Domestic and Family Violence Death Review and Advisory Board

2020–21 Annual Report

Queensland Government

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

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

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

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

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

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About this report

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

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

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

Acknowledgments

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

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

This figure is a visual representation of each life lost in Queensland during the past 15 years to a homicide within an intimate partner or family relationship, or by collateral homicide (between 1 July 2006 and 30 June 2021). In total this includes:

- 141 women and girls killed by an intimate partner
- 30 women killed within a family relationship
- 89 children killed by a parent or caregiver
- 45 men killed in an intimate partner relationship*
- 41 men killed in a family relationship
- 29 collateral homicides (inclusive of 2 women and 27 men)

During the past six years, between 1 July 2015 and 30 June 2021, an additional 280 apparent suicides were identified as domestic and family violence related. This includes:

- 44 apparent suicides of women
- 215 apparent suicides of men
- 21 apparent suicides of children and young people

* In all cases the deceased male was identified as the primary perpetrator of violence in the relationship.

Seek help

If you, or someone you know, is experiencing domestic and family violence and need immediate support:

Triple Zero (000) is a 24-hour emergency call service to the Police for anyone requiring assistance in life threatening or time critical emergency situations.

Policelink (131 444) is a 24-hour service for non-urgent incidents, crimes or police enquiries.

DVConnect Womensline is a 24-hour crisis support line for anyone who identifies as female being impacted by domestic or family violence, and can be contacted on **1800 811 811** or 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, and can be contacted on **1800 600 636** or www.dvconnect.org

Lifeline is a 24-hour telephone counselling and referral service, and can be contacted on **13 11 14** or www.lifeline.org.au

Kids Helpline is a 24-hour free counselling service for young people aged between 5 and 25, and can be contacted on **1800 55 1800** or www.kidshelpline.com.au

Suicide Call Back Service can be contacted on **1300 659 467** or www.suicidecallbackservice.org.au

Beyond Blue can be contacted on **1300 22 4636** or www.beyondblue.org.au

The *Domestic and Family Violence Media Guide* provides information for journalists about responsible reporting of domestic and family violence.

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

Chair's message

This Annual Report outlines the work of the Board throughout the 2020–21 financial year. During this time, the Board undertook in-depth reviews of 12 domestic and family violence homicides and apparent suicides. In accordance with the Board's statutory mandate to identify common systemic failures, gaps or issues, and make recommendations to improve systems, practices, and procedures, these cases were selected because of the cross-agency systemic issues identified.

While these deaths are statistically rare, a domestic and family violence death is a sentinel event that can be used to identify systemic shortcomings and strengthen our understanding of potential risks to others. This process is enhanced with the number of cases the Board reviews, and it is important to recognise, and build upon, this collective knowledge. Accordingly, findings from previous Annual Reports published by the Board, as well as data from the Queensland Domestic and Family Violence Homicide and Suicide Databases, have been considered as part of the development of this report.

The Board's case reviews consistently show that many victims, their children, and perpetrators have contact with a range of specialist and generalist services in the lead up to the death/s. Although issues in service responses are a primary focus of the Board's published reports, with these cases representing opportunities for us all to consider possible opportunities for earlier intervention or prevention, death review processes do not assign blame to any agency or individual's action or inaction prior to the death.

When considering the findings of these case reviews, it is also important to remember that the perpetrator is responsible for the violence. Death reviews focus on improving systemic responses to domestic and family violence, but the perpetrator, not the system, must be recognised as the cause of the problem. Similarly, it is important for death reviews to shift the focus away from the actions of victims in response to their experiences of violence, and to focus the attention on community and service responses to domestic and family violence.

Review of these deaths can be both challenging and distressing and I would like to take the opportunity to recognise the commitment and dedication of Board members in the performance of their duties. In particular, I would like to acknowledge outgoing members Commissioner Peter Martin, Assistant Commissioner Ben Marcus, and Ms Barbara Shaw, who all brought valuable and unique perspectives to the Board. I would also like to congratulate Dr Jeannette Young on her appointment as Queensland's next Governor.

There have been substantial reforms at a state and national level to better recognise and respond to domestic and family violence in Queensland since the Board was established in 2016–17. Despite this, we can, and must, do more.

To put an end to domestic and family violence in our community, we must move toward an accountable system that recognises the effects of trauma, and that people using and experiencing domestic and family violence require long-term support to disrupt underlying patterns of violence and abuse. In this way, we must also put the safety of victims and their children at the front and centre of all service responses and ensure there is ongoing consideration of the potential for unintended consequences.

To build on activities undertaken during this reporting period, the Board identified the following priority areas for 2021–22, which include:

- focused attention on cases that have occurred in an area where a High Risk Team or integrated service response is operating, and the victim or perpetrator was known to participating representatives or the team.[1]
- revisiting how systems and services respond to family violence among Aboriginal and Torres Strait Islander individuals, families and communities, particularly in remote areas of Queensland.
- undertaking a deeper analysis of the frequency and incidence of service contact in these cases to better differentiate between opportunities for intervention immediately prior to a death, and over the longer term.

It is the intention of the Board that its findings, as published within this report, be shared widely so that valuable insights may be gained to improve our understanding of domestic and family violence and its immediate and cumulative impacts.

In March 2021, the Queensland Government announced the establishment of the Women's Safety and Justice Taskforce to conduct a wide-ranging review into the experiences of women across Queensland's criminal justice system, including on how to best legislate against coercive control. The Board has continued to engage with the Taskforce since its establishment to share knowledge gathered as part of its review process, and the recommendations in this report are intended to compliment this important work.

1. In the final report of the *Special Taskforce on Domestic and Family Violence in Queensland* (2015), the Taskforce recommended that the Queensland Government implement integrated service response models. Three pilot sites commenced in 2017 and there are now eight High Risk Teams (HRT) operating across Queensland. HRTs consist of dedicated staff from both government and non-government agencies (i.e., Queensland Police Service; Queensland Corrective Services; the Department of Child Safety, Youth Justice and Multicultural Affairs; Queensland Health and specialist domestic and family violence services) who collaborate to share information to develop multi-agency safety plans to support victims and their children assessed to be at a high risk of serious harm or lethality.

Board Members

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Chairperson

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Deputy Chairperson
Professor of Midwifery; Director of Midwifery,
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Solicitor
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Secretariat
Domestic and Family Violence Death Review Unit
Coroners Court of Queensland

Acknowledgements

The Board acknowledges the significant effort of those individuals, services and government agencies working across Queensland to reduce and prevent domestic and family violence. Responding to domestic and family violence is complex and multilayered. There are no simple solutions, and it will take time to enact the change we want to see.

While domestic and family violence 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 that not one agency or person had access to all available information prior to the death.

It is for this reason that it is necessary to share learnings from the Board's reviews, so that we can all continue to work towards putting an end to domestic and family violence in Queensland.

During 2020–21, the Board continued to be impacted by the ongoing COVID-19 pandemic. The Board was supported by Special Advisors from Queensland Government agencies to ensure this important work continued with minimal disruption:

- Dr Kylie Stephen, Acting Executive Director, Office for Women and Violence Prevention.
- Brian Codd, Assistant Commissioner, Domestic, Family Violence and Vulnerable Persons Command, Queensland Police Service.
- Bronwyn Nardi, Assistant Deputy Director-General, Prevention Division, Queensland Health.

The Board has also been fortunate to hear from a range of experts, government agencies and community members regarding key issues identified throughout the review process. In particular, the Board would like to acknowledge the contribution of:

- Dr Samara McPhedran, Honorary Associate Professor, TC Beirne School of Law, University of Queensland.
- Rebecca Lang, CEO, Queensland Network of Alcohol and Other Drug Agencies.
- Professor Ed Heffernan, Director, Queensland Forensic Mental Health Service.
- Dr John Reilly, Chief Psychiatrist and Chief Mental Health Alcohol and Other Drugs Officer.
- Di MacLeod, Director, Gold Coast Centre Against Sexual Violence.

Contents

Executive Summary

At least 655 lives have been lost to domestic and family violence in Queensland since 2006. These deaths highlight the devastating social harm of domestic and family violence, the need to learn from these deaths, and to translate these learnings into action to prevent similar deaths from occurring in the future.

In 2020–21, the Board reviewed the deaths of 12 women and men who died by homicide or apparent suicide in the context of domestic and family violence between 2017 and 2020. This report outlines the Board's findings from its review of these deaths and the personal stories of the deceased and other parties are summarised in Chapter 1. While these stories may be distressing, they are also stories of strength and resilience shown by victims of domestic and family violence, their children, and family members.

Chapter 2 provides an overview of statistical findings from Queensland's domestic and family violence homicide and suicide datasets that help to inform the Board's understanding of domestic and family violence deaths in Queensland. A focused analysis of these datasets is undertaken in Chapter 6.

Key points in Chapter 2 include:

- between 1 July 2006 and 30 June 2021, there were 375 homicides in a domestic and family relationship in Queensland. This includes 346 women, men and children who were killed by a family member or by someone they were, or had been, in an intimate partner relationship with. An additional 29 collateral homicides occurred during this time.
- Aboriginal peoples and Torres Strait Islander peoples were significantly over-represented as deceased in homicides within an intimate partner or family relationship.
- between 1 July 2015 to 30 June 2021, a total of 280 apparent suicides were identified as being domestic and family violence related.
- of all apparent domestic and family violence suicide cases, 87.5% occurred in the context of intimate partner relationships and the remaining 12.5% occurred in the context of family relationships.

Understanding our current context

During the past decade, there have been substantial reforms at both a state and national level to address domestic and family violence and child abuse and maltreatment, which are guided by:

- the *National Plan to Reduce Violence against Women and their Children 2010–2022*.
- *Queensland's Domestic and Family Violence Prevention Strategy 2016–26*.

In Queensland, the most significant reforms have occurred in response to the landmark report of the Special Taskforce on Domestic and Family Violence (the Special Taskforce): *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* (2015).

The Special Taskforce made 140 recommendations to address domestic and family violence in our community and in September 2019 the Queensland Government announced that all recommendations had been implemented.

However, more needs to be done to embed these reforms across the state and ensure that the current momentum for change is sustained.

In March 2021, the Queensland Government announced the establishment of a Women's Safety and Justice Taskforce to conduct a wide-ranging review into the experiences of women across Queensland's criminal justice system. The Taskforce is required to report to government on how best to legislate against coercive control by November 2021 and on how best to improve women's experiences in the criminal justice system by June 2022. Moving forward, the Board recognises that the final Taskforce report will shape the future approach to be taken in Queensland in responding to domestic and family violence.

In 2020–21, the Board had the opportunity to reflect on its prior findings in the context of current reform activities and noted several reoccurring issues, including:

- the need for all agencies and sectors to be better equipped to respond to complexity across distinct but interrelated portfolio areas, including domestic and family violence; alcohol and other drugs; child protection; and mental health and suicide prevention.
- to improve recognition of patterns of abuse, risk and harm, all services who encounter victims, their children and perpetrators must have an appropriate understanding of domestic and family violence, including non-physical forms of abuse, as well as the risks posed to children in this context.
- that there is an ongoing need to improve the way that systems understand and respond to family violence among Aboriginal and Torres Strait Islander individuals, families and communities.

Monitoring our progress

The Board is empowered to make recommendations about system changes that seek to reduce or prevent domestic and family violence deaths from occurring; and to monitor their implementation.

Since its establishment in 2016–17, the Board has made 59 recommendations. Of these, all but one has been accepted (in full, in part or in principle) by the Queensland Government. Implementation is ongoing for 57% of recommendations made by the Board, with 41% of recommendations completed.

Broadly, the Board's recommendations have been informed by the ongoing progress of the current reform agenda in Queensland, as well as the issues identified in the cases reviewed. Recommendations have been far-reaching, with the majority aiming to change organisational practices, educate providers, and influence policy and reform.

The information contained within the Board's publicly available reports represent only a de-identified fraction of the full information considered by the Board about a particular case or cases reviewed. This lost nuance may impact the implementation approach undertaken by agencies who may not fully understand the basis of the Board's recommendation or the systemic issues it identified.

Establishing our foundations

Since its establishment, the Board has been confronted by the level of extreme violence and abuse that some perpetrators choose to inflict on their partners, children, and other family members. This was not always physical in nature, and the Board has also observed many examples of insidious, coercive controlling behaviours.

The Board reflected on the need for services to better understand that using violence is a choice, and that perpetrators use many tactics to avoid detection and accountability for their abuse.

The Board also identified issues with the way in which services identify the person most in need of protection,[2] particularly when female victims have used resistive violence in self-defence or self-protection. It is natural for victims to resist abuse; however, the way in which victims of domestic and family violence resist is dependent on their individual circumstances and perceived level of risk.

In the course of its reviews, the Board identified the ongoing need for increased awareness and understanding of how victims resist and attempt to stay safe and reassert their dignity throughout their experiences of domestic and family violence.

The way in which services use language to describe domestic and family violence must be through the lens of perpetrator accountability and an understanding that using violence is a choice, as well as respecting the lived realities of victims experiencing domestic and family violence, and the ways in which they resist abuse.

This is important because the way that domestic and family violence and/or the actions of perpetrators and victims are recorded, shapes the interpretation of, and responses to, what occurred.

Understanding service contact and lethality risk indicators

In the majority of homicides in a domestic and family relationship where a history of violence could be established (between 1 July 2006 and 30 June 2020) and domestic and family violence suicides (between 1 July 2015 and 30 June 2020), there was a prior history of service contact for victims, their children, and/or perpetrators.

This included contact with police and other criminal justice system agencies (e.g. courts and corrective services), child safety, health services (e.g. hospital and mental health services), and specialist domestic and family violence services.

Patterns of service contact differed dependent on the type of death, and was either directly related to domestic and family violence or pertained to other co-occurring issues (e.g. mental health or child protection concerns), where domestic and family violence was an underlying issue.

In considering the existing data contained within its Domestic and Family Violence Homicide and Suicide Databases, the Board noted that a deeper understanding is required about how, when, and why victims, their children and perpetrators have contact with services in relation to domestic and family violence as either a presenting or underlying issue.

This includes the need to better understand how information about domestic and family violence is recorded and reported across agencies, and the frequency and incidence of known service contact, including within immediate proximity of the death/s.

The Ontario Domestic Violence Death Review Committee lethality coding system has been applied to 92 intimate partner homicides that have occurred in Queensland between 2011 and 2018.

Some of the most prevalent lethality risk indicators were a prior history of domestic and family violence (83.6%), excessive alcohol and other drug use by the perpetrator (57.6%), actual or pending separation (53.2%), and sexual jealousy (49%).

2. Section 4(2)(d) of the *Domestic and Family Violence Protection Act 2012* (Qld) (DFVPA) requires that consideration be given to the person most in need of protection in circumstances where there are mutual allegations of violence. Under s 37(1)(c) of the DFVPA, consideration must also be given to whether a protection order is necessary or desirable.

Our system challenges

During the 2020–21 reporting period the Board conducted in-depth systemic reviews of the deaths of 12 people who died by homicide or apparent suicide in the context of domestic and family violence.

While there were varying levels of contact with different services for the deceased and other relevant persons (such as the homicide offender), the Board observed a number of challenges in appropriately recognising and responding to domestic and family violence that were consistent across agencies and systems.

These include that:

- Queensland is diverse and regionally distinct.
- service models are rigid, crisis oriented and not always accessible.
- services are not domestic and family violence informed or tailored to consider safety.
- service delivery is fragmented both within and across agencies.
- service responses are inconsistent within and across agencies.

The Board acknowledges that these issues are complex and require the shared commitment of government, non-government and community organisations to effectively address.

Consolidating our approach

Death reviews consistently show that people using and experiencing domestic and family violence (and who have co-occurring needs) have multiple points of contact with the service system, each of which provides an opportunity to recognise and respond. In many cases, regardless of the death type, contact with services commenced many years before the death.

The Board also gave consideration as to what a future system that prioritises victim and children's safety, extends on current reforms and invests in continuous improvement, would look like.

The need for an expanded service system that recognises the impacts of trauma, and that people experiencing or using domestic and family violence require long-term support, is becoming increasingly evident.

Repetitive patterns of violence experienced by victims and perpetrators across relationships is an issue that has been repeatedly identified by the Board in its case reviews.

To disrupt underlying patterns of violence and abuse more effectively, the Board discussed the need to work together to prioritise the safety of victims and their children at every point of contact with services, regardless of the level of risk identified. This extends to a greater recognition that behavioural change for perpetrators takes time, and that there is a need for ongoing support over the longer term to help disrupt entrenched patterns of abuse.

Our cases

At least **655** lives lost to domestic and family violence.

76.5%

The vast majority of offenders in intimate partner, family and collateral homicides are men.

There are differences in case characteristics and service contact between intimate partner and family homicides.

Our work

5 Annual Reports delivered, and **3** systemic reports published.

59 recommendations made by the Board.

24 recommendations implemented, with another **34** in progress.

Recommendations

In accordance with section 91D(e) of the Act, the Board is empowered to make recommendations to the Attorney-General about improvements to legislation, policies, practices, services, training, resources and communication for implementation by government and non-government entities to prevent or reduce the likelihood of domestic and family violence deaths in Queensland.

A key consideration throughout the Board's case review process has been the significant reforms currently underway that aim to address domestic and family violence and improve the capacity of all services to recognise, respond and refer (discussed further in Chapters 3 and 4).

While the Board recognises that some reforms take time to embed into practice, recommendations have been made within this report where a clear and compelling need for change has been identified. Recommendations have been informed by the issues identified in the findings from the cases reviewed in 2020–21, as well as the Board's collective knowledge and understanding of the systemic failures that have been identified during the past five years since its establishment.

Accordingly, recommendations made by the Board in this reporting period aim to enhance existing activities across Queensland and address identified systemic gaps, where applicable. It is also hoped that the key learnings outlined in this report can shape planning and implementation processes to further enhance reform. The importance of embedding change over the longer term should not be underestimated, and while there will always be occasions where a call for immediate action is compelling and resounding, there is also the need to recognise the complexities of embedding reform across sectors to ensure that meaningful outcomes are achieved.

In this context, and in accordance with section 91D(e) of the Act, the Board makes the following recommendations to the Attorney-General and Minister for Justice, Minister for Women and Minister for the Prevention of Domestic and Family Violence:

1. That the Queensland Government explore opportunities to improve service collaboration and the coordination of support provided to families, particularly children, bereaved by a domestic and family violence death. This should consider existing approaches to postvention support for those bereaved by suicide or homicide.

2. That the Queensland Government implement the recommended policy and practice reform proposed by Australia's National Research Organisation for Women's Safety (ANROWS) in its report *'Accurately identifying the "person most in need of protection" in domestic and family violence law'*.

   This should include creating guidance for police and courts on identifying the person most in need of protection that is informed by international models and approaches in other jurisdictions.

   Taking into account recent case law, this should also extend to the consideration of potential legislative amendments to strengthen existing provisions designed to ensure the identification of the person most in need of protection in proceedings under the *Domestic and Family Violence Protection Act 2012*.

3. That the Queensland Government explore the development of an approach to triage and case management for domestic and family violence cases before the Magistrates and District Courts to identify those that are complex, high risk, or that involve cross applications for protection orders. This should seek to ensure that all relevant evidence is available to inform judicial decision-making, beyond the information gathered by police at scene at a point of crisis.

   This approach should focus on identifying all relevant information and enable the gathering of additional information where gaps are identified to support judicial decision-making. It should also take into account what is known about systems abuse, and the inherent disadvantage that many victims of domestic and family violence face in their interactions with the justice system; as well as existing models operating in other jurisdictions or courts.

4. That the Queensland Government trial and evaluate the use of the *Domestic and Family Violence Capability Assessment Tool for Alcohol and Other Drug Settings* in alcohol and other drug treatment and harm reduction services in multiple trial sites across Queensland.

   This should include both government and non-government organisations with input from the peak body for alcohol and other drug services and domestic and family violence services within the trial sites.

5. That the Queensland Government commit to designing a model for a peak body for domestic and family violence services to further the objective of increased integration, and workforce development, undertake broader sector advocacy, and support the successful implementation of government policies and reforms.

6. That the Queensland Government explore trauma informed options to improve the accessibility, availability and acceptability of longer term supports for victims and their children beyond the point of crisis to support them to rebuild their lives. There should also be consideration of the longer term support needs of perpetrators of domestic and family violence to embed ongoing behavioural change and improve protective outcomes for victims and their children.

Section 1
Our foundations

Chapter 1: Understanding the journey

The Board is established under the Act to identify systemic issues, make preventative recommendations and increase awareness of the context in which domestic and family violence deaths occur.[3]

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

This chapter provides a brief summary of each of the cases reviewed by the Board within the 2020–21 reporting period to enhance understanding of the complex dynamics of domestic and family violence, and highlight the personal, familial, and community impact of these types of deaths.

In total, the Board reviewed the deaths of 12 women and men who died by homicide or apparent suicide in the context of domestic and family violence. Three deaths occurred in 2017, two in 2018, six in 2019, and one death occurred in 2020.

While distressing, these are stories of strength and resilience, often in the face of relentless and enduring violence. The courage of the victims in these cases should not go unacknowledged.

While the material may be confronting for some readers, the Board trusts that we can all learn from these tragedies to enhance our understanding.

Under section 91ZD of the Act, the Board is prohibited from publishing identifying details of cases.

As such, cases have been de-identified to protect the identities of the deceased and their loved ones. This means the full circumstances of the death and the nature of the relationship between the homicide offender and deceased have been removed.

Elisa

Elisa was a female in her late thirties who died by apparent suicide.

At the time of her death, Elisa had been in the process of separating from her partner of approximately four years, Norman. Elisa had experienced domestic and family violence in a prior relationship and several of her children had passed away in an accident.

Records in relation to Norman's abusive behaviours toward Elisa commenced around three months prior to the death. Although the domestic and family violence perpetrated by Norman toward Elisa was not disclosed to formal services until the days preceding her apparent suicide, according to Elisa's family, Norman perpetrated verbal, physical, sexual, emotional, and financial abuse toward Elisa throughout the course of their four-year relationship. These behaviours are said to have included attempts to isolate Elisa from her family and others; and using their child to control Elisa.

At the time of Elisa's death, there was a Police Protection Notice (PPN)[4] in place naming Norman as the respondent and Elisa as the aggrieved. This was made by police in the days before the death, following an episode of domestic and family violence whereby Norman physically intimidated and verbally abused Elisa. Norman then took their child away without Elisa's permission.

There is no information in any of the records to suggest that Elisa had expressed suicidal or self-harm ideation to services in proximity to the death.

3 *Coroners Act 2003 (Qld) s 91A.*

4 Section 101 of the *Domestic and Family Violence Protection Act 2012 (Qld)* enables a police officer to make a Police Protection Notice ('PPN') if certain conditions are met. A PPN is made when police attend a location where domestic and family violence is occurring or has occurred. A PPN requires the respondent to be of good behaviour towards the aggrieved and it 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.

Evelyn

Evelyn was an older female who died as a result of injuries sustained during a prolonged assault that included sexual violence perpetrated by her husband of several decades, Arthur.

There was a significant history of (unreported) domestic and family violence perpetrated by Arthur towards Evelyn that included verbal, emotional, physical, financial, and sexual abuse. Shortly before her death, Evelyn called police to report Arthur's violence for the first time. Police initially took no action in response to Evelyn's report of verbal abuse and non-lethal strangulation as they determined there was insufficient information to act. The responding officers left the address and Evelyn called police again a short time later due to Arthur's escalating abuse.

The same officers who attended the first call for service attended the address again the second time. On this occasion, police detained Arthur following further allegations of abusive behaviour perpetrated by him toward Evelyn, including verbal abuse and threats to damage property. Police conveyed Arthur to the watchhouse and issued him with a PPN. He was then released.

Evelyn was not provided with a copy of the PPN issued by police, nor was she notified of Arthur's release from custody or made aware that the information she disclosed to police regarding Arthur's violence would be provided to him (in the PPN).

On Arthur's return home, he fatally assaulted Evelyn.

Philip

Philip, a male in his late twenties, died by apparent suicide.

Philip had an extremely complex history that included problematic substance use from his early teens, significant ongoing mental health issues, as well as a history of repeated suicide attempts, and periods of incarceration.

Philip had a significant history of trauma and grew up in a violent household. He also had an extensive history of perpetrating domestic and family violence within his intimate relationships and exhibited a range of behaviours that are known to be associated with domestic and family violence lethality, including: threats to kill previous partners, prior suicide attempts, non-lethal strangulation, obsessive behaviour, sexual jealousy, and problematic substance use.

At the time of his death, Philip was subject to court ordered parole as a result of previous acts of non-lethal strangulation (among other charges). His current partner, Leah, was the victim of these offences.

In the 12 months prior to the death, Philip had contact with a range of generalist and specialist services including police, corrective services, court services and public and private health and mental health services. During this time, Philip continued to perpetrate domestic and family violence toward Leah that included verbal, emotional, physical and sexual abuse.

Approximately one month prior to Philip's death, his relationship with Leah broke down due to his ongoing violence and repeated allegations of infidelity.

Philip attempted suicide and a risk assessment was completed by Community Corrections. It was determined that an appropriate risk mitigation strategy would be to develop a safety plan to avoid further suicide attempts; monitor Philip's engagement with his psychologist; and direct Philip to have no contact with Leah.

Philip died by apparent suicide around a month later.

Amari

Amari, a male in his forties, died in an apparent suicide that followed the attempted homicide of his long-term partner, Hailey.

Amari had previously attempted suicide after seriously assaulting a former partner.

Records indicate that Amari exhibited coercive controlling behaviours towards Hailey including suicide threats; past suicide attempts; assaults with a weapon; and destruction of Hailey's property. He also exhibited multiple behaviours that are known indicators of domestic and family violence lethality, including minimisation or denial of his history of abuse; excessive alcohol use; sexual jealousy; and misogynistic attitudes.

Overall, police responded to around eight reported episodes of domestic and family violence in the three years prior to the death. Hailey was listed as the aggrieved on all occasions.

After the third call for service, police identified Hailey to be at risk of future harm; however, no further action was taken to protect her until the fifth time she called police to report Amari's violence.

On that occasion, Amari was intoxicated and verbally abused Hailey and threatened to damage her property. Police responded by making an application for a protection order naming Amari as the respondent and Hailey the aggrieved. The order was in place at the time of the death.

Records and witness statements suggest that Amari's use of violence was escalating in proximity to the attempted homicide-suicide. Hailey had tried to separate from Amari and had asked him to move out of the house. Amari refused to do so and threatened suicide in the context of separation, although this was not reported to services prior to the death.

On the day of his suicide, Amari waited for Hailey to fall asleep. He then repeatedly hit her in the head with an object and stabbed her multiple times. Hailey sustained serious, physical injuries. Amari then took his own life, with records indicating that he believed Hailey was dead.

Abigail

Abigail, an Aboriginal female in her thirties, was killed by her de-facto partner of two years, Tyler, who was also Aboriginal.

Tyler had a physical disability and Abigail was his carer at the time of her death. They both had extensive histories of family violence in multiple other relationships. While Tyler was identified as the primary perpetrator of violence toward Abigail and other members of his immediate family, Abigail's extensive history related to being a victim of violence in multiple former intimate partner and family relationships.

Tyler had a history of exhibiting destructive and threatening behaviours. He also exhibited verbal and physical abuse toward his parents, including threats to kill, assaults with weapons and destruction of property.

These episodes of violence usually occurred when Tyler was intoxicated.

Tyler's criminal history extended to other violent offences, including multiple counts of wilful damage and serious assault and one common assault.

Tyler was non-compliant with the conditions of any orders made against him. He had a significant history of breaching justice orders, particularly protection orders. In total, Tyler was convicted of 10 contraventions of protection orders.

Tyler stabbed and killed Abigail during an episode of domestic and family violence.

Stella

Stella, an Aboriginal female in her twenties, was killed by her de-facto partner, Ashton, who was also Aboriginal.

