other agencies in Cheshire, England assists PVs in safety planning to protect themselves and their property from fire risks;
- d) specialist DFV training for firefighters, police, community corrections and health professionals has been identified as a way in which referrals and support for PVs can be provided; and
- e) public awareness campaigns regarding effective first aid strategies, such as immediately cooling burn injuries with running water addresses the severity of burn injuries, improved burn treatment outcomes.

Brief media content analysis of DFV-related intimate partner homicides involving wilful fire-setting (2020–2022)

The impact of media reporting on DFV-related homicides is of particular interest to the Board. Therefore, a brief media content analysis was undertaken.

The way media outlets report on DFV is known to impact PVs, PUVs and the broader community in their understanding of and responses to DFV. Media reporting can raise community awareness and provide useful information about DFV. Information concerning support services is often provided to the community through media reporting of DFV cases. The media has an important role in enhancing community knowledge and understanding of DFV, and a responsibility to depict cases involving wilful fire-setting in the context of DFV in a safe, trauma-informed and DFV-informed manner.⁹

News coverage on DFV may also trigger feelings of fear and concern for PVs. Depictions of wilful fire-setting and DFV in the media may also be used by PUVs to threaten PVs or be used as a tool of control. For example, a PUV may threaten a PV they will end up like the victim portrayed in a news article if they don't comply with their demands. Additionally, gender stereotypes and myths relating to DFV can be perpetuated by the media, stressing the importance of responsible reporting of DFV.¹⁰

There are several media guidelines about responsible reporting on DFV, including the Queensland Government guide and the Our Watch national media guidelines, which promotes the importance of evidence-based reporting.¹¹ The *Domestic and Family Violence Media Guide Edition Two* was developed by the Department of Justice in Queensland to support responsible, DFV-informed, trauma-informed, and evidence-based reporting. The guide recommends using relevant statistics and expert advice to inform media reporting of DFV and enhance societal awareness of this issue. The Our Watch media guidelines titled *How to report on violence against women and their children* accentuates the importance of promoting support options when reporting DFV, using appropriate imagery when reporting, using respectful language and naming the form of violence used. Media articles not adhering to media guidelines may depict DFV in a sensationalist or explicit manner.

Six DFV-related intimate partner homicides involving wilful fire-setting between 2020 and 2022 were selected for a media content analysis. Media articles for a seven-day period following the

⁹ Sutherland G, McCormack A, Pirkis J, Vaughan C, Dunne-Breen M, Eastal P, and Holland K (2016) *Media representations of violence against women and their children: Final report* (ANROWS Horizons, 03/2016), Sydney: ANROWS. www.anrows.org.au/publication/media-representations-of-violence-against-women-and-their-children-final-report/.

¹⁰ Lelliott J, and Wallis R (2023) 'Threats of fire in the context of domestic and family violence: views on prevalence, forms and contexts from service providers in Queensland', *Current Issues in Criminal Justice*, 35(2), 234–248. <https://doi.org/10.1080/10345329.2022.2161844>.

¹¹ Queensland Department of Justice and Attorney-General (2025) *Domestic and Family Violence Media Guide*. www.justice.qld.gov.au/community-engagement/media/dfv-media-guide; Our Watch (2019) *How to report on violence against women and their children: 2019 National Edition*. www.ourwatch.org.au/media-reporting/resources/guidelines-for-reporting.

six deaths were obtained from the Media Relations, Strategic Communications Unit at the Queensland Department of Justice. A total of 132 media articles, from 29 media outlets were sourced and analysed. A codebook was developed using a framework informed by ANROWS tips on reporting filicide.¹² The content of each media item was coded in accordance with the codebook. Blind coding by a second coder was undertaken to cross check the qualitative analysis.

When examining media reporting on DFV, articles can be categorised into two styles of reporting: thematic reporting and episodic reporting. Thematic reporting appropriately positions DFV within the sociocultural context and acknowledges contributing factors in DFV cases. Episodic styles of reporting portray DFV cases as a one-off event and fail to place them in the context of sociocultural factors or recognise that a violent incident is a part of a greater pattern of violence spanning the course of time.¹³

The brief media content analysis undertaken for the Board's case review found across all the articles 53% reported in a thematic style, and 34.8% of the articles were reported in an episodic style, while 12.2% were neither style. When examining media articles about each death, two out of the six reported in an episodic style in the seven days following the death. However, these deaths were not identified as being DFV-related during the early stages of media reporting, as more information became available about the DFV-related homicides, the tone of the media articles changed to more thematic. The two deaths that received the most media attention used both episodic and thematic styles of reporting.

Across all the articles:

- a) PVs' names were mentioned 1,275 times, and the PUV was mentioned 695 times in the media articles reviewed;
- b) references to fire and wilful fire-setting, and images of the scene of the incident were present;
- c) support for readers was provided; and
- d) history of DFV in the relationship was addressed.

Figure 2.1 describes the elements of reporting present in the media articles for each of the deaths. It is worth noting the media articles reporting on four of the six deaths:

- a) referenced previous matters involving DFV;
- b) framed DFV as extending beyond physical violence; and
- c) recognised children as victims of DFV in their own right.

¹² Australia's National Research Organisation for Women's Safety (2024) *Tips for reporting findings from Australia's first national report on filicides in the context of domestic and family violence* [Media resource]. ANROWS. www.anrows.org.au/resources/tips-for-reporting-findings-filicides-in-a-domestic-and-family-violence-context/.

¹³ Wilson JA (2024) *Mixed messages: Representations of intimate partner abuse in Australian true crime narratives* [Doctoral dissertation, Macquarie University]. Macquarie University.

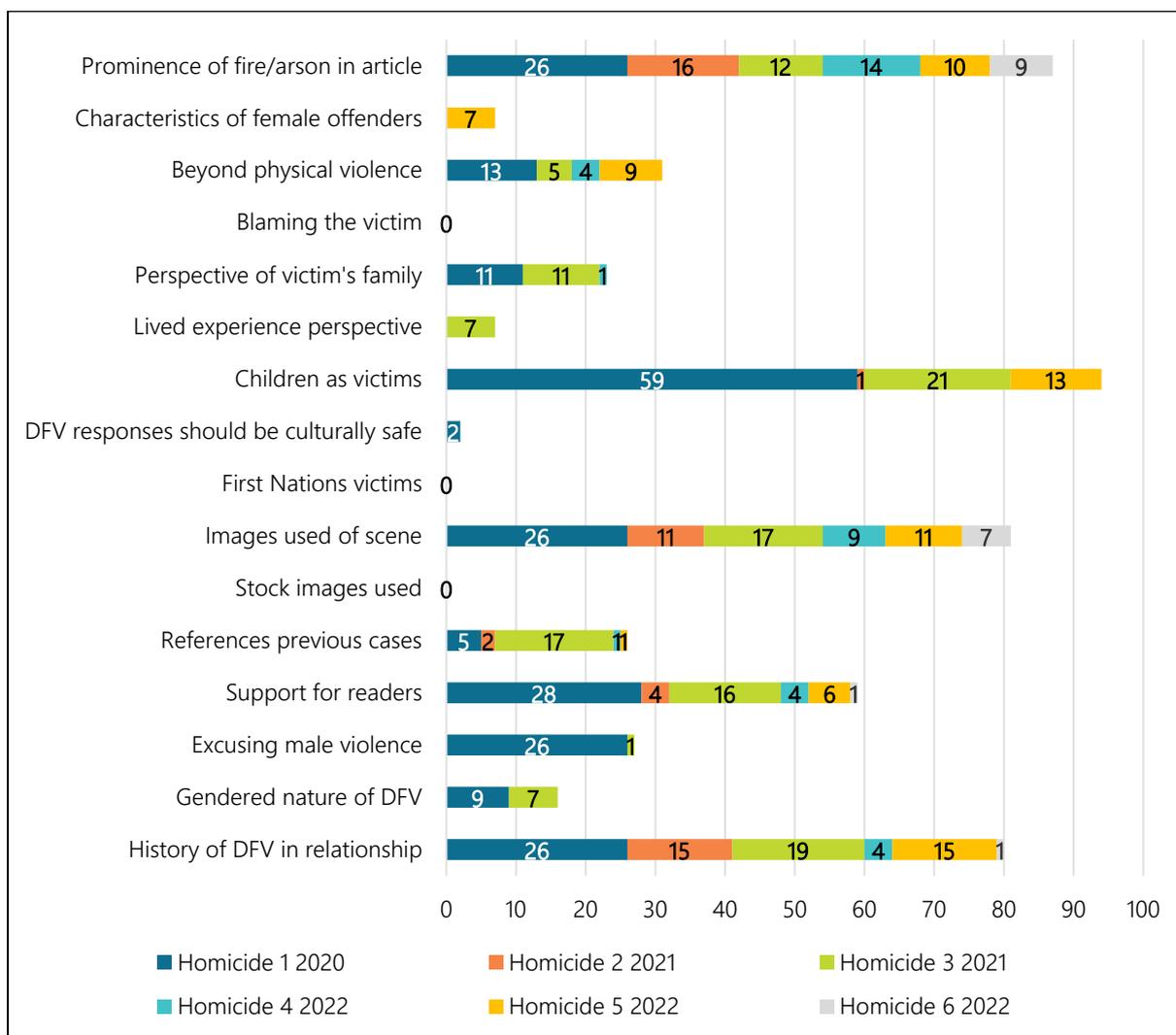


Figure 2.1: Elements of reporting present, by intimate partner homicide involving wilful fire-setting (2020–22).

In the media articles for three deaths the perspective of victims’ families was included. It is worth noting none of the articles reviewed used victim blaming language or problematic stock images.

Responsible media reporting and adherence to media guidelines when reporting fire-related violence in the context of DFV is an important way to enhance community awareness and DFV support pathways. The *Our Watch national media guidelines* state media reporting should be evidence based, safety focussed, respectful, should use appropriate imagery, and include support options.¹⁴

¹⁴ Our Watch (2019) *How to report on violence against women and their children: 2019 National Edition*. www.ourwatch.org.au/media-reporting/resources/guidelines-for-reporting.



The crucial role the media has in shaping the discourse surrounding DFV in Australia underlines the importance of reporting fire-related violence in the context of DFV in accordance with media guidelines. Taking an evidence-based, trauma-informed, DFV-informed and respectful approach to media reporting helps to educate the public, while respectfully acknowledging the experiences of families impacted by DFV.¹⁵

The Board discussed media influence on community perceptions of DFV and considered the way death by suicide is often not reported for both the privacy of the deceased and their family, and for the protection of the general public.¹⁶ The Board is aware of the Australian Press Council's Specific Standards on coverage for suicide and the Advisory guideline on family and domestic violence reporting.¹⁷ There is an opportunity for a Specific Standard on the coverage of DFV-related incidents and deaths, particularly those involving the use of fire, to be developed.

¹⁵ Sutherland G, McCormack A, Pirkis J, Vaughan C, Dunne-Breen M, Eastaer P, and Holland K (2016) *Media representations of violence against women and their children: Final report* (ANROWS Horizons, 03/2016). Sydney: ANROWS.

¹⁶ Australian Press Council (2021) *Advisory guideline on family and domestic violence reporting*. https://presscouncil.org.au/wp-content/uploads/2023/03/Advisory_Guideline_on_Family_and_Domestic_Violence_Reporting_09072021_CURRENT.pdf.

¹⁷ Australian Press Council. (2014). *Specific standards of practice: Reporting on suicide*. https://presscouncil.org.au/wp-content/uploads/2021/11/SPECIFIC_STANDARDS_SUICIDE_-_July_2014.pdf.

Case review design

Aim

The Board undertook a review of DFV-related homicides involving wilful fire-setting occurring between 1 July 2009 and 30 June 2024. The death did not have to be caused by wilful fire-setting to be included (for example, where wilful fire-setting was used to cover up a homicide by other means). The Board examined a series of DFV-related homicides involving wilful fire-setting across a 15-year period to describe the PV and PUV demographics, service system touchpoints and DFV risk factors (a retrospective population-based case series analysis).

Ethical considerations

Several ethical considerations were identified and managed in the preparation and conduct of the case review. It was determined there was potential for psychological harm to those working on the case review, given the confronting and traumatic nature of the subject matter.

It was identified, should high rates of DFV-related homicides involving wilful fire-setting be found among First Nations communities, there was potential for psychological or social harm to Aboriginal and Torres Strait Islander peoples if data sovereignty principles were not applied to ensure context and constructive reporting.

A suite of strategies to mitigate the identified potential harms were implemented. Strategies included written alerts at the beginning of papers provided to Board members and expert advisors, verbal alerts prior to initiating case review discussions, provision of contact details for the Employee Assistance Program in all communication with distressing content and at the beginning of each case review Board meeting. To limit the underlying bias and privilege of agency perspective records about Aboriginal and Torres Strait Islander peoples, the Board also drew on witness statements from family, friends, colleagues, and community to better understand the perspective of any First Nations DFV victim. The perspectives and experiences of Board members also provided further context.

Data sources

To prepare for the Board's case review, a point in time snapshot was extracted from the Queensland DFVDRU DFV-related homicide database on 18 October 2024.

This database uses the ADFVDRN Homicide Consensus Statement to define DFV-related homicides (see Appendix B for full statement). This statement sets out the process for identifying, including, and categorising cases. The definition for homicide used in this statement is broader than the legal definition.

Case inclusion criteria

To identify cases involving wilful fire-setting, the following inclusion criteria were used:

- a) deaths recorded as DFV-related homicides;
- b) deaths occurred in Queensland between 1 July 2009 and 30 June 2024;
- c) deaths involved the use of fire, burning, dousing or explosion as the mechanism for death or as part of the circumstances leading to and following the death; and
- d) search terms included: arson, fire, burn, scald, douse and explosion.

A total of 19 homicide events, resulting in 34 deaths, occurring between 2009 to 2024 were identified as potential cases for the Board to review. Two cases had ongoing criminal proceedings, and two cases had pending coronial inquests. A high-level assessment of each case was undertaken with the DFVDRU to determine inclusion into the case review. Three DFV-related homicides were excluded as:

- a) the death resulted from scalding rather than wilful fire-setting;
- b) the death was not yet confirmed as a homicide at time of data extraction; and
- c) wilful fire-setting was used to attempt to cover up homicide, however there was no relevant relationship between the parties or prior history of DFV.

Following these exclusions, the finalised data set consisted of 16 homicide events, resulting in 31 deaths.

Limitations of design

There are several limitations to this case review of DFV-related homicides involving wilful fire-setting. These include the under-reporting of Aboriginal and Torres Strait Islander peoples as DFV victims and offenders, the under-reporting of people living with a disability, and likely under-reporting of wilful fire-setting threats or injuries occurring prior to homicide.

While there was a depth and diversity of information available from coronial records, police briefs of evidence, sentencing remarks and agency data, four of the selected homicide events were open coronial cases at the time data was drawn for the case review. Consequently, further relevant information may have been gathered following the point in time data selection, as part of the coronial investigation.

Identifying cases

The inclusion criteria for the dataset included whether the death was the result of a homicide, as defined by the ADFVDRN Homicide Consensus Statement (see Appendix B). This definition provides that homicide comprises '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'. Therefore, when a manner of death could not be directly linked to an intentional act of harm, or failure to act, the case was excluded. Hence, homicides without a clear manner of death have potentially been excluded from the data set.

Source data about Aboriginal and Torres Strait Islander peoples

Another limitation of this case review is the complexity in determining when homicides involved Aboriginal and Torres Strait Islander peoples. The case review used information from various agencies, such as health records and police reports to understand if someone identified as an Aboriginal and Torres Strait Islander person. The Board understands the accuracy of these data sources can be inconsistent as it relies on agencies accurately capturing a homicide victim or offender's identity, which may not be sought. Accuracy may also be impacted by any self-reported data, where Aboriginal and Torres Strait Islander peoples, who are often over-surveilled by statutory services, choose not to self-identify, or by a person who falsely identifies as an Aboriginal and Torres Strait Islander person. Gaps and inconsistencies in agency data relating to cultural status creates a potential limitation for the case review.

Source data about people living with disability

This case review did not identify any victims or offenders living with disability. It is possible the rates found in this case review are under-represented, given agencies do not consistently capture data about people living with disability. Gaps and inconsistencies in agency data relating to disability create a potential limitation for the case review.

Data coding and analysis for case review

Data captured in the DFVDRU DFV-related homicide database included the following categories:

- a) case type – intimate partner and familial homicides, homicide–suicides, filicides, and collateral deaths;
- b) case characteristics – location and date of incident and death, manner of death, and criminal charges and outcome;
- c) victim and offender characteristics – demographic details such as age, gender and First Nations status, static risk factors (such as mental health and history of alcohol and other drug misuse) as well as any known service contact;
- d) relationship characteristics – relationship of deceased to offender, history of DFV (informal and formal), protection orders, family law proceedings, separation (actual or intended); and
- e) lethality indicators – using the Queensland DFV Common Risk and Safety Framework (CRASF) indicators such as the victims fear, threats to kill or harm, isolation or deprivation, and monitoring or surveillance.

The context of the use of fire and wilful fire-setting was also coded for each of the cases, with aspects drawn from desktop research regarding common factors present when wilful fire-setting is used in a DFV setting. The factors include:

- a) presence of coercive controlling environment;
- b) threats to use fire or burning;
- c) threats to kill;

- d) use of fire or burning as a tool of control;
- e) mental health concerns;
- f) alcohol and other drug misuse;
- g) pending separation, separation, family court; and
- h) pre-planning wilful fire-setting.

Data analysis was undertaken on the dataset for the Board's case review. Predominately univariate descriptive statistics were used.

A summary of each DFV-related homicide event was prepared, outlining details of the homicide victim and offender, the context and circumstances of the death, the DFV context, the known service system contact for the victim and offender, the context of the use of fire, the known system response and any systemic issues featured by the case. Fourteen of these cases were grouped by the following case characteristics:

- a) First Nations PV;
- b) intimate partner homicide;
- c) familicide;
- d) system interaction;
- e) filicide;
- f) female offender; and
- g) collateral deaths.

In addition to the summary, a timeline of events prior to death and evident lethality indicators were also developed for two homicide events selected for a deep dive approach. A review of media content relating to six of the homicide events reviewed by the Board was also undertaken.

Expert advisors

To complement the extensive knowledge of the Board, additional expert advisors participated in the Board's case review.

Assistant Commissioner Neil Francis and Assistant Commissioner Kevin Reading from Queensland Fire Department shared their expertise at each case review meeting. Staff Specialist Dr Elizabeth Vujcich, Burns and General Surgery, Department of Surgery, Metro North Hospital and Health Service also shared her expertise at one meeting.

Additionally, the Board contracted research and content area experts from the University of Melbourne—Professor Heather Douglas and Associate Professor Kristin Diemer. They shared their extensive knowledge and expertise in DFV with the Board, particularly relating to the use of fire and burning. Professor Douglas and Associate Professor Diemer undertook a literature review and analysed the case summaries for all 16 homicide events independently, providing the Board with their unique perspective for the case review. Throughout the case review they called

attention to system issues, made suggestions relating to the issues and facilitated discussions with the Board.

Review process

The Board undertook the case review across two meetings and utilised a third meeting to develop findings and recommendations. Reviews of the homicide events were presented by the expert advisors from University of Melbourne, who also facilitated discussions. Evidence from the literature review, media content analysis and all the case reviews and discussion were utilised by the Board to explore findings and recommendations addressing various systemic issues. Several systemic issues were identified by the Board, which were present across numerous cases, and in the current research. These are outlined in the Findings and Recommendations sections below.

Case sample included in review

The figures below broadly describe the cases included in the Board's review. The Board reviewed a total of 16 DFV-related homicide events resulting in 31 deaths, occurring between 1 July 2009 and 30 June 2024.¹⁸

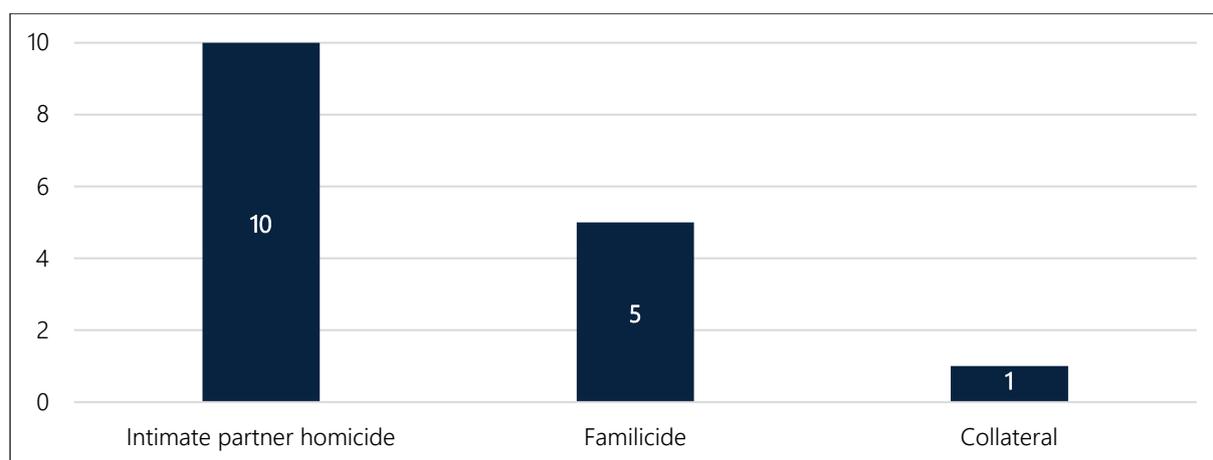


Figure 2.2: Domestic and family violence-related homicides involving wilful fire-setting, by case type (2009–24), n=16.

Most cases of DFV-related homicides involving wilful fire-setting were intimate partner homicides (n=10), five were familicides, while there was one case where the deceased had no relationship to the PUV (i.e.: collateral death).

¹⁸ 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.

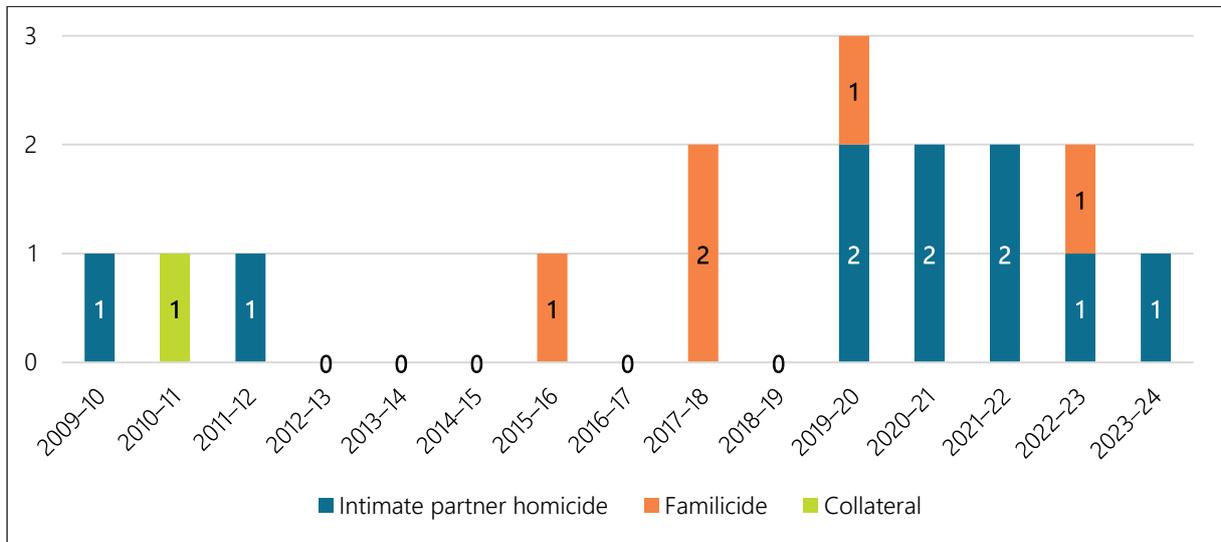


Figure 2.3: Domestic and family violence-related homicides involving wilful fire-setting, by year and case type (2009–24), n=16.

The number of cases of DFV-related homicides involving wilful fire-setting in Queensland appear to have been steady across time, however, there has been a shift in the type of case with more recent cases being intimate partner homicides.

Findings and recommendations

The Board's case review of DFV-related homicides involving wilful fire-setting identified several systemic issues which were also present in the literature and research review, and the data analysis. These systemic issues have been used to describe the Board's findings and are aligned to recommendations from the Board.

The systemic issues include:

- community awareness and appropriate supports for bystanders of DFV to support victims;
- availability of appropriate DFV services;
- adequate assessment of risk supporting safety planning; and
- persistent data gaps and need for further research.

Prior to discussing the findings and recommendations, results of the data analysis of the 16 homicide events will be detailed. Following this, the findings and recommendations will be presented by systemic issue with examples from cases.

Data analysis

Case characteristics

The Board reviewed a total of 16 cases, with the characteristics described in the figure below.

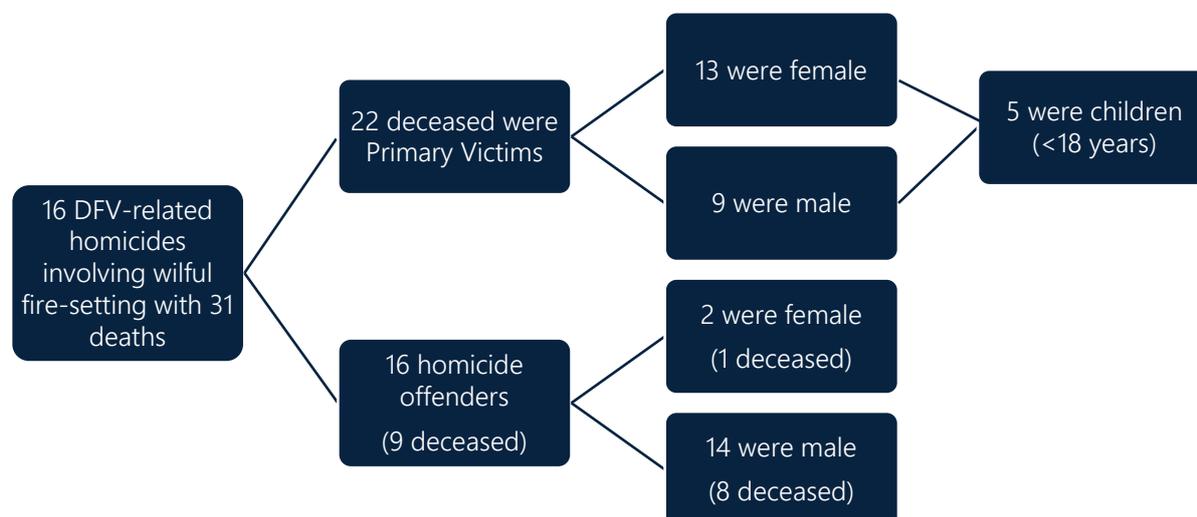


Figure 2.4: Domestic and family violence-related homicides involving wilful fire-setting (2009–24).

Figure 2.5 shows most DFV-related homicides involving wilful fire-setting occurred in a metropolitan area.

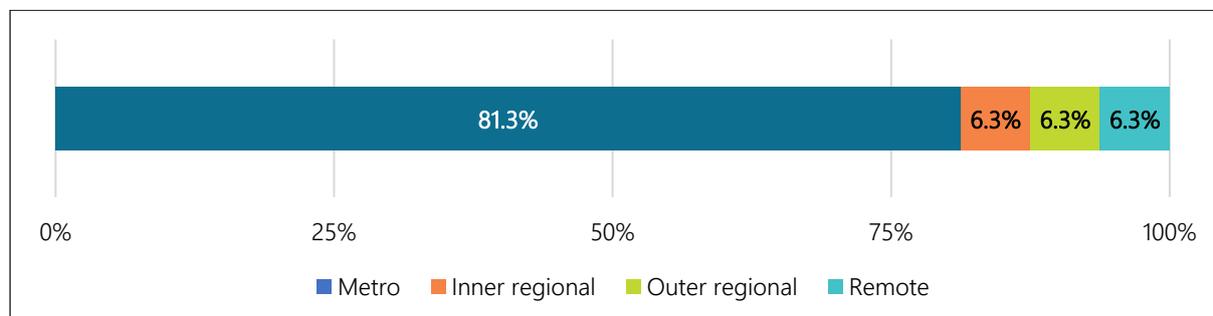


Figure 2.5: Domestic and family violence-related homicides involving wilful fire-setting, by remoteness of homicide location (2009–24), n=16.

Figures 2.6 and 2.7 describe the context in which the homicide occurred, with respect to the recent involvement with services and case characteristics for 15 of the 16 cases.¹⁹

Over half the homicides reviewed had evidence of contact with a health service, police, or a mental health service prior to the homicide. Four cases reviewed had evidence of contact with a DFV service.

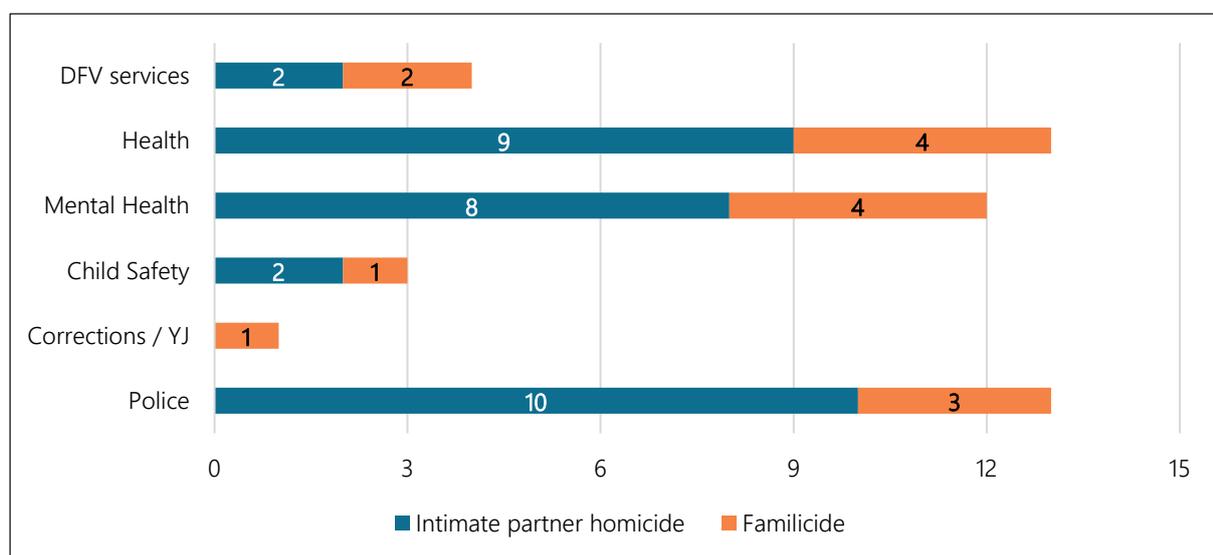


Figure 2.6: Domestic and family violence-related homicides involving wilful fire-setting, by service contact and case type (2009–24), n=15. (Excluded collateral case as there was no applicable information in coronial records).

¹⁹ One case was excluded from data analysis as the collateral deaths had no applicable DFV characteristics prior to DFV-related homicide variables available on the coronial records.

Most cases (n=9) had evidence of DFV in the relationship preceding the DFV-related homicide involving wilful fire-setting. There were six cases with no recorded/reported evidence of DFV in the relationship preceding the DFV-related homicide involving wilful fire-setting. Eight cases had evidence of informal disclosures, while eight cases had evidence of formal disclosures of DFV. Nine cases had DV protection orders present, with one familicide having an order in place between the parents of the family, not between the PV and PUV.

The presence of separation (actual or intended) and family law proceedings are known risk factors for lethal violence.²⁰ In eight cases there was evidence of separations, while one case involved both separation and family law proceedings.

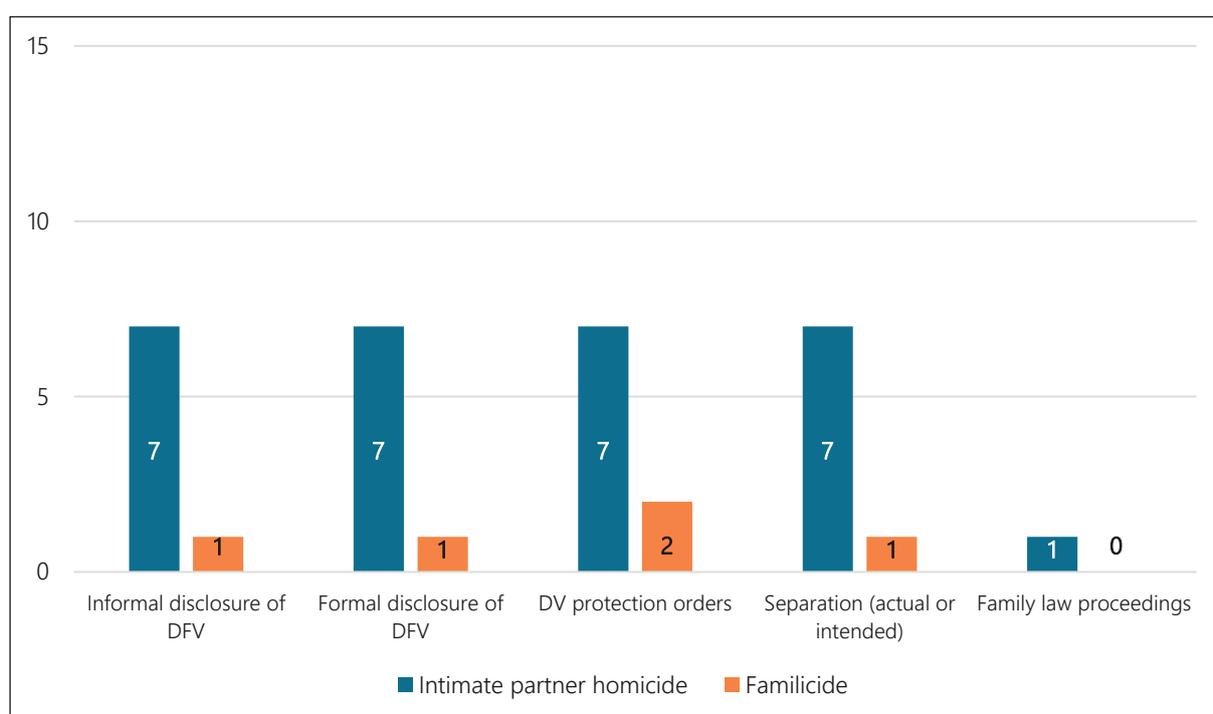


Figure 2.7: Domestic and family violence-related homicides involving wilful fire-setting, by DFV characteristics and case type (2009–24), n=15. (Excluded collateral case as there was no applicable information in coronial records).