Stella and Ashton were in an intimate partner relationship for most of their adult lives, commencing when they were in their early teens (almost 15 years).

Ashton was violent towards Stella from the early stages of their relationship, with the known episodes of violence occurring during periods of intoxication (for Ashton). Ashton was shown to repeatedly use serious violence against Stella. This included emotional and physical abuse (including assaults with weapons), non-lethal strangulation and forced sexual acts/assaults toward Stella.

There was only one instance during their long-term relationship where Stella was recorded to have used physical violence against Ashton, when he confronted Stella after he became jealous about her having contact with another man. Stella allegedly became angry and slapped Ashton in the face and struck his chest several times.

Ashton had an extensive criminal history that comprised of multiple violent and sexual offences, break and enters and breach of justice orders including bail and protection orders. Ashton also had a significant history of perpetrating violence across numerous familial relationships and had a history of child sexual offending.

In the six months leading up to the death, Ashton physically assaulted Stella during at least one episode of violence.

At the time of Stella's death, Ashton was also subject to reporting requirements under the Child Protection Offender Register (CPOR).[5] He was also supervised by Community Corrections on a community-based order for violent offences perpetrated against Stella.

As a condition of his community-based order, Ashton was mandated to attend a three-day Alcohol, Tobacco and Other Drugs Services (ATODS) program to address his problematic alcohol use; however, he only attended one day.

Ashton was also mandated to attend a men's behavioural change program. He successfully completed this program a week before he killed Stella.

Aiden

Aiden, a male in his fifties, died in an apparent suicide following the attempted homicide of his estranged wife, Charlotte.

Aiden and Charlotte had been together for more than a decade. Records indicate that their relationship was characterised by domestic and family violence, with violence perpetrated by both parties. Aiden also had a significant history of perpetrating domestic and family violence against other members of his family. This involved multiple episodes of violence against his stepchildren, a partner of his stepchild, and towards his own son.

Records indicate that Aiden engaged in coercive controlling behaviours towards Charlotte, such as monitoring her shopping and expenditure and constantly interrogating Charlotte about her movements and who she spent time with. Charlotte described Aiden as a controlling, jealous and aggressive person.

Aiden was diagnosed with severe alcohol dependence and mental health issues. He had a criminal history in Queensland and interstate in relation to perpetrating physical and sexual violence against others, including within his intimate partner and family relationships.

Across relationships, Aiden exhibited numerous behaviours that are known indicators of high risk domestic and family violence lethality, including verbal abuse; physical assaults; threats to kill his estranged son and burn his house down; threats to kill an ex-partner; and threats to damage property.

At the time of the attempted homicide-suicide, a protection order was in place naming Aiden as the aggrieved and

5 An Australian Child Protection Offender Reporting scheme was established by legislation in each Australian State and Territory. The Queensland component of the scheme, the Child Protection Offender Registry (CPOR) was established under the *Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004* (Qld).

Charlotte as the respondent. The order was made by police following an episode of violence that involved Charlotte stabbing Aiden with a knife during a '*verbal argument*'; though no further details were recorded in relation to this event, or the context of the argument.

Shortly before the attempted homicide-suicide, Charlotte separated from Aiden. When she ended their marriage, Aiden became increasingly obsessive, his drinking escalated, and he continued to contact Charlotte, refusing to accept that their relationship was over.

On the day of his suicide, Aiden waited for Charlotte to return home and then violently assaulted her with an object. Aiden non-lethally strangled Charlotte and then took his own life, with records indicating that he believed Charlotte was dead.

Hugo

Hugo, an Aboriginal male in his twenties, died in an apparent suicide. Six months prior to his death, Hugo separated from his partner of four years, Mia, who was also Aboriginal.

During their relationship two protection orders were granted, both naming Mia as the aggrieved and Hugo as the respondent. The second order was current when Hugo died, and their three children were named on that order.

Hugo had a history of perpetrating family violence against Mia that included threatening suicide, hitting Mia with objects, punching her and slamming her head into the ground. These episodes of violence were often witnessed by their children. Hugo also had a history of perpetrating violence across numerous familial relationships.

At the time of Hugo's death, he was supervised by Community Corrections on a parole order. Hugo was released from custody to community supervision shortly before his death, for offences relating to assaulting a family member and two contraventions of the protection order.

In the lead up to the death, Hugo reported to his Community Corrections officer that he was in a new relationship and that it was causing hostility between himself and Mia.

On the day of his death, Hugo reportedly had an argument about Mia with his new partner. He died by suicide shortly afterwards.

Felicity

Felicity, a Maori woman in her forties, died in an apparent suicide.

In the two years before her death, Felicity had extensive service system contact in relation to her experiences of domestic and family violence, polysubstance use, mental health diagnoses, and suicidal ideation/attempts. This included contact with police, specialist domestic and family violence services, and multiple public and private health and mental health services.

At the time of her death, Felicity was married to her partner of several years, Cameron. Records indicate that Cameron engaged in problematic alcohol use and that he was physically, financially, verbally, and emotionally abusive towards Felicity.

At the time of the death, there was a protection order in place requiring Cameron (respondent) to be of good behaviour toward Felicity (aggrieved). The order was made by police following an episode of domestic and family violence whereby Cameron was aggressive toward Felicity. In fear of Cameron, Felicity locked herself in her bedroom and called police.

A few months before her death, Felicity attempted suicide following an episode of domestic and family violence that involved Cameron verbally abusing and berating Felicity for seeking help for her substance use.

Following her suicide attempt, Felicity contacted a domestic and family violence service for support, with records indicating that she was attempting to leave Cameron. She also sent text messages to a friend, which detailed Cameron's escalating emotional, verbal and physical abuse.

Felicity died by apparent suicide shortly after she attempted to separate from Cameron and he sexually assaulted her.

Sandra

Sandra, a female in her fifties, died in an apparent suicide.

Sandra and James had been in a relationship for around three years.

In the year before her death, Sandra had contact with different services in relation to mental health issues (depression and anxiety) and suicidal ideation and attempts. However, there was a limited reported history of domestic and family violence until the week before her death.

Three days prior to her death, police attended an episode of domestic and family violence whereby James non-lethally strangled Sandra.

In response, police issued a PPN to protect Sandra (aggrieved) from James (respondent). Sandra advised police that she wished to pursue criminal charges against James in relation to the non-lethal strangulation, but this was not actioned by officers at the time.

On the day prior to her death, Sandra attended her general practitioner (GP) and disclosed that she had been assaulted and non-lethally strangled by James two days before, and that she was still experiencing pain in her neck. Sandra's GP did not refer her to a domestic and family violence service for support, or to hospital for further examination.

Later that day, Sandra called police and reported that James had threatened to kill her. James denied the allegation and stated that Sandra had clenched her fists at him. Police took no further action and the matter was finalised, with James recorded as the aggrieved and Sandra the respondent.

Sandra was encouraged to contact police if further episodes of violence occurred, but she questioned, '*what's the point?*' Sandra referred to the PPN in place to protect her, stating that she had already been told to call police again '*if he threatened me and I've done that*'.

Within the context of the lack of police response to the apparent breach, Sandra expressed suicidal ideation. This was not assessed or addressed by the responding officers and this was Sandra's last contact with services prior to her death by suicide the following day.

Melanie

Melanie, a New Zealand woman in her forties, died in an apparent suicide.

Melanie and Mitch were in a relationship for more than a decade and had two children together.

Melanie separated from Mitch in the year before her death due to ongoing domestic and family violence that included physical, verbal, emotional, financial, and sexual abuse.

Mitch told Melanie that he was going to punish her for ending the relationship and he took their children and Melanie's pets. He then moved interstate without Melanie's permission, isolating her from her children. Records indicate that this was a cause of significant stress to Melanie, who experienced escalating depression, anxiety, and suicidal ideation.

While it appears that both parties used violence, including at times physical violence, records indicate that Mitch was the primary perpetrator of domestic and family violence in the relationship.

Melanie's use of violence related to name calling and verbal abuse in the context of her concerns for the welfare of the children, and in response to coercive controlling behaviours being perpetrated against her by Mitch.

Mitch engaged in systems abuse and impression management. He frequently used legal and criminal justice agencies to further control and punish Melanie. For example, on one occasion Mitch taunted Melanie and then filmed her lunging at him, which framed Melanie as the primary perpetrator of violence in the relationship.

Melanie died by suicide after Mitch refused to allow her to see or speak with her children for months.

Elizabeth

Elizabeth was a female in her early twenties who died by an apparent suicide. Elizabeth moved to Queensland from another state shortly before her death to be with her partner, Chris, who was significantly older than her.

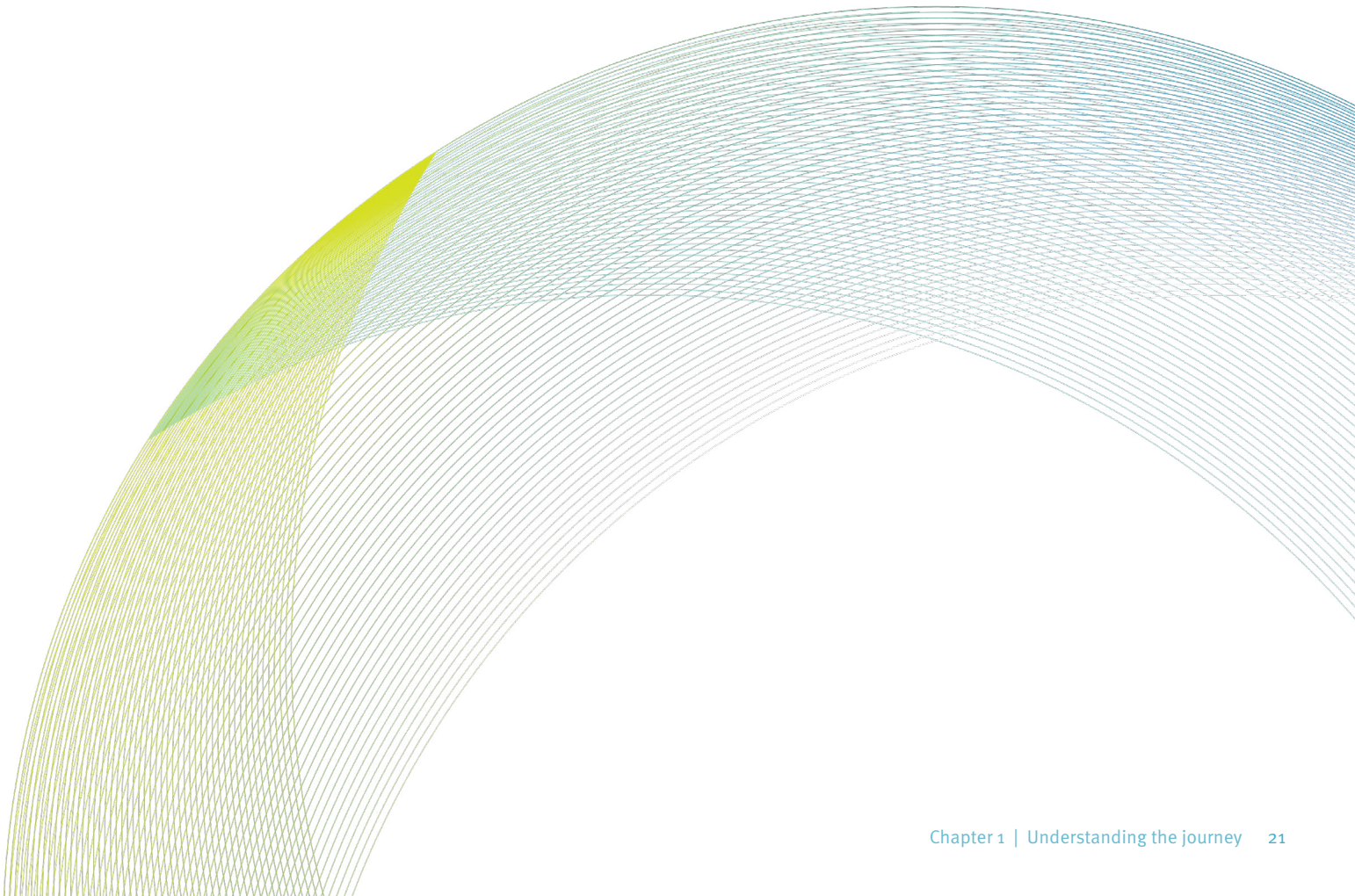
There was a limited documented history of domestic and family violence for the couple in Queensland, though witness statements from Elizabeth's friends and family indicate that Chris was physically, verbally, and emotionally abusive towards Elizabeth and that his violence would escalate when under the influence of 'ice'.

Shortly after moving to Queensland, Elizabeth separated from Chris because of his abusive behaviours.

There was only one documented report of domestic and family violence in Queensland between the couple. Approximately one month before her death, Elizabeth reported Chris' violence to police and explained that he had been making threats to '*ruin*' her family and assault her male friend.

Police advised Elizabeth that they needed to speak with Chris before determining whether to apply for a protection order. Elizabeth expressed concerns that this would make matters '*worse*', stating that she would wait a few days and think about what she wanted to do. Police did not obtain Chris' version of events and no further action was taken by police in response to Elizabeth's report. This was Elizabeth's last contact with formal services prior to her death.

Witness statements indicate that Elizabeth had a history of self-harming behaviour, but there is no information to suggest this was reported to formal services in Queensland or that she disclosed suicidal ideation in the lead up to her death.



Chapter 2: Understanding the data

Key findings

- Between 1 July 2006 and 30 June 2021, there were 375 domestic and family violence homicides in Queensland. This includes 346 women, children and men who were killed by a family member or by someone they were, or had been, in an intimate partner relationship with. An additional 29 collateral homicides occurred during this time.
- There were 41 homicide-suicide events in Queensland between 1 July 2006 and 30 June 2021, resulting in 53 deceased.
- Males were the homicide offender in 76.5% of all domestic and family violence homicides, including collateral homicides.
- Aboriginal peoples and Torres Strait Islander peoples were significantly over-represented as deceased in homicides within an intimate partner or family relationship.
- For homicides in a family relationship, children aged less than four years represented the highest number of deaths (by age category).
- Between 1 July 2015 to 30 June 2021, a total of 280 apparent or suspected suicides were also identified as being domestic and family violence related.
- Of all apparent domestic and family violence suicide cases, 87.5% occurred in the context of intimate partner violence and the remaining 12.5% occurred in the context of family violence.
- Men who had a history of violence perpetration were over-represented in the domestic and family violence related suicides, which reflects the overall pattern of suicide deaths more broadly, with males being significantly over-represented, at a ratio of 3:1.
- Comparative to other death types, actual/pending relationship separation and/or the presence of a protection order at time of death was more likely to be present in both intimate partner homicides, and intimate partner violence suicides.

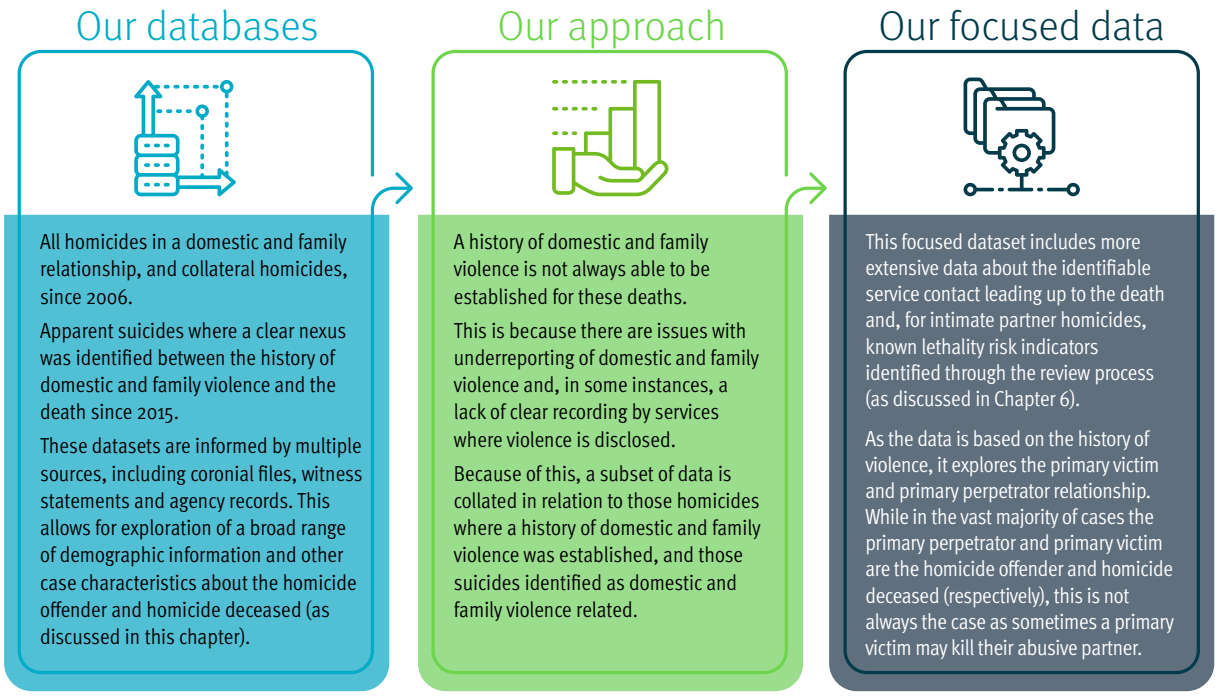
In accordance with section 91D of the Act, the Board is required to analyse data and apply research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland.

This chapter provides a statistical overview of homicides and homicide-suicides that have occurred in an intimate partner or family relationship, as well as collateral[6] homicides, in Queensland since 1 July 2006. It also includes data about domestic and family violence suicides that have occurred in Queensland since 1 July 2015. A range of demographic characteristics and key trends identified by the Board are also explored.

Chapter 6 outlines the known history of service system contact and identifiable risk factors for a sub-sample of homicides and suicides where a history of domestic and family violence was able to be established. In considering this data, Board members acknowledged the need to better understand and share data across systems and consider how it can be utilised to inform system responses and improvements.

The Queensland Domestic and Family Violence Homicide and Suicide Databases draw upon information obtained as part of coronial investigations and reviews completed by the Board. These databases contain information on all domestic and family violence homicides that have occurred in Queensland since 2006, and domestic and family violence suicides since 2015. This information includes demographic characteristics as well as the prior identifiable history of domestic and family violence, known service system contact and identified risk factors prior to the death/s.

As the databases include information from open and finalised coronial investigations, it is subject to change as new information is obtained as part of a coronial investigation or the Board's review. Information coded about a particular case will vary dependent on the availability of records and reported history of violence. Given the known underreporting of domestic and family violence, homicide data is reported on those deaths that have occurred in a relevant relationship in this chapter, and separately in Chapter 6 for those cases where a history of domestic and family violence was able to be established. This accords with the nationally agreed approach to data collation and reporting of these deaths, as outlined within the *Australian Domestic and Family Violence Death Review Network Homicide Consensus Statement*.



6 Collateral homicides include the death of a person who may have been killed intervening in an episode of domestic and family violence or a new partner who was killed by their current partner's abusive former spouse.

Homicides in a domestic and family relationship

Between 1 July 2006 and 30 June 2021, there were a total of 375 domestic and family violence homicides in Queensland. This includes 346 women, children and men who were killed by a family member or by someone they were, or had been, in an intimate partner relationship with. A further 29 collateral homicides also occurred in this period.

As shown in Figure 1, there were 186 intimate partner homicides, 160 family homicides, and 29 collateral homicides in Queensland between 1 July 2006 and 30 June 2021.

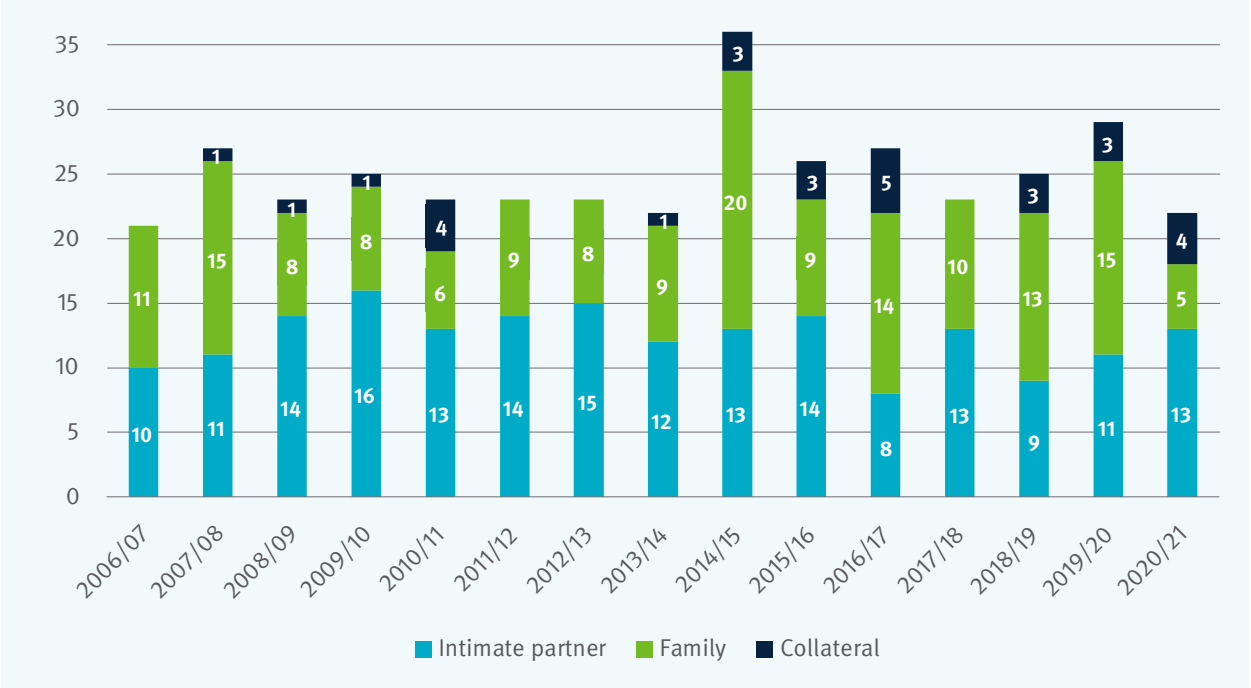


Figure 1. Homicides in a domestic and family relationship (2006–07 to 2020–21)

Of the 375 homicides in a domestic and family relationship in this time period, females were the homicide deceased in 58.1% (218 of 375) of cases and males were the homicide deceased in 41.9% (157 of 375) of cases. While this appears to be an approximately equal sex distribution, as per Figure 2, there were significant differences in the sex of the deceased in intimate partner homicide cases, compared to family and collateral homicide cases:

- for intimate partner homicides, females were the homicide deceased in 75.8% (141 of 186) of cases and males were the homicide deceased in 24.2% (45 of 186) of cases.
- for homicides in a family relationship, females were the homicide deceased in 46.9% (75 of 160) of cases and males were the homicide deceased in 53.1% (85 of 160) of cases.
- for collateral homicides, females were the homicide deceased in 6.9% (2 of 29) of cases and males were the homicide deceased in 93.1% (27 of 29) of cases.

Of the homicide deceased in a family relationship, 55.6% (89 of 160 cases) were children. This means that almost one-quarter (23.7%) of domestic and family violence homicides in Queensland were homicides of children who were killed by a parent or caregiver (filicide). Of this number, 49.4% (44 of 89 cases) were male children and 50.6% (45 of 89 cases) were female children.

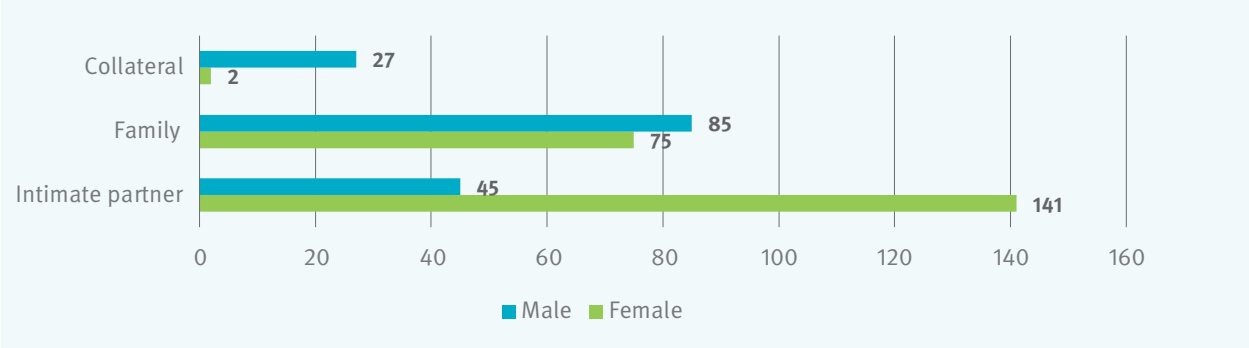


Figure 2. Homicides in a domestic and family relationship by type and sex of deceased (2006–07 to 2020–21)

The youngest homicide deceased was aged less than four years, and the eldest was older than 85. As shown in Figure 3, most intimate partner homicide deceased were between the ages of 25-44 years at the time of their death. For homicides in a family relationship, children aged less than four years represented the highest number of deaths.

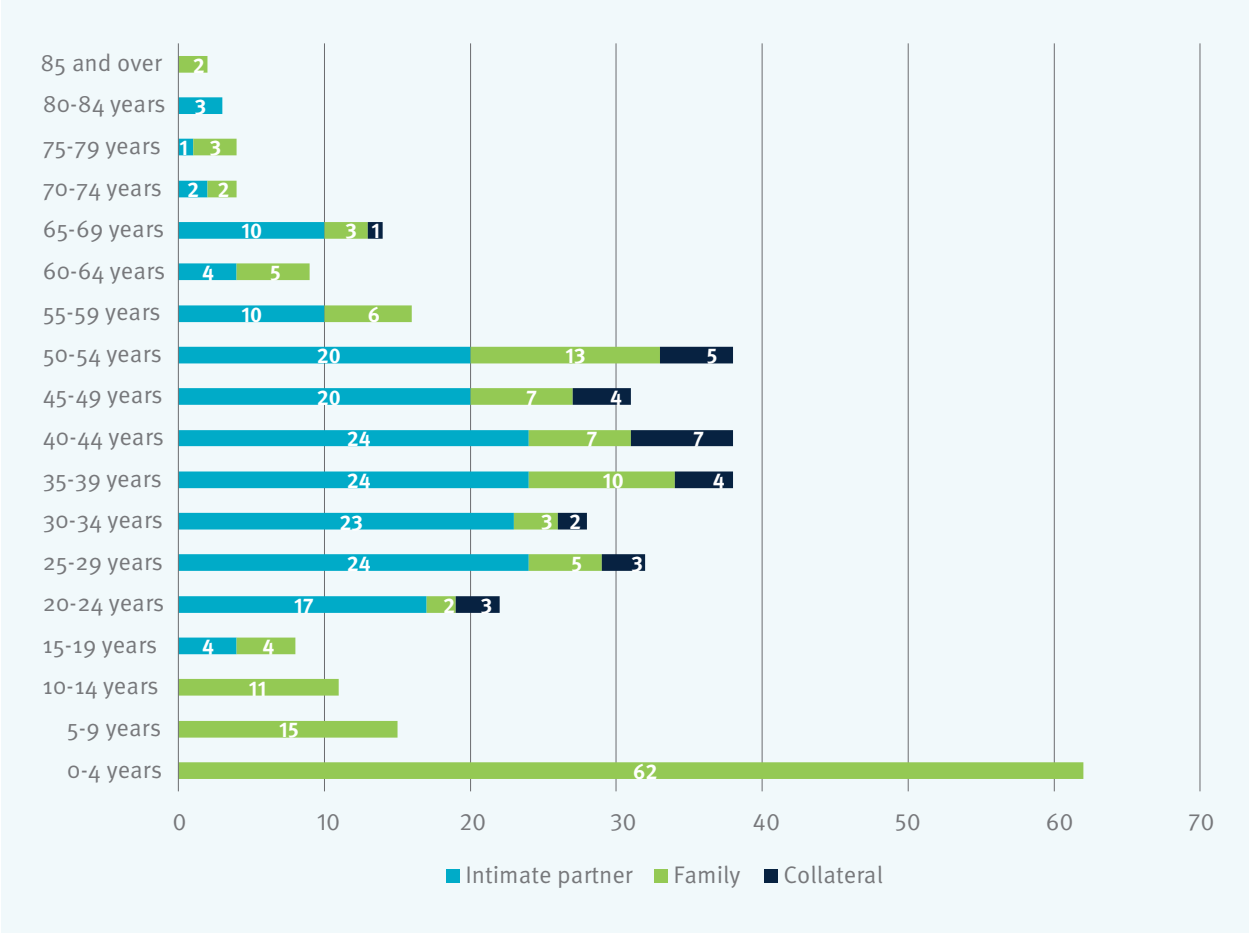


Figure 3. Homicides in a domestic and family relationship by type and age of deceased (2006–07 to 2020–21)

As shown in Figure 4, in 21.5% (76 of 353) of all homicides in a domestic and family relationship where cultural background could be identified[7] (353 of 375), the homicide deceased identified as Aboriginal and/or Torres Strait Islander.