There were several risk factors present in the relationship the PV had with the offender. The most common risk factor across the relevant cases was the presence of manipulation, followed by the presence of the victim’s fear of the offender.

²⁰ Krella KA, Painter FL, Booth AT, Holtzworth-Munroe A, Evans E, Jiang H, and McIntosh JE (2025), ‘Enhancing Safety for Separating Families Affected by Domestic and Family Violence: A Scoping Review of Modifiable Factors’, *Trauma, Violence, and Abuse*, 0(0). <https://doi.org/10.1177/15248380251325195>.

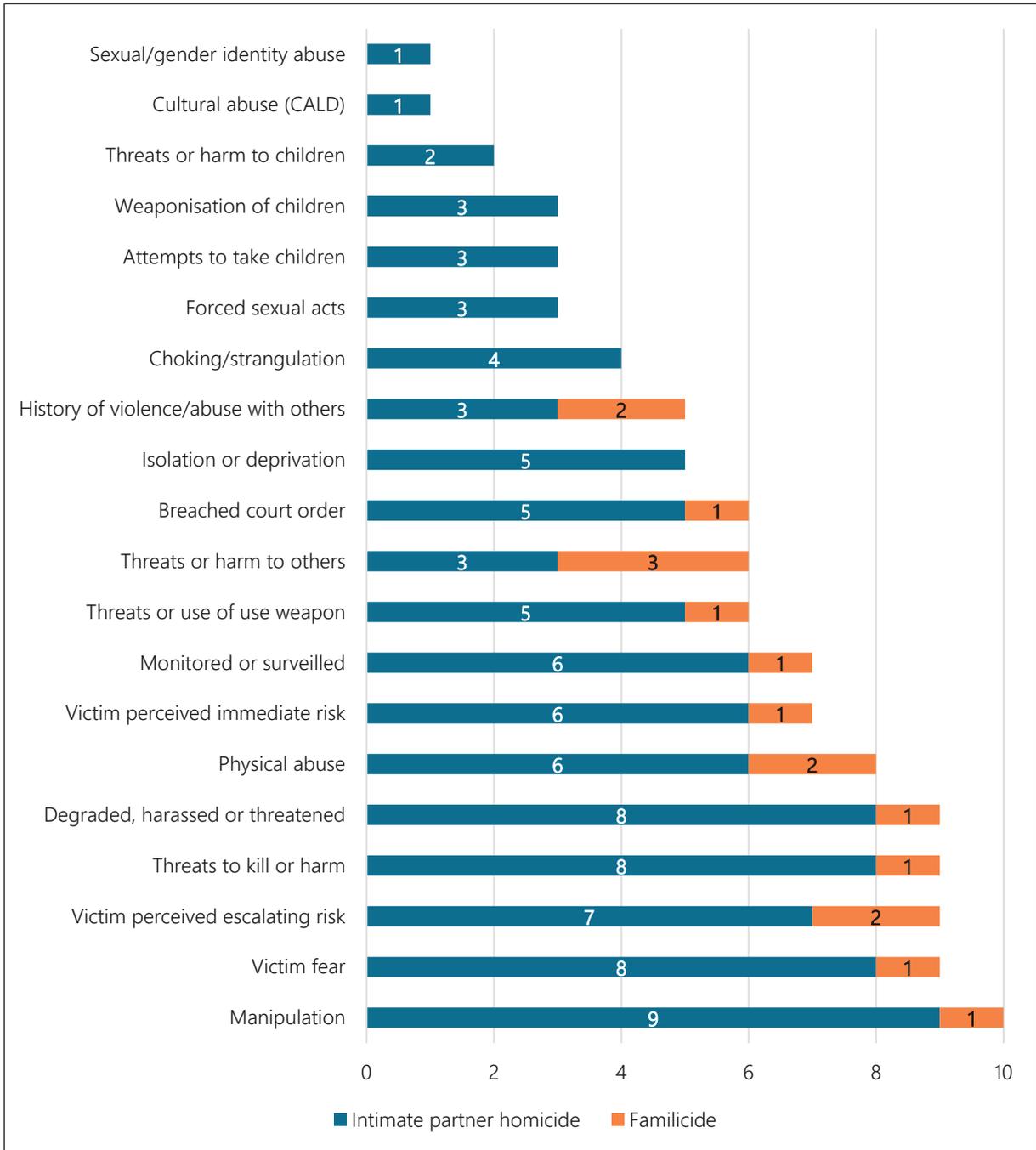


Figure 2.8: Domestic and family violence-related homicide deaths involving wilful fire-setting, by risk factor and case type (2009–24), n=15. (Excluded collateral case as there was no applicable information in coronial records).

Victim characteristics

As noted in Figure 2.9 there were 22 deaths of primary victims across the 16 DFV-related homicides involving wilful fire-setting. This section outlines relevant victim characteristics. The figure below describes the gender of each victim, by the case type.

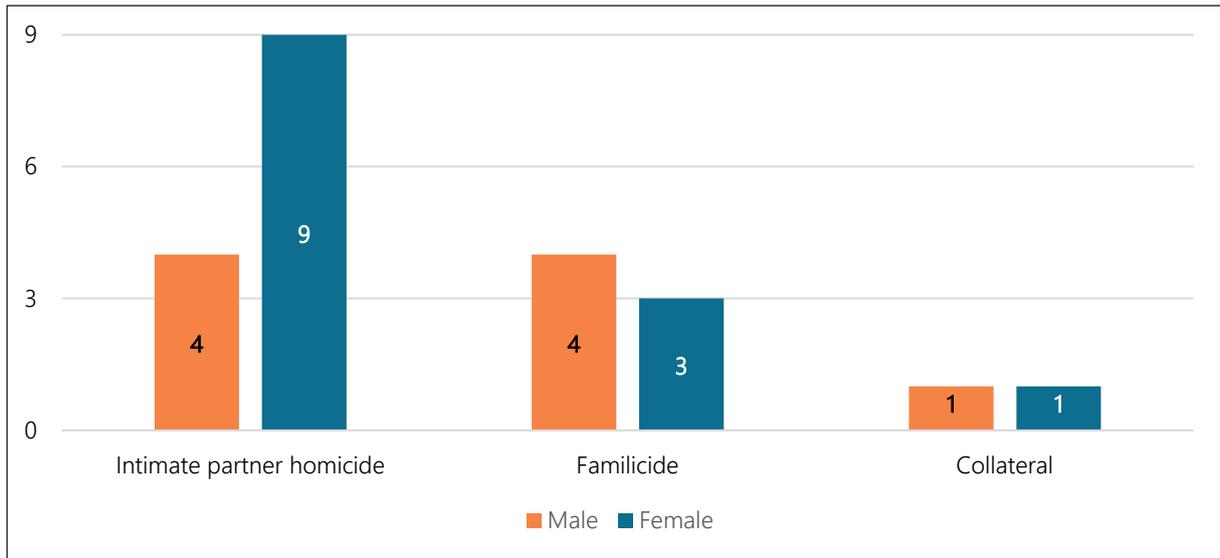


Figure 2.9: Victims of domestic and family violence-related homicide involving wilful fire-setting, by gender and case type (2009–24), n=22.

There was a total of 13 female victims and nine male victims across the 16 homicide events. Two of the victims were Aboriginal and Torres Strait Islander peoples and four were from culturally and linguistically diverse (CALD) backgrounds, while the majority were non-Indigenous people (n=13).

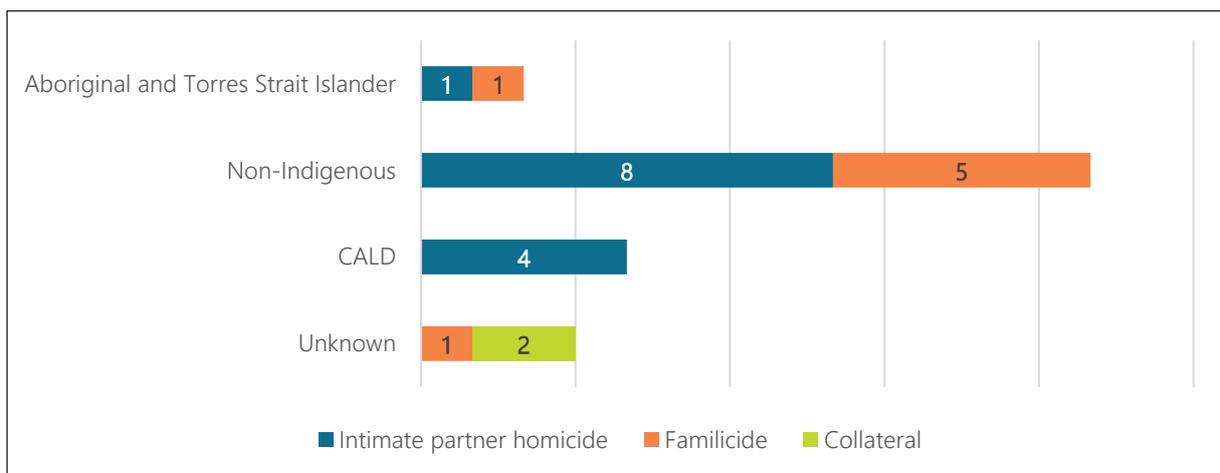


Figure 2.10: Victims of domestic and family violence-related homicide involving wilful fire-setting, by cultural identity and case type (2009–24), n=22.

The age of the victims of DFV-related homicide involving wilful fire-setting varied across various groups, with the majority aged between 20 and 54 years.

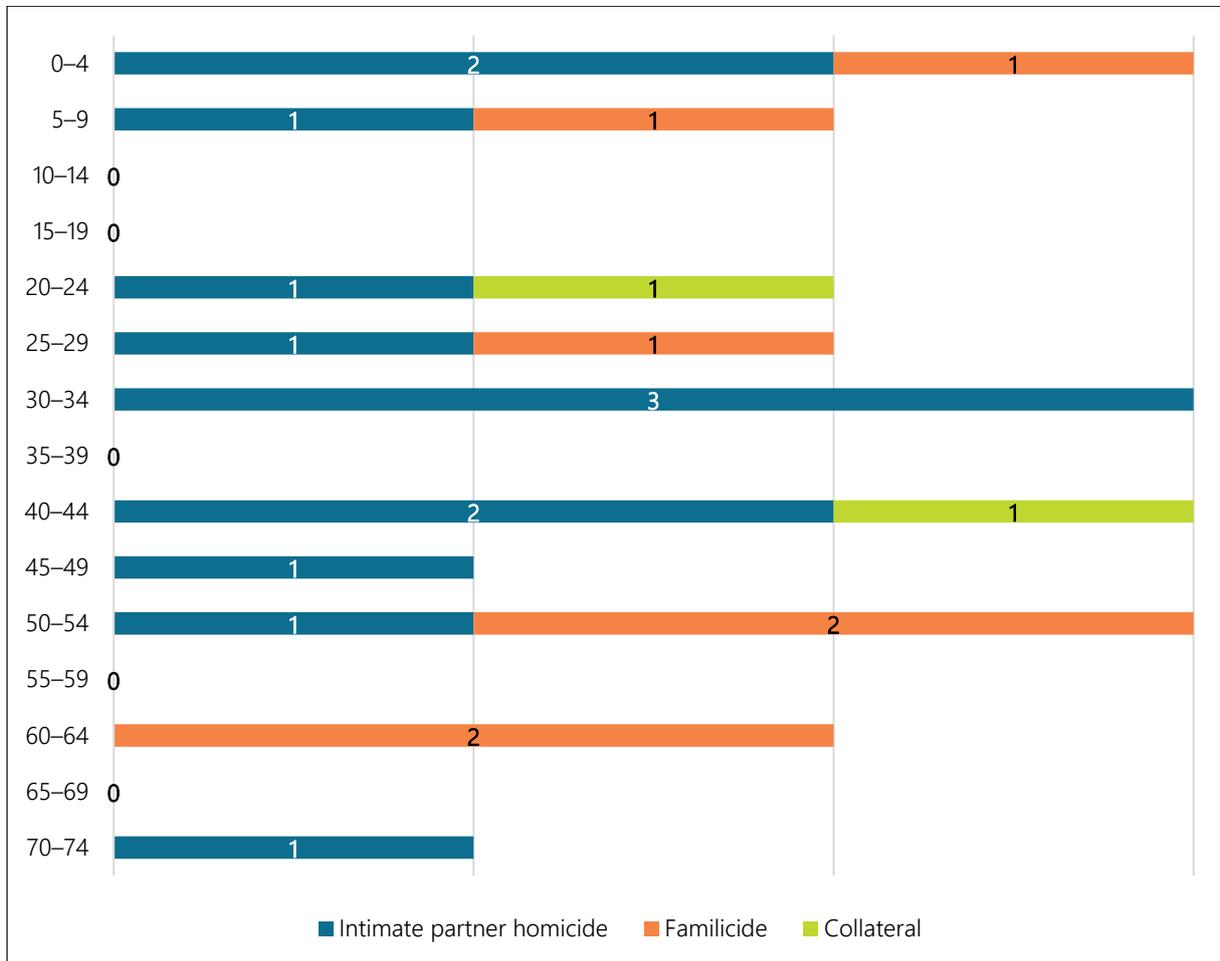


Figure 2.11: Victims of domestic and family violence-related homicide involving wilful fire-setting, by age and case type (2009–24), n=22.

Offender characteristics

Across the 16 cases, there was a total of 16 homicide offenders of which nine were deceased in the same event as their victim/s. All the offenders in the case review were the PUV in the relevant relationship. This section features the characteristics of the offenders. The figure below describes the gender of each offender, by the case type.

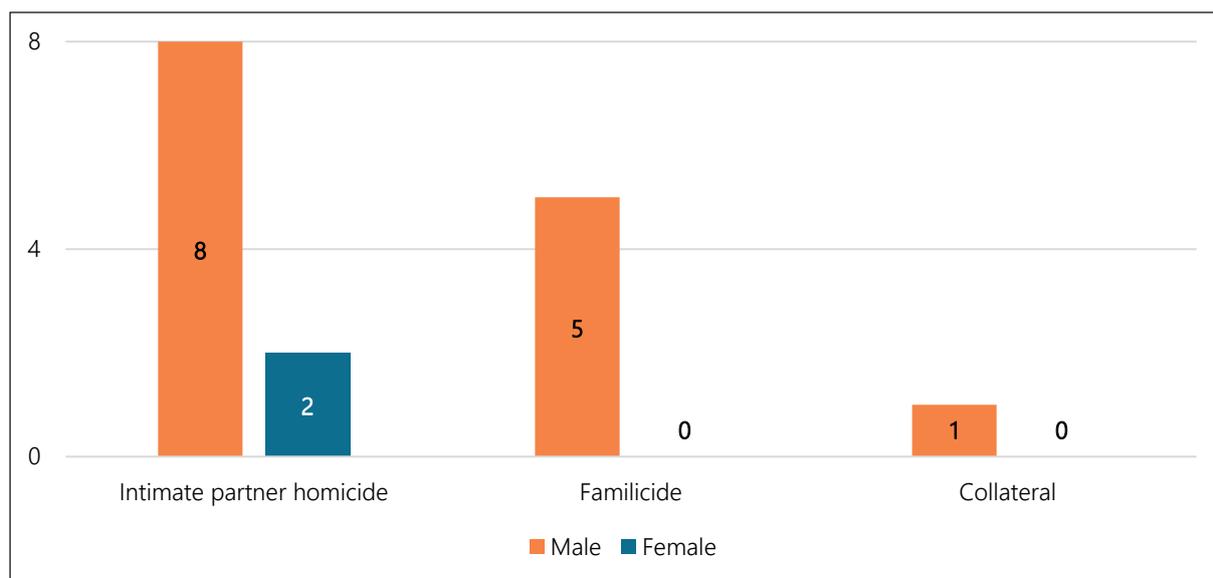


Figure 2.12: Domestic and family violence-related homicide involving wilful fire-setting offenders, by gender and case type (2009–24), n=16.

Most of the offenders were male (n=14). Only two offenders were female. One offender was an Aboriginal and Torres Strait Islander person and four were from CALD backgrounds. Most offenders were non-Indigenous people (n=10).

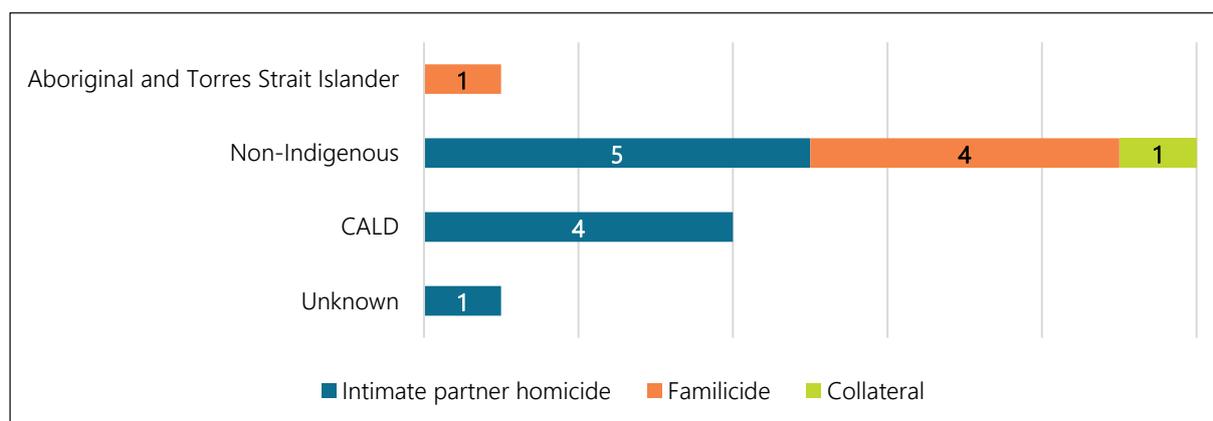


Figure 2.13: Domestic and family violence-related homicide involving wilful fire-setting offenders, by cultural identity and case type (2009–24), n=16.

The age of the offender varied as shown in Figure 2.14, with most offenders aged between 20 and 49 years of age.

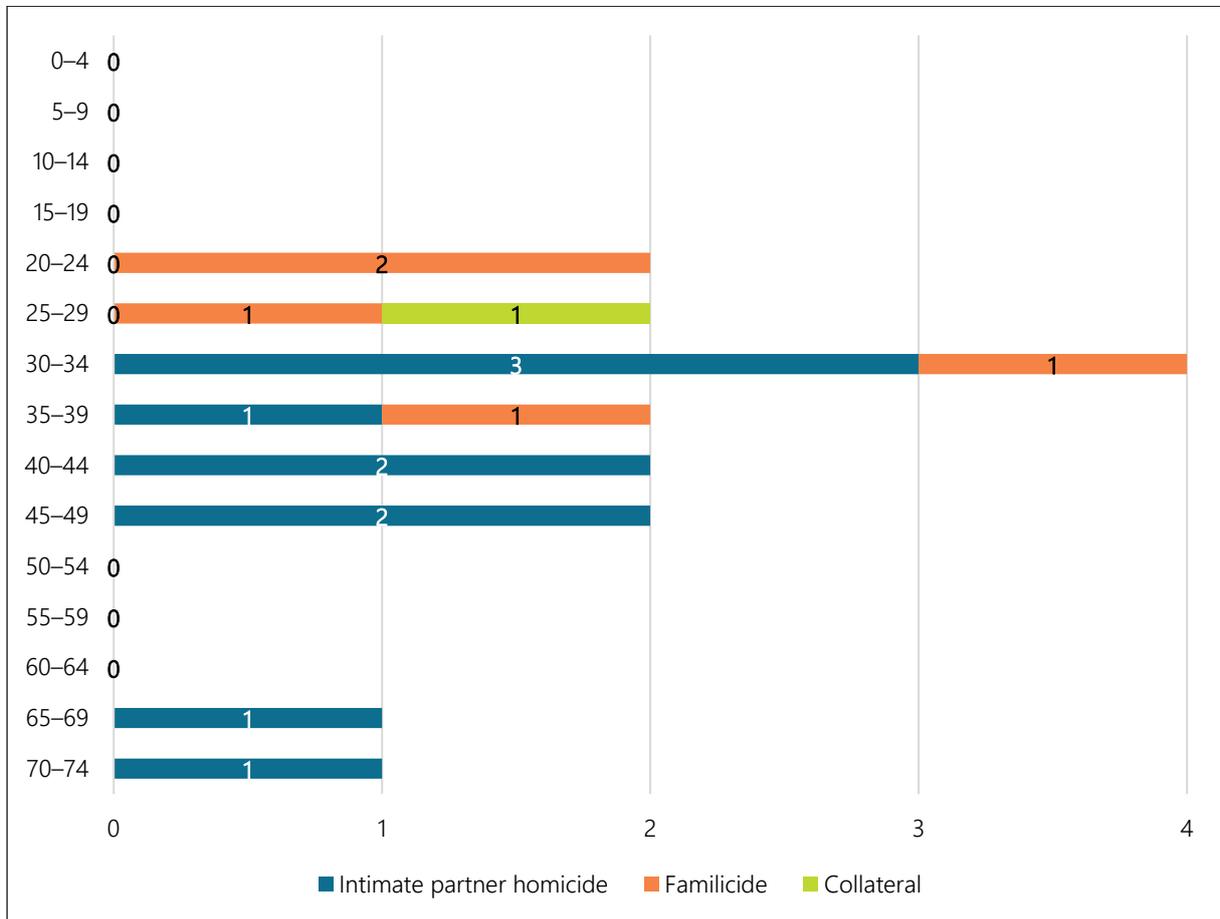


Figure 2.14: Domestic and family violence-related homicide involving wilful fire-setting offenders, by age and case type (2009–24), n=16.

In relation to the relationship between the homicide offender and their homicide victims, eight victims were killed by their current or former intimate partner. Five victims were killed by a parent and four by an adult child. There was one homicide involving one offender, in which the offender had no prior relationship with the victims but had a previous domestic and family violent relationship with a person who survived the homicide event, which is described in Figure 2.15.

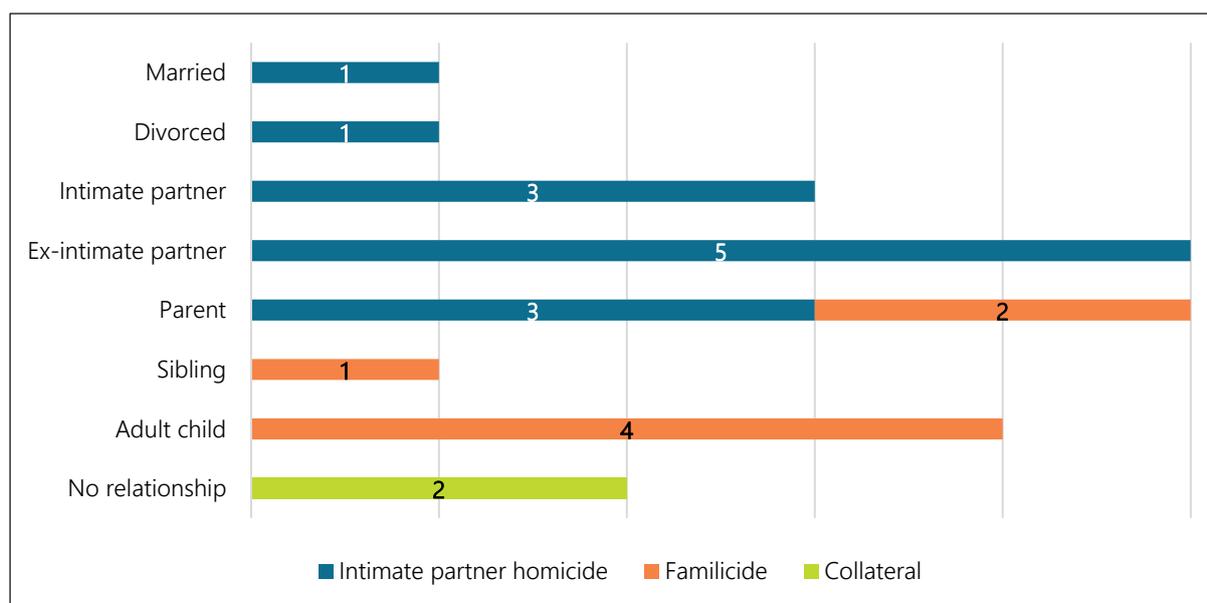


Figure 2.15: Domestic and family violence-related homicide involving wilful fire-setting offenders, by relationship of offender to victim, per victim, and case type (2009–24), n=22.

Ten of the 16 homicide offenders showed evidence of misusing alcohol and other drugs, while 13 had a mental health condition present.

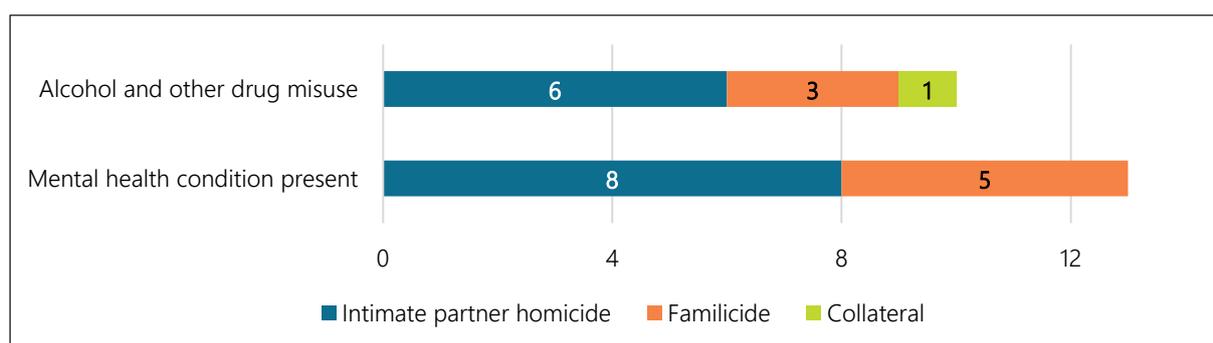


Figure 2.16: Domestic and family violence-related homicide involving wilful fire-setting offenders, by alcohol and other drug misuse, presence of mental health condition, and case type (2009–24), n=16.

Nine of the homicide offenders died in the same event as their PV, seven from the effects of the fire, and three by other self-inflicted means. Intimate partner homicide was the most common case type where the offender was also deceased.

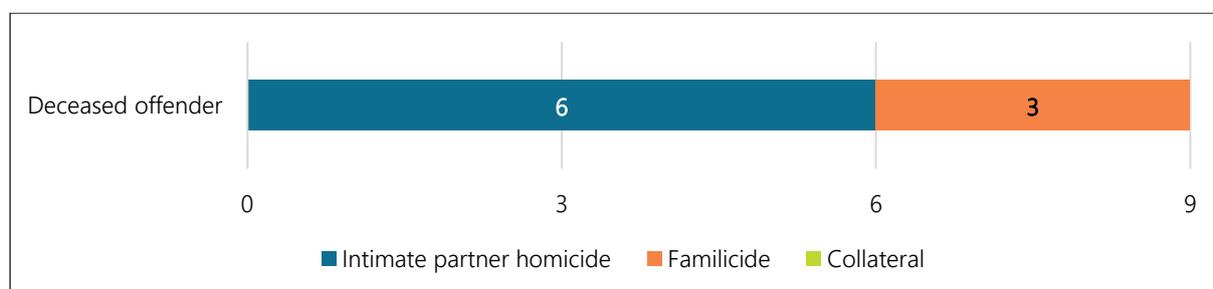


Figure 2.17: Deceased offenders of domestic and family violence-related homicide involving wilful fire-setting, by case type (2009–24), n=9.

There were seven offenders who faced criminal outcomes for their actions (the remaining nine offenders died during the homicide event). The figures below show the primary criminal charge for the offender and the outcome of the criminal proceedings (two cases were pending an outcome at the time of the Board’s case review). Figure 2.18 describes the primary criminal charge laid against most of the offenders was Murder (n=5), while two had their primary charge as Manslaughter.

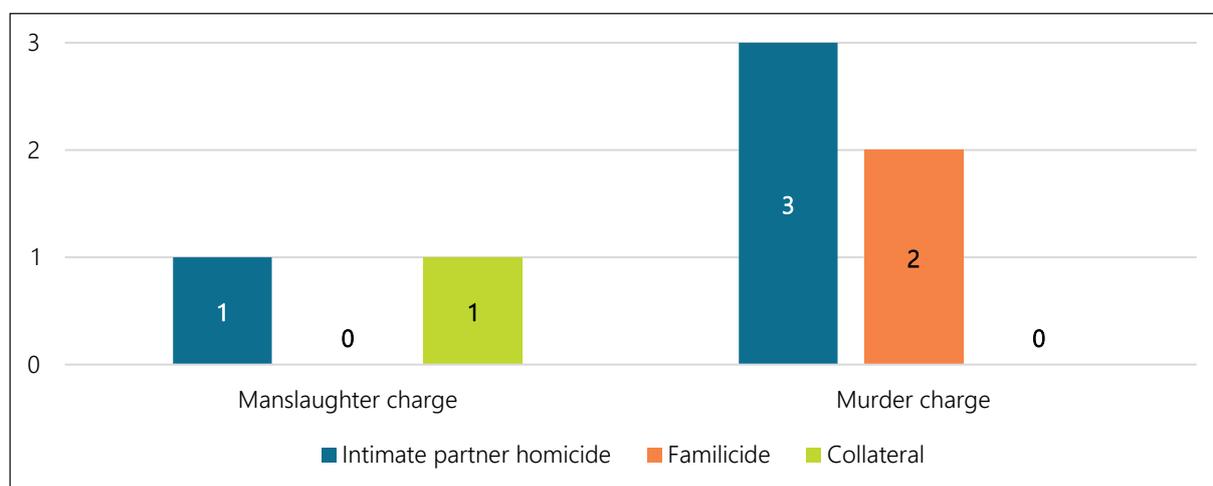


Figure 2.18: Domestic and family violence-related homicide involving wilful fire-setting offenders, by Primary criminal charge and case type (2009–24), n=7.

Figure 2.19 describes the outcome of the criminal proceedings of the offenders, with most (n=4) pleading guilty. There were two offenders who had proceedings pending when the case review was undertaken.

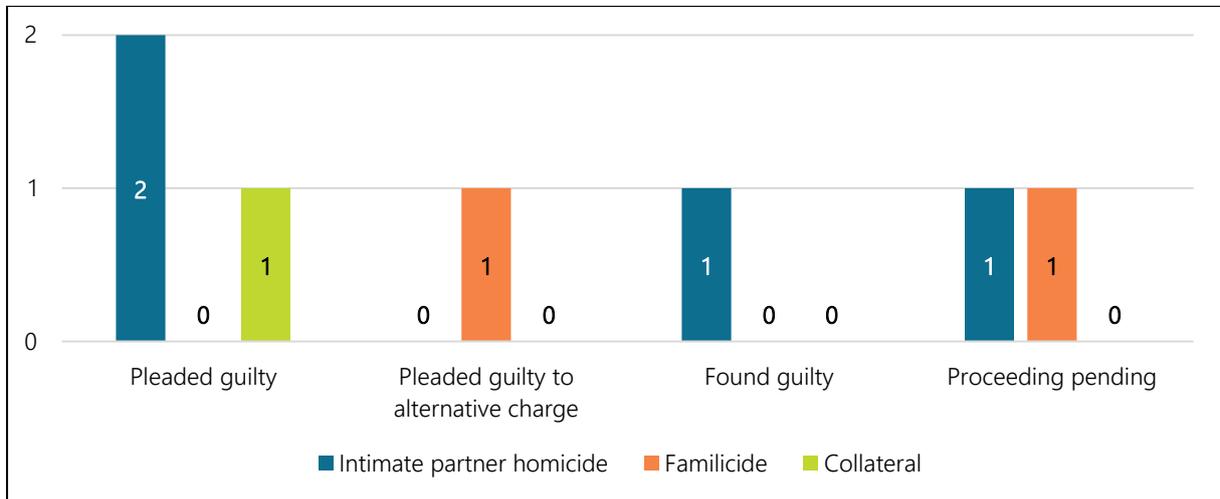


Figure 2.19: Domestic and family violence-related homicide involving wilful fire-setting offenders, by outcome of criminal proceedings and case type (2009–24), n=7.

Risk factors of fire-related violence in a DFV context

There were several risk factors pertaining to fire-related violence in a DFV context highlighted across the case review. This section features these risk factors. Coercive control and threats to kill were the most common factors setting the context for an offender to use wilful fire-setting, as shown in the figure below.

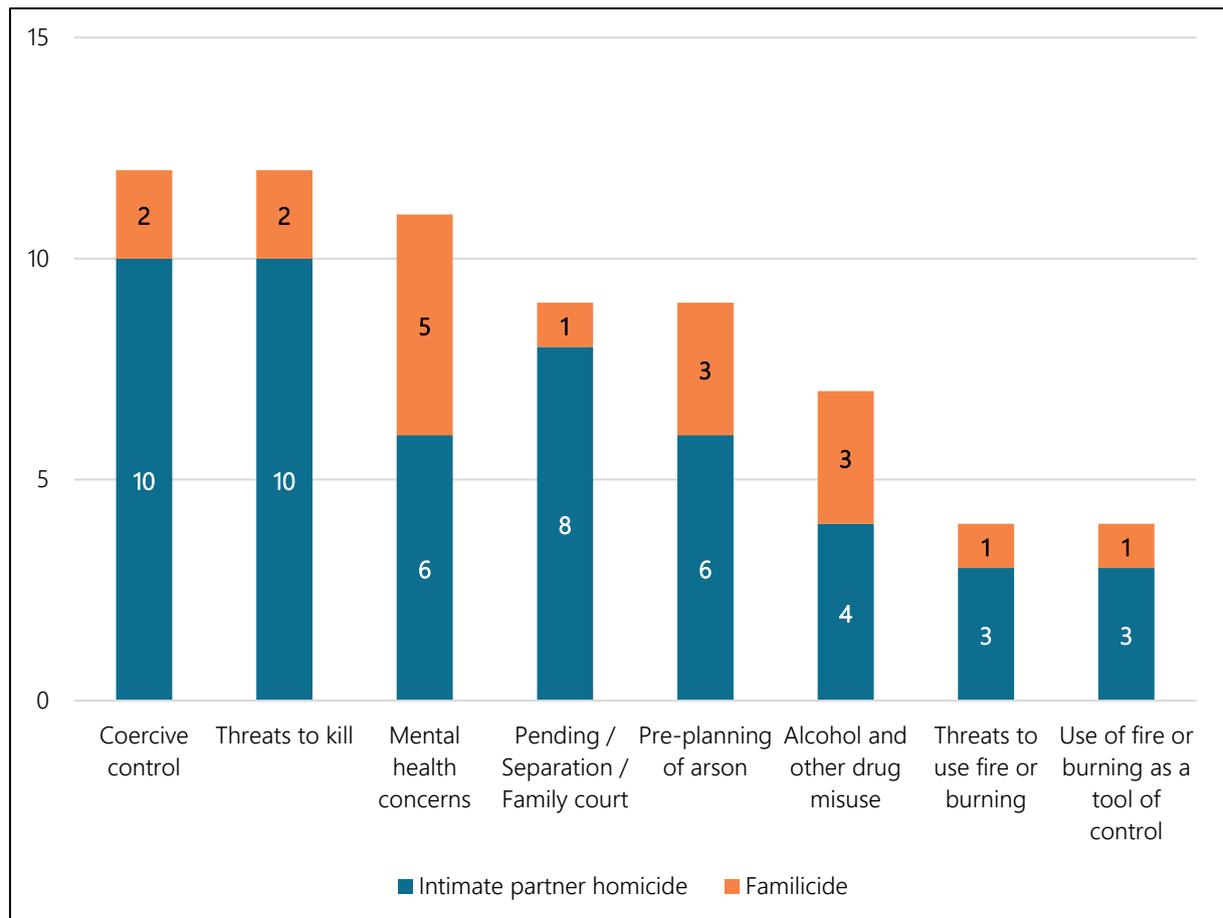


Figure 2.20: Domestic and family violence-related homicide involving wilful fire-setting, by case type (2009–24), n=15. (Excluded collateral case as there was no applicable information in coronial records).