Where cultural background could be identified, Aboriginal peoples and Torres Strait Islander peoples represented 20.3% of intimate partner homicide deceased (35 of 172) and 22.9% of family homicide deceased (36 of 157).

There were also 47 domestic and family violence homicides where the deceased identified as culturally and linguistically diverse, representing 13.3% (47 of 353) of all homicides in a domestic and family relationship in Queensland where cultural background was identifiable.

	Intimate partner	Family	Collateral	Total
Aboriginal	32	23	5	60
Torres Strait Islander	0	11	0	11
Aboriginal and Torres Strait Islander	3	2	0	5
Culturally and linguistically diverse	23	21	3	47
Non-Indigenous and non-culturally and linguistically diverse	114	100	16	230
Total	172	157	24	353

Figure 4. Homicides in a domestic and family relationship by cultural background of deceased (2006–07 to 2020–21)

As shown in Figure 5, of the 375 homicides in a domestic and family relationship between 2006–07 and 2020–21, males were the homicide offender in 76.5% (287 of 375) of cases and females were the homicide offender in 23.5% (88 of 375) of cases. Males were over-represented as the homicide offender in all domestic and family violence homicides:

- for intimate partner homicides, males were the homicide offender in 78.5% (146 of 186) of cases and females were the homicide offender in 21.5% (40 of 186) of cases.
- for homicides in a family relationship, males were the homicide offender in 71.2% (114 of 160) of cases and females were the homicide offender in 28.8% (46 of 160) of cases. In 6.3% (10 of 160) of cases, both a male and female were charged in connection with the death.
- for collateral homicides, males were the homicide offender in 93.1% (27 of 29) of cases and females were the homicide offender in 6.9% (2 of 29) of cases.

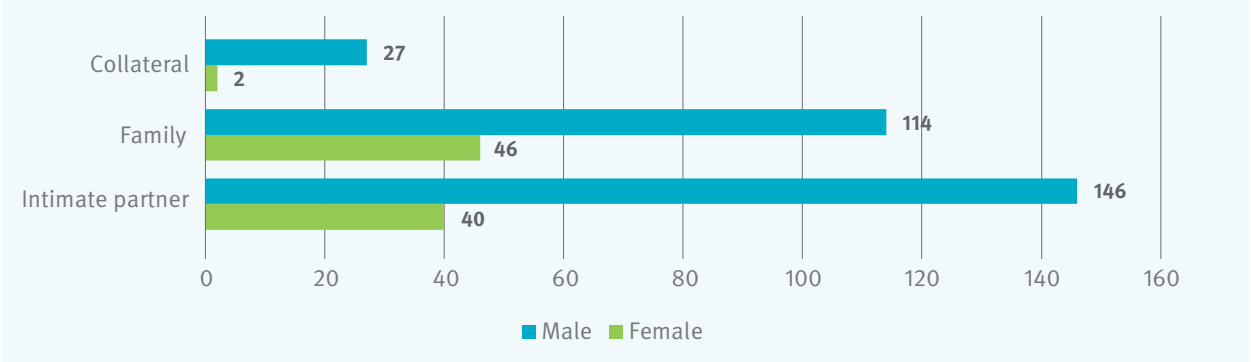


Figure 5. Homicides in a domestic and family relationship by type and sex of homicide offender (2006–07 to 2020–21)

7 Given the nature of the information available, it is not always possible to identify the cultural identity of the person that has died. At the time of the publication of this report, this information was not available in 22 cases. There are greater data gaps in relation to the cultural background of the homicide offender which is why it is not presented in this report.

Between 1 July 2006 and 30 June 2021, there were 93 intimate partner homicides involving a female deceased where a history of domestic and family violence was able to be established. Of these cases, the female homicide deceased was identified as the primary victim of violence in 99% (92 of 93) of cases and was identified as the primary perpetrator of violence in 1% (1 of 93) of cases.

Between 1 July 2006 and 30 June 2021, there were 30 intimate partner homicides involving a male deceased where a history of domestic and family violence was able to be established. The male homicide deceased was identified as the primary perpetrator of violence in 100% (30 of 30) of these cases.

As shown in Figure 6, most intimate partner homicide offenders were aged 25-44 years at the time of the homicide event. For homicides in a family relationship, the most common age for homicide offenders was slightly younger at 25-39 years of age.

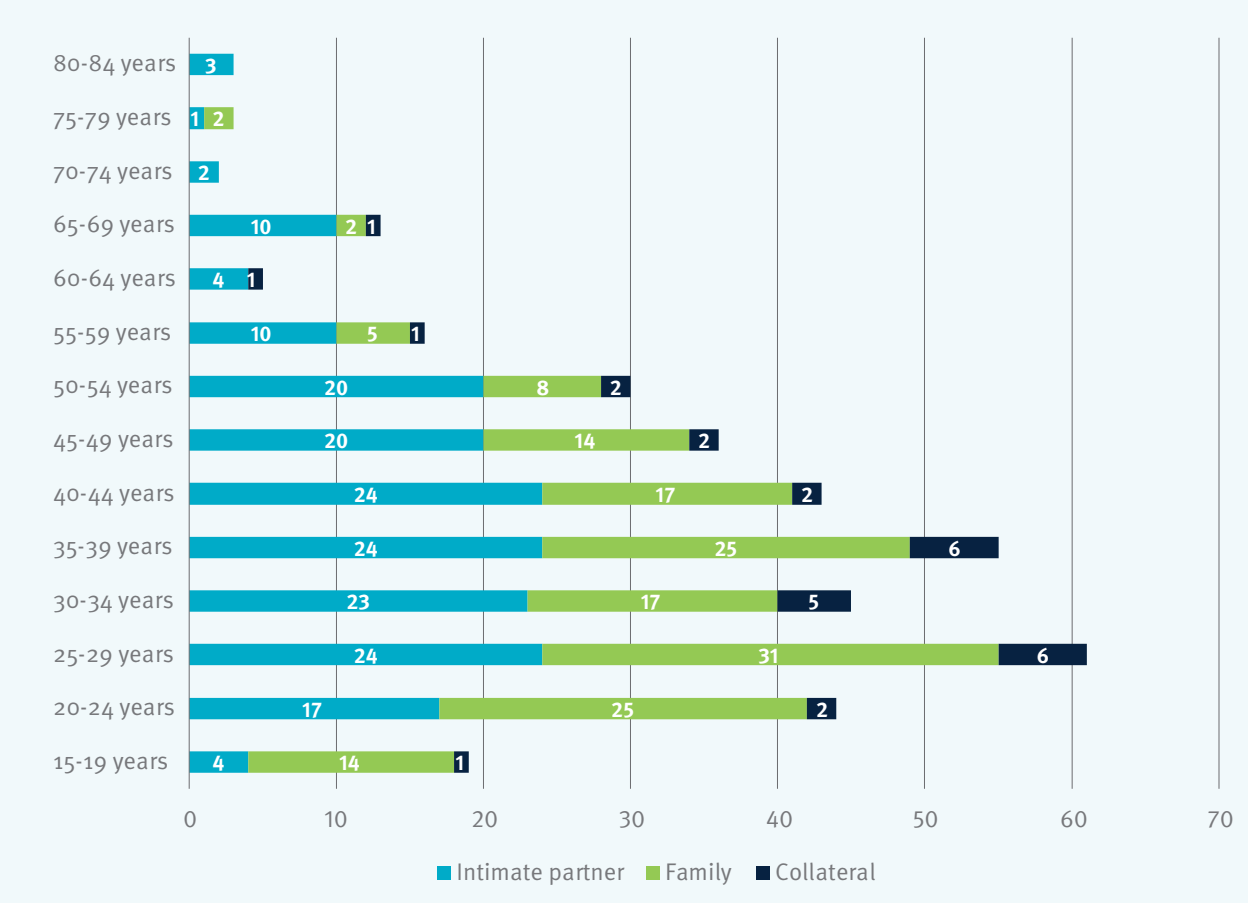


Figure 6. Homicides in a domestic and family relationship by type and age of homicide offender (2006–07 to 2020–21)

Homicide-suicides in a domestic and family relationship

A homicide-suicide is defined as a homicide that is followed by the suicide of the homicide offender, generally within one week of the homicide event.

Between 1 July 2006 and 30 June 2021, there were 41 homicide-suicide events in Queensland, which equated to 53 homicide deceased.

As shown in Figure 7, this included 27 intimate partner homicide-suicides, 25 family homicide-suicides, and one collateral homicide-suicide in Queensland.

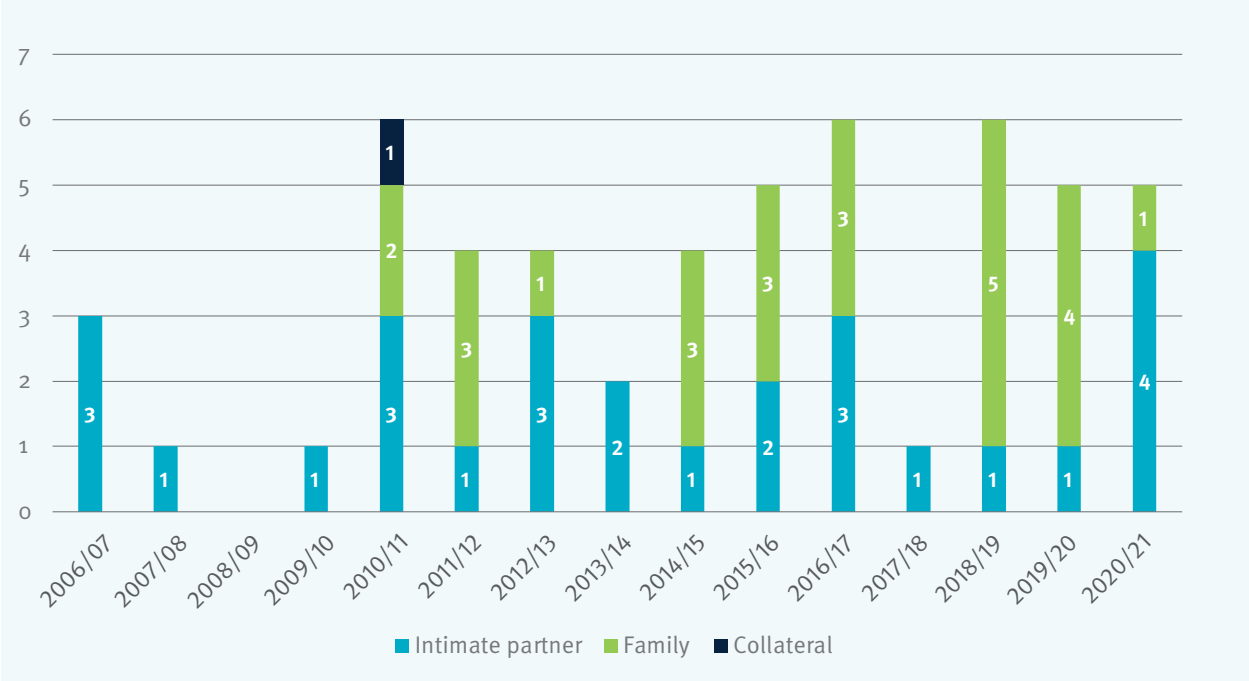


Figure 7. Homicide-suicides in a domestic and family relationship (2006–07 to 2020–21)

Of the 53 people who died by homicide-suicide in a domestic and family relationship during this 15-year period, males were the homicide deceased in 15 cases and females were the homicide deceased in 38 cases.

For intimate partner homicide-suicides, females were disproportionately the homicide deceased and males the homicide offender (as per Figure 8 and Figure 9, respectively).

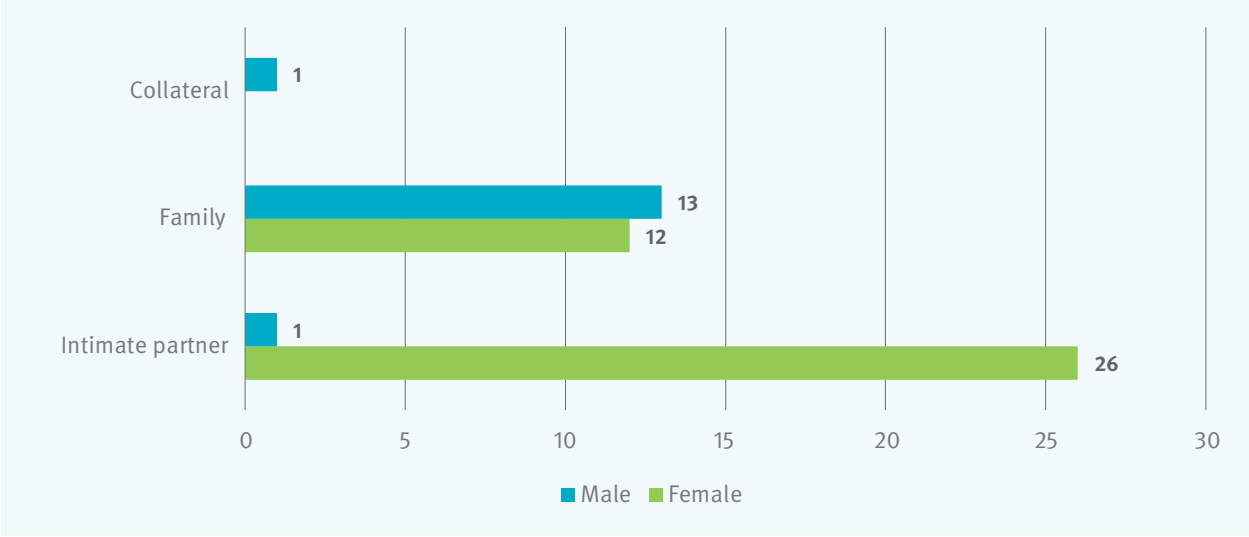


Figure 8. Homicide-suicides in a domestic and family relationship by type and sex of homicide deceased (2006–07 to 2020–21)

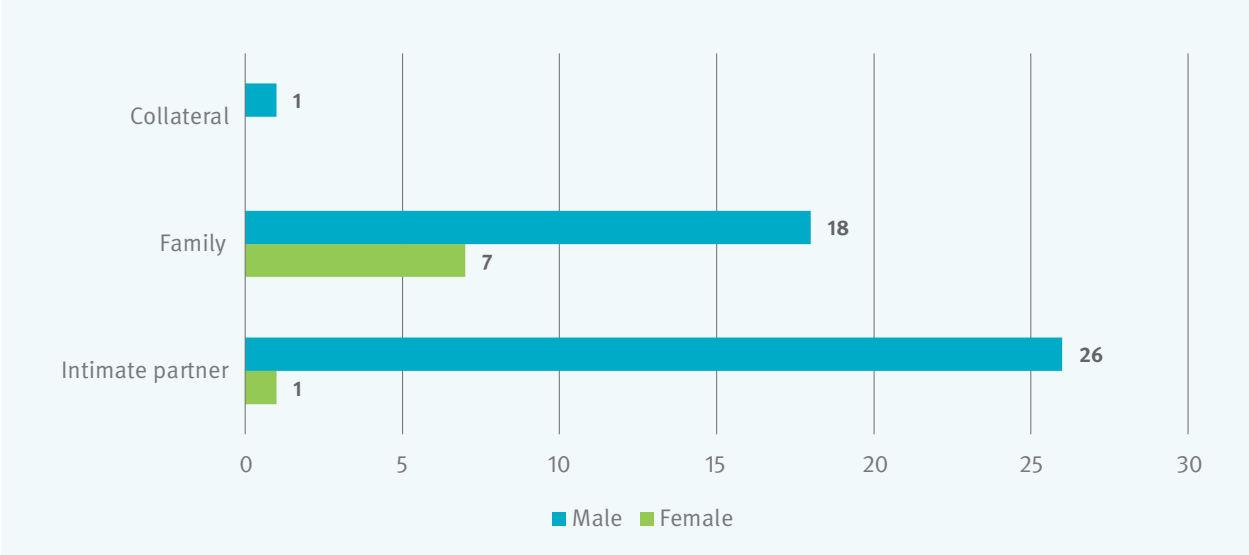


Figure 9. Homicide-suicides in a domestic and family relationship by type and sex of offender (2006–07 to 2020–21)

As shown in Figure 10, the most common age range for intimate partner homicide-suicide deceased was 45-49 years of age. For homicide-suicides in a family relationship, children aged less than four years represented the highest number of these deaths.

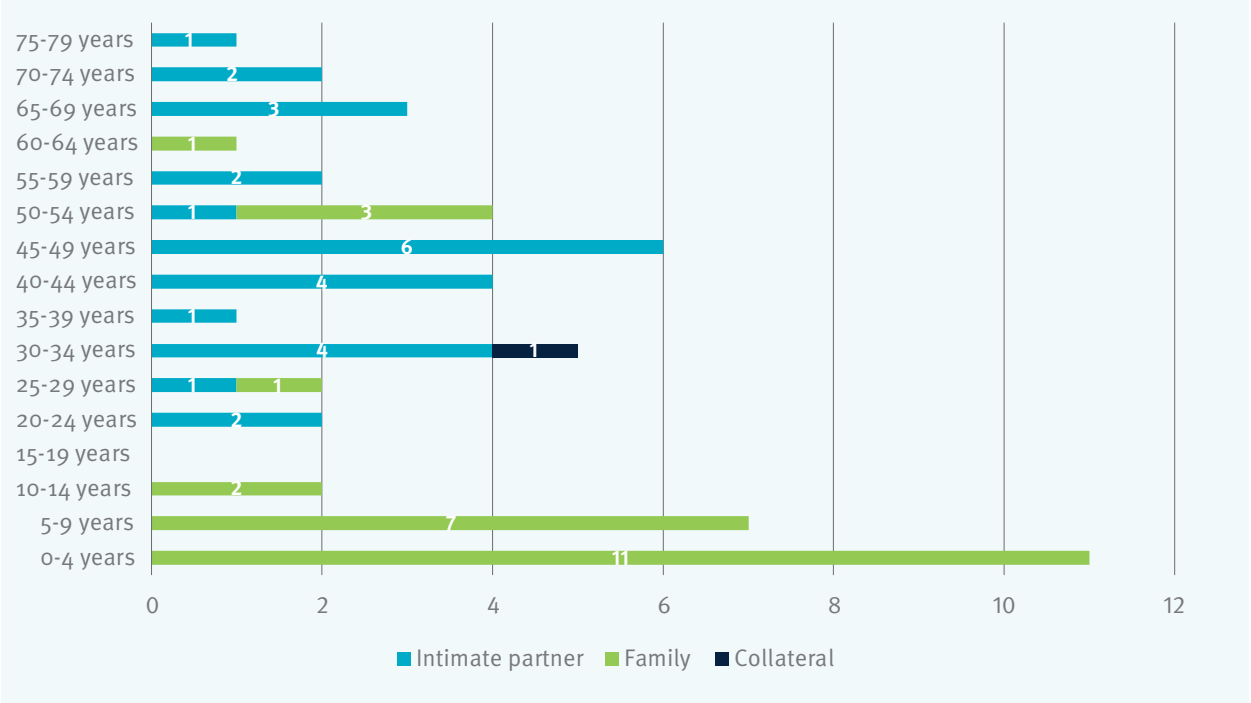


Figure 10. Homicide-suicides in a domestic and family relationship by type and age of deceased (2006–07 to 2020–21)

As shown in Figure 11, the average age for intimate partner homicide-suicide offenders was between 40-49 years. Most homicide-suicide offenders in a family relationship were aged between 35-39 and 45-49 years.

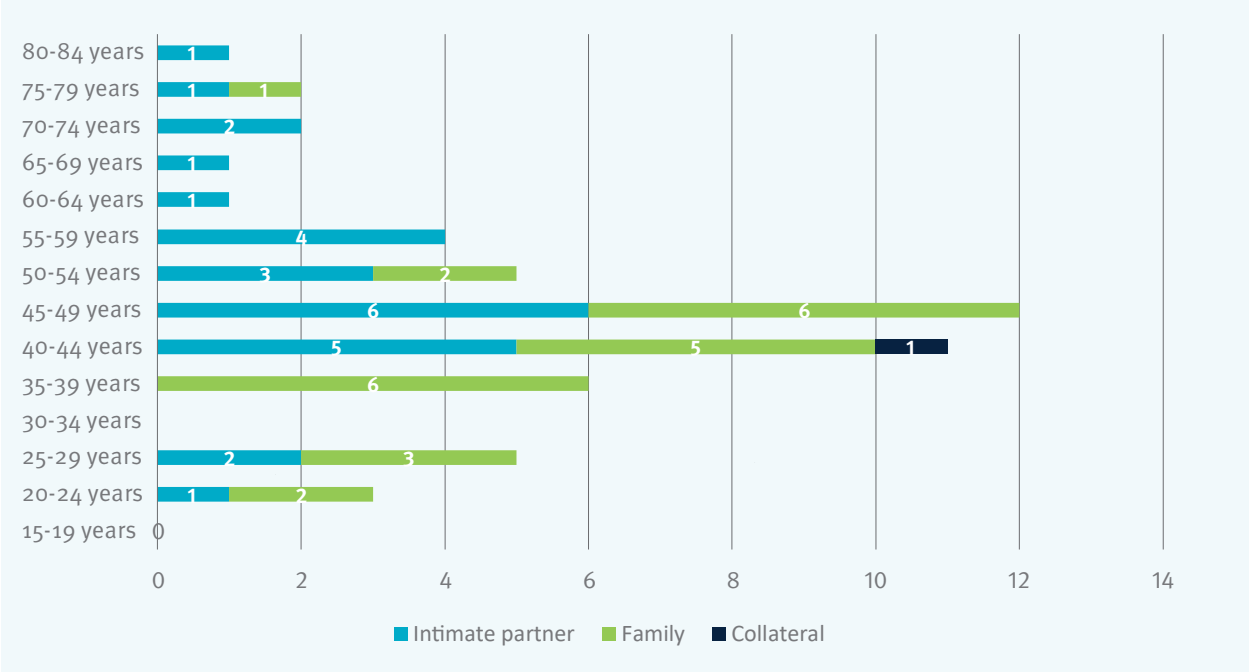


Figure 11. Homicide-suicides in a domestic and family relationship by type and age of offender (2006–07 to 2020–21)

Other case characteristics

A history of domestic and family violence was able to be established in 55.2% (191 of 346) of all homicides in a domestic and family relationship between 1 July 2006 and 30 June 2021. This number excludes collateral homicides as, by their nature, there is no relevant relationship between the homicide offender and the homicide deceased.

This is a preliminary figure as an underlying history of violence may become more apparent as a full review of a death is undertaken and more information becomes available (e.g. from agency records, witness statements and police briefs of evidence). Due to the known underreporting of domestic and family violence, it is also acknowledged that these figures are likely to be under-representative of the actual prior history.

It is for this reason that a more focused analysis of this data is undertaken in Chapter 6, which outlines the known service system contact for a subset of the domestic and family violence homicides and suicides where a prior history was able to be established. The presence of known intimate partner homicide lethality risk indicators is also discussed in that chapter.

For those cases where a history of domestic and family violence was able to be established, information is collated about known case characteristics or risk factors, including relationship separation or the presence of a protection order.

As outlined in Figure 12, separation was more prevalent within intimate partner homicides than those that occurred in a family relationship.

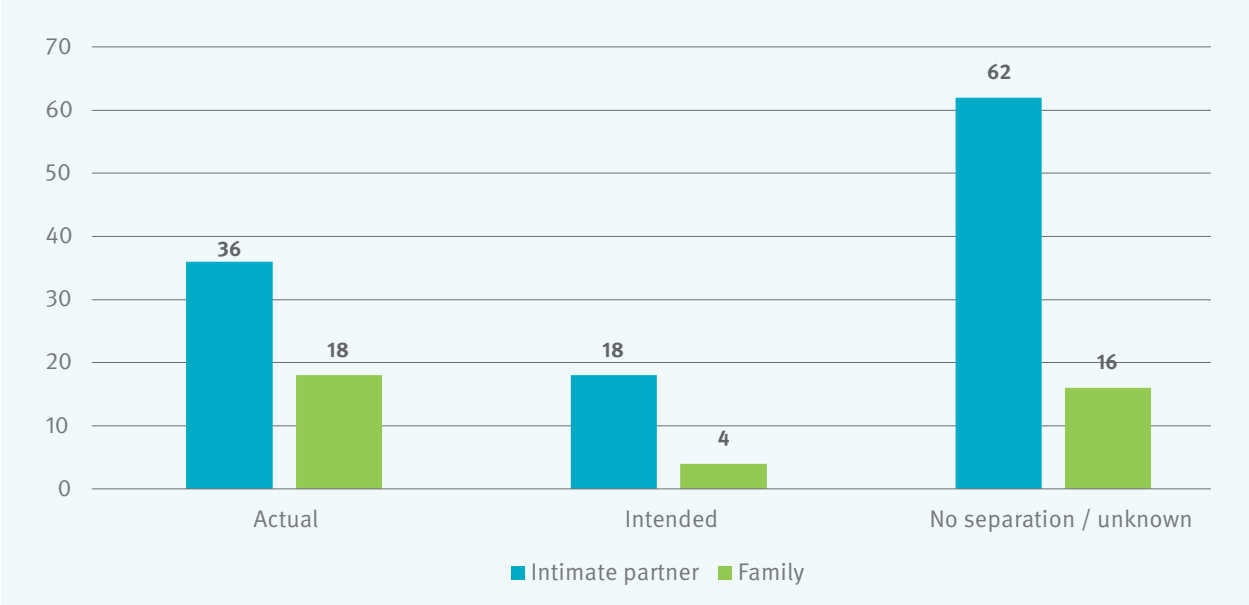


Figure 12. Presence of separation in homicides with a documented history of domestic and family violence (2006–07 to 2020–21)

In 34% (65 of 191) of the homicide cases with a documented history of domestic and family violence that occurred between 1 July 2006 and 30 June 2021, a protection order was in place at the time of the death. As shown in Figure 13, a protection order was in place at the time of the death in 39% (46 of 118) of intimate partner homicides and 26% (19 of 73) of homicides within a family relationship.