In nine of the homicides, bystanders were aware the offender made threats to kill and, in many cases, heard the threats firsthand. A few of the offenders also made a threat to use fire or burning. In some instances, there were friends, family or work colleagues who were aware of the threats. The figure below describes the level of bystander awareness by threat type and case type. In two of the homicides, bystanders were aware the offender had made threats to the PV regarding the use of fire-related violence.

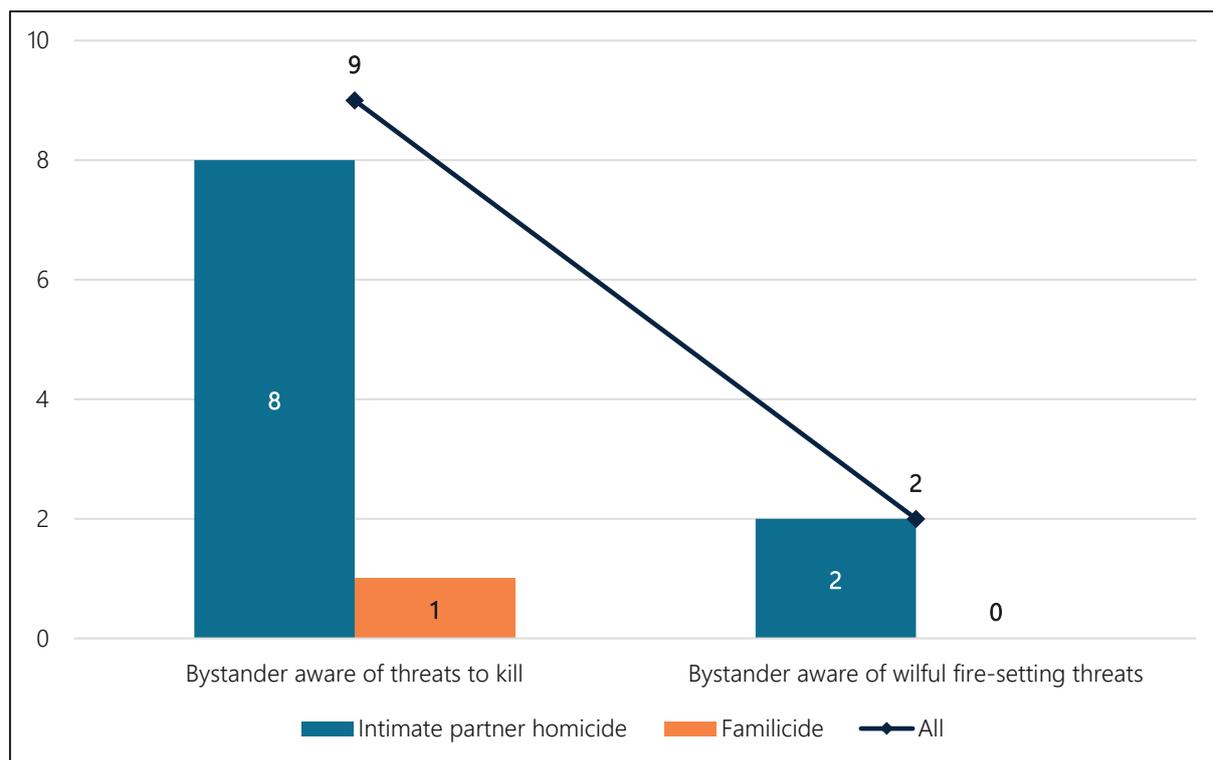


Figure 2.21: Domestic and family violence-related homicide involving wilful fire-setting, by bystander awareness, threat type, and case type (2009–24), n=16.

This data provided several insights about DFV-related homicides involving wilful fire-setting, as did the review of individual cases.

Systemic issues identified through the case review

The Board's case review of 16 DFV-related homicides involving wilful fire-setting highlighted several systemic issues. Each of these systemic issues is outlined below with a definition, findings, and recommendations grounded in evidence from various deaths reviewed, current literature, and research and data analysis.



Systemic issue 1: Community awareness and appropriate supports for bystanders of DFV to support victims.

There are broad prevention and community awareness campaigns across Australia and in Queensland to increase the community's knowledge of what DFV is and the coercive controlling environment created by PUV, particularly for those in heterosexual intimate partner relationships. As the knowledge of the community increases, there may be an opportunity for more nuanced messages to be developed and delivered engaging bystanders of DFV in a more active role.

The next stage of these campaigns could address supports for bystanders and pathways to support affected family, friends, or colleagues. There is evidence interpersonal relationships can contribute to normalising DFV behaviours.²¹ Currently Queensland government information does not provide guidance around what to do when a member of the community is aware of a DFV threat.

Findings

Across nine homicides the Board reviewed there was evidence bystanders had an awareness DFV was present. Bystanders in these homicides, sometimes family members, friends, neighbours, work colleagues or church members, were either told of the threats by the PV or heard the threat from the offender themselves. In the six homicides there is no evidence these threats were reported formally, nor was any support sought for themselves or the PV. The Board considered barriers to acting on the threat, concluding not knowing what to do, fears of retaliation or community backlash, and feeling it is not their business, impacts the decision of bystanders to intervene.

The Board recognised the need for threats to kill or wilful fire-setting against the PV to be taken very seriously. It observed when threats to the PV by the offender were made openly in front of friends and colleagues, the threats were not made idly and conveyed their true intentions. The Board reflected on the lack of action of bystanders in these moments and identified the offender

²¹ Mulawa MI, Kajula LJ, and Maman S (2018) 'Peer network influence on intimate partner violence perpetration among urban Tanzanian men', *Culture, Health and Sexuality*, 20(4): 474-488. <https://doi.org/10.1080/13691058.2017.1357193>.

likely became emboldened when the expression of their intentions was met with inaction and silence.

This finding presents an opportunity to build on existing public health and preventative community campaigns to raise awareness about the combination of DFV risk factors that could be flagged as key moments to be active as a bystander. This combination of risks is:

- a) PVs innate level of fear (expressed verbally or non-verbally);
- b) PVs awareness of escalating level of threat;
- c) threats to kill;
- d) stalking;
- e) PUVs mental health deteriorates; and
- f) separation or pending separation in intimate partner relationships (especially if cohabitating).

Additionally, there may also be an opportunity to offer support to family, friends and colleagues who have been told about threats by the PV, or directly heard and seen threats. While community awareness programs have made people aware this is of concern, the next step of acting remains challenging for bystanders. The importance of the provision of pathways to report any concerns, pathways to receive their own support and empowering them to be a part of the network providing support to the PV cannot be understated. Engaging the community to build understanding that DFV is everyone's business and providing tools to intervene safely and support victims of DFV is vital.

The literature review of current research and evidence about DFV- and fire-related injuries and deaths noted the importance of public health campaigns and fire prevention initiatives.²² There is clear evidence that effective and timely first aid for burns plays a crucial role in reducing the severity of fire-related injuries, especially for those in areas where treatment may be delayed, such as rural and remote areas. There is further evidence having a fire escape plan established also plays a crucial role in reducing the incidence and severity of fire-related injuries. The Board acknowledged a fire is a shocking and terrifying event and both victims and bystanders may be too fearful to act rationally. The Board recognises the work of the Queensland Fire Department in leading public messaging about escape planning and the importance of smoke detectors.

²² Keshri VR, Abimbola S, Parveen S, Mishra B, Roy MP, Jain T, Penden M, and Jagnoor J (2023) 'Navigating Health Systems for Burn Care: Patient Journeys and Delays in Uttar Pradesh, India', *Burns*, 49(7), 1753. <https://doi.org/10.1016/j.burns.2023.03.009>.

Recommendation 1: Build bystander awareness, action, and reporting mechanisms.

The Board's case review called attention to the need to engage and support bystanders of DFV. In nine of the 16 homicide events reviewed family, friends, colleagues or neighbours of the offender or PV were aware of threats to the PV's life but did not report them.

Building on existing public health campaigns already raising awareness of DFV, will further support community bystanders to report threats and support PVs of DFV. Any campaign developed must also extend beyond the portrayal of DFV in heterosexual intimate partner relationships and raise awareness of the occurrence of DFV in LGBTQI+ relationships, family relationships and informal care relationships.

As several cases reviewed had evidence of work colleagues hearing threats made by the PUV, a bystander training program should be developed for workplaces and community members to:

- a) recognise warning signs of DFV and stalking;
- b) understand how to report threats safely and confidentially; and
- c) reduce social normalisation of abuse within peer groups.

The Board is aware public service organisations already provide this support to their employees, however, supports should be provided for small businesses and private sector organisations to provide such workplace education as well.



Systemic issue 2: Availability of appropriate DFV services.

There is evidence that access to support is challenging for Aboriginal and Torres Strait Islander peoples, LGBTQI+ people, people living with a disability and culturally and linguistically diverse people. Additionally, specific support and referral pathways may be beneficial for parents with violent adult children living with them. There are limited opportunities to support PV's who have concerns and want support to end the violence, not the relationship, however not through the traditional channels such as the police. Those living in rural and remote areas also have difficulty accessing appropriate services.

The need for DFV services is high and has increased over time, limiting the capacity of those services, and forcing them to focus on only those PVs who have high levels of threat and risk. This means services are supporting those with the highest levels of risk and threat, which may result in services becoming more reactive and missing the opportunity to de-escalate the situation. The impact of this type of service pressure is significant to PVs, the service, and the workforce.

Additionally, there is a consistent need and high priority for perpetrator behaviour-change programs due to delays for men to access these programs. There is also a need for perpetrator programs for LGBTQI+ people who are violent with their partner or within their family.

Findings

Across twelve of the homicides the Board reviewed, there was evidence a more nuanced or tailored DFV service could have been applied, improving access and impact of services for the PVs.

For homicides where Aboriginal and Torres Strait Islander peoples were impacted, there was little evidence of culturally appropriate interactions, service provision, or referral for assistance through an Aboriginal and Torres Strait Islander support service. The Board recognised there is a lack of culturally appropriate supports and services, resulting in Aboriginal and Torres Strait Islander peoples not seeking or receiving DFV supports. Anecdotally, Board members noted positive responses from PV engagement with the QPS Vulnerable Persons Unit and reiterated the importance of Aboriginal and Torres Strait Islander-led services.

While many of the homicides occurred in metropolitan areas, a few occurred in regional and remote parts of Queensland. Across these regional and remote homicides, the Board noted many of the staff in front line services (such as QPS and Queensland Health) were more inexperienced staff, building their skills while providing supports to some very complex DFV cases. The

homicides reviewed by the Board underscored the importance of an experienced staff member working with these complex cases or reviewing in-tandem with less experienced staff. This type of review support from experienced staff ensures the holistic treatment of the PV, and expertise is shared with less experienced staff. This way of working has been implemented by QPS, and Board members noted Queensland Health staff may also find this type of supervision helpful. The Board also acknowledged the ongoing challenges of attraction and retention of staff in regional and rural areas.

Several of the intimate partner homicides highlighted services find it challenging to respond when the relationship has periods of separation and reunification, or if the couple cohabitate while separated. The ability of services to be flexible with PVs appears limited and wrapping other services such as housing, around the PV also appeared challenging for DFV service providers.

Another homicide demonstrated how DFV in LGBTQI+ relationships can be minimised or overlooked. It was noted the PV and PUV can be perceived as equal, and there may be a perception the PV is not as in need of protection, when compared to female PVs in heteronormative relationships. This may be due to personal biases, lack of appropriate services or services not knowing how to respond.

Several familicides reviewed showed evidence the family would have preferred a non-adversarial response to DFV. Additionally, the Board members noted from their own experience, engagement with DFV services is challenging for those affected by violence from a family member and can result in the criminalisation of their family member, or retribution from other family members. The Board is aware of the Orange Door service operating in Victoria.²³ A trial of this type of service, which offers pathways for families not based in law enforcement, and acts as a central referral point, is underway in several sites in Queensland. The Board looks forward to the evaluation of this trial.

The Board also explored the involvement of the Queensland Fire Department (QFD) in call outs to DFV-related homicides involving wilful fire-setting. Currently, QFD attends fires but may not be aware of the context for the incident. Expert advisors informed the Board there are no DFV flags on high-risk addresses to increase QFD awareness of DFV. The literature review of current research and evidence about DFV- and fire-related injuries and deaths noted other jurisdictions have offered an Enhanced Fire Safety Check to relevant PVs which consists of a smoke alarm check, window alarms and fire safety strategies.²⁴ The Board noted the Safehome program currently offered by QFD, and considered this may be an opportunity to offer specific support to

²³ The Orange Door is an intake and assessment service for Victorians. It provides free, confidential support to meet the needs of people of any age gender, sexuality, culture, religion and ability. The service supports individuals and families experiencing family violence, adults using family violence and young people using violence in the home. www.orangedoor.vic.gov.au.

²⁴ Douglas, H (2023) 'The Use of Fire and Threats to Burn in the Context of Domestic and Family Violence and Coercive Control' *Current Issues in Criminal Justice*, 35(1), 27-47. <https://doi.org/10.1080/10345329.2022.2095794>.

PVs who have been threatened with the use of fire.²⁵ The Board also acknowledged the opportunity to include QFD in DFV high-risk teams, specifically when a threat or use of fire has been noted in a risk assessment with a PV.

Recommendation 2: Increase appropriateness of DFV services available.

The review demonstrated the need to increase the appropriateness of DFV services available for PVs, particularly for Aboriginal and Torres Strait Islander peoples, LGBTQI+ people, people living with a disability, parents living with adult children, people with mental health concerns and culturally and linguistically diverse people. This is a complex multi-faceted recommendation which may be addressed by implementing the below measures.

Providing nuanced and tailored supports to meet the needs of PVs by:

- a. improved culturally appropriate police interactions and service options for all parties, including access to Aboriginal and Torres Strait Islander-led services;
- b. access to safe housing for parties following separation, rather than cohabitation; and
- c. availability of services and supports that are non-adversarial and reduce barriers for PVs who do not wish to engage through QPS. Pathways should include options for those experiencing family violence, including those located in rural and regional areas.

Enhancing multi-agency coordination through:

- a. improved information sharing between QPS, Queensland Health, and DFV services to identify high-risk cases;
- b. development of a standardised LGBTQI+ DFV risk assessment tool to be used across agencies; and
- c. annual DFV reviews to track systemic gaps in LGBTQI+ DFV responses and ensure continuous improvement.

Improving services and supports for LGBTQI+ people impacted by DFV through:

- a. mandatory LGBTQI+ DFV training for Queensland Health frontline staff including doctors, nurses, psychologists, social workers, sexual health clinicians and burns clinics. Queensland Health has already developed this training in collaboration with the LGBTQI+ Domestic Violence Awareness Foundation and has access to *See, Hear, Believe*,²⁶ but it is not

²⁵ QFD's *Safehome* program is designed to assist Queensland householders to recognise fire and safety hazards in and around their home. Firefighters visit homes when requested and identify hazards and steps to eliminate them. www.fire.qld.gov.au/safety-education/programs/safehome.

²⁶ The *See, Hear, Believe* eLearning course, developed by the LGBTQI+ Domestic Violence Awareness Foundation, is the only nationally available, free resource tailored to LGBTQI+ DFV. www.dvafoundation.org/see-hear-believe/.

- 
- mandatory. Making this training compulsory will increase early identification and intervention for LGBTQI+ DFV victims and improve healthcare responses;
- b. mandatory LGBTQI+ DFV training for Queensland Police Service. Training should cover barriers to reporting, coercive control, and specific risk factors in LGBTQI+ DFV, including HIV-related abuse, social isolation, and LGBTQI+ related abuse; and
 - c. review and update of QPS procedures to ensure cases involving LGBTQI+ people impacted by DFV are triaged with specialist involvement, including LGBTQI+ Liaison Officers being automatically assigned to cases involving LGBTQI+ PVs.



Systemic issue 3: Adequate assessment of risk supporting safety planning.

When undertaken effectively, a DFV risk assessment supports the management of a PV's risk and builds a strong safety plan, which minimises the likelihood of an adverse outcome. For it to be fully effective, the risk assessment should be considered a living document which is updated if threats escalate, with the safety plan updated and adapted.

DFV assessment and safety planning is an underappreciated set of expertise, requiring numerous specialist skills, including developing rapport and trust with the PV, rapidly understanding the nature of the DFV experienced, including the environment and pattern of DFV, and any existing safety measures the PV has in place. All this needs to be done while considering the level of threat, and what other services and agencies can also support the PV.

The Queensland DFV sector uses a whole-of-system framework for risk assessment and safety planning—CRASF.²⁷ While this framework does empower a PV to identify their level of self-assessed risk, it is not intended to shift responsibility for mitigating risks to the PV. Responsibility to identify and mitigate risks remains with the service and the system. The CRASF works well when the DFV is impacting heterosexual intimate partner relationships, however it is limited for its use in the context of family violence, with LGBTQI+ people, with young people in a relationship, with Aboriginal and Torres Strait Islander peoples and with people with a culturally and linguistically diverse background.

Findings

Across eight of the homicides reviewed, there was evidence the assessment of risk and safety planning with PVs required further refinement to recognise and escalate the risk level when necessary, such as when a threat of wilful fire-setting had been made.

In several homicides there was evidence the PUV made threats to kill or use fire, but this was not always escalated through the DFV risk assessment or shared with relevant agencies. The Board notes while a threat to kill is within the CRASF, a threat to use fire is not. In the DFV-related homicides the Board reviewed PUVs made verbal threats to the PVs, but also flicked matches or lighters at the PVs, set fire to the PVs hair or burned PVs possessions. Identifying and mitigating the threat to use fire or dousing is important, with the Board recognising the threat being

²⁷ The CRASF provides a shared understanding, language, and common approach to recognising, assessing, and responding to DFV, with guides on best-practice approaches. www.families.qld.gov.au/our-work/domestic-family-sexual-violence/for-service-providers/integrated-service-responses/dfv-common-risk-safety-framework.

comparable to a threat to kill. This finding offers an opportunity to add the threat to use fire or dousing to the CRASF, and ensuring the level of risk is escalated to imminent when identified.

Several of the homicides reviewed had existing protection orders in place to protect the PV. The Board noted under section 81 of the *Domestic and Family Violence Act 2012* (Qld), any item can be treated as a weapon, which the PUV can be prohibited from having access to.²⁸ There is an opportunity to raise awareness of this provision within the legal system.

When reviewing the DFV-related intimate partner homicides involving wilful fire-setting the Board noted there were some consistent DFV risk factors. These consistent factors included:

- a) cohabitation following separation, due to issues of housing security and cost of living;
- b) an age differential between partners creating a vulnerability of being controlled by the PUV;²⁹
- c) duration of separation, with many DFV-related homicides occurring within two months of separation suggesting urgency of response in this period should be prioritised; and
- d) PUV had a pattern of stalking behaviour and threats.

The case review undertaken by the Board illustrated these risk factors pose significant threat to the PV and should be considered a level of lethality to the PV when present.

A further risk factor of DFV noted by the Board was the presence of mental health issues. The Board acknowledged mental health can be a risk factor for the perpetration or victimisation of DFV. The homicides reviewed also revealed when a person presents at a health service with a mental health concern an evaluation of the person's risk to others and themselves is undertaken, but this does not have a DFV-informed lens. Hence, the risk assessment may not specifically look for DFV risk and the risk the person presents to their partner, children, or family. Anecdotally, the Board also acknowledged an intersection with family violence against parents, when parents reside with their adult children who have mental health and DFV issues in their relationships. In a few of the DFV-related familicides involving wilful fire-setting there was evidence parents had taken in their adult children due to family and cultural obligations and may have been reluctant to seek help as they did not want to implicate their family member. This finding offers an opportunity for mental health services to work holistically and apply a DFV-informed lens when assessing its patients. Additionally, when considering safety planning with a patient, inclusion of the patient's partner, children, or family should be considered to ensure safety and awareness of the plan prior to discharge.

²⁸ *Domestic and Family Violence Act 2012* (Qld), s81. www.legislation.qld.gov.au/view/html/inforce/current/act-2012-005#sec.81.

²⁹ Breitman N, Shackelford TK, and Block CR (2004) 'Couple age discrepancy and risk of intimate partner homicide', *Violence and Victims*, 19(3):321-42. <https://doi.org/10.1891/vivi.19.3.321.65764>.

The literature review of current research and evidence about DFV- and fire-related injuries and deaths noted studies indicate between 28% and 62% of burns presented to hospital were initially classified as accidental, but with follow up were later reclassified as intentional or self-inflicted.³⁰

For the Board this affirmed the importance of a holistic, DFV-informed assessment in health settings, noting questions, setting, and other people present all affect the assessment. There is an opportunity for a nation leading rapid research project, trialling Social Work follow-up with burns patients to explore if classification of cause of burns changes, and determine if further support for DFV is required. There is a further opportunity for hospital and health records to enable health professionals to record results of a secondary diagnosis of DFV injury when treating relevant burns victims. The Board discussed making this alteration to the records would also provide more accurate data to inform prevalence and causality.

Understanding this finding from the literature review, the Board sought advice regarding the care for burn patients in Queensland. The Board was informed to treat people with burn injuries requiring hospital admission, photographs and information relating to the burn are provided via a portal where the burn will be assessed, and treatment is planned. This can result in the cause of the burn being missed, along with the opportunity to support people impacted by DFV. The Board believes follow up with patients offers the opportunity for classifying the burn's cause, providing a secondary diagnosis to flag DFV on a patient's file, if applicable, and assessing any risk to the PV.

Recommendation 3: Assessment of risk and safety planning when there is a threat of fire-related violence.

This recommendation can be addressed by implementing the below measures.

Addressing the lack of risk assessment regarding the threat or use of fire by:

- a. adding items to CRASF relating to threats and use of fire and dousing;
- b. escalating the level of risk when a PUV uses or threatens use of fire or dousing;
- c. gauging the PVs level of fear (especially if fear is increasing), and appropriately considering or weighing when determining the risk level;
- d. determining the PVs awareness of the escalation in threats being made by the PUV; and
- e. including a fire risk assessment of a PV's home when safety planning for threats of fire and engaging QFD as a partner in safety planning.

³⁰ Bhate-Deosthali, P and Lingam, L (2016) 'Gendered Pattern of Burn Injuries in India: A Neglected Health Issue', *Reproductive Health Matters*, 24(47), 96-103. <https://doi.org/10.1016/j.rhm.2016.05.004>.



Working in the intersection between mental health and DFV by:

- a. Mental Health services using a DFV-informed lens to assess risk and safety plan when there are mental health concerns. Including identifying if the patient has a partner, children, or family member and undertaking safety planning for all; and
- b. planning for safe housing when mental health issues are present, including the safety of the person/s the patient will be living with.



Systemic issue 4: Persistent data gaps and need for further research.

While collection of data about DFV has improved at both a national and jurisdictional level, inconsistencies and gaps remain. There are challenges in the collection of quality data about DFV given the various government and non-government agencies involved often collect different information, in different ways, on different systems. Access to high quality data is crucial to understanding and resourcing the extent, nature, and impact of DFV. Additionally, there is limited data regarding wilful fire-setting in the context of DFV.

There is also a dearth of Australian research related to wilful fire-setting in the context of DFV. To understand more about wilful fire-setting as a tool for control, to assess risk factors and develop effective safety planning, further research is required.

In Queensland the death review data of DFV-related homicides is managed and maintained by the DFVDRU in the Coroners Court of Queensland. This data is important to the work of the Board, including where case review homicide events are drawn from and reporting on the statewide data. This database also contributes to the national DFV research agenda and provides data to genuine researchers when requested.

Findings

The literature review of current research and evidence about DFV- and fire-related injuries and deaths noted while national datasets offer valuable information on fire-related deaths and injuries, it does not capture whether it occurred in the context of DFV. This makes identifying the prevalence of these threats and deaths challenging.

The literature review also found Queensland and other jurisdictions have no systematic collection of when fire is used as a threat in the context of DFV. These threats are included with generalised threats to kill, making it challenging to understand the frequency in which threats to use fire occur.³¹ There is an opportunity for Queensland to lead the way and include these specific threats in QPS risk assessments and into the CRASF.

The Board discussed the challenge of how the information is captured when the threat to use fire is not present in the risk assessment documentation, noting this can vary across agencies, with some capturing it through individual systems, and some within the person's case notes or file. Another dataset the Board is interested in is information about when support or help is initially sought. Additionally, data from services such as refuges and DFV centres may also provide further

³¹ 'Domestic and Family Violence and Fire-Related Injuries and Deaths: Literature Review' will be published on the Coroners Court of Queensland website in December 2025. www.coronerscourt.qld.gov.au/dfvdrab/reports-research-and-data.

information about risk assessment, and safety planning. The Board remains interested in improved data collection and information gathering across the various points in the DFV service system.

Research into the use of fire or wilful fire-setting in the DFV context is limited, particularly in the Australian setting. Further research is required, but limits on the available data is challenging to researchers. The Board believes there is an opportunity to undertake small but robust research projects to trial the collection of data about the use of fire and wilful fire-setting as threats, placing Queensland as a leader in the progression of this type of data collection.

Recommendation 4: Address data gaps and the need for further research.

Addressing the gap in data and research about the use of wilful fire-setting in the context of DFV by:

- a. adding a question to the Australian Personal Safety survey regarding when fire or wilful fire setting is used as a threat in the context of DFV. This would establish a national prevalence rate which could be monitored over time and will increase understanding of the frequency in which threats to use fire or wilful fire-setting occur;
- b. collecting and collating system level data from DFV specialist services, including about the use of fire and wilful fire-setting as a threat;
- c. undertaking targeted research projects to trial novel ways to collect data about DFV, including the use of fire and wilful fire-setting as threats or to kill; and
- d. enabling health professionals to record results of a secondary diagnosis of DFV injury when treating relevant fire-related burns victims, increasing the collection of prevalence and causality DFV data in Queensland.

Conclusion

This year the Board reviewed DFV-related homicides involving wilful fire-setting occurring between 1 July 2009 and 30 June 2024. The review comprised of 16 homicide events, resulting in the deaths of 22 PVs and nine homicide offenders, across 15 years. This case review highlighted the gendered nature of DFV, as 13 of the 22 PVs were female. Additionally, of the 16 offenders, 14 were male. These offenders commonly used coercive control and threats to kill against the PV. In several of the homicide events family, friends, neighbours, work colleagues or church members were aware of threats to kill and to use fire against the PV.

The case review increased the Board's understanding of the use of wilful fire-setting in DFV, and the exceptionally lethal nature of this form of violence when used, often resulting in widespread harmful effects. In the homicide events reviewed by the Board, the violence was devastating and often caused significant distress to the family and friends of the victims, but also throughout the broader local communities.

The Board's case review of DFV-related homicides involving wilful fire-setting identified several opportunities for systemic improvement, including:

Systemic issue	Opportunity
Community awareness and appropriate supports for bystanders of DFV to support victims.	Build bystander awareness, action and reporting mechanisms.
Availability of appropriate DFV services.	Increase appropriateness of DFV services available.
Adequate assessment of risk supporting safety planning.	Assessment of risk and safety planning when there is a threat of fire-related violence.
Persistent data gaps and need for further research.	Address data gaps and the need for further research.

The Board remains steadfast in the work it is undertaking to learn from the DFV-related deaths to improve the whole system, whether the system is seeking to support victim-survivors, change the behaviour of perpetrators, undertake research to fill knowledge and practice gaps, prevent DFV, or bring broader awareness to Queensland to prevent future deaths.



**Section Three:
Domestic and family
violence-related
homicides 2016–25**



This Annual Report contains content which may be distressing for readers. Please be mindful of the impact of this content and seek support as required. A list of relevant support services is provided at the front of this report.

Identifying domestic and family violence-related homicides

Working closely with the Queensland Police Service Coronial Support Unit, the DFVDRU identifies homicides and homicide–suicides occurring in an intimate partner, family or informal care relationship in Queensland. The DFVDRU considers all available information to identify those that have occurred in the context of DFV. This includes the classifications outlined in Table 3.1.

Table 3.1: DFV-related homicide classifications.

Relationship	Context
Intimate partner, family, or informal care relationship.	Evidence of DFV, whether this was reported to police.
Child or young person.	A child dies as a result of an intentionally or recklessly harmful act by a parent/carer and the parent/carer had been a victim or perpetrator of DFV.
Young person.	A young person killed by an intimate partner where there was evidence of DFV.
No relationship – collateral or bystander.	The person killed due to DFV between others (such as new partner of a former victim–survivor or a person intervening in an episode of DFV).

There is no universally agreed definition of the behaviours that comprise DFV. Australian definitions include 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, DFV 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)³², which is adopted by the ADFVDRN. The DFVDRU adopts the definition of ‘homicide’ used by the ADFVDRN, which includes ‘all circumstances in which an individual’s intentional act, or failure to act, resulted in the death of another person,

³² *Family Law Act 1975* (Cth), s4AB, www.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/consol_act/fla1975114/s4ab.html.

regardless of whether the circumstances were such as to contravene the provisions of the criminal law' (see Appendix B).³³

To identify DFV-related homicides, deaths flagged as 'domestic violence-related' and/or 'interpersonal violence/apparent homicide' in the Coronial Case Management System, those identified by the Queensland Police Service Coronial Support Unit and by the Domestic, Family Violence and Vulnerable Persons Command are reviewed against the ADFVDRN Consensus Statement. The Consensus Statement requires four criteria be met for cases to be included in reporting:

Death from external cause	Any deaths resulting directly or indirectly from environmental circumstances that cause injury, poisoning and/or other adverse effects. The DFVDRU also includes natural cause deaths that would not have occurred but for the action or inaction of another (e.g., failure to seek medical attention).
Intent	Injury arising from an act of violence with the intent of causing harm (i.e., assault); injury inflicted by police or law enforcement in the course of their duties (i.e., police responses to DFV). The DFVDRU also include deaths arising from a failure to meet the ongoing basic needs of a person who is dependent on care, by either act or omission (i.e., neglect).
Relationship	Homicides occurring in the context of an intimate, familial, or Aboriginal and/or Torres Strait Islander kinship relationship. The DFVDRU also include informal care relationships and collateral/bystander deaths.
Domestic and family violence	Evidence of DFV behaviours within the relevant relationship. The existence of a relevant relationship does not, constitute a DFV-related homicide. Homicides <i>may</i> be excluded where there is no prior evidence of DFV AND other factors can be shown to have been the primary contributing factor (such as an acute episode of mental illness or a suicide pact).

The following analysis represents the data held as at 24 July 2025, acknowledging this is an evolving dataset and reported figures will change over time. As police and coronial investigations continue and more information is obtained, additional cases may be identified for inclusion, cases may be excluded, and new details about the cases may emerge. As such, the data presented in this report should be interpreted as a point-in-time snapshot. In addition, although the utmost

³³ Australian Domestic and Family Violence Death Review Network (2022) 'Australian Domestic and Family Violence Death Review Network Data Report: Intimate partner violence homicides 2021–2018', ANROWS: Sydney, 8. www.anrows.org.au/publication/australian-domestic-and-family-violence-death-review-network-data-report-intimate-partner-violence-homicides-2010-2018/.



care is taken to identify and record all relevant demographics and risk factors related to a homicide event, it is not always possible to review the high volume of agency records in detail within the available resources of the DFVDRU.

Domestic and family violence-related homicides 2024–25³⁴

Between 1 July 2024 and 30 June 2025, there were 22 DFV-related homicide events identified in Queensland, resulting in the deaths of 25 people. Two homicide events resulted in the death of more than one person (one homicide event claimed the lives of three victims; in another, the homicide offender also took their own life).

Table 3.2: Domestic and family violence-related homicides by type of event, number of events and number of deaths, Queensland, 1 July 2024–30 June 2025.

Type of homicide event	Number of events	Number of deaths
Homicide	21	23
Homicide–suicide	1	2
Total	22	25

Homicide victims

This section describes the characteristics of the 24 homicide victims (i.e., excluding the homicide offender who took their own life). Ten victims were killed by current or former intimate partners and 14 were killed by a family member. Of the 14 familial homicides, six victims were children killed by a parent or carer. Four victims were being cared for by the homicide offender in an informal care arrangement (one cared for by an intimate partner and three cared for by family members).

Table 3.3 outlines the demographic characteristics of homicide victims in 2024–25 by homicide type.

³⁴ 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.

Table 3.3: Demographic characteristics of domestic and family violence homicide victims, by type of homicide, Queensland, 1 July 2024–30 June 2025 (n=24).

Characteristic	Intimate partner homicide	Familial homicide	Total
Gender			
Female	10	8	18
Male	0	6	6
Age			
0–17 years	0	6	6
18–29 years	3	1	4
30–39 years	1	0	1
40–49 years	6	0	6
50–59 years	0	1	1
60–69 years	0	3	3
70–79 years	0	3	3
First Nations status			
Aboriginal and/or Torres Strait Islander	3	4	7
Non-Indigenous	7	10	17
CALD status			
Culturally and linguistically diverse	1	2	3
Not culturally and linguistically diverse	9	12	21
Total	10	14	24

All victims of intimate partner homicide were female. Approximately 57% of familial homicide victims were female and almost 43% were male. The most common age category of victims of



intimate partner homicide was 40–49 years, while the most common age category for familial homicide victims was under 17 years. Most homicide victims were non-Indigenous and not culturally and linguistically diverse.