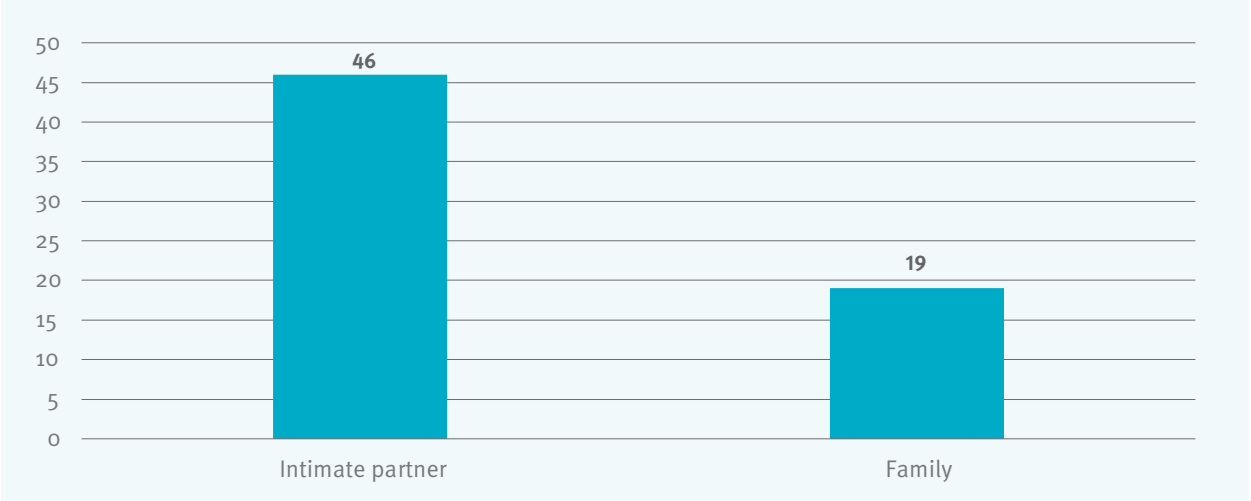


Figure 13. Presence of a protection order in intimate partner and family homicides with a documented history of domestic and family violence (2006–07 to 2020–21)

As shown in Figure 14, for intimate partner homicides, female deceased were the aggrieved on a protection order in 60.9% (28 of 46) of cases where there was a documented history of domestic and family violence. In 8.7% (4 of 46) of these cases the male deceased was recorded as being the aggrieved and in another eight cases cross orders were in place.

	Male	Female	Total
Aggrieved	4	28	32
Respondent	5	1	6
Cross orders	5	3	8
Named person	0	0	0
Total	14	32	46

Figure 14. Presence of a protection order in intimate partner homicides with a documented history of domestic and family violence by sex of deceased (2006–07 to 2020–21)

As shown in Figure 15, in 26% (19 of 73) of homicides in a family relationship (including filicides), a protection order was in place at the time of the death. All named persons were children, which means 15 children died by homicide while an order was in place to protect them.

	Male	Female	Total
Aggrieved	2	1	3
Respondent	1	0	1
Cross orders	0	0	0
Named person	9	6	15
Total	12	7	19

Figure 15. Presence of a protection order in family homicides with a documented history of domestic and family violence by sex of deceased (2006–07 to 2020–21)

Domestic and family violence suicides

As outlined in section 91B of the Act, a suicide or apparent suicide of a person who was, or had been, in a relevant relationship with another person that involved domestic and family violence is considered a domestic and family violence death.

The Queensland Domestic and Family Violence Suicide Database is a register of all apparent suicide cases where a *clear link* has been established between the deceased's history of domestic and family violence and their self-inflicted death. It is recognised that there are likely to be other cases where this nexus was not able to be established in the information available for review.

Similar to domestic and family homicides, this data is subject to revision as more information becomes available as part of the review of these deaths.

Refinements to the case identification and data collection processes continued in 2020–21 that resulted in revised case numbers from previous reports.

While there appears to be an increased number of domestic and family violence suicides in recent years (as per Figure 16), this may be associated with improvements in the case identification process, or general increases in the reporting of domestic and family violence within Queensland, and not reflective of an actual increase in these types of deaths.

Apparent domestic and family violence suicides include suicides of perpetrators and victims of domestic and family violence, and the suicides of children and young people who were exposed to domestic and family violence in an intimate partner or family relationship.

From 1 July 2015 to 30 June 2021, there were 280 apparent domestic and family violence suicides recorded in Queensland.

As per Figure 16, 87.5% of apparent domestic and family violence suicides occurred in the context of intimate partner violence (245 of 280), and the remaining 35 cases (12.5%) occurred in the context of family violence.

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'.

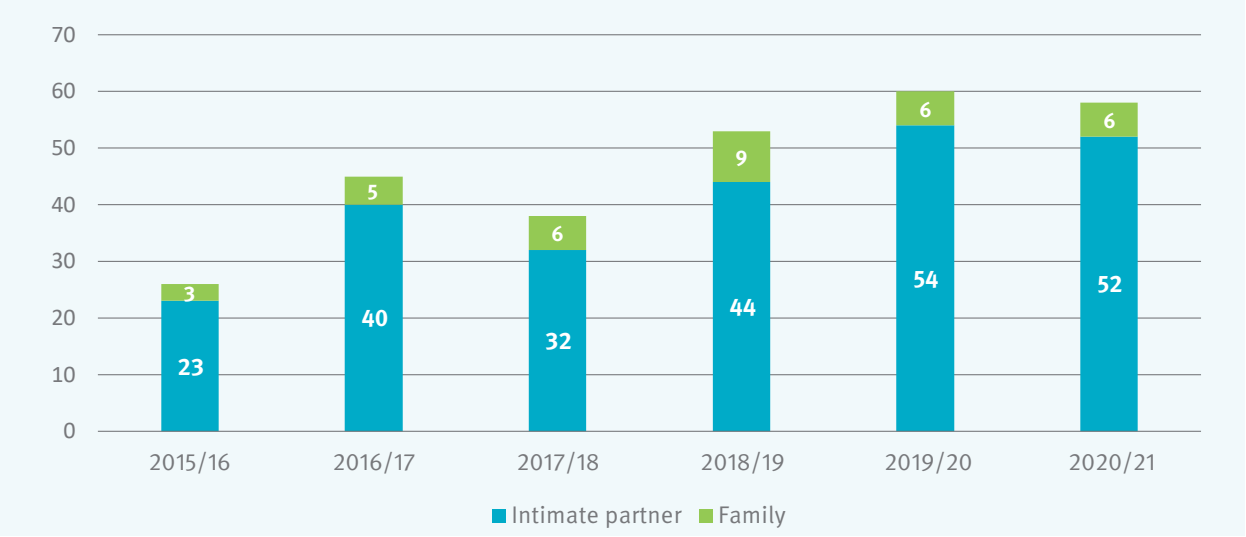


Figure 16. Apparent domestic and family violence suicides by relationship type (2015–16 to 2020–21)

As shown in Figure 17, 81.1% (227 of 280) of domestic and family violence suicides involved a male deceased, and the remaining 18.9% (53 of 280) involved a female deceased. This reflects the overall pattern in suicide deaths more broadly, in which males are significantly over-represented, at a ratio of 3:1.[8]

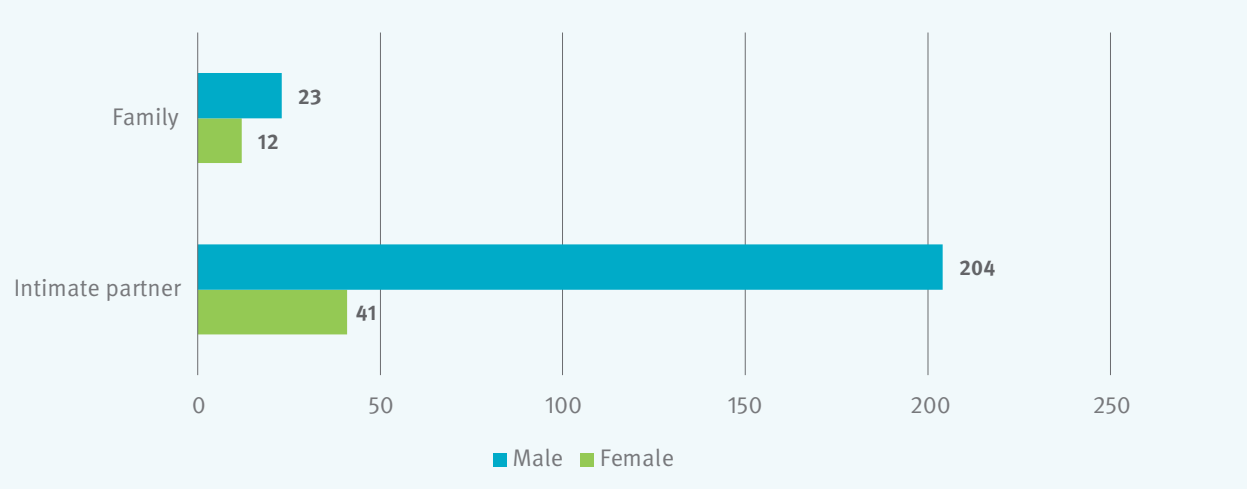


Figure 17. Apparent domestic and family violence suicides by relationship type and sex (2015–16 to 2020–21)

As shown in Figure 18, the most common age range for apparent domestic and family violence suicide deceased was 40-44 years (15.7%, 44 of 280) with the majority occurring in the context of intimate partner violence.

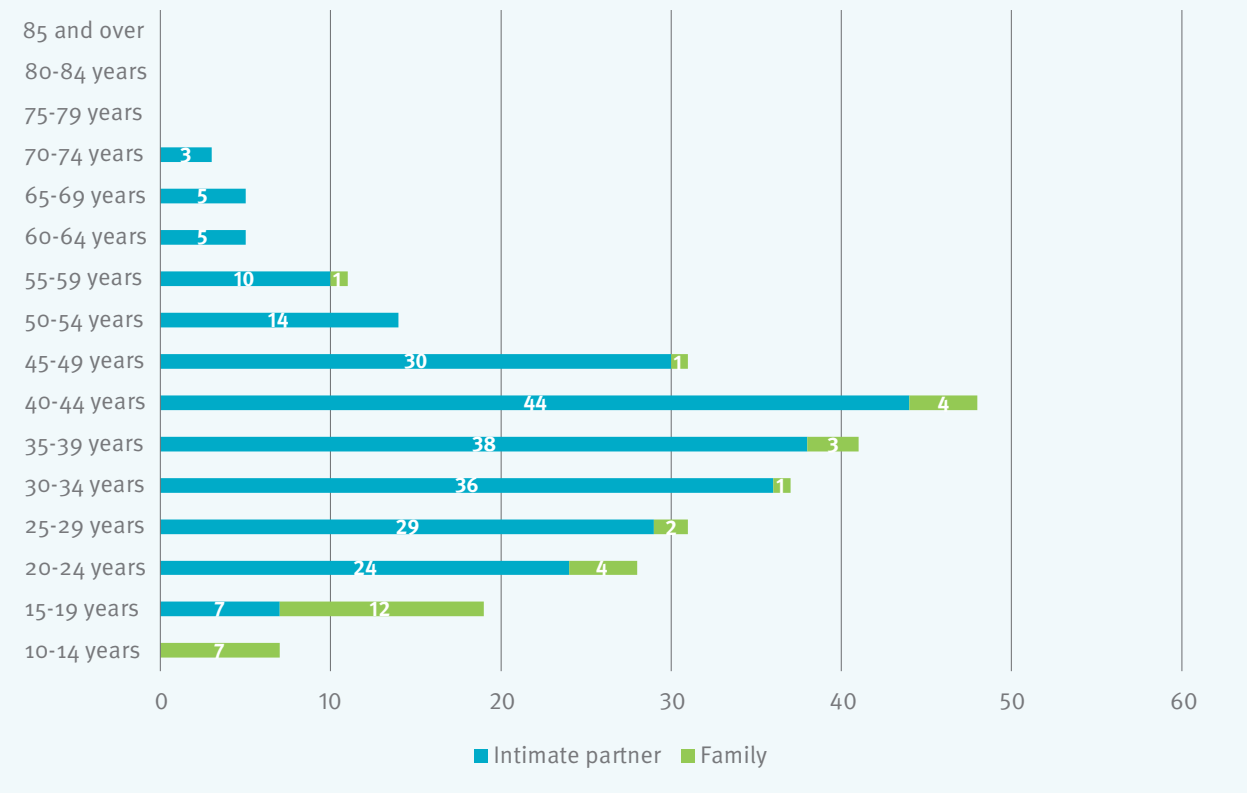


Figure 18. Apparent domestic and family violence suicides by relationship type and age (2015–16 to 2020–21)

8 Stuart Leske, Ghazala Adam, Ina Schrader, Amra Catakovic, Bridget Weir, and David Crompton, 'Suicide in Queensland: Annual Report 2020' *Institute for Suicide Research and Prevention, School of Applied Psychology, Griffith University*, Queensland, Australia, (2020), https://www.griffith.edu.au/__data/assets/pdf_file/0035/1196855/QSR_Annual_Report_2020.pdf.

As shown in Figure 19, in 16.4% (46 of 280) of all apparent domestic and family violence suicides the deceased identified as Aboriginal and/or Torres Strait Islander. For the apparent domestic and family violence suicides in a family relationship, 31.4% (11 of 35) of cases involved an Aboriginal and/or Torres Strait Islander deceased, compared to 14.3% (35 of 245) of cases that occurred in an intimate partner relationship. Eight percent of suicides in an intimate partner relationship involved a person from a culturally and linguistically diverse background (20 of 245), compared to 8.6% for family relationships (3 of 35).

	Intimate partner	Family	Total
Aboriginal	32	11	43
Torres Strait Islander	0	0	0
Aboriginal and Torres Strait Islander	3	0	3
Culturally and linguistically diverse	20	3	23
Non-Indigenous and non-culturally and linguistically diverse	190	21	211
Total	245	35	280

Figure 19. Apparent domestic and family violence suicides by relationship type and cultural background (2015–16 to 2020–21)

As shown in Figure 20, actual or intended relationship separation was identified in 71% (174 of 245) of all apparent intimate partner violence suicides in Queensland. The presence of separation in family violence suicides has been excluded due to its inapplicability in such cases.

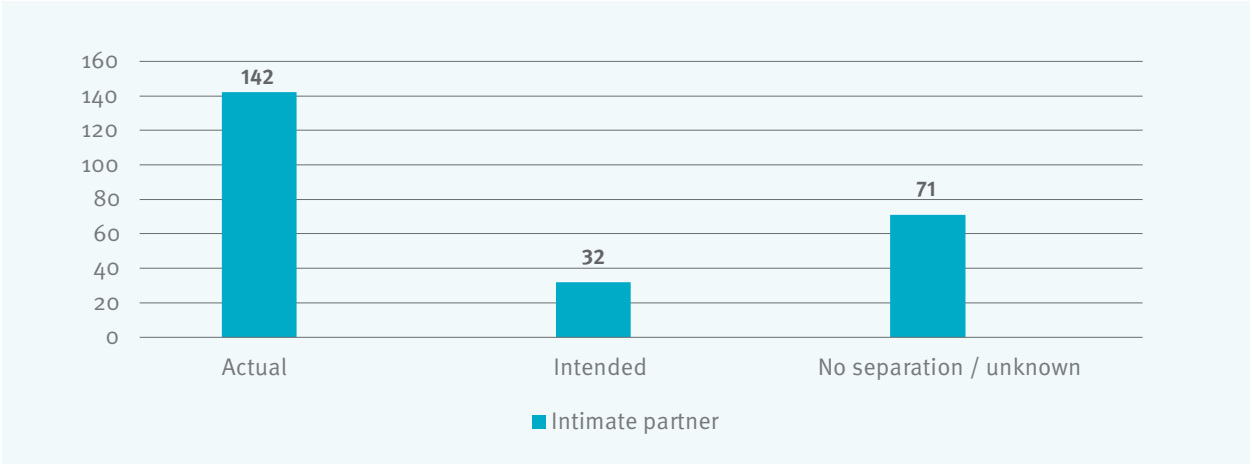


Figure 20. Presence of separation in apparent intimate partner violence suicides (2015–16 to 2020–21)

As shown in Figure 21, in 69.6% (195 of 280) of apparent domestic and family violence suicides, a protection order was in place at the time of the death. In 69.7% (136 of 195) of cases the male deceased was listed as the respondent on protection orders. The female deceased were named as a respondent in 2.5% (5 of 195) of these cases.

In 11.3% (22 of 195) of these cases, the female deceased was listed as the aggrieved on a protection order, with male deceased listed in 3.6% (7 of 195) of the cases as the aggrieved person.

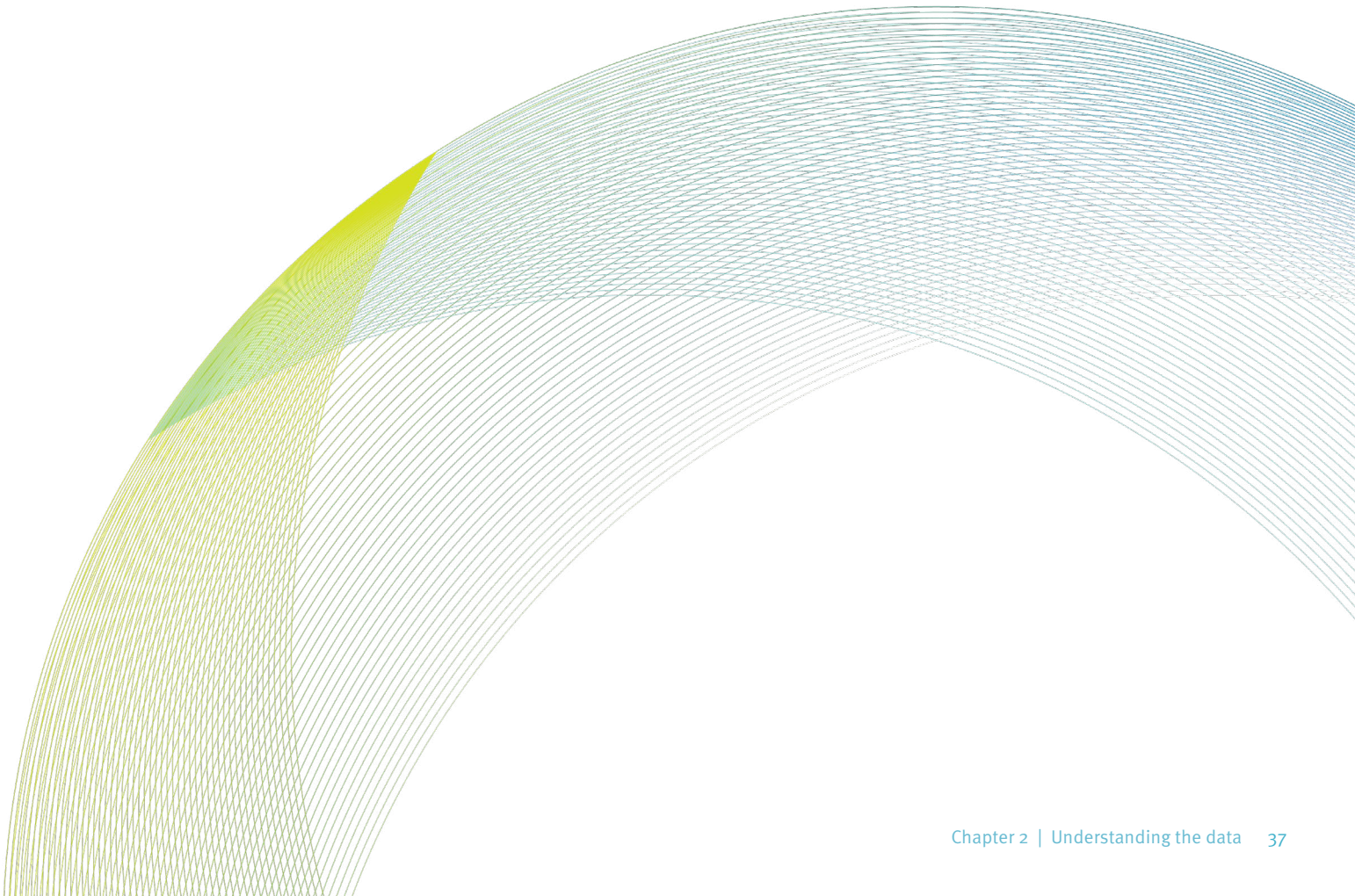
	Male	Female	Total
Respondent	136	5	141
Aggrieved	7	22	29
Cross orders	13	5	18
Named person	3	4	7
Total	159	36	195

Figure 21. Status of deceased on protection orders in apparent domestic and family violence suicides (2015–16 to 2020–21)

As shown in Figure 22, of the 35 apparent family violence suicides, a protection order was in place in 48.6% (17 of 35) of cases at the time of death. The male deceased was the respondent in 41.2% (7 of 17) of these cases and the female deceased were listed as a respondent in 5.9% (1 of 17) of these cases. There were no cases where the male deceased was listed as the aggrieved person, while in 17.6% (3 of 17) of these cases, the female deceased was listed as the aggrieved person.

	Male	Female	Total
Respondent	7	1	8
Aggrieved	0	3	3
Cross orders	0	0	0
Named person	3	3	6
Total	10	7	17

Figure 22. Status of deceased on protection orders in apparent family violence suicides (2015–16 to 2020–21)



Chapter 3: Understanding the current context

Key findings

- During the past decade, there have been substantial reforms at both a state and national level to address domestic and family violence and child abuse and maltreatment.
- This includes improved recognition of the need for tailored and locally led strategies and approaches for Aboriginal and Torres Strait Islander families and communities.
- The Queensland Government is currently delivering the Third Action Plan 2019–20 to 2021–22 of the Domestic and Family Violence Prevention Strategy 2016–26, which aims to strengthen system responses to identified and emerging areas of need, and to sustain the current momentum for change.
- In March 2021, the Queensland Government announced the establishment of the Women's Safety and Justice Taskforce to conduct a wide-ranging review into the experiences of women across Queensland's criminal justice system, including on how to best legislate against coercive control.
- The Queensland Audit Office (QAO) recently completed a performance audit of reforms undertaken to improve the safety and protection of children by the family support and child protection system. The audit found that, while agencies often cooperate well, share information, and have a collaborative approach, the system is still under pressure.
- The QAO also identified that agencies must be better equipped to respond to complexity across distinct but interrelated portfolios such as domestic and family violence, child protection, alcohol and other drugs, mental health, and suicide prevention.
- The need for all agencies to be better equipped to respond to a person's presenting and underlying needs remains an ongoing issue identified by the Board across the cases reviewed.

Responding to domestic and family violence is a shared responsibility between Commonwealth and state and territory governments.

While states and territories have responsibility for most laws related to investigating, policing, and responding to domestic and family violence, the Australian Government has responsibility for the family law system and setting national policy and research priorities. The Australian Government also provides secondary funding for a range of associated policy and program initiatives to address domestic and family violence, though states and territories primarily fund domestic and family violence services.

This work is supported by multiple overlapping national and state strategies for responding to domestic and family violence and other distinct but interrelated issues (e.g. housing or substance use as outlined below).

In February 2011, the *National Plan to Reduce Violence against Women and their Children 2010–2022* (the National Plan) was endorsed by the (former) Council of Australian Governments.

The National Plan seeks to provide an overarching link in the work being completed by state and territory governments, community organisations and individuals to reduce violence and improve safety for women and children.[9] The aim of the plan is to achieve *'a significant and sustained reduction in violence against women and their children'*, focusing specifically on domestic and family violence and sexual assault.

The current Fourth Action Plan of the National Plan prioritises primary prevention initiatives and improving service system responses. There are five primary focus areas under the Fourth Action Plan:

1. prioritising primary prevention to stop violence before it starts.
2. supporting Aboriginal and Torres Strait Islander women and children to live safely and free from violence.
3. acknowledging the lived experience of women and their children affected by violence and delivering targeted interventions to priority populations.
4. responding to sexual violence and harassment.
5. embedding trauma-informed practice into support services provided to victims, their children and perpetrators of domestic and family violence and sexual violence.

9. Department of Social Services, *National Plan to Reduce Violence against Women and their Children* (2011), https://plan4womenssafety.dss.gov.au/the-national-plan/

Relevant to some of the cases reviewed by the Board in 2020–21, the Fourth Action Plan has prioritised the development of locally led and responsive programs or activities. It also calls upon services to deliver trauma-informed and healing centred care for Aboriginal and Torres Strait Islander women, children, and men.

In Queensland, this has included a focus on community led responses to domestic and family violence, the embedding of specialist domestic and family violence workers into family wellbeing programs, building the skills, knowledge and understanding of professionals to be able to provide culturally informed services to Aboriginal and Torres Strait Islander families, and exploring alternative models for delivering men's behavioural change programs.

The current National Plan is coming to a close in 2022, but the goal of achieving a significant and sustained reduction of violence against women and their children has not been achieved. According to the Australian Institute of Health and Welfare, the rates of intimate partner violence and sexual violence remained relatively stable between 2005 and 2016.[10] In 2020, a parliamentary inquiry also found that the National Plan had not achieved its objective.[11] Development of the next National Plan is currently underway.

During the past decade, the Queensland Government has also made substantial investments to address domestic and family violence, child abuse and maltreatment, and other related concerns.

The most significant reforms in Queensland were made in response to the Special Taskforce's landmark report, *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* (2015). The Special Taskforce made 140 recommendations to government and in September 2019 the Queensland Government announced that all recommendations had been implemented.

As the Queensland Government has acknowledged, significant reform takes time, and the implementation of the Special Taskforce's recommendations is the first step on a longer journey to end domestic and family violence in Queensland.

Queensland's current strategy is reflected in the *Domestic and Family Violence Prevention Strategy 2016–26* (the Strategy). The Strategy provides a staged plan for collaborative government and community action through the implementation of four action plans.

Queensland is currently implementing the *Third Action Plan 2019–20 to 2021–22* (Third Action Plan) of the Strategy, which aims to embed cultural change and system reforms delivered to date, strengthen system responses in identified and emerging areas of need, and to sustain the momentum for change.

In March 2021, the Queensland Government announced the establishment of a Women's Safety and Justice Taskforce to conduct a wide-ranging review into the experiences of women across Queensland's criminal justice system. The Taskforce is headed by the former president of the Queensland Court of Appeal, the Honourable Margaret McMurdo AC. The Taskforce is required to report to government on how to best legislate against coercive control by November 2021 and on how to best improve women's experiences in the criminal justice system by June 2022.

The Board has continued to engage with the Taskforce since its establishment to share knowledge gathered as part of its review process. The recommendations made in this report acknowledge that there will be more change across agencies and sectors because of the Taskforce and are intended to complement these upcoming reforms.

The recommendations in this Annual Report have been made because there is a clear and compelling need for change, which is informed not just by the findings of the cases reviewed within this reporting period, but by the Board's collective knowledge and understanding of the systemic failures that have been identified during the past five years since its establishment.

Since its establishment, the Board has consistently noted the need for system reforms to not be delivered in isolation of each other. The importance of embedding change over the longer term should not be underestimated, and while there will always be occasions where a call for immediate action is compelling and resounding, there is also the need to recognise the complexities of embedding reform across sectors to ensure that meaningful outcomes are achieved.

The Queensland Audit Office (QAO) recently completed a performance audit of reforms undertaken across the family support and child protection system. The QAO's report, titled *Family Support and Child Protection System* (Report 1: 2020–21), identified that agencies have made good progress in implementing recommendations from reviews and that in most cases, agencies cooperate well, share information, and have a collaborative approach. However, the audit recognised that this can be enhanced, and that the child protection system remains under pressure from high demand and the growth in families with multiple and complex needs.

The social and economic impacts of the COVID-19 pandemic have added further pressure to the system and agencies need to be prepared to respond to this.

The audit also found that improving the number of families engaging with family support services would strengthen Queensland communities and reduce pressure on the child protection system, thereby increasing the safety of children. The QAO recognised that, at present, family support services do not have the capacity to provide more services within a highly complex environment.

As the Board has also identified, this audit found that there is a need for all agencies and sectors to be better equipped to respond to complexity across distinct but interrelated portfolio

10. Australian Institute of Health and Welfare, *Family, Domestic and Sexual Violence in Australia: Continuing the National Story 2019* (2019), https://www.aihw.gov.au/getmedia/b0037b2d-a651-4abf-9f7b-00a85e3de528/aihw-fdv3-FDSV-in-Australia-2019.pdf.aspx?inline=true

11. House of Representatives Standing Committee on Social Policy and Legal Affairs, *Inquiry into Family, Domestic and Sexual Violence* (2021), https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/024577/toc_pdf/Inquiryintofamily,domesticandsexualviolence.pdf;fileType=application%2Fpdf

areas including domestic and family violence, child protection, alcohol and other drug, mental health, and suicide prevention.