Homicide offenders

There were 24 homicide offenders involved in the 22 DFV-related homicide events that occurred in 2024–25 (two homicide events involved more than one offender). Table 3.4 outlines the demographic characteristics of offenders.

Table 3.4: Demographic characteristics of domestic and family violence homicide offenders by type of homicide, Queensland, 1 July 2024–30 June 2025 (n=24).

Characteristic	Intimate partner homicide	Familial homicide	Total
Gender			
Female	1	6	7
Male	11	6	17
Age			
0–17 years	0	1	1
18–29 years	4	4	8
30–39 years	2	4	6
40–49 years	4	3	7
50–59 years	2	0	2
First Nations status			
Aboriginal and/or Torres Strait Islander	2	2	4
Non-Indigenous	10	10	20
CALD status			
Culturally and linguistically diverse	2	1	3
Not culturally and linguistically diverse	10	11	21
Total	12	12	24

All but one intimate partner homicide offender was male, while 50% of familial homicide offenders were female. Homicide offenders were, on average, slightly younger than homicide victims. The average age of the homicide offenders was 35.8 years, compared with 38.1 years for victims. There were no homicide offenders over 60 years of age, while there were six homicide victims aged over 60 years in 2024–25. Most homicide offenders were non-Indigenous and not culturally and linguistically diverse.

Relationship characteristics

Seventy percent (n=17) of the DFV-related homicide victims had been the PV of DFV throughout their relationship with the offender. All but one of the victims killed by an intimate partner were the PV of DFV within their relationship with the homicide offender. However, in six of the 14 family violence homicides, the person who died was *not* the PV of DFV perpetrated by the homicide offender.

Half of the intimate partner homicide victims had been in the relationship for more than 10 years (n=5), while two had been in a relationship for less than a year. Seventy percent of intimate partner homicide victims were cohabiting with the offender at the time of the homicide event (n=7). Of the 10 intimate partner homicides, three of the relationships had either formally ended or one party had indicated their intention to leave, which is a known risk factor of intimate partner homicide.³⁵

In 16 of the 22 homicide events, there was at least one recorded police response to an episode of DFV between relevant parties.³⁶ In the remaining six cases, while there were no recorded police responses, there was other evidence of DFV available in agency records. Under-reporting of DFV is common, and a known barrier to establishing the true prevalence of DFV in the community. The *2021–22 Personal Safety Survey*³⁷ conducted by the Australian Bureau of Statistics found most DFV is not reported to police. For example, 79% of women experiencing violence from a current partner and 68% of women who had experienced violence from a previous partner had never reported the violence to police.

There were no identified DFV-related homicide events involving a person without a relevant relationship with the offender (e.g., a bystander or collateral death) during the reporting period.

Homicide event

Assault with a sharp weapon was the most frequent mechanism of death across all DFV-related homicides (n=6 deaths), followed by assault without a weapon (n=5 deaths) and wilful fire setting (n=3 deaths).

No clear patterns emerge with respect to the assaultive behaviours used when comparing intimate partner and familial homicides. Figure 3.1 notes mechanism of death, by category of homicide event.

³⁵ The Board has noted this risk factors in most of its Annual Reports. www.coronerscourt.qld.gov.au/dfvdrab/annual-reports-and-government-responses.

³⁶ This may be regarding the relationship between the homicide offender and the homicide victim. It may also be regarding the relationship between the homicide offender and another person (e.g., in the case of collateral deaths or child deaths where the homicide offender has a history of DFV with a previous partner).

³⁷ Australian Institute of Health and Welfare (2024) 'How do people respond to FDSV?', accessed 28 July 2025, www.aihw.gov.au/family-domestic-and-sexual-violence/responses-and-outcomes/how-do-people-respond-to-fdsv.

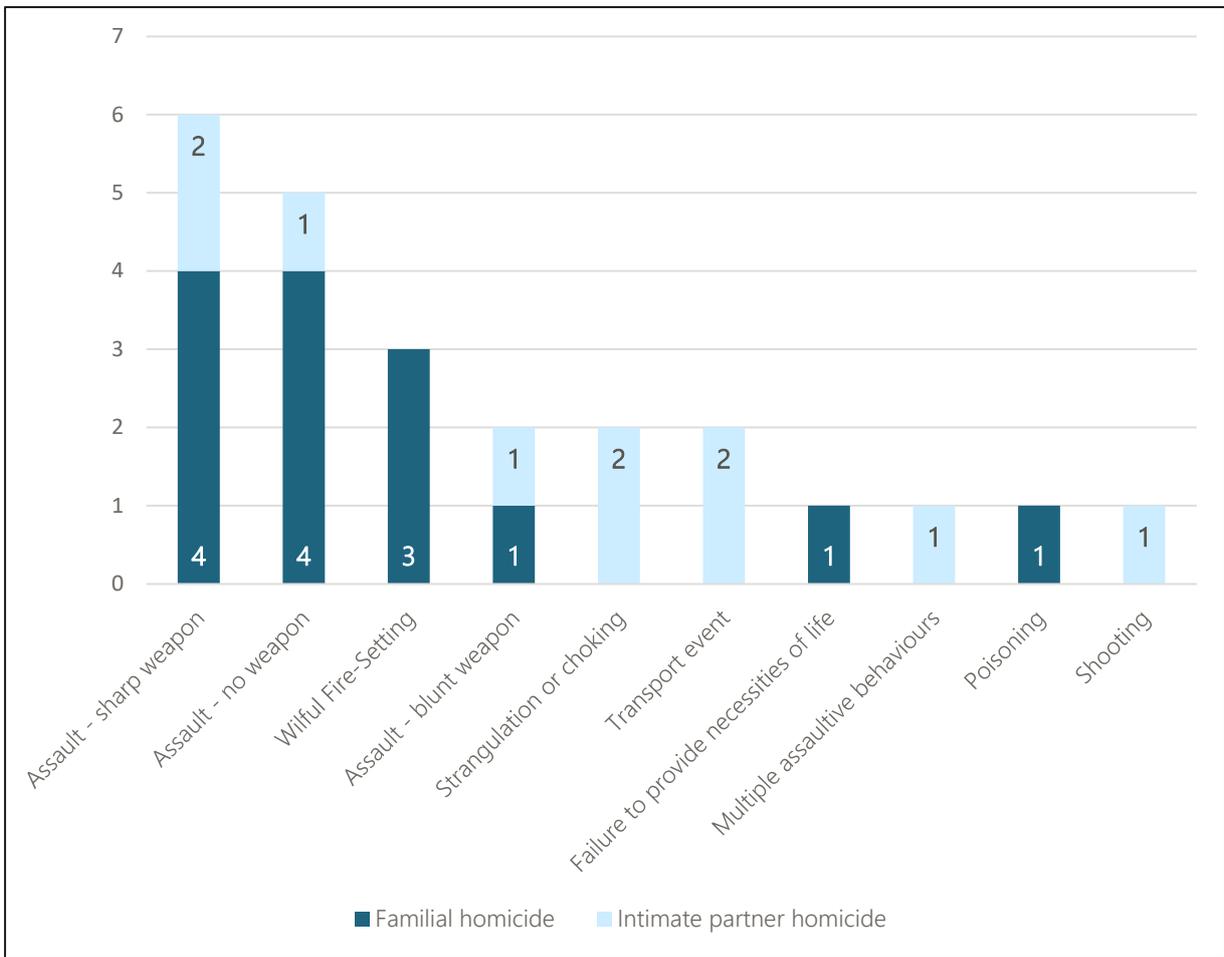


Figure 3.1: Domestic and family violence homicide victims by type of homicide and mechanism of death, Queensland, 1 July 2024–30 June 2025 (n=24).

Domestic and family violence-related homicides 2020–25

In 2024–25, the first phase of the homicide database improvement project was completed, resulting in significant improvements to the DFVDRU’s database of DFV-related homicides in Queensland. This involved database restructure, expansion of the information held about each homicide event and a rigorous quality assurance process. The quality assurance process involved strenuous review and discussion of cases previously reported on to ensure the ADFVDRN Consensus criteria was met for inclusion. This resulted in the exclusion of several matters, particularly for the 2020–21 financial year reporting period. Further, the ongoing nature of the homicide database improvement project has temporarily restricted the number of years of available data for reporting.

The following analysis pertains to DFV-related homicides occurring between 1 July 2020 and 30 June 2025. During this five-year period, there were 89 DFV-related homicide events in Queensland, resulting in the deaths of 103 people (inclusive of 9 homicide offenders who died in the same event). As shown in Table 3.5, across the five-year period there was only a small number of homicide–suicide events. In four of the 83 homicides, the homicide offender also died in either a separate event or as an unintentional outcome of their actions during the homicide event.

Table 3.5: Domestic and family violence homicide deaths by type of homicide event and number of deceased, Queensland, 1 July 2020–30 June 2025 (n=103).

Event type	Number of events	Number of deceased victims	Number of deceased offenders
Homicide	83	88	3
Homicide–suicide	6	6	6
Total	89	94	9

As shown in Table 3.6, of the 94 homicide victims over this five-year period, 87 had a direct relationship with the homicide offender (48 familial relationships and 39 intimate partner relationships). A further six people died in circumstances arising from violence within an intimate partner or family relationship but were not in a relevant relationship with the offender. Examples include bystanders intervening in an episode of DFV, and new partners of people previously in a domestic and family violent relationship.

Table 3.6: Victims of domestic and family violence homicide by type of homicide and relationship, Queensland, 1 July 2020–30 June 2025.

Type of DFV homicide	Direct relationship	Collateral death	Total
Familial homicide	48	1	49
Intimate partner homicide	39	6	45
Total	87	7	94

The annual number of homicide victims was variable over the five-year period, noted in Figure 3.2. While the total number of victims of DFV-related homicide was higher in 2024–25 (n=24) than in 2020–21 (n=14), there was no overall increasing trend in the rate detected over the five-year period, see Figure 3.3.³⁸

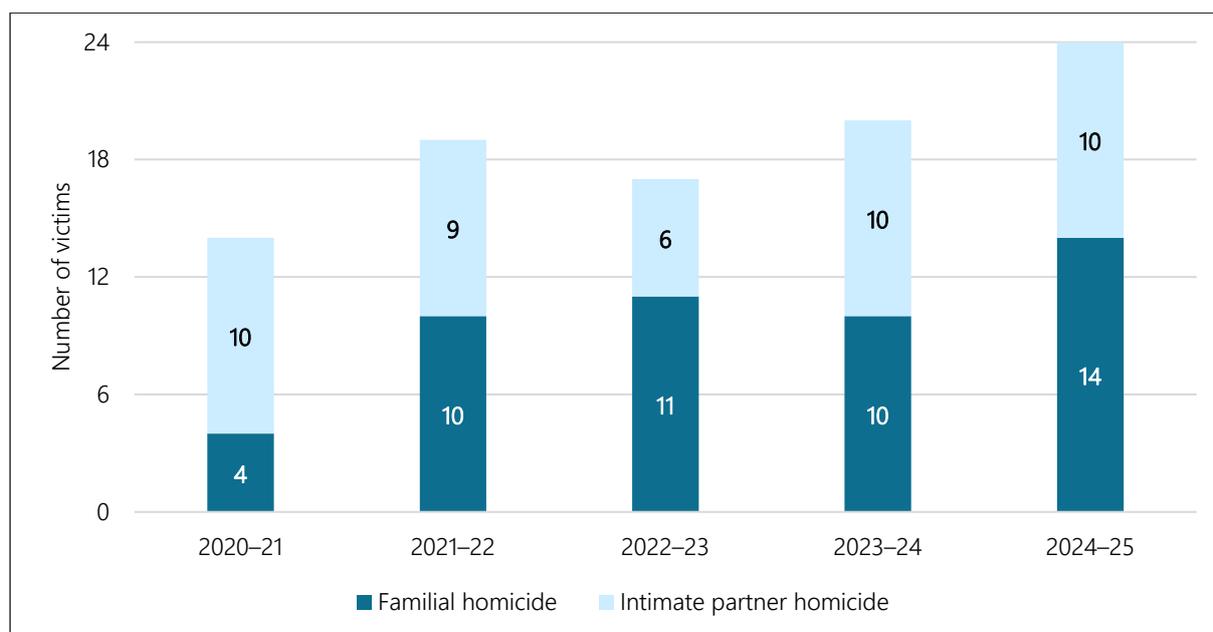


Figure 3.2: Domestic and family violence homicide victims, by relationship type and year, Queensland, 1 July 2020–30 June 2025, (n=94).³⁹

³⁸ We acknowledge the support of the Queensland Government Statistician’s Office for its quality assurance of rates per 100,000 population calculations and interpretation.

³⁹ Collateral deaths have been included in the total count of deceased for the relevant relationship type between the PUV and PV.

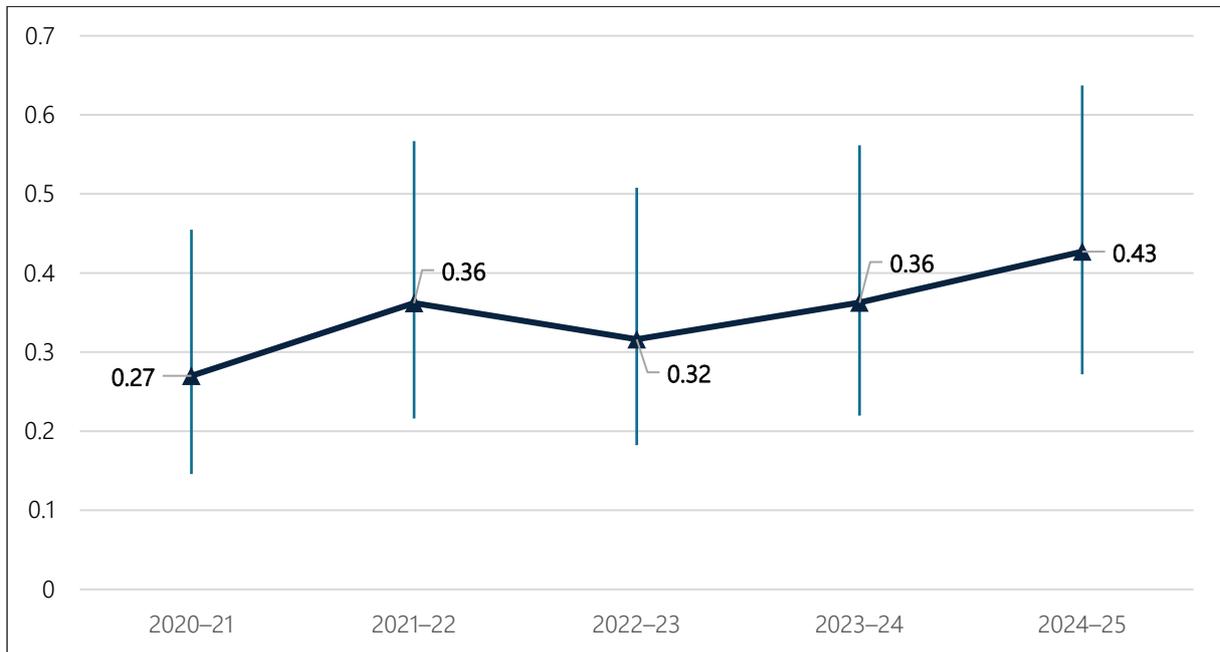


Figure 3.3: Rate of domestic and family violence homicide victims per 100,000 population, by year, Queensland, 1 July 2020–30 June 2025.⁴⁰

In the coming year the Board and DFVDRU anticipate reporting further details on DFV-related homicides in Queensland over time in a dedicated data report. Additionally, the DFVDRU is undertaking a body of work to improve the data held about DFV-related suicides in Queensland. This involves restructuring and quality assuring data in a similar fashion to the DFV-related homicide database project.

⁴⁰ Each year's DFV-related homicide rate per 100,000 population is an estimate based on reported data. As data can vary (e.g., due to population changes or reporting differences), a confidence interval is used to show the range where the true rate likely falls. A 95% confidence interval means that 95 out of 100 times the estimated rate will fall between the upper and lower values of the confidence interval (i.e., it is a reliable method). When the confidence intervals do not overlap, it suggests the difference between the two averages is statistically significant, and unlikely to be due to random chance. When the confidence intervals overlap, as in Figure 3.3, we cannot confidently say the rates per 100,000 population are different. This indicates there has been no significant change over time.