The embedding of domestic and family violence specialist workers within Intensive Family Support services is one approach that has been taken to help improve cross-sectoral responses to children experiencing harm or/at risk of harm. The QAO report found that this approach has increased the capacity of practitioners to recognise and respond to domestic and family violence within the child protection system.

As outlined in its 2019–20 Annual Report, during its first term, the Board completed in-depth systemic reviews of the deaths of 15 children who were killed by a parent or caregiver, and/or who ended their lives in the context of exposure to domestic and family violence and cumulative harm.

In 2019–20, the Board had the opportunity to reflect on its prior findings and noted several reoccurring issues. In particular, the Board reiterated the need for services to move beyond a superficial approach to assessing the immediate risks to children and young people based on physical violence being directed at them.

The Board's report also identified that an accurate assessment of risks to children should include an equivalent emphasis on their mental health and wellbeing in the context of exposure to domestic and family violence, even when they are not the primary victim of the violence in the family. Cumulative harm to children, including direct and indirect victimisation, should be part of the analysis and decision-making process.

It was further highlighted by the Board that children in their first two years of life are particularly vulnerable to violence, abuse, and neglect.

Most importantly, the Board identified that to improve recognition of patterns of abuse, risk and harm, all services who encounter victims, their children, and perpetrators require an appropriate understanding of domestic and family violence, including non-physical forms of abuse and the risks posed to children in this context.

For children, the impacts of repeated abuse and exposure to domestic and family violence are profound and traumatic. Children do not become used to violence; they learn to adapt. When there is violence in the home, children are always affected, even if they are asleep or not in the room when the violence occurs. The longer children live in a violent situation, the harder it is for them to develop trusting relationships. Children may feel scared and ashamed, or they may even think that they caused the problem.

In the cases reviewed in the 2020–21 reporting period, the Board noted that an additional 10 children lost a parent or caregiver to domestic and family violence or were otherwise affected by the death.

Perhaps even more significantly, the Board reviewed a perpetrator suicide of a young man whose father killed his mother in a high profile domestic and family violence homicide-suicide some six years earlier. In this case, the perpetrator exhibited many of the same coercive controlling behaviours that his father had used towards his mother, and both exhibited many of the same indicators of high risk domestic and family violence lethality, including non-lethal strangulation, obsessiveness and suicidal threats/attempts.

Records indicate that the father and son had been close and that, as an adult, the perpetrator appeared to empathise with his father's decision to kill his mother. He told one service that his mother had *'abandoned the family'* for leaving the violent relationship and that he held '*no anger or animosity towards his father for the murder of his mother*'. Notably, the homicide-suicide of the perpetrator's parents was a case previously considered by the Board in 2016–17.

The Board considered this case to be a compelling example of the intergenerational nature of domestic and family violence and the impact of growing up in a violent household. This case also reinforces the importance of providing support to children in cases where a parent or other family member has been killed in the context of domestic and family violence, whether that be a homicide or suicide.

Recommendation 1:

That the Queensland Government explore opportunities to improve service collaboration and the coordination of support provided to families, particularly children, bereaved by a domestic and family violence death.

This should consider existing approaches to postvention support for those bereaved by suicide or homicide.

The Board also continues to highlight the need for improvement in the way that systems understand and respond to family violence among Aboriginal and Torres Strait Islander individuals, families and communities.

Within this reporting period, the Board reviewed the homicides of two Aboriginal women who were killed by their male intimate partners, from the same discrete Indigenous community (across different years).

The Board recognised that responding to family violence in discrete Indigenous communities represents unique challenges that are compounded by a range of factors including geographical environment and isolation, lack of support services and available response options.

Queensland's *Framework for Action – Reshaping our approach to Aboriginal and Torres Strait Islander domestic and family*

violence (the Framework), is the government response to a previous recommendation made by the Board in its 2016–17 Annual Report, that called for the development of a dedicated response to family violence involving Aboriginal and Torres Strait Islander individuals, families and communities.

The Framework includes specific actions to break the cycle of violence in remote/discrete communities by supporting Aboriginal peoples and Torres Strait Islander peoples to develop community-led domestic and family violence action plans that align with the development of co-designed Local Thriving Communities Plans and community safety plans. It also includes supporting one remote/discrete community in the development of a Domestic and Family Violence Social Reinvestment Project, based on community identified goals.

Since making this recommendation in its 2016–17 Annual Report, the Board acknowledges that there have been further commitments at a national and state level to prioritise responses in this area. This includes the recent national recommitment to the *Closing the Gap* strategy, which has a target for reducing family violence by at least 50% as progress toward zero. The Australian Government has also committed to developing a specific plan to address violence against Aboriginal and Torres Strait Islander women and children.

At a state level, implementation is continuing with both the *Local Thriving Communities* reforms, and the implementation of *Supporting Families, Changing Futures* Reforms.

As part of these broader reforms, *Our Way: a generational strategy for Aboriginal and Torres Strait Islander children and families 2017–2037* and the *Changing Tracks Action Plan 2020–2022* focus on the changes needed to deliver the systems and policy settings necessary to eliminate the disproportionate representation of Aboriginal and Torres Strait Islander children in the child protection system by 2037.

Given the comparatively higher number of domestic and family violence homicides involving Aboriginal peoples and Torres Strait Islander peoples in Queensland, the Board is committed to prioritising these cases in its 2021–22 reporting period and considering what more can be done to prevent these types of deaths. This commitment includes a recognition of the need to align our review process with the principles of the Warawarni-gu Guma (Healing Together) Statement (right).

Spotlight on: Healing together in Ngurin Ngarluma

The Board has repeatedly raised concerns about the over-representation of Aboriginal peoples and Torres Strait Islander peoples in family violence deaths in Queensland, including the need for more nuanced, tailored and community led responses.

In doing so, it recognises the Warawarni-gu Guma (Healing Together) Statement developed by Aboriginal and Torres Strait Islander delegates at Australia's National Research Organisation for Women's Safety (ANROWS) second National Research Conference on Violence against Women in 2018.

The Warawarni-gu Guma (Healing Together) Statement provides an Aboriginal and Torres Strait Islander perspective on family violence including a pathway forward for Aboriginal and Torres Strait Islander communities.

This includes a recognition of the following principles taken directly from Warawarni-gu Guma:

> *We are the First Peoples of this country. We need a new way – our way for addressing family violence in our communities; a way that recognises the impact of intergenerational trauma on our people, our families and our communities.*
>
> *Our women and girls and our men and boys must have a strong voice, a seat at the table, to be the architects of our own lives, our own destinies. This is our fundamental human right.*
>
> *'Nothing about our mob, without our mob'. This is not a slogan. This is critical not only for our healing, but for yours as our fellow Australians; this is the starting point for our relationship.*
>
> *When working with us, you must identify the right people to engage with. We must include our Cultural Bosses and not just the CEOs and managers of organisations in communities.*
>
> *Co-design means taking a 'blank page' approach where we set the parameters; we say what's in the foreground; we say what's in the background; and all the complexity within (see Linda Smith, 1999).*
>
> *We need an open and transparent process about where and how data is collected, and where and how research is conducted; and by whom. This data collection must as a first step, be based on our stories about our realities; this provides the foundations to knowing what needs to be asked, how it needs to be asked, and who should ask the questions.*
>
> *Finally, we want to say that family and sexual violence is not our culture.*

Section 2
Our approach

Chapter 4: Monitoring our progress

Key findings

- The Board is established to make recommendations to the Attorney-General to prevent or reduce the likelihood of domestic and family violence deaths, and to monitor the implementation of these recommendations by government and non-government entities.
- Since its establishment in 2016, the Board has made 59 recommendations. Of these, all but one has been accepted (in full, in part or in principle) by the Queensland Government. Implementation is ongoing for 57% of recommendations made by the Board, with 41% of recommendations completed.
- Recommendations made by the Board have been far-reaching with the majority aiming to change organisational practices, educate providers and influence policy and reform. Their main areas of focus have been workforce development, systems and process, service accessibility and availability, and culturally informed responses.
- Recommendations made by the Board seek to address the specific issues identified in the cases reviewed; however, the information contained within the Board's publicly available reports represent only a de-identified fraction of the full information considered by the Board about a particular case or cases reviewed.
- This lost nuance may impact the implementation approach undertaken by agencies who might not fully understand the basis of the Board's recommendation.
- It is not clear in some progress reports provided by agencies to the Board what new actions have been taken to implement recommendations made, that are in addition to work already underway.

The Board is empowered to make recommendations to the Attorney-General for implementation by government and non-government entities to prevent or reduce the likelihood of domestic and family violence deaths. Under section 91D(1)(f) of the Act, the Board is also required to monitor and report on the implementation of recommendations it has made as part of its review process. In practice, agencies provide both an initial whole-of-government response to all recommendations made by the Board, and then regular progress updates throughout implementation. All responses are published on the Board's webpage.

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

In total, the Board has made 59 recommendations since its establishment across multiple portfolio areas. While in some instances multiple secondary agencies were nominated to support the lead agency in delivering the recommendation, six agencies have been nominated as having lead responsibility for implementing the Board's recommendations in the initial government responses.

As outlined in Figure 23, most recommendations were within the portfolio responsibility of the former Department of Child Safety, Youth and Women (21), followed by Queensland Health (16) and the Department of Justice and Attorney-General (10). It is noted that the large number of recommendations directed to the former Department of Child Safety, Youth and Women reflects its portfolio responsibility for child protection and domestic and family violence reforms until 2020, when the domestic and family violence portfolio transferred to the Department of Justice and Attorney-General in the machinery of government changes.[12]

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

Although these entities are not the responsible agency for reporting on implementation, they play a part in the implementation of the recommendation.

Recommendations made by the Board have been far-reaching with the majority aiming to change organisational practices, educate providers and influence policy and reform (as per Figure 24). As the Board considers the current policy context in the making of its recommendations, these reflect both the issues identified in its case reviews, as well as the Board's consideration of current activities underway across Queensland that can reasonably be considered to improve the way agencies and systems respond into the future (relevant to the issue identified).

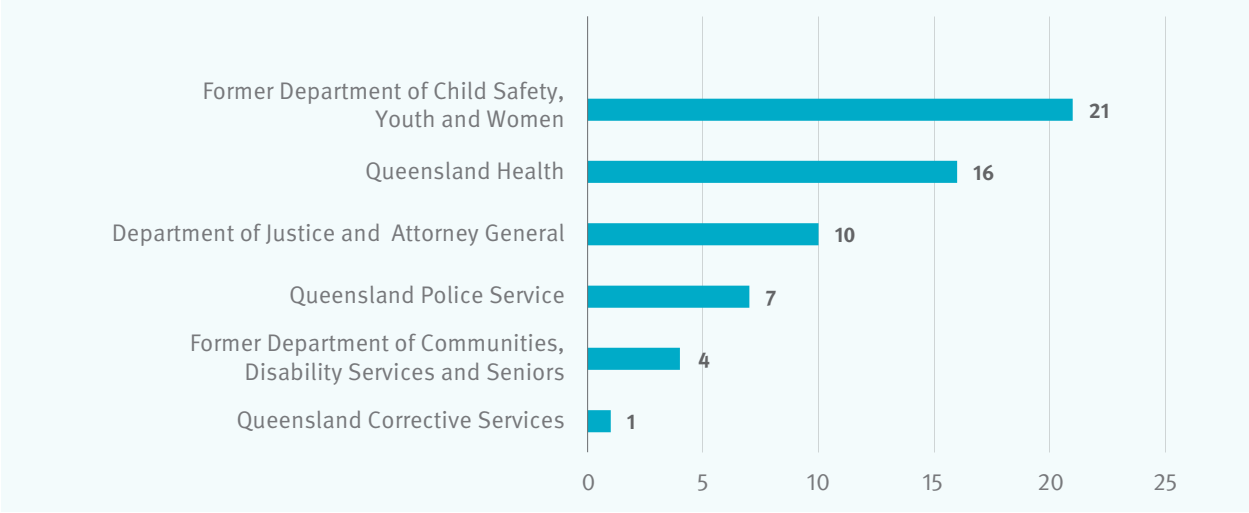


Figure 23. Original lead agency with responsibility for recommendations made by the Board from 2016–17 and 2019–20 [13]

12 As the machinery of government changes occurred prior to the government response to the Board's 2019–20 Annual Report, five of the recommendations from the Board's 2019–20 Annual Report that are reflected in Figure 23 as the responsibility of the Department of Justice and Attorney-General, are being implemented by the Office for Women and Violence Prevention.

13 This figure reflects the agencies with lead responsibility for implementing the recommendation at the time of the original government response to the Board. While in some instances multiple secondary agencies were nominated to support the lead agency in delivering the recommendation, these are not reflected in this graph. It is noted that as a result of the machinery of government changes in 2020, there has been a redistribution of program areas and some nominated agencies no longer have responsibility for recommendation implementation. For example, the Office for Women and Violence Prevention has now been moved to the Department of Justice and Attorney-General and was previously in the former Department of Child Safety, Youth and Women portfolio.

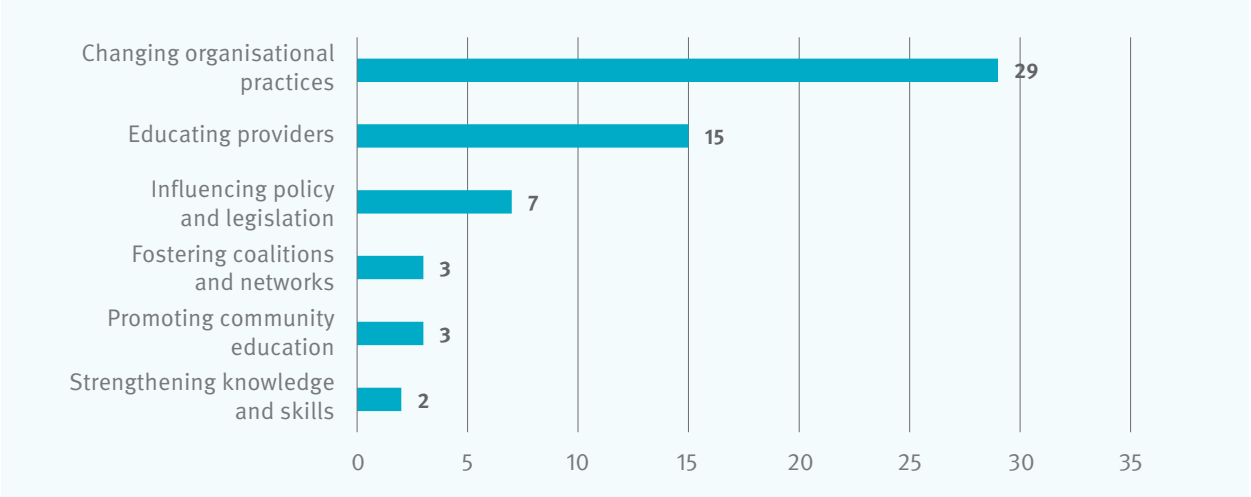


Figure 24. Level of recommendation made by the Board from 2016–17 and 2019–20[14]

While it is not always possible to accurately capture the sheer depth and breadth of activities being undertaken across the state, the multidisciplinary expertise of the Board helps to support this kind of targeted approach.

Where appropriate, consultation also occurs with agencies and other key experts prior to any recommendations being made to further refine their scope and focus.

Figure 25 outlines the Board's primary areas of focus in making recommendations, that were most commonly focused on improving workforce development, followed by those that aim to improve service accessibility and availability, or enhance systems and processes.

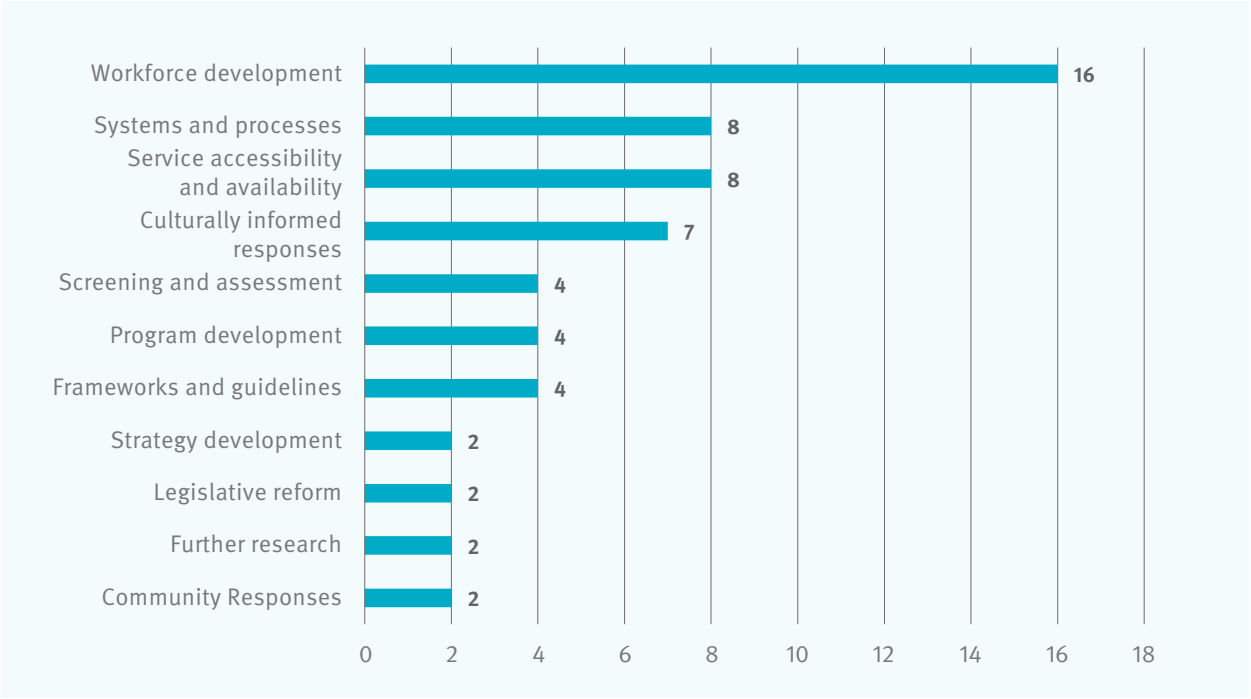


Figure 25. Main areas of focus recommendation made by the Board from 2016–17 and 2019–20

As outlined in Chapter 3, the Queensland Government is continuing to progress reforms that seek to build upon those outlined in *Not Now, Not Ever, Putting an End to Domestic* and *Family Violence in Queensland* (2015) and the *Queensland Child Protection Commission of Inquiry* (2013). This includes undertaking evaluations and reviewing key initiatives to consider ways to improve and extend upon current approaches.

This makes it an opportune time for the Board to similarly reflect on the recommendations it has made in its past four reports.

Key recommendations that have been implemented by agencies include:

- the introduction of a targeted suicide prevention framework to support the detection of, and response to, vulnerable individuals within domestic and family violence services.
- the development of a specific framework to respond to Aboriginal and Torres Strait Islander family violence.
- the commissioning of research that aims to identify how best to respond to the person most in need of protection where there are mutual allegations of abuse (as outlined in Chapter 5).
- the development of guidelines and resources about the *Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004* to ensure that applications for an Offender Reporting Order are made for serious offences against children that are not prescribed offences.
- that a feasibility study be undertaken about the use of online men's behaviour change programs in Queensland.

Recommendation responses and implementation

In considering the effectiveness of recommendations made by the Board, an analysis has been undertaken on responses provided by the Queensland Government to past recommendations made.

Figure 26 outlines that the Queensland Government has accepted all but one recommendation[14] made by the Board since its establishment in 2016 (either in full, in part or in principle).

As of the date of publication of this report, 24 recommendations have been closed by agencies. Fifty-seven percent of recommendations made by the Board are still in progress (Figure 27 and Figure 28).

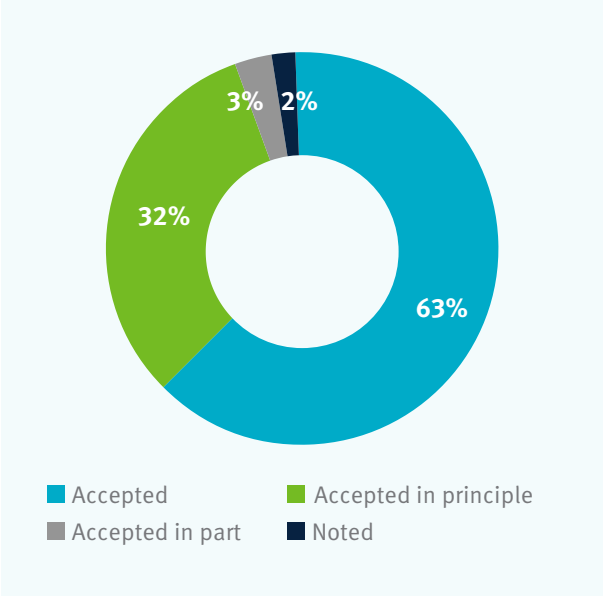


Figure 26. Acceptance status of recommendations made by the Board, 2016–17 to 2019–20

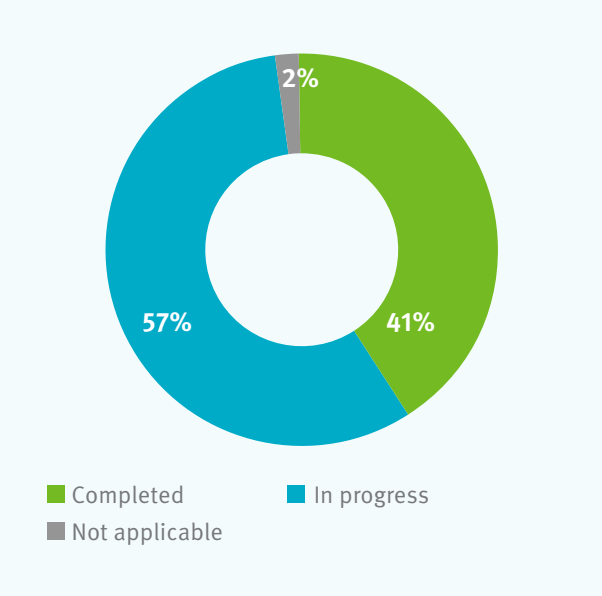


Figure 27. Implementation status of recommendations made by the Board, 2016–17 to 2019–20

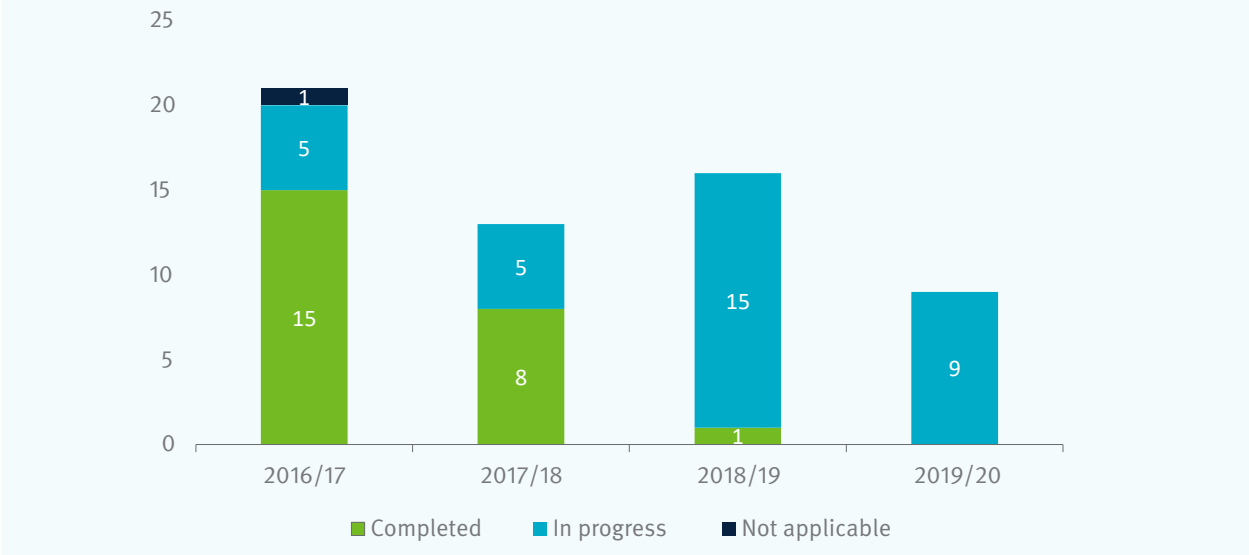


Figure 28. Implementation status of recommendations made by the Board, 2016–17 to 2019–20

14 This recommendation from the Board's 2016–17 Annual Report with respect to extending upon culturally informed, family responsive alcohol and other drug treatment options was 'noted' on the basis that it related to a national portfolio responsibility and not a state one.

As outlined in Figure 26, 35% of recommendations made by the Board have been accepted in part or in principle. Broadly speaking, reasons provided by agencies for accepting a recommendation in part in or in principle generally included that related activities were already underway,[15] and/or the implementation approach chosen may have differed from that recommended by the Board.[16]

It is acknowledged that agencies may be required to consult with stakeholders to determine the actual approach to be taken to implement the Board's recommendations and the initial acceptance of a recommendation is not necessarily reflective of the scope of changes that occur.

While there is always a balance in ensuring agencies have sufficient flexibility to consider how to implement recommendations within the broader context of their organisational priorities, when formulating recommendations, the Board tailors them to address the specific issues identified.

The information that the Board includes in its publicly available reports represents only a de-identified fraction of the full information considered by the Board about a particular case or cases reviewed. De-identification is necessary, not only because it is required by the Act, but also to protect the privacy of the deceased and their loved ones. However, it is also the case that in the de-identification process, crucial context and nuance is often lost. Therefore, the complete circumstances of the systemic shortcomings identified by the Board may not be fully apparent to those who are required to respond to a recommendation. This lost nuance may impact the implementation approach taken by agencies who might not fully understand the basis of the Board's recommendation.

As an example, the Board has made continued recommendations about domestic and family violence training for all health practitioners working across the private and public health sectors, as well as the introduction or promotion of routine screening for domestic and family violence within health settings.

In total, the Board has made 14 recommendations across its four Annual Reports to improve training and screening across the health sector. This is because people working in this system play a critical role in recognising and responding to domestic and family violence, and in addressing other support needs that a person may be experiencing.

Relevant recommendations made by the Board have included:

- the introduction of mandatory training for staff who come into contact with victims, their children, and perpetrators to be delivered to a level that proficiency can be measured.
- that routine screening be promoted, alongside enhanced responses to high risk families or vulnerable parents, in private obstetrics and health facilities.
- that routine mandatory screening for domestic and family violence victimisation and perpetration be implemented within all Queensland Health and government funded mental health and alcohol and other drug services; alongside cross-professional training and relationship building.
- that liaison occurs with professional bodies to recommend that all relevant registered practitioners complete specialist domestic and family violence awareness training within one year of obtaining registration or membership and be required to complete ongoing training.
- exploring opportunities to increase the knowledge of public health clinicians and general practitioners around the signs of, and responses to, non-lethal strangulation; and evaluate existing training in this area.
- funding the development of a training package or module for professionals from generalist services (including mental health, GPs and alcohol and other drug treatment services).
- that Primary Health Networks play a leadership role in training and workforce development initiatives to improve cross-agency responses within primary health care settings and enhance local partnerships.
- that a review be undertaken of all training delivered to frontline service providers who may come into contact with victims, their children, and perpetrators, with a focus on identifying opportunities to embed trauma-awareness and trauma-informed service delivery.
- that consideration be given as to how to effectively and sustainably deliver training to all frontline Queensland Health workers to build and maintain domestic and family violence literacy across the secondary and tertiary health care systems.
- that a review be undertaken of relevant training and resources to ensure all frontline Queensland Health workers, particularly those in the areas of sexual health, mental health and alcohol and other drug services, understand domestic and family violence perpetrator tactics, complex trauma presentations, and the intersection between suicidality and experiences domestic and family violence.

15 For example: the recommendation that mandatory training be implemented within health settings in the Board's 2016–17 Annual Report.
16 For example: the recommended development of a mechanism to identify high risk persons or families who have presented to the service previously, and to better take into account prior presentations to enhance future responses in the Board's 2016–17 Annual Report.

» that universities and peak professional bodies incorporate evidence-based domestic and family violence education into key areas including psychology, social work, law, criminology and health.

While all recommendations made by the Board have aimed to enhance the way health practitioners respond to domestic and family violence through improved awareness and screening, they have also sought to ensure:

» that practitioners have an understanding of how to safely respond to perpetrators of violence, as well as victims and their children.

» that a deeper understanding of the underlying complexities of domestic and family violence is developed across the workforce to improve how the health system responds to a person's presenting and underlying needs.

In making these recommendations, the Board has also recognised the broad range of providers and various professional bodies who have a role to play in responding to domestic and family violence across the health, mental health and alcohol and other drug sectors at a local, state, and national level.

This workforce is large, diverse, highly mobile, and spread across the private, public, and non-government health systems. Equipping all practitioners to appropriately respond to domestic and family violence across this system is highly complex, with no single entity having lead responsibility to ensure this training occurs. It requires the shared commitment and ownership of multiple professional bodies and networks, as well as both the state and national government.

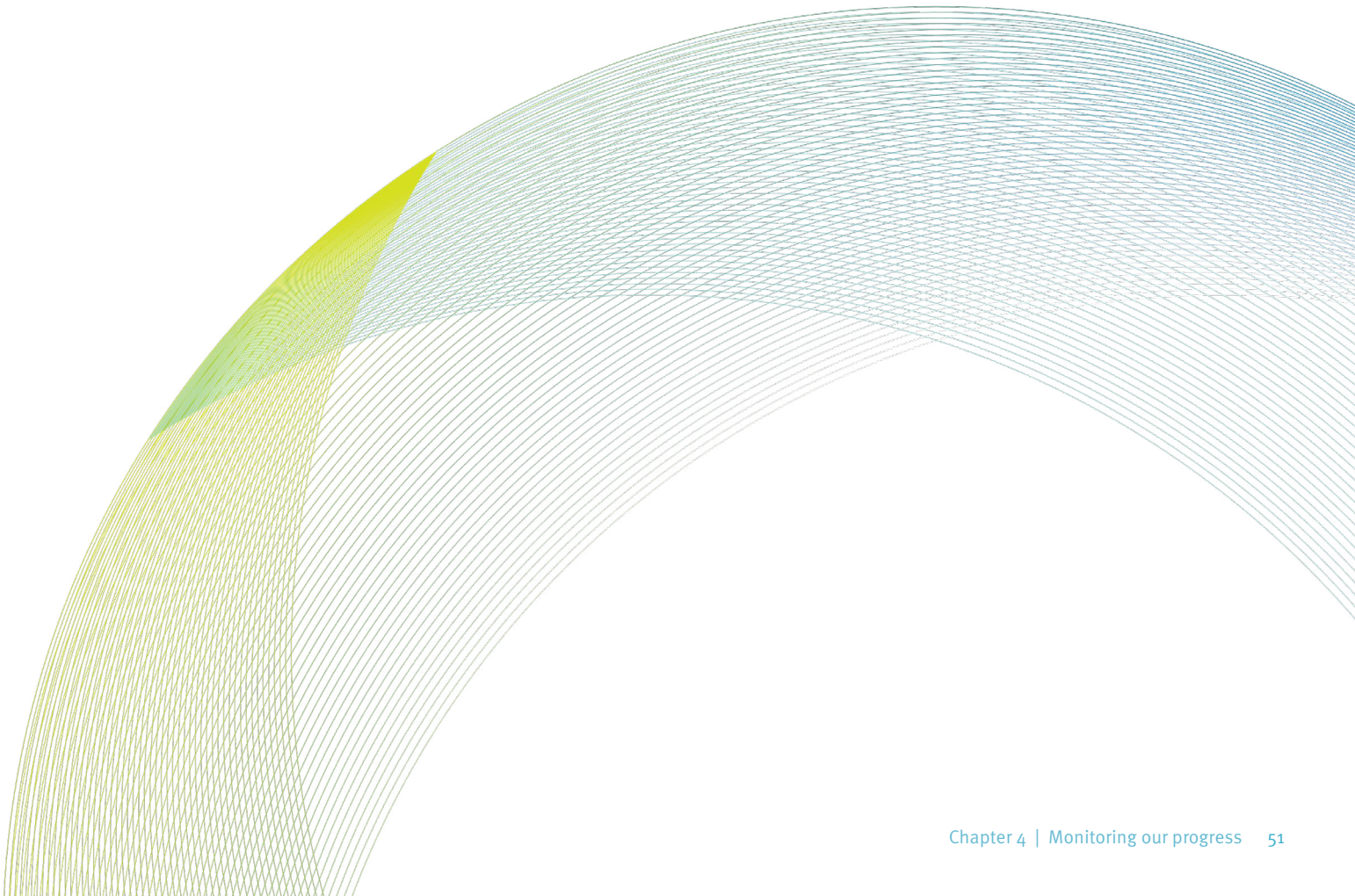
Four of the total recommendations made by the Board in this area were accepted in principle and one was accepted in part, with it being noted that existing activities were underway to meet the intent of the recommendation. In circumstances where a lead agency considers there is sufficient alignment between an existing activity and a recommendation made by the Board, there are still benefits for this agency to incorporate the Board's findings into related future activities. This is important to ensure that the specific nuances of the recommendation are not lost.

As such, the Board welcomes the Queensland Government's commitment to recommendations made in its 2019–20[17] Annual Report to ensure that key elements will be included in any new or revised domestic and violence related training for health practitioners and be incorporated into policies and practice standards wherever appropriate.

Detailed progress reports to the Board are particularly beneficial in understanding what actions have been taken towards implementation, as it is unclear from some agency responses the extent to which recommendations (whether accepted in full, in part or in principle) have been fully adopted as intended by the Board, or what action has been taken beyond reforms already underway.

It is also noted that while the most recent implementation updates were received just prior to publication of this report, responses to the Board's 2019–20 Annual Report reference that implementation will be shaped by the findings of the Women's Safety and Justice Taskforce report on coercive control, which is due to be provided to government a year after the tabling of the Board's Annual Report in which the respective recommendations were made.

17 Specifically, the Queensland Government review all domestic and family violence training delivered to frontline services who may come into contact with victims and their children or perpetrators of domestic and family violence, with a focus on identifying opportunities to embed trauma-awareness and trauma-informed service delivery.



Chapter 5: Establishing our foundations

Key findings

- Since its establishment, the Board has been confronted by the level of extreme violence and abuse that some perpetrators choose to inflict on their partners, children, and other family members.
- Extreme levels of violence were not always physical in nature and the Board has also observed many examples of ongoing and insidious coercive controlling behaviours.
- There is an ongoing need for services to improve their understanding that using violence is a choice, and that perpetrators use many tactics to avoid detection and accountability for their violence.
- The Board has also reflected on the need for consistent terminology across the service system to ensure that there is a shared understanding of domestic and family violence and coercive control.
- In the current reporting period, the Board repeatedly observed clear instances of poor or inaccurate record keeping that contributed to simplistic responses that failed to keep victims and their children safe. This often occurred with the use of mutualising or minimising language that implied the victim was at least partly to blame, distorted the reality of who did what to whom, and re-framed women's lived experiences of violence.
- The Board also identified issues with the way in which services identify the person most in need of protection, particularly when female victims have used resistive violence in self-defence or for self-protection.
- Victims naturally resist abuse, but the way in which victims of domestic and family violence resist is dependent on their individual circumstances and perceived level of risk. During its reviews, the Board identified the ongoing need for increased awareness and understanding of how victims resist and attempt to stay safe and reassert their dignity throughout their experiences of domestic and family violence.

Domestic and family violence impacts people across all ages and sociodemographic groups, but disproportionally affects women and children.[19] It is a gendered form of violence, with women far more likely than men to experience domestic and family violence and more likely to experience severe health impacts including serious injury, hospitalisation, or death.[20] Recent statistics suggest that:

- one in three Australian women have experienced physical abuse perpetrated by a current or former intimate partner.
- one in four women have experienced emotional abuse perpetrated by a current or former intimate partner.[21]

Actual numbers are likely to be significantly higher, due to the general underreporting of this type of abuse.

Although many women across our community have experienced men's violence, there appears to be a persistent assumption across the service system, and the community more broadly, that certain types of women experience domestic and family violence. This includes women who have histories of trauma, abuse, criminal offending, mental illness, homelessness and/or substance use. These women may not present as 'ideal' or 'real' victims and are more likely to experience stigma and discrimination when seeking help for their experiences of domestic and family violence.

During the 2020-21 reporting period, the Board questioned whether the concept of the 'ideal victim' is helpful when referring to victims of domestic and family violence and whether this may contribute to problematic stereotypes about victimhood, such as that women are partly to blame for men's violence towards them.

Alarmingly, in 2017 the National Community Attitudes towards Violence against Women Survey (NCAS) found that:[22]

- one in five Australians believe domestic and family violence is a normal reaction to stress and that sometimes a woman can make a man so angry he hits her without meaning to.
- one in three Australians believe that if a woman does not leave a relationship in which there is violence then they hold some responsibility for the violence continuing.
- there continues to be a decline in understanding that men are far more likely to perpetrate domestic and family violence towards women.

This chapter seeks to break down stereotypes about people experiencing and using domestic and family violence, honour victim's resistance to abuse, and broaden our understanding of perpetrator behaviour, specifically that using violence is a choice.

Broadly, this chapter discusses domestic and family violence in intimate partner relationships only. Current research and policy largely focus on responding to intimate partner violence and the Board recognises that more research is required to better understand the unique dynamics of violence in family relationships, to ensure that services are appropriately equipped with the knowledge and tools to effectively respond.

Understanding domestic and family violence and coercive control

Based on its review of cases within this reporting period, the Board identified the need for consistent terminology to be used across the service system to ensure that there is a shared understanding of domestic and family violence and coercive control. This is important because the way in which domestic and family violence is described and conceptualised within service system records:[23]

- reinforces the way domestic and family violence is viewed by workers and organisations.
- shapes the way domestic and family violence is assessed and responded to.
- informs subsequent interactions with victims, their children, and perpetrators.
- affects the integrity of information sharing between agencies.

Coercive control is an ongoing, relentless pattern of behaviour that is intended to control and dominate another person (usually an intimate partner, but it can be directed toward other family members).[24]

It is almost exclusively perpetrated by men against women and includes tactics of physical and non-physical abuse. Since its establishment, the Board has repeatedly observed a range of coercive controlling behaviours across its case reviews, including:

Emotional, verbal and psychological abuse

- mocking and humiliating victims including insults, name calling, derogatory put downs, constant criticisms, and belittling.
- systems abuse (e.g. using legal mechanisms to portray the victim in a negative manner or as the abuser).
- gaslighting (e.g. by confusing victims and making them question their memory of events).
- threatening suicide and/or self-harm.
- yelling and screaming.

19. Australian Institute of Health and Welfare, *Family, Domestic and Sexual Violence in Australia: Continuing the National Story 2019* (2019), https://www.aihw.gov.au/getmedia/b0037b2d-a651-4abf-9f7b-00a85e3de528/aihw-fdv3-FDSV-in-Australia-2019.pdf.aspx?inline=true.
20. Tracy Cussen and Willow Bryant, *Domestic/family Homicide in Australia* (2015), https://www.aic.gov.au/sites/default/files/2020-05/rip38.pdf.
21. Department of Justice and Attorney-General, *Domestic and Family Violence Prevention Strategy 2016-2026* (2021), https://www.publications.qld.gov.au/dataset/16330158-3152-436f-8d58-baeff2dd87ad/resource/95c7fadf-b6bd-40c7-9298-3115ac3244ac/download/dfv-prevention-strategy.docx.
22. Australia's National Research Organisation for Women's Safety, *Summary Findings from the 2017 National Community Attitudes towards Violence Against Women Survey* (NCAS) (2017), 300419_NCAS_Summary_Report.pdf.
23. Denise Wilson, Rachel Smith, Julia Rowena Tolmie, and Irene de Haan, 'Becoming Better Helpers: Rethinking Language to Move Beyond Simplistic Responses to Women Experiencing Intimate Partner Violence', *Police Quarterly* 11/1 (2015), 25-31. https://10.26686/pq.v11i1.4529.
24. Australia's National Research Organisation for Women's Safety, *Defining and Responding to Coercive Control: Policy Brief* (2021), https://www.anrows.org.au/publication/defining-and-responding-to-coercive-control/.

Isolation and intimidation

- trying to stop victims from having contact with friends, family and support systems (e.g. threatening to harm other people the victim may have contact with, constant accusations of infidelity and expressing jealousy and suspicion of friends and family).
- threats to harm or kill the victim, children and pets.
- threats to take children away.
- monitoring victims through online communication tools, spyware, or physically stalking them.
- making victims account for their whereabouts at all times.
- depriving victims of their basic needs (e.g. access to transport, food, finances and medical care).
- damaging victims' property or removing their access to property.
- deprivation of liberty or autonomy (e.g. preventing victims from leaving their house or restricting their movements beyond the household).
- attempting to control victims through fear and intimidation.
- neglecting children to control victims.
- using weapons to threaten victims.

Financial abuse

- stealing victims money or belongings/borrowing money and refusing to give it back.
- refusing to contribute to shared costs/making the victim pay for everything.
- controlling victims finances and expenditure.
- restricting victims access to bank accounts/credit cards/financial information.
- preventing victims from obtaining employment.

Physical abuse

- non-lethal strangulation.
- assaulting victims through punching, kicking, shoving, grabbing, slapping.
- assaulting victims with weapons (e.g. knives, bats and household objects).

Sexual abuse

- rape and sexual assault.
- pressuring victims to have sex or perform sexual acts through threats and intimidation.
- making degrading sexual comments.

Melanie's story

Melanie and Mitch were in a relationship for more than a decade and had young children together. Mitch exhibited a high level of coercive control over Melanie that included physical and non-physical acts of abuse. Mitch isolated Melanie from friends, family and support systems by monitoring her communication and restricting her access to money, food and transport. For example, Mitch read all of Melanie's text messages and installed spyware on her phone and computer to monitor who she spoke with.

Mitch would not allow Melanie to speak with other men and, on one occasion, Mitch assaulted another man who had texted her.

Mitch would confiscate Melanie's car for weeks at a time and she was often forced to walk significant distances to take her children to and from school, or to provide them with access to medical care. When Mitch went away for work, Melanie and the children were sometimes left without adequate food. During several episodes of violence, Mitch smashed Melanie's property to intimidate and frighten her. On one occasion, Mitch threatened Melanie with a knife. Melanie tried to protect herself and her children by hiding in a room and calling a family member for help.

Melanie described feeling as though she *'was in a prison rather than a marriage'* and that she was '*constantly under house arrest with no freedom or decision making*'. When Melanie decided to leave the relationship, Mitch's use of violence escalated. He told Melanie that he would *'punish'* her, and he took Melanie's children and pets, as well as her car and other belongings, away from her. Mitch then moved away with the children without Melanie's knowledge or consent. Melanie died by suicide after Mitch refused to allow her to see or speak with her children for months.

Coercive control is different to violent or aggressive behaviour that is not intended to diminish or deny a person's autonomy and sense of self but may be associated with a range of other factors.[25]

When viewed in isolation, some of these behaviours may be difficult to identify as indicators of domestic and family violence. They can be subtle and different in every relationship. Perpetrators may also behave or present one way in public or social situations to disguise their use of violence in private.

When viewed in the broader context of the relationship, it becomes clear that such behaviours are intended to induce fear and take away a victim's right to think and act independently of the perpetrator.[26]

In one case considered by the Board in the current reporting period, the victim was pregnant and engaged with hospital services for antenatal care. During an appointment, the victim disclosed to hospital staff that she had a history of depression and anxiety, but that her partner did not want her to seek treatment because *'he didn't like her being depressed'* and he *'gets angry if she is down'*. The victim also disclosed that her partner would *'get angry'* if she spoke about her older child (from a prior relationship).

Positively, in this case hospital staff recognised the perpetrator's attempts to isolate the victim from her child and support services as an indicator of domestic and family violence and coercive control and took steps to refer the victim to appropriate supports.

While there was a positive response in this case, this example highlights that coercive controlling behaviours may be subtle and not readily apparent, especially non-physical acts of abuse.

Although some perpetrators use physical abuse to maintain control over their victims, physical violence is not always present in coercive and controlling relationships.

As highlighted in Chapter 6, many non-physical forms of abuse are also high risk indicators of intimate partner homicide (e.g. sexual jealousy, obsessiveness and suicide threats).

However, there appears to be a tendency within legal and other settings to formulate a hierarchy of abusive behaviours, where non-physical forms of abuse (when they are recognised at all) are perceived to be less serious than physical and/or sexual abuse.[27] This is despite research indicating that many victims perceive non-physical abuse as more significant than any physical injuries inflicted upon them.[28]

This hierarchical understanding of domestic and family violence is also reflected in the community. For example, a recent study found that women experiencing coercive control were unlikely to seek help from formal services or informal supports unless they had also experienced physical and/or sexual abuse.[29]

The effects of coercive control can be severe and long-lasting, impacting a victim's sense of safety, identity, autonomy and relationships with others. Without increased awareness and understanding of coercive control across the service system and community more broadly, victims will continue to be isolated by their experiences and the support required to rebuild their lives will be misunderstood and unmet.

In November 2021, the Women's Safety and Justice Taskforce will report to the Queensland Government on how best to legislate against coercive control and on whether there is a need to create a specific offence of 'commit domestic violence'. The Taskforce has received multiple submissions from stakeholders on the benefits and limitations of such an approach.

Domestic and family violence is deliberate behaviour

Since its establishment, the Board has been confronted by the level of violence and brutality that some perpetrators choose to inflict on their partners, children and other family members.

The Board has consistently observed serious and deliberate acts of violence, including violence that was planned and premeditated.

In two cases reviewed by the Board in the current reporting period, the perpetrators died by suicide after attempting to kill their former partners, leaving both women with catastrophic injuries. In both cases the attempted homicide-suicide occurred when the victim was trying to separate from the perpetrator, reinforcing what we know about the significant risk to victims and their children during periods of relationship separation.

In one case the perpetrator stalked his former partner and waited for her to return home. He then forced entry into the home and repeatedly beat her with an object. The perpetrator non-lethally strangled the victim and raped her when she fell unconscious.

In the other case, the perpetrator waited for the victim to fall asleep. He then repeatedly hit her in the head with an object and stabbed her more than a dozen times. She sustained significant physical injuries, including skull fractures and the *'evisceration'* of her internal organs.

Extreme levels of violence were not always physical in nature and there were also many examples of ongoing and insidious coercive controlling behaviours.

For example, in one case the perpetrator repeatedly belittled his partner for her substance use, called her derogatory names, and humiliated her by telling friends and neighbours private details about her life. He threatened her family and repeatedly told the victim to kill herself. Shortly before her suicide, the victim disclosed to a friend that she was *'at rock bottom'* and that she *'must be all the things he says I am'*.

25. Elena Campbell, Jessica Richter, Rob Hulls, Helen Cockburn, and Jo Howard, *The PIPA Project: Positive Interventions for Perpetrators of Adolescent Violence in the Home (AVITH)* (2020), https://www.anrows.org.au/project/the-pipa-project-positive-interventions-for-perpetrators-of-adolescent-violence-in-the-home-avith/.
26. Evan Stark, *Coercive Control: How Men Entrap Women in Personal Life* (Oxford, UK: Oxford University Press, 2009).
27. Australia's National Research Organisation for Women's Safety, *Defining and Responding to Coercive Control: Policy Brief* (2021), https://www.anrows.org.au/publication/defining-and-responding-to-coercive-control/.
28. Anthony Morgan and Hannah Chadwick, *Key Issues in Domestic Violence* (2009), https://www.aic.gov.au/publications/rip/rip7.
29. Hayley Boxall and Anthony Morgan, *Experiences of Coercive Control Among Australian Women* (2021), https://www.aic.gov.au/publications/sb/sb30.

A recurring theme in current research and across the Board's case reviews, is that perpetrators strategically use language to deny, justify, minimise and avoid responsibility for their violence, and to maintain power and control over their victims.[30] These types of behaviours are often a form of systems abuse,[31] commonly linked to coercive control. Even when perpetrators do acknowledge their violent behaviour, they often blame the victim for their own choices to use violence.

In one case considered by the Board in the current reporting period, the victim was assaulted and non-lethally strangled by her partner before she was able to flee and call police for help.

Upon the arrival of police, the perpetrator attempted to minimise and justify his violence by placing blame onto the victim, telling the responding officers that he *'may have possibly grasped her by the throat'* but that it was because she was *'being aggressive'*.

Positively, in this case police recognised the perpetrator's impression management tactics and attempts to divert blame onto the victim. In consultation with the victim, police took action to protect her by making an application for a protection order.

While the Board identified that there was a positive response in this case, in other cases, the Board has unfortunately observed evidence of collusion[32] where there is an acceptance of a perpetrator's minimisation, denial or victim-blaming without challenge, and/or where empathy is exhibited toward the perpetrator but not to the victim.

This can embolden perpetrators and places victims at further risk.

Spotlight on: the Safe and Together model

Significant investment has been made to improve contemporary understanding and child protection practice relating to domestic and family violence, such as through ongoing provision of Safe and Together training for child safety practitioners.

The Safe and Together model is an internationally recognised training program that maintains a strong focus on partnering with victims to keep themselves and their children safe, while also holding perpetrators accountable for their behaviour. The model highlights the intersection between child protection and domestic and family violence and is based on the concept that children are best served when child safety works toward keeping them safe and together with the non-offending parent.

In one case considered by the Board in the current reporting period, the perpetrator and victim had a young child together. Records indicate that the victim was attempting to separate from the perpetrator due to escalating verbal and emotional abuse, which included threats to take the victim's child. On one occasion, the perpetrator contacted child safety services and claimed that the victim had mental health issues and that he was worried she *'can't deal with the changes of parenting'* and would *'have another meltdown'*. He stated the victim was trying to leave him and take the baby and that she was *'not right in the head'*.

During the call, the victim spoke to child safety and stated that the department *'didn't have to worry'* because she '*had handed the baby back*' to her partner. Although child safety services were aware of prior concerns in relation to domestic and family violence perpetrated by the child's father towards its mother, it appears that the father's allegations were taken at face value.

The Board observed that child safety staff did not appear to recognise that the context and content of the father's phone call may have been behaviour designed to intimidate or control his partner, and this may have warranted further investigation. The Board also noted that no assessment or consideration was made in relation to the father's capacity to care for the child, but concerns were recorded in relation to the mother's *'capacity to be a protective parent'*.

30. Jeff Hearn, *The Violences of Men: How Men Talk About and How Agencies Respond to Men's Violence to Women* (Thousand Oaks, CA: SAGE Publications, 1998).
31. Systems abuse is a tactic used by perpetrators to gain advantage over, or to harass, intimidate, discredit, or otherwise control victims: Heather Douglas, 'Legal Systems Abuse and Coercive Control', *Criminology & Criminal Justice* 18/1 (2015), 84-99. https://doi.org/10.1177/1748895817728380.
32. Collusion' within this context does not reflect a legal definition of the term. It is the conscious or unconscious collaboration of two or more individuals to protect those engaged in unethical or illegal practices. This can involve friends, family or service systems, and can include the justification or minimisation of abusive behaviours, blaming the victim, and failing to intervene when violence is detected.

Telling it like it is: language matters

Across the cases reviewed in this reporting period, the Board repeatedly identified clear instances of poor or inaccurate record keeping by services that contributed to simplistic responses that failed to keep victims and children safe and hold perpetrators to account.

This often occurred through the use of mutualising and minimising language, such as by describing domestic and family violence or episodes of violence as '*communication issues*', '*relationship issues*', '*toxic*' relationships, '*domestic situations*', or '*anger management*' issues.

Language that mutualises violent behaviour implies that the victim is at least partly to blame, minimising the perpetrator's choice to use violence, distorting the reality of who did what to whom, and re-framing women's lived experiences of violence.[33] This almost always benefits perpetrators and disadvantages victims by concealing:[34]

- a perpetrator's responsibility and choice to use domestic and family violence.
- the impact of domestic and family violence on victims and children.
- how victims attempt to resist the violence they are experiencing.
- the severity of the domestic and family violence and dangerousness of the perpetrator.

They way in which domestic and family violence and/or the actions of perpetrators and victims are recorded, shapes the interpretation of, and responses to, what occurred. This includes responses to future reports of violence, which can result in ongoing, and compounding, harm.

As discussed by the Board previously, information sharing is a key component to understanding and responding to domestic and family violence risk and improving safety. This is because agencies often hold different information regarding the circumstances and risk factors relevant to the victim and perpetrator (and children) in each case.

Death review processes consistently show that not one individual or agency had a full picture of a perpetrator's pattern of violence prior to the death, regardless of the death type. It is only when this information is shared that the full picture of risk can be recognised and responded to.

However, effective information sharing is reliant on:[35]

- the integrity and quality of information shared.
- how the information is then understood.
- what action is taken in response to the information shared.

For example, in one case reviewed by the Board in the 2020-21 reporting period, the perpetrator was subject to a parole order for violent offences perpetrated against his partner, which included assaulting her and chasing her with an axe.

In this case the perpetrator had a significant history of intimate partner violence perpetration and had demonstrated high risk indicators of domestic and family violence lethality toward the victim and multiple prior partners (e.g. sexual assault, threats with weapons and non-lethal strangulation).

During his supervision, Community Corrections received information that the perpetrator had verbally abused and assaulted his partner during a further episode of violence. On receipt of this information, Community Corrections staff requested police to attend the victim's residence and conduct a 'welfare check'.

Given the perpetrator's significant history of violence towards the victim and prior partners, the Board questioned whether the term 'welfare check' accurately reflected the urgency of the response required.

The Board considered whether the term 'safety and risk assessment' may be more appropriate, as this reinforces the actions that must be undertaken, rather than just sighting a person and confirming they are still alive.

Domestic and family violence is often conceptualised and/or responded to as discrete 'incidents'; however, this narrow approach overlooks both the immediate risks and cumulative impact of violence and abuse.

Domestic and family violence is not a series of isolated incidents, but rather a pattern of behaviour that is characterised by coercive control. Therefore, experiences of domestic and family violence are best conceptualised as 'episodes', which acknowledges that there is both a past and future.[36]

An understanding of this can assist services and practitioners to better recognise the context in which behaviours occur (e.g. when victims use resistive violence in self-defence or self-protection), as well as any immediate and/or cumulative risk factors.

Appropriate language and terminology can also be used by services to:

- expose a perpetrator's choice to use domestic and family violence.
- respect and honour how victims resist domestic and family violence.
- assess the severity of domestic and family violence, dangerousness of the perpetrator and future risk toward victims and children.
- reduce stigma and discrimination toward both victims and perpetrators.

33. Allan Wade and Linda Coates, 'Language and Violence: Analysis of Four Discursive Operations', *Journal of Family Violence* 22 (2007), 511-522. https://doi:10.1007/s10896-007-9082-2.
34. Allan Wade and Linda Coates, 'Telling it Like It Isn't: Obscuring Perpetrator Responsibility for Violent Crime, *Discourse & Society* 15/5 (2004), 499–526. https:/doi:10.1177/0957926504045031.
35. Denise Wilson, Rachel Smith, Julia Rowena Tolmie, and Irene de Haan, 'Becoming Better Helpers: Rethinking Language to Move Beyond Simplistic Responses to Women Experiencing Intimate Partner Violence', *Police Quarterly* 11/1 (2015), 25-31. https://10.26686/pq.v11i1.4529.
36. Ibid.