Appendices

Appendix A: Remuneration of the Board

<i>Domestic and Family Violence Death Review and Advisory Board.</i>					
Act or instrument	<i>Coroners Act 2003 (Qld).</i>				
Functions	Review DFV-related deaths.				
Achievements	In 2024–25, the Board met on five occasions, including two meetings to prepare the 2023–24 Annual Report, and three case review meetings. A total of 16 cases were reviewed in this period involving 31 deaths. A Board meeting was cancelled due to the impact of Tropical Cyclone Alfred.				
Financial reporting	The Board is audited as part of the Department of Justice. Accounts are published in the annual report.				
Remuneration					
Position	Name	Meeting/ sessions attendance	Approved fee per meeting attended	Approved sub- committee fees if applicable	Actual fees received
Chair	Stephanie Gallagher*	5	\$300	N/A	N/A
Deputy Chair	Nadia Bromley	5	\$300	N/A	\$1,500
Member	Julia De Boos*	5	\$300	N/A	N/A
Member	Kristina Deveson* ⁴¹	1	\$300	N/A	N/A
Member	Molly Dragiewicz ⁴²	2	\$300	N/A	\$600
Member	Christopher Jory* ⁴³	2	\$300	N/A	N/A
Member	Keryn Ruska	5	\$300	N/A	\$1,500
Member	Paul Stewart* ⁴⁴	4	\$300	N/A	N/A
Member	Brian Sullivan	5	\$300	N/A	\$1,500
Member	Belinda Drew* ⁴⁵	2	\$300	N/A	N/A
Member	Aletia Twist	4	\$300	N/A	\$1,200
Member	Ben Bjarnesen	4	\$300	N/A	\$1,200
Member	Katherine Innes* ⁴⁶	5	\$300	N/A	N/A
Member	Meegan Crawford* ⁴⁷	3	\$300	N/A	N/A
No. scheduled meetings/sessions	Five (5)				
Total out of pocket expenses	\$2,016.02				

* Public sector employees are not paid fees unless approved by the Queensland Government.

⁴¹ Kristina Deveson resigned from the Board on 9 December 2024.

⁴² Molly Dragiewicz resigned from the Board on 6 March 2025.

⁴³ Assistant Commissioner Christopher Jory resigned from the Board on 21 October 2024.

⁴⁴ One meeting was attended by a proxy appointed by Queensland Corrective Services.

⁴⁵ Belinda Drew resigned from the Board on 9 December 2024.

⁴⁶ One meeting was attended by a proxy appointed by the Queensland Police Service.

⁴⁷ One meeting was attended by a proxy appointed by the Department of Families, Seniors, Disability Services and Child Safety.

Appendix B: Australian Domestic and Family Violence Death Review Network Homicide Consensus Statement

Background and purpose

Following the implementation of DFV death review mechanisms in several Australian jurisdictions, the Australian Domestic and Family Violence Death Review Network (ADFVDRN) was established in March 2011. ADFVDRN comprises representatives from each of the established Australian death review teams, namely:

- a) Domestic Violence Death Review Team (New South Wales).
- b) Domestic and Family Violence Death Review Unit (Queensland).
- c) Domestic and Family Violence Death Review (South Australia).
- d) Victorian Systemic Review of Family Violence Deaths.
- e) Review Team Ombudsman Western Australia.
- f) Family Violence Death Review Unit (Northern Territory).

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

- a) improve knowledge regarding the frequency, nature, and determinants of domestic and family violence deaths.
- b) identify practice and system changes that may improve outcomes for people affected by domestic and family violence and reduce these types of deaths.
- c) identify, collect, analyse, and report data on domestic and family violence related deaths.
- d) analyse and compare domestic and family violence death review findings and recommendations.⁴⁸

These goals align with the *National Plan to Reduce Violence Against Women and their Children 2022–2032*.⁴⁹

Definitions

This Consensus Statement defines the inclusion criteria adopted by ADFVDRN for DFV homicide. While there is no universally agreed definition of the behaviours that comprise DFV, in Australia it includes a spectrum of physical and non-physical abuse within an intimate or family relationship. DFV behaviours include physical assault, sexual assault, threats, intimidation, psychological and emotional abuse, social isolation, and economic deprivation. Primarily, DFV is predicated upon inequitable relationship dynamics in which one person exerts power and

⁴⁸ www.anrows.org.au/project/australian-domestic-and-family-violence-death-review-network-national-data-update/.

⁴⁹ Commonwealth of Australia (2022) *National Plan to End Violence against Women and Children 2022–32*. www.dss.gov.au/ending-violence.

coercive control over another. This accords with the definition of family violence contained in the *Family Law Act 1975* (Cth), which is adopted by ADFVDRN.

The definition of 'homicide' adopted by ADFVDRN is broader than the legal definition of the term. 'Homicide', as used by ADFVDRN, 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 (WHO) 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.'*⁵⁰

Surveillance processes produce data describing 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. ADFVDRN 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 DFV homicide incidents is conducted both retrospectively and prospectively.

Categorisation

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

- a) case type.
- b) role of human purpose in the event resulting in a death (intent).
- c) relationship between the parties (i.e., the deceased-offender relationship).
- d) DFV context (i.e., whether or not the homicide occurred in a context of DFV).

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.

⁵⁰ Adopting the definition in Last J (ed) (2001) *A Dictionary of Epidemiology* (4th ed), Oxford: Oxford University Press.

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 ⁵¹	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
Neglect ⁵²	Deaths arising from a failure to meet the ongoing basic needs of a person who is dependent on another person for their care. This includes acts or omissions on the part of a caregiver that are deliberate, irresponsible, or reckless. Examples include failure to provide the necessities of life such as food, water, shelter, clothing, or failure to seek medical attention.	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

⁵¹ Mortality classification systems refer to 'homicide' as 'assault.'

⁵² DFVDRU recognises Neglect as a standalone category for intent.

Intent	Definition	Inclusion
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 (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 (i.e., not on purpose). This category includes those injuries and poisonings described as unintended or "accidental", regardless of whether the injury was inflicted by oneself or by another person.	No
Unlikely to be known	Upon case completion, the coroner was unable to determine whether the death was due to Natural or External causes, therefore unable to make a determination on intent.	No

Consideration 3: Relationship

The third consideration for classification is whether a domestic or familial relationship existed between the deceased and the PUV. ADFVDRN recognises the various state and federal legislative instruments that define and address deceased-offender relationship. It is acknowledged the member jurisdictions operate within the following legislative frameworks:

- a) *Coroners Act 2009* (NSW).
- b) *Domestic and Family Violence Protection Act 2012* (Qld).
- c) *Family Violence Protection Act 2008* (Vic).
- d) *Intervention Orders (Prevention of Abuse) Act 2009* (SA).
- e) *Restraining Orders Act 1997* (WA) and *Parliamentary Commissioner Act 1971* (WA).

f) *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 ADFVDRN.

Relationship type	Definition	Inclusion
Intimate ⁵³	Individuals who are or have been in an intimate relationship (sexual or non-sexual).	Yes
Relative ⁵⁴	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 (where DFV context present)
Unknown	Relationship is unknown.	No

Consideration 4: Domestic and family violence context

Having determined a homicide has occurred and 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 DFV 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 DFV. For example, this might

⁵³ This includes current and former intimate relationships irrespective of the gender of the individuals.

⁵⁴ This includes formal and informal family-like relationships, and explicitly includes extended family-like relationships that are recognised within that individual's cultural group.



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, ADFVDRN recognises the existence of an intimate or familial relationship between a deceased and PUV does not constitute a DFV 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 DFV, 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.

In addition to the above, the DFVDRU also recognises that a single act causing death may be considered a DFV homicide where there are indicators the act was designed to threaten, control, coerce or to cause the victim fear prior to their death.

Appendix C: Glossary of terms

Term	Description
Accelerant	Accelerants are flammable substances used to accelerate or increase the intensity of a fire.
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.
Arson	Under Section 461 of the <i>Criminal Code Act 1899</i> (Qld), arson is defined as wilfully and unlawfully setting fire to property. Arson may involve an intentional or malicious intent to damage property, injure a victim or cause death.
Burns	Burns are injuries caused by heat including fire, electricity, chemicals and hot liquids. Burn injuries are classified as first-degree, second-degree, third-degree or fourth-degree burns depending on their severity and thickness.
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. ⁵⁵ 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.

⁵⁵ Johnson, M (2008) *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance and Situational Violence*, Boston, University Press of New England.

Term	Description
Common-law	When two adults live together in a marriage-like relationship but are not legally married. The couple can be either same sex or opposite sex. This is also known as a de facto relationship. ⁵⁶
Deceased	The person/s who died.
DFVPA 2012	<i>Domestic and Family Violence Protection Act 2012 (Qld).</i>
Domestic and family violence (DFV)	DFV is defined by section 8 of the <i>Domestic and Family Violence Protection Act 2012 (Qld)</i> , 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	<p>Queensland uses a nationally consistent definition of a 'domestic and family violence homicide' as outlined within the ADFVDRN 'Homicide Consensus Statement' that recognises that although there is no universally agreed definition of the behaviours that comprise DFV, 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.</p> <p>Primarily, DFV 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 <i>Family Law Act 1975 (Cth)</i>, which is adopted by ADFVDRN. The definition of homicide adopted by ADFVDRN 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.</p>
Dousing	Dousing involves covering a person or property with a flammable substance which may accelerate the spread of fire.

⁵⁶ Family Law Act 1975 (Cth), s4AA, www.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/consol_act/fla1975114/s4aa.html.

Term	Description
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 (as opposed to 'incidents', for example) allows professionals 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 they died.
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.
Fire-related violence	The intentional use of fire to harm, intimidate, control, or threaten others. This form of violence may involve acts such as wilfully setting property, homes, or vehicles on fire, or using fire as a weapon to cause physical injury or psychological distress. Fire-related violence is often associated with broader patterns of DFV, and poses significant risks to lives, property, and public safety.
Flammable substance	Flammable substances are gases, liquids, solids, and combustible materials that may ignite and burn when exposed to an ignition source.
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

Term	Description
	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 <i>Special Taskforce on Domestic and Family Violence in Queensland</i> titled <i>Not Now, Not Ever: Putting an end to domestic and family violence in Queensland</i> (2015).
Homicide event	An event resulting in the unlawful killing of a person.
Homicide offender	The person whose actions, or inaction, caused the person (the deceased) to die.
Hospital burn unit	Hospital burns units specialise in the treatment of severe burn injuries. ⁵⁷
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	DFV 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 DFV.

⁵⁷ In Queensland the Hospital burns units are Professor Stuart Pegg Adult Burn Centre, Royal Brisbane and Women's Hospital Burn Unit, and Queensland Children's Hospital Burn Unit, www.anzba.org/resources/burn-units/. These units report burns to the Burns Registry of Australia and New Zealand, www.anzba.org/quality-care/burns-registry-of-australia-new-zealand/.

Term	Description
Person using violence (PUV)	The person who was the aggressor in the relationship prior to the death and who used domestic and family violent abusive tactics to control the victim.
PUV interventions	Typically refers to specific programs (for example, behaviour change programs) for PUV of DFV. These interventions generally seek to change men's attitudes, beliefs, and behaviour to prevent them from engaging in violence in the future. ⁵⁸
Person most in need of protection	The <i>Domestic and Family Violence Protection Act 2012</i> (Qld) requires 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 <i>Domestic and Family Violence Protection Act 2012</i> (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 DFV 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.
Primary victim (PV)	This is the person who was subjected to DFV 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 <i>Domestic and Family Violence Protection Act 2012</i> (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 DFV.
Queensland Fire Department	Queensland Fire Department is the primary fire and emergency service provider in Queensland.

⁵⁸ Mackay, E, Gibson, A, Lam, H and Beecham, D (2015) 'Perpetrator Interventions in Australia: Part One – Literature Review'. *Landscapes: State of Knowledge Paper*. www.anrows.org.au/publication/perpetrator-interventions-in-australia/.

Term	Description
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, stepparent, sibling, grandparent, aunt, nephew, cousin, half-brother, or mother-in-law.
Relevant relationship	As defined by section 13 of the <i>Domestic and Family Violence Protection Act 2012</i> (Qld), 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 <i>Domestic and Family Violence Protection Act 2012</i> (Qld).
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 (for example, 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.
Scalds	Scalds are burn injuries caused by steam or hot liquids.
Service system	A term used to refer to all services and agencies that play a role in identifying and responding to DFV including health and mental health

Term	Description
	services, alcohol and other drug services, child protective services, police, corrections, court services, housing services and DFV services.
Smoke alarms	Smoke alarms detect smoke and sound an alarm to notify occupants of a dwelling of smoke or fire hazards.
Special Taskforce on Domestic and Family Violence in Queensland (the Special Taskforce)	Established on 10 September 2014 to define the DFV 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, <i>Not Now, Not Ever: Putting an end to domestic and family violence in Queensland</i> (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 DFV (for example, victim services, women's refuges, PUV intervention programs).
Threats of fire	Threats of fire include verbal or implicit threats to set fire to a person or property. Threats of fire may also involve dousing a person or property with a flammable substance.
Victim	The person who was the primary victim of DFV in the relationship and the person most in need of protection.
Wilful fire-setting	The deliberate and intentional act of starting a fire with the aim of causing damage to property, vegetation, or even endanger lives. Also known as arson.
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.

Appendix D: Queensland Government Response to the Domestic and Family Violence Death Review and Advisory Board 2023–24 Annual Report

The Queensland Government response to the Board’s 2023–24 Annual Report was received on 30 May 2025. The Attorney-General and Minister for Justice and Minister for the Prevention of Domestic and Family Violence wrote to the Deputy State Coroner and Board Chair Stephanie Gallagher acknowledging the Board’s 2023–24 Annual Report and the role of the Board in contributing to and shaping the ongoing reform in Queensland.⁵⁹

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

Recommendation	Government response
<p>Recommendation 1:</p> <p>Relevant risk assessment that includes more nuanced measure of intimate partner sexual violence</p>	<p>Accept</p> <p>The Queensland Government supports implementation of evidence informed, responsive risk assessments of DFV and IPSV by practitioners in the DFV sector, including health practitioners.</p> <p>Queensland Health is updating and improving DFV tools and resources to improve the understanding and capacity of health professionals, particularly frontline health clinicians, to respond to victim-survivors and those at risk of DFV and IPSV in public health settings. This includes development of updated training and resources related to PUV, nonfatal strangulation and other forms of intimate partner violence.</p> <p>Queensland Health is also developing a new DFV Capability Framework to support a more proactive, considered, and consistent response to DFV across Hospital and Health Services, based on consideration of what is needed to support disclosures or suspicions across different operating contexts. The Framework will provide clear guidance about the DFV knowledge and training requirements for all staff to build capability in responding to DFV.</p> <p>Additionally, all Hospital and Health Services have now been resourced to establish a core team to coordinate and oversee local models of care for people disclosing sexual assault, with a focus on the provision of timely, high quality forensic medical examinations. Forensic Medicine Queensland has also been resourced to expand the statewide Forensic Examiner Training Program for doctors and nurses, as well as providing 24/7 phone support for any clinician required to</p>

⁵⁹ www.coronerscourt.qld.gov.au/dfvdrab/annual-reports-and-government-responses.

	<p>perform a forensic medical examination. The Office of the Chief Medical Officer provides statewide oversight of this work, informed by the multi-agency Sexual Assault Reform Oversight Committee.</p> <p>The Department of Families, Seniors, Disability Services and Child Safety (DFSDSCS) has commenced procurement to find a supplier to evaluate and validate the Queensland Common Risk and Safety Framework (CRASF) and victim-survivor, persons using violence (PUV) and young persons' risk assessment tools. This review will consider whether the current CRASF and associated tools appropriately identify and respond to IPSV risks. CRASF training and practice guidance will be reviewed to enhance content on IPSV and/or develop new resources as appropriate.</p>
<p>Recommendation 2:</p> <p>Place-based and culturally relevant community education on intimate partner sexual violence</p>	<p>Accept</p> <p>The Queensland Government, through the DFSDSCS, will identify and pursue opportunities to continue to further embed broad community awareness and understanding of domestic, family and sexual violence (DFSV) through the delivery of evidence-based communications initiatives underpinned by government strategies.</p> <p>This includes building community understanding of intimate partner violence and the spectrum of violence, and challenging community misconceptions around the contexts in which DFSV occurs and that allow DFSV to continue.</p> <p>Communications will cater to Queensland's diversity and prioritise opportunities to deliver tailored responses for diverse communities and vulnerable cohorts.</p>
<p>Recommendation 3:</p> <p>Accessible and linked datasets to identify intimate partner sexual violence</p>	<p>Accept</p> <p>The Queensland Government acknowledges the timely sharing of information and consistent DFV and IPSV data collection is crucial.</p> <p>Queensland Health will consider the options available to flag and capture DFV or IPSV presentations and aim to ensure consistency of data collection regardless of the format of the health patient record i.e., digital or paper based.</p>

	<p>Methods to embed triggers to support the health service beyond the hospital setting, for patients presenting in the context of DFV or IPSV, will also be considered.</p>
<p>Recommendation 4:</p> <p>Review of current models for intensive and escalated responses to high-risk cases of DFV</p>	<p>Accept in Principle</p> <p>The Queensland Government has committed to improving responses to high-risk PUVs through the development of a PUV risk assessment tool. The evaluation and validation of the CRASF and associated tools, as noted in the response to Recommendation 1, will provide guidance on how it may be best used in a HRT environment and by services in contact with a PUV. Any learnings from the evaluation will be used to strengthen the HRT model as well as guide future development of statewide protocols, operations, and practice guidance.</p> <p>In developing a refreshed DFV Strategy, the DFSDSCS will identify opportunities to enhance integrated service responses, including responses to high-risk PUVs, and explore opportunities to deliver stronger, innovative, and effective responses to PUV.</p> <p>DFSDSCS will identify strategies to strengthen the capability of government and community organisations to respond to the needs of people affected by DFV, including sexual violence that occurs within a DFV context.</p>
<p>Recommendation 5:</p> <p>Greater research on suicide in the context of domestic and family violence</p>	<p>Accept in Principle</p> <p>The Queensland Government will continue to support Australia's National Research Organisation for Women's Safety to build on the existing research and evidence base, in line with the Australian National Research Agenda. This includes advocating for research that aims assist in the identification of the use of DFV and responding to threats to suicide and/or suicide ideation expressed by PUV.</p>



Queensland
Government