In considering how services gather and share information about people's experiences of domestic and family violence, it is also necessary to be mindful that perpetrators and victims may both use language to minimise and conceal domestic and family violence, but for different reasons.

As discussed throughout this report, and by the Board previously, perpetrators often use tactics of minimisation and denial to conceal their choice to use violence and place blame on the victim.

In contrast, victims may seek to minimise their experiences of violence to:[37]

- try and maintain control over their circumstances.
- avoid victim-blaming, stigma, discrimination, or unwanted service intervention (e.g. child removal).
- conceal their resistance to the abuse (that may involve resistive violence).
- keep themselves and their children safe.

Consequently, the way in which services use language to describe and contextualise domestic and family violence must be through the lens of perpetrator accountability and an understanding that using violence is a choice, as well as respecting the lived realities of victims experiencing domestic and family violence, including the ways in which they resist.

Spotlight on: Stigma and discrimination

People using and experiencing domestic and family violence often present with other complex, psycho-social needs. For example, they may also experience issues associated with criminal offending, homelessness/housing instability, disability, sexuality and gender identity, cultural background, mental illness, physical health conditions, and substance use. For perpetrators, victims, and their children, the added stigma and discrimination associated with these factors can create significant barriers to help-seeking and engagement. Experiences of stigma and discrimination can occur across all areas of the service system including healthcare, child safety, social services, and the criminal justice system. It can also occur within the community more broadly.

For example, substance use (particularly illicit substance use) is recognised as one of the most stigmatised health conditions in the world. A recent report by the Queensland Mental Health Commission titled *Changing attitudes, changing lives*, found that people with lived experience of problematic substance use commonly experience stigma and discrimination in their day to day lives, including in their interactions with services. This can involve feeling judged or looked down on, causing further shame and embarrassment. This is particularly damaging for people at a time when they are seeking help.

There are many misconceptions and stereotypes about substance use, such as that people who experience problematic substance use are untrustworthy or inherently violent and erratic. While many perpetrators of domestic and family violence experience co-occurring issues like problematic substance use, this does not *cause* their violence. It may simply contribute to situations where violence, particularly physical violence, occurs.

For victims with problematic substance use, stigma and discrimination can create additional barriers when trying to access support. For example, perpetrators may exploit victim's substance use as a further means to control or humiliate them. In one case considered by the Board in the current reporting period, the victim had a significant history of polysubstance use associated with her experiences of abuse from a young age, including domestic and family violence. In this case, while the perpetrator also had a history of problematic substance use, he would repeatedly belittle the victim about her substance use, calling her a *'junkie'* and other derogatory names. He also attempted to isolate the victim from support services, calling her *'weak'* when she tried to seek treatment and support.

For people using or experiencing domestic and family violence, a respectful, non-judgemental approach is required to break down stereotypes and address underlying patterns of abuse, risk, and harm. In any service interaction with perpetrators, they must, however, also be held accountable for their behaviour and choice to use violence.

37. Allan Wade and Linda Coates, 'Language and Violence: Analysis of Four Discursive Operations', *Journal of Family Violence* 22 (2007), 511-522. https://doi:10.1007/s10896-007-9082-2.

Honouring resistance

How domestic and family violence is recorded and conceptualised within agency records will influence how services perceive the role of victims in the violence they have or continue to experience, as well as the actions taken or not taken by victims to keep themselves and their children safe.

Across its case reviews, the Board has repeatedly observed that agency records and responses fail to reflect that perpetrators *choose* to engage in violent and abusive behaviour and that it is natural for victims to resist this abuse. This results in victim-blaming, where services place blame on a woman's character, appearance, decision-making, or situation for the violence that she has experienced, or for 'failing' to keep herself and her children safe, rather than placing blame on the perpetrator who chooses to use violence.[38]

Unfortunately, the Board has observed many instances of victim-blaming attitudes across its case reviews, which has then resulted in a lack of understanding about the victim's level of risk and poor service responses that have failed to keep the victim and their children safe.

For example, in one case considered by the Board in the current reporting period, the victim called police for assistance in relation to her experiences of domestic and family violence from her partner. Although both parties were noted by police to be intoxicated, the victim was perceived to be '*more intoxicated*' and therefore *'the person causing trouble'*.

In this case, police did not document the victim's allegations about her partner's behaviours but determined that they were '*clearly not a form of intimidation, harassment or abuse, despite what* [she] *may say*'.

This was despite a protection order being in place to protect the victim from her partner following prior police callouts in relation to domestic and family violence.

While victims are often stereotypically viewed as passive and submissive, whenever an individual experiences violence or abuse they resist. The way in which victims of domestic and family violence resist, is dependent on their individual circumstances and perceived level of risk.

Victims understand that any defiant acts will result in an increase in the perpetrator's use of violence and abuse.[39] Similarly, perpetrators anticipate that victims will resist their violence and so they take strategic and deliberate steps to conceal their behaviour, minimise their use of violence, or suppress victim resistance through coercive control (e.g. through threats and intimidation and isolating victims from formal and informal support systems).

In their day to day lives, victims resist violence in many ways that may be unsuccessful in stopping the abuse, but are important expressions of dignity, self-respect and their efforts to protect themselves and others, particularly their children.[40] Victims may use covert and/or overt forms of resistance to regain a sense of achievement or autonomy (which is often eroded over time), sometimes in the hope of changing, or leaving, an abusive partner.[41]

Because of the dangerous situation many victims are faced with, they generally engage in covert resistance strategies like complying with the perpetrator's demands, trying to maintain relationships with others, or thinking and acting in ways that may expose the violence to others.

In one case reviewed by the Board in the current reporting period, the victim (and homicide deceased) attempted to resist her partner's abuse by developing a secret code and keeping a diary of every time he assaulted her. The Board identified this to have been a form of covert resistance, which may have been an attempt by the victim to maintain her dignity or regain a sense of control over her situation. She may also have been attempting to gather evidence of the perpetrator's abuse.

To resist and expose the violence that they are experiencing, some victims may seek formal support (e.g. engaging with specialist domestic and family violence services and counselling services) or pursue criminal justice responses (e.g. making private protection order applications or calling police).

When victims of domestic and family violence do seek support from formal services, it is highly likely that they have experienced abuse for an extended period of time and/or feel that they are no longer able to manage the situation on their own.[42] For example, research suggests that when women do call police for help, this often occurs when they believe their life is in danger.[43]

Victims may also call police because they want the perpetrator removed from their property or to seek help for the abuser.[44]

This is a common theme throughout the Board's case reviews, where victims have called police seeking help for perpetrators after they made suicidal threats or used self-harm in the context of coercive control. In many cases, the initial report to police was not recognised as domestic and family violence related.

38. Jessica Taylor, *Why Women Are Blamed for Everything* (London, UK: Little, Brown Book Group, 2020).
39. Jennifer Caldwell, Suzanne Swan, Christopher Allen, Tami Sullivan, and David Snow, 'Why I Hit Him: Women's Reasons for Intimate Partner Violence', *Journal of Aggression, Maltreatment & Trauma* 18/7 (2009), 672-697. https://doi:10.1080/10926770903231783.
40. Allan Wade and Linda Coates, 'Language and Violence: Analysis of Four Discursive Operations', *Journal of Family Violence* 22 (2007), 511-522. https://doi:10.1007/s10896-007-9082-2.
41. Brittany Hayes, 'Women's Resistance Strategies in Abusive Relationships: An Alternative Framework', *SAGE Open* 3/3 (2013), 1-10. https://doi:10.1177/2158244013501154.
42. Silke Meyer, 'Seeking Help for Intimate Partner Violence: Victim's Experiences When Approaching the Criminal Justice System for IPV Related Support and Protection in an Australian Jurisdiction', *Feminist Criminology* 6/4 (2011), 268-290. https://doi:10.1177/1557085111414860.
43. Betty Barrett and Melissa St Pierre, 'Variations in Women's Help Seeking in Response to Intimate Partner Violence: Findings from a Canadian Population-based Study', *Violence Against Women* 17/1 (2011), 47-70. https://doi:10.1177/1077801210394273.
44. Betty Barrett, Amy Peirone, Chi Ho Cheung, and Nazim Habibov, 'Pathways to Police Contact for Spousal Violence Survivors: The Role of Individual and Neighbourhood Factors in Survivors' Reporting Behaviors', *Journal of Interpersonal Violence* 36/2 (2021), 636-662. https://doi:10.1177/0886260517729400; Betty Barrett, Melissa St Pierre, and Nadine Vaillancourt, 'Police Response to Intimate Partner Violence in Canada: Do Victim Characteristics Matter?', *Women & Criminal Justice* 21/1 (2011), https://doi:10.1080/08974454.2011.536057; Amy Leisenring, 'Victims' Perceptions of Police Response to Intimate Partner Violence', *Journal of Police Crisis Negotiations* 12/2 (2012), 146–164. https://doi:10.1080/15332586.2012.728926.

Emerging Practice: Police Communication Centre initiatives

In 2015, the Police Communications Centre Mental Health Liaison Service (PCC MHLS) was established as a joint initiative between the Queensland Police Service and Queensland Health. The PCC MHLS was established to improve responses to people with mental illness who may also have contact with police and/or ambulance services during a mental health episode.

The PCC MHLS aims to improve outcomes for individuals experiencing mental health crisis in the community by increasing situational awareness for frontline police officers, enhancing mental health service responses and facilitating mental health service collaboration between police, health and ambulance services state-wide. An important function of the PCC MHLS is to interpret relevant clinical information and provide this in a way that is readily understood and able to be implemented by frontline police officers. For example, information provided to police may influence how frontline officers respond to an individual in crisis, including communication strategies and styles, triggers and strategies for de-escalation and engagement with the individual.

In response to a prior recommendation of the Board, police also commenced a trial in September 2018 to embed two Domestic and Family Violence Coordinators (DFVPC) within the Brisbane Police Communications Centre (PCC). The purpose of the initiative was for DFVPCs to provide specialised, timely and relevant advice to frontline officers attending domestic and family violence related calls for services, such as a relevant summary of the parties involved in the occurrence; enhanced questioning techniques; legislative and procedural advice; and possible safety management strategies.

Due to its success, the trial has continued to be extended. On 1 March 2021, the number of DFVCs was increased to six full-time officers to provide ongoing support to frontline police officers responding to domestic and family across Queensland.

In many instances, a victim may also not wish for any further action to be taken by police, beyond the initial crisis response, such as by pursuing criminal charges against the perpetrator.

There are many reasons for this. For example, it has long been established that fear of retaliation or retribution by the perpetrator is a powerful deterrent against victims taking, or supporting, further action after a police callout.[45] In some instances, victims may also wish to protect the perpetrator from punitive consequences.[46]

This adds additional challenges for police in responding as they are required to investigate all allegations of domestic and family violence.[47]

For example, in one case considered by the Board, the victim called police after she became frightened of her partner, who was intoxicated and verbally abusive towards her. In response, police made an application for a protection order naming the victim as the aggrieved.

In this case, the victim was also engaged with a counsellor for support in relation to her experiences of domestic and family violence. The victim later told her counsellor that she was worried about calling police again, because of her partner's high-profile employment and the potential consequences for him if he was charged/convicted of breaching the protection order.

To strengthen system responses to domestic and family violence, there is a need to ensure sufficient flexibility and recognition of the choices victims make to stay safe and re-assert their dignity throughout their experiences of domestic and family violence.

Victim resistance is often overlooked or misunderstood across the system. Frequently, it is invisible to services unless it is overt or successful in stopping the violence, such as when women use physical violence for self-defence or self-protection.[48] This is known as resistive violence.

While women are more likely to use physical violence in self-defence and in the context of violence being perpetrated against them, men are more likely to use physical violence to maintain control of their female partner and erode their autonomy and personhood (coercive control).[49]

To effectively respond, services need to understand the gendered nature of domestic and family violence and consider women's use of physical violence in context, such as by identifying any underlying patterns of coercive control. This is particularly important to avoid the misidentification of female victims as perpetrators of domestic and family violence when they have tried to resist their abusers overtly.

45. For early examples, see: Joanne Belknap, Ruth Fleury-Steiner, Cris Sullivan, and Heather Melton, 'To Go or Not to Go? Preliminary Findings on Battered Women's Decisions Regarding Court Cases' in Helen Eigenberg (ed.), *Woman Battering in the United States: Till Death Do Us Part* (United States: Waveland Press Inc., 2000); Frank Cannavale and William Falcon, *Witness Cooperation: With a Handbook of Witness Management* (Washington, D.C.: Lexington Books, 1976); Daisy Quarm and Martin Schwartz, 'Domestic Violence in Criminal Court: An Examination of New Legislation in Ohio' in Claudine SchWeber and Clarice Feinman (eds.), *Criminal Justice Politics and Women: The Aftermath of Legally Mandated Change* (Binghamton, NY: Haworth Press, 1985).
46. Richard Felson, Steven Messner, Anthony Hoskin, and Glenn Deane, 'Reasons for Reporting and Not Reporting Domestic Violence to the Police', *Criminology* 40/3 (2002), 617–648. https://doi:10.1111/j.1745-9125.2002.tb00968.x.
47. In accordance with s. 100 of the *Domestic and Family Violence Protection Act 2012* (Qld), police are required to investigate allegations of domestic and family violence if a police officer reasonably suspects that domestic and family violence has been committed.
48. Allan Wade and Linda Coates, 'Language and Violence: Analysis of Four Discursive Operations', *Journal of Family Violence* 22 (2007), 511-522. https://doi:10.1007/s10896-007-9082-2.
49. Walter DeKeseredy and Molly Dragiewicz, 'Understanding the Complexities of Feminist Perspectives on Woman Abuse: A Commentary on Donald G. Dutton's Rethinking Domestic Violence', *Violence Against Women* 13/8 (2007), 874-884. https://doi:10.1177/1077801207304806.

Spotlight on: Enhanced identification of the person most in need of protection

Since 2017, there have been a range of legislative amendments designed to improve criminal justice system responses to victims of domestic and family violence, such as by ensuring that consideration must be given to the identification of the person most in need of protection, and whether a protection order is necessary or desirable. The *Domestic and Family Violence Protection Act 2012* requires that in circumstances where there are conflicting allegations of domestic and family violence or an indication that both persons in a relationship are committing acts of violence, including for their self-protection, the person who is most in need of protection should be identified.

In response to a prior recommendation made by the Board, Australia's National Research Organisation for Women's Safety (ANROWS) was commissioned to undertake research to consider opportunities for improvement in identifying the person most in need of protection by police and courts. ANROWS found there is a gap between the stated intention of the Queensland legislation and its practical application. This is predominantly due to a lack of understanding around key concepts (such as the gendered nature of domestic and family violence, patterns of coercive control and resistive violence), organisational practices and culture, and uncertainty about procedural expectations.

There is also a lack of explicit guidance in relevant legislation, policy, and guidelines to assist police and courts to identify patterns of coercive control to distinguish between the primary perpetrator and victim of violence.

ANROWS also found that police often focus on single acts of violence without appropriate consideration or regard to the context in which the violence occurred. This incident-based approach contributes to the misidentification of primary victims as perpetrators that is further exacerbated by gendered expectations of women, misperceptions of victim behaviour, and a lack of understanding in relation to violence that is used by victims for self-protection or self-defence.

It was also identified that police sometimes err on the side of caution when making protection order applications and defer to the magistrate to determine whether an order is warranted. However, magistrates and prosecutors may be reliant on the initial assessment made by police. ANROWS noted that this can create a *'pinball effect where each decision-maker defers to another's assessment of the appropriateness of an order'*. This also means that system accountability for that assessment is unclear.

To address these concerns, ANROWS made three key recommendations for policy and practice reform and to create guidance for police and courts on identifying patterns of coercive control; improving processes of decision making and accountability between police and courts; and creating guidance for magistrates so that they have consistent understandings of how and when they can dismiss inappropriate applications and/or protection orders. ANROWS found that effective training on the appropriate application of the law would result in:

- trauma-informed and culturally and gender-sensitive understandings of domestic and family violence.
- an understanding of Aboriginal peoples and Torres Strait Islander peoples' resistance to police intervention and strategies to support victim/survivor cooperation.
- an ability to detect image management and systems abuse by perpetrators of domestic and family violence.
- skills to investigate and present evidence of coercive control and resistive violence.
- an ability to determine when action other than an application for a protection order is appropriate.

Understanding the intention and concepts linked to relevant legislation and policy is crucial to the appropriate application of the law.

In considering the findings by ANROWS, the Board noted that there has been recent case law* that may influence how magistrates identify the person most in need of protection; however, this may not necessarily align with the overarching intent of the relevant provisions.

During this reporting period, the Board again noted issues in identifying the person most in need of protection in five cases. In each case, regardless of the death type, this occurred when the primary female victim had used resistive violence in self-defence or for self-protection. This demonstrates the ongoing need for greater awareness and understanding of how, when and why women may use violence in intimate partner relationships and that it is critically important that the person most in need of protection is correctly identified at every point of contact with services who are in a position to respond.

* For example, see: SRV v Commissioner of the Queensland Police Service & Anor [2020] QDC 208.

In one case considered by the Board, the victim (and homicide deceased) pushed her partner in the chest after he repeatedly accused her of infidelity (an example of his coercive control within the context of this relationship). The perpetrator then grabbed a knife and threatened the victim, who was able to run away when a family member intervened. The perpetrator then assaulted the family member (the victim's mother) and repeatedly punched her in the head.

Police completed applications for cross protection orders on the basis that both parties had used physical violence. This was despite the perpetrator having a documented history of physical violence towards the victim, including sexual assault. In reviewing this case the Board considered that this was a misunderstanding of how and when female victims use violence in self-defence or to resist the abuse that they have, or are continuing, to experience.

In this case, the victim and perpetrator were both Aboriginal. As the Board has discussed previously, the use of resistive violence by Aboriginal and Torres Strait Islander women can be more likely to result in criminal charges, contributing to the increasing over-representation of Aboriginal and Torres Strait Islander women in the criminal justice system and fear and distrust in relation to reporting violence to police or other services.

Recommendation 2:

That the Queensland Government implement the recommended policy and practice reform proposed by Australia's National Research Organisation for Women's Safety (ANROWS) in its report 'Accurately identifying the "person most in need of protection" in domestic and family violence law'.

This should include creating guidance for police and courts on identifying the person most in need of protection that is informed by international models and approaches in other jurisdictions.

Taking into account recent case law, this should also extend to the consideration of potential legislative amendments to strengthen existing provisions designed to ensure the identification of the person most in need of protection in proceedings under the Domestic and Family Violence Protection Act 2012.

Recommendation 3:

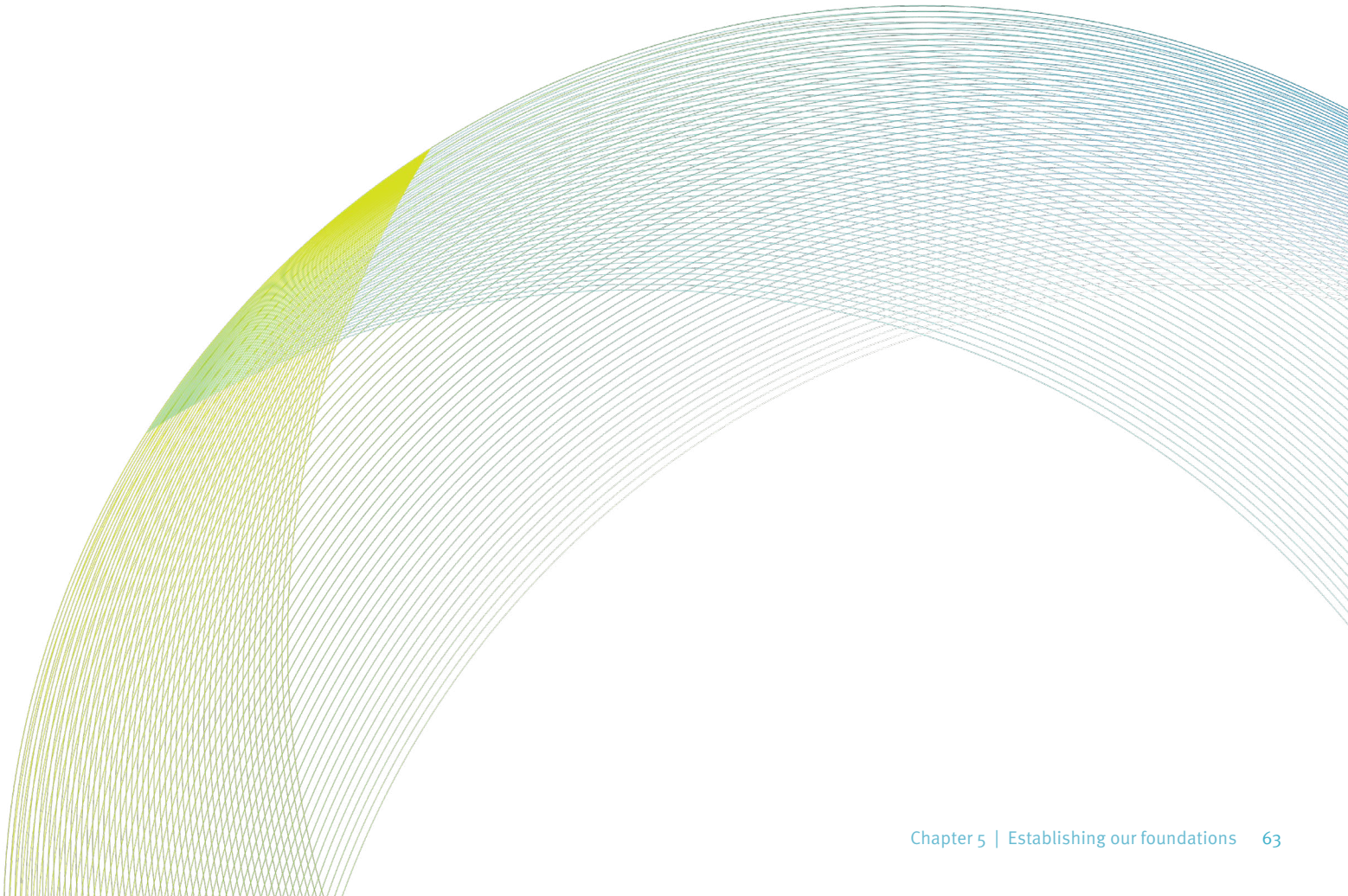
That the Queensland Government explore the development of an approach to triage and case management for domestic and family violence cases before the Magistrates and District Courts to identify those that are complex, high risk, or that involve cross applications for protection orders. This should seek to ensure that all relevant evidence is available to inform judicial decision-making, beyond the information gathered by police at the scene at a point of crisis.

This approach should focus on identifying all relevant information and enable the gathering of additional information where gaps are identified to support judicial decision-making. It should also take into account what is known about systems abuse, and the inherent disadvantage that many victims of domestic and family violence face in their interactions with the justice system; as well as existing models operating in other jurisdictions or courts.

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

Conversely, collusion with a perpetrator's deflections, minimisations or victim-blaming by services contributes to inconsistent, incoherent, and ineffective responses to those who use violence in their intimate partner or family relationships and serves to reinforce their use of violence within the relationship. If initial attempts at reporting the violence are not responded to because service providers believe a perpetrator's version of events, this reduces further help-seeking by a victim by reinforcing that no-one is likely to believe them or assist even if help is sought.

Procedural Guidelines of the Board, 2016



Chapter 6: Understanding service contact and lethality risk indicators

Key findings

- A history of domestic and family violence was able to be established in 58% (206 of 353) of homicides in a domestic and family relationship that occurred between 1 July 2006 to 30 June 2020.
- Of these, there was identifiable service contact prior to the death in 76.2% (157 of 206) of cases, and in another 49 cases the domestic and family violence was known to family or friends, but not reported to any services prior to the death.
- For domestic and family violence suicides that occurred between 1 July 2015 to 30 June 2020, there was identifiable service contact prior to the death in 89.6% (199 of 222) of cases. In another 23 cases, the domestic and family violence was known to family or friends, but not reported to services prior to the death.
- Patterns of service contact differed dependent on the type of the death. This contact was either directly related to domestic and family violence or pertained to other related concerns such as mental health, child protection, suicidal ideation or attempts, or alcohol and other drug use where domestic and family violence was an underlying issue.
- In considering this data, it is important to be mindful that this contact was not always immediately prior to the death, and some contacts may have related to violence within previous relationships. However, this is still important to collate as it supports a consideration of how systems respond to victims and perpetrators over the longer term, even if a lack of system contact within proximity to the death may have limited the ability of individual agencies to directly intervene immediately prior to a homicide or suicide.
- This highlights the need to better understand how, when and why data is recorded and reported across systems. In support of this, further work will be undertaken during 2021–22 to consider the frequency and incidence of service contact across cases.
- For intimate partner homicides, some of the most prevalent lethality risk indicators were a prior history of domestic and family violence (83.6%), excessive alcohol and other drug use by the perpetrator (57.6%), a victim's intuitive sense of fear of the perpetrator (53.2%), actual or pending separation (52.2%), sexual jealousy (49%) and a perpetrator controlling most or all of a victim's daily activities (40.2%).

As outlined in Chapter 2, the Board is required to analyse data and apply research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland.

This chapter outlines the known history of service contact for homicides in a domestic and family relationship where a history of violence could be established[50] (between 2006–07 and 2019–20), and domestic and family violence suicides (between 2015–16 and 2019–20).

This data is subject to change as the investigation and review of a death progresses, as it can take some time for a full understanding of the circumstances of a death, its relationship to domestic and family violence, and the prior history to be established. This means that, for more recent cases, there can be data gaps. Therefore, data from the 2020–21 reporting period has been excluded in relation to service contact.

This chapter also presents data in relation to lethality risk indicators from a smaller subset of intimate partner homicides that occurred between 2011 and 2018, where a history of violence could be established. This is a smaller subset of data because the Queensland domestic and family violence death review process was initially established in 2011 and data pertaining to deaths prior to this point tends to be quite limited (especially in relation to risk indicators).

The history of domestic and family violence prior to a death, and not the homicide or suicide event in and of itself, is the focus of this chapter.

This is an important distinction, as it recognises the complex circumstances in which a domestic and family violence death may occur, and the need for a nuanced approach to be undertaken when reviewing and identifying opportunities for possible intervention or prevention of these deaths. While in most cases the homicide deceased is the primary victim and the homicide offender is the primary perpetrator, this is not always the case. In a small proportion of cases a female victim may kill their abusive partner, and in others a child may be killed by a parent or caregiver who was in a relationship where one person perpetrated domestic and family violence toward the other.

Australian Domestic and Family Violence Death Review Network Homicide Consensus Statement

The Australian Domestic and Family Violence Death Review Network is a collaboration of established death review teams from each state and territory. To support a nationally consistent approach to the reviews of these deaths, the Network has developed the Homicide Consensus Statement. This Statement establishes a nationally consistent definition of a domestic and family violence related homicide and sets out the processes for identifying and classifying these types of deaths, taking into consideration the case type, the intent, the relationship between the deceased and the homicide offender, and the domestic and family violence context prior to a death.

Importantly, the agreed definition recognises that the existence of an intimate partner or familial relationship between a deceased and offender does not, in itself, constitute a domestic and family violence homicide.

In a small proportion of cases, other situational factors determine the fatal event, such as the offender experiencing an acute mental health episode. These deaths do not feature many of the characteristics known to define domestic and family violence, such as controlling, threatening or coercive behaviour; having previously caused the other person to feel fear; or evidence of past physical, sexual and/or other abuse.

50 The Board reviews service system records as well as witness statements and other information obtained as part of the coronial investigation. The presence of domestic and family violence may have been identified by review of service system records or by consideration of other documented information.

Accordingly, data in this chapter is differentiated by:

- the *primary victim*, who upon review is the person most in need of protection, even if they themselves were known to use violence. A primary victim may be the deceased (by homicide or suicide), the parent or caregiver of a deceased child (filicide cases), or (while statistically rare) a homicide offender. For domestic and family violence suicides, the primary victim may be otherwise connected to the death, such as the partner of the primary perpetrator of violence who died by suicide.
- the *primary perpetrator*, who upon review is the person most likely to cause harm, and who exhibited a pattern of coercive controlling behaviour prior to the death. A primary perpetrator may be a suicide deceased, homicide offender, parent or caregiver of a deceased child (filicide cases), or (while statistically rare) a homicide deceased. For suicides, the primary perpetrator may also be otherwise connected to the death, such as the partner of the primary victim of violence who died by suicide.

While known service system contact is recorded for all victims and perpetrators of domestic and family violence involved in a death to inform the identification of potential opportunities for intervention or prevention, when considering this chapter, it is important to be mindful that:

- the data presented records where primary victims and primary perpetrators have had contact with a service and does not reflect the nature of this contact (including whether the response was to a high standard or systemic issues were identified).
- the victim or perpetrator may have had contact with other entities or agencies, but this was not identified through the review process.
- the service contact may relate to a person's experience of domestic and family violence in current or former relationships and may not have been within immediate proximity of the death. While much of the contact recorded is directly related to domestic and family violence, it may also have been in relation to mental health or alcohol and other drug use, suicidal ideation or attempts, child protection concerns, and/or maternity and antenatal care where domestic and family violence was an underlying issue.
- the percentages outlined in Figures 29, 30, 31, 32 and 33 do not reflect the number of contacts with respect to an individual perpetrator and/or victim, which can span from minimal contact with one or two agencies, to multiple contacts across (current and former relationships) and many agencies.

In considering this data, the Board noted that a deeper understanding is required about how, when and why victims, their children and perpetrators come into contact with services in relation to domestic and family violence as a presenting or underlying issue.

This includes the need to better understand how information about domestic and family violence is recorded and shared across agencies, and the frequency and incidence of known service contact, including within immediate proximity of the death. This will be an area of focus throughout 2021–22 by the Board to support an increased understanding of immediate and longer-term opportunities for intervention.

Our approach

- A history of violence is not able to be established in all homicides in a domestic and family relationship.
- This is in part because of a known under-reporting of domestic and family violence (to formal and informal supports).
- As recognised by the Australian Domestic and Family Violence Death Review Network this also acknowledges that not all homicides in a domestic and family relationship are, upon review, domestic and family violence related.

Our focused data

- This chapter focuses on those homicides and suicides where a history of domestic and family violence prior to the death was able to be established and a review undertaken.
- This seeks to support a deeper understanding of what services victims and perpetrators may have had contact with.
- For intimate partner homicides, this chapter also outlines lethality risk indicators that were identified prior to the death where a full review was completed.

Our future priorities

- As the data contained in this chapter relates to a persons' experiences of violence in current and former relationships; and includes contact where domestic and family violence was either a presenting or underlying issue, more analysis is required.
- This will help improve understanding of how, when and why victims and perpetrators present to services, including within immediate proximity of the death and over the longer term.

Domestic and family violence homicides known service contact

A history of domestic and family violence was able to be established in 58.4% (206 of the 353) of homicides in a domestic and family relationship that occurred between 1 July 2006 and 30 June 2020. This number is inclusive of collateral homicides. In an additional 13 homicides in a domestic and family relationship, a history of domestic and family violence was not yet identifiable, but could not be excluded due to insufficient information.

Of the 353 homicides in a domestic and family relationship in this time period, a history of domestic and family violence was able to be established in:

- 68.2% (118 of 173) of intimate partner homicides that occurred between 1 July 2006 and 30 June 2020.
- 47.1% (73 of 155) of family homicides that occurred between 1 July 2006 and 30 June 2020.
- 60% (15 of 25) collateral homicides that occurred between 1 July 2006 and 30 June 2020.

Intimate partner violence homicides

As outlined in Figure 29, of the 118 homicides in an intimate partner relationship where a history of violence was established, the primary victim of violence had contact with services in 91 cases. In another 27 cases, the domestic and family violence that the primary victim experienced was reported to family or friends but was not reported to any services prior to the death.

By contrast, in 87 of the 118 intimate partner homicides where a history of domestic and family violence was established, the primary perpetrator had prior contact with services. In another 31 of these cases, the domestic and family violence was known to family or friends but was not reported to any services prior to the death.

As shown in Figure 29, in cases where there was recorded service contact, most primary victims in the intimate partner homicide had prior contact with police (84.6%) (77 of 91). This reflects the role of the police as a first responder to domestic and family violence, and other related concerns (e.g. suicidal threats or attempts).

Recorded contact may have been in relation to a victim or perpetrator's experiences of violence within current and/or former intimate partner and/or family relationships.

In some instances, while contact was not explicitly recorded by police as domestic and family violence related, the qualitative review of all available information identified that the behaviour disclosed to attending officers was indicative of domestic and family violence. For example, this may have included disclosures in relation to destruction of property, expressed suicidal ideation within the context of a relationship separation, a verbal altercation where a relevant relationship was disclosed or, in some instances, physical violence.

On occasion, this contact was recorded on the police system as a 'street check', 'welfare check', 'child harm report' or 'community assist', instead of a domestic and family violence occurrence. In other instances, the initial call for service may have been for assistance for another issue, and the victim and/or perpetrator made disclosures about domestic and family violence to responding officers.

The importance of services accurately recording domestic and family violence contacts is expanded on in greater detail in Chapter 5, although it is recognised that there are challenges in easily achieving this within existing agency systems. In its 2016–17 Annual Report, the Board also recognised issues in the accuracy of services recording of domestic and family violence-related contact, and changes have been progressed by agencies in response to the Board's recommendations.[51]

For primary victims, the next most common contact was with the Magistrates Courts for protection order/s in 47.3% (43 of 91) of cases, and with hospitals in 27.5% (25 of 91) of cases. Contact with hospitals may have been directly related to a victim's experiences of violence (e.g. treatment for assault related injuries) or because of other presenting concerns where domestic and family violence was an underlying issue (e.g. alcohol and other drug treatment, suicidal ideation or attempts, or antenatal care).

For primary perpetrators of violence, contact with police and Magistrates Courts was proportionally similar to primary victims (88.5%; 77 of 87 and 47.1%; 41 of 87, respectively).

Primary perpetrators had higher levels of contact with corrective services in 26.4% (23 of 87) of cases compared to 14.3% (13 of 91) of cases for primary victims. Primary perpetrators also had higher levels of contact with mental health services[52] in 28.7% (25 of 87) of cases compared to 20.9% (19 of 91) of cases for primary victims. As discussed by the Board within this report, this highlights the importance of mental health practitioners understanding how to safely respond to perpetrators of domestic and family violence.

A history of violence was able to be established in 73 homicides within a family relationship that occurred between 2006–07 to 2019–20.

There are key differences in the patterns of service contact for homicides in a family relationship for the adults and children who were killed by a family member where a history of violence was able to be established, compared to service contact in the intimate partner homicides.

51 For example, the Board recommended that the Queensland Police Service ensure that all first responding officers have timely access to electronically available, current, relevant, and accurate information held across their data systems in relation to a prior history of domestic and family violence for perpetrators and victims, in a format which aims to enhance but not disrupt, an operational response: Recommendation 1 of the 2016–17 Domestic and Family Violence Death Review and Advisory Board.

52 Inclusive of contact with psychologists and counsellors.

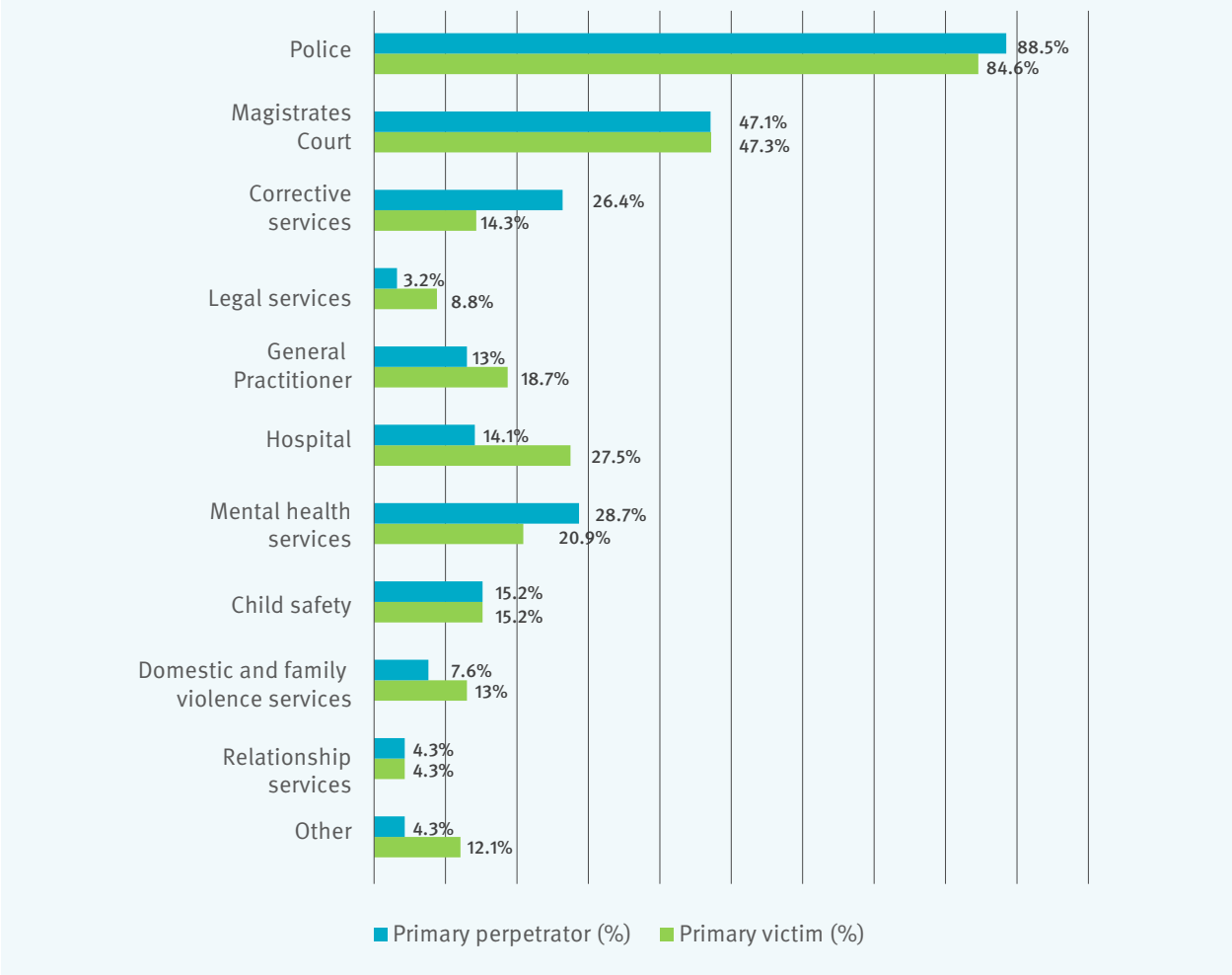


Figure 29. Service system contact, intimate partner homicides, primary victims and perpetrators of violence, 2006–07 to 2019–20

Family violence related homicides

A history of violence was able to be established in 73 homicides within a family relationship that occurred between 2006–07 to 2019–20. This included:

- 27 homicides of adults who were killed by a family member.
- 46 homicides of children who were killed by a parent or caregiver (filicides).

When considering the analysis of service system contact in relation to filicides, it is important to be mindful that the term primary victim does not refer to the deceased child and instead refers to the parent or caregiver of the child who was identified as the person most in need of protection prior to the death. Similarly, the primary perpetrator is the parent or caregiver who was identified as the person most likely to cause harm in the context of domestic and family violence, irrespective of whether they themselves were solely charged for the death.

For the 46 filicides where a history of domestic and family violence was able to be established, 37 of the primary victims of domestic and family violence (most commonly the child's mother) had prior contact with services, and 38 of the primary perpetrators of domestic and family violence (most commonly the child's paternal caregiver) had prior contact with services. A history of domestic and family violence was known to family and friends, but not reported to services for another 9 primary victims, and 8 primary perpetrators.

For primary victims of domestic and family violence in filicide cases, 70.2% (26 of 37) had contact with child safety services, compared to 31.6% (12 of 38) of the primary perpetrators.

This contact may have been in relation to allegations of harm to the deceased child, their siblings, or other children that the primary victim or primary perpetrator had care of.

This contact refers to those cases where direct action was taken by child safety services (including an investigation and assessment or intervention) as well as child concern reports,[53]

53 A child concern report is recorded when the information received by the Child Safety Intake Service does not meet the threshold for a notification. A child safety officer may respond by providing information and advice to the person making the concern report; making a referral to a FaCC Service for early intervention and prevention services and/or providing any relevant information to Police where there is a possible criminal offence.

where child safety services may have received a notification of harm and determined that no further action was required without having direct contact with that child or family.

Comparative to intimate partner and family homicides of adults, far fewer primary victims in filicide cases had contact with the police (35.1%; 13 of 37). Almost 60.5% (23 of 38) of perpetrators had some contact with police.

There were relatively similar levels of contact with Magistrates Courts and GPs between primary victims and primary perpetrators. Primary victims were also more likely to have contact with legal services[54] (13.5%; 5 of 37) than primary perpetrators (2.6%; 1 of 38).

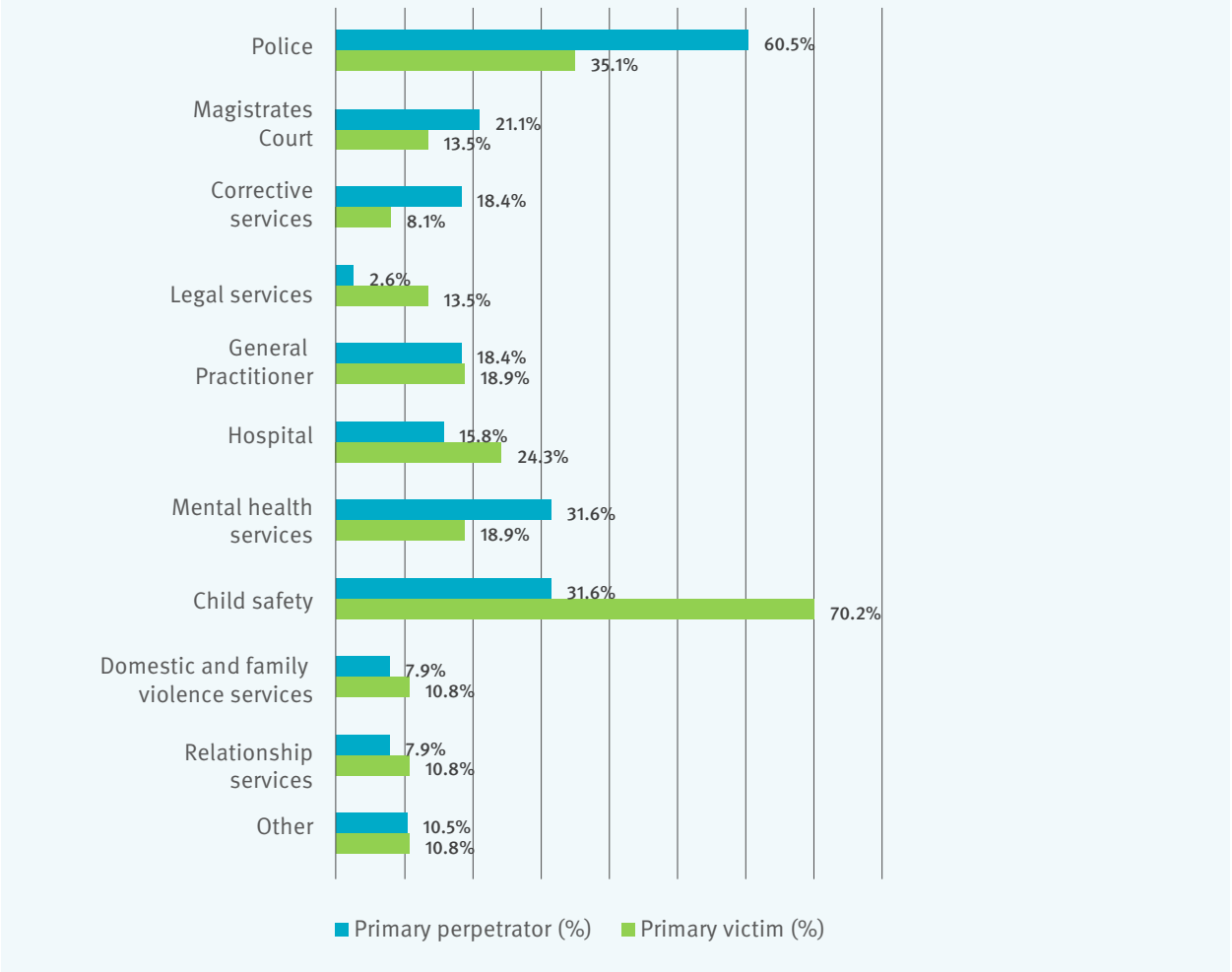


Figure 30. Service system contact, homicides in a family relationship, child deceased, 2006–07 to 2019–20

As outlined in Figure 31, compared to intimate partner homicides, there was slightly less contact with police for the family homicides involving adult victims where a history of domestic and family violence was established and where service contact was recorded. This contact was less likely to be in relation to reports of violence between the homicide offender and deceased.

54 This includes family law proceedings.

Contact may instead have been in relation to episodes of domestic and family violence with other persons (such as current or former partners and other family members) or other related concerns. There was also less contact with Magistrates Courts in relation to protection order proceedings for both the primary victim and primary perpetrator (22.2%; 4 of 18 and 31.6%; 6 of 19, respectively) compared to intimate partner homicide cases.

For both primary victims and primary perpetrators of family homicides, there was also no recorded contact for homicides in a family relationship where a history of violence could be established with domestic violence services, and minimal contact with legal services.

Primary perpetrators also had a higher level of contact with mental health services than primary victims for the homicides in a family relationship involving an adult deceased where a history of violence was able to be established and service contact recorded (63.2%; 12 of 19 and 16.7%; 3 of 18, respectively).

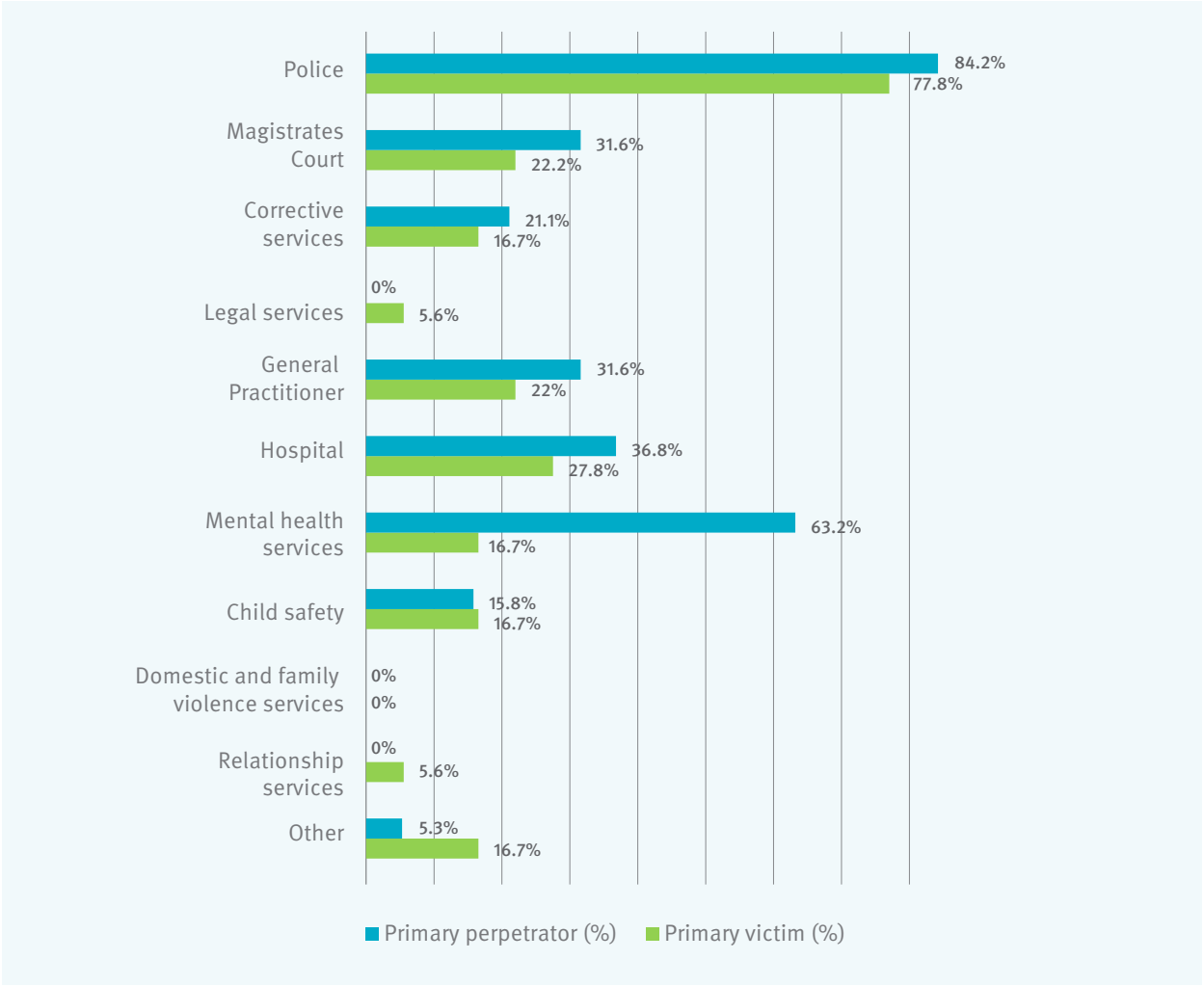


Figure 31. Service system contact, homicides in a family relationship, adult deceased, 2006–07 to 2019–20

Domestic and family violence suicides known service contact

A domestic and family violence suicide is an apparent suicide where a clear link between a person's experiences of domestic and family violence and the death itself can be established. It is recognised that other people who die by suicide in Queensland may have also had prior experiences of domestic and family violence, but a clear link to the death was unable to be established.

Data pertaining to these types of deaths in Queensland is only available since 2015–16, when a specific domestic and family violence suicide dataset was established.[55] Data from 2020–21 is excluded from this reporting because reviews are ongoing into these deaths, which means the data about known service contact is incomplete.

Intimate partner violence suicides represent the vast majority of domestic and family violence suicides in Queensland during this time (193 cases). Far fewer apparent suicides are identified as family violence related (29 cases). Of these 222 apparent suicides, 166 of the deceased were men, 36 were women, and 20 were children and young people.

Data in Figure 32 outlines the known service contact for intimate partner violence suicides as it relates to the person who died. When considering this data, it is important to be mindful that the vast majority of intimate partner related suicides are men who were identified as the primary perpetrator of violence (155 of 222).

Figure 33 outlines the known service contact for family violence related suicides, which includes the apparent suicides of children and young people who were exposed to or experienced domestic and family violence prior to their death.

Comparative to the domestic and family violence homicides, there were higher levels of service contact for both intimate partner and family violence suicides. This is attributable to the case categorisation criteria, which requires that a clear link between the apparent suicide and the person's experiences of domestic and family violence be established.

Of the 193 intimate partner violence suicides that occurred between 2015–16 and 2019–20, 89.1% (172 of 193) of the deceased had prior contact with services. Of the 29 family violence related suicides that occurred during this same time period, 93.1% (27 of 29) of the deceased had prior contact with services. In another 21 of the intimate partner violence suicides and in two of the family violence related suicides, a history of domestic and family violence was known to family and friends but not reported to services prior to the death.

A far higher percentage of intimate partner violence suicides had contact with Magistrates Courts in relation to protection orders (72.1%; 124 of 172) compared to family violence related suicides (55.6%; 15 of 27). A similar pattern was seen in relation to service contact with:

- corrective services – 42.4% (73 of 172) of cases for intimate partner violence suicides and 33.3% (9 of 27) of cases for family violence related suicides.
- hospitals – 59.9% (103 of 172) of cases for intimate partner violence suicides and 48.1% (13 of 27) of cases for family violence related suicides.
- GPs – 46.5% (80 of 172) of cases for intimate partner violence suicides and 51.9% (14 of 27) of cases for family violence related suicides.
- mental health services – 77.9% (134 of 172) of cases for intimate partner violence suicides and 77.8% (21 of 27) of cases for family violence related suicides.

As outlined in Figures 32 and 33, there was less contact with child safety services (13.4%; 23 of 172) in the intimate partner violence suicides than there was for the family violence related suicides (51.6%; 14 of 27). This is largely because more than half of the family violence suicides with identifiable service system contact were of children and young people (59.3%; 16 of 27). Of the 16 children and young people who died by apparent suicide between 2015–16 and 2019–20, 14 were known to child safety services.

55 Queensland's domestic and family violence death review process was established in 2011 through the Domestic and Family Violence Death Review Unit with an exclusive focus on domestic and family violence homicides. The focus was expanded in 2016 with the establishment of the Board following recommendations made by the *Special Taskforce on Domestic and Family Violence in Queensland 2015*.

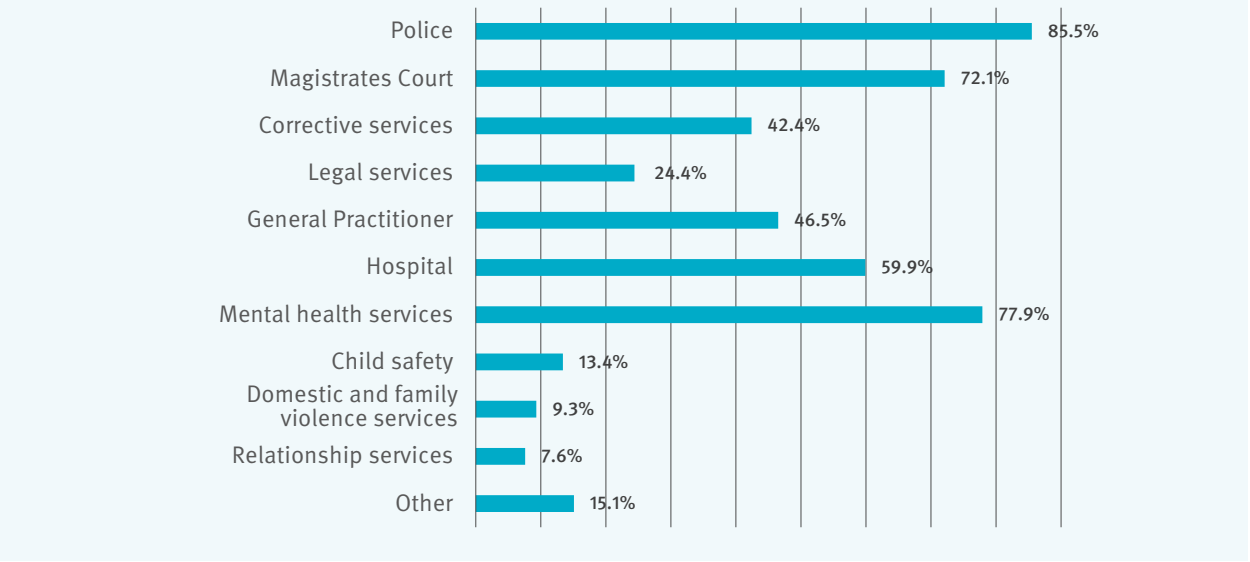


Figure 32. Service system contact, intimate partner violence suicides, deceased (2015–16 to 2019–20)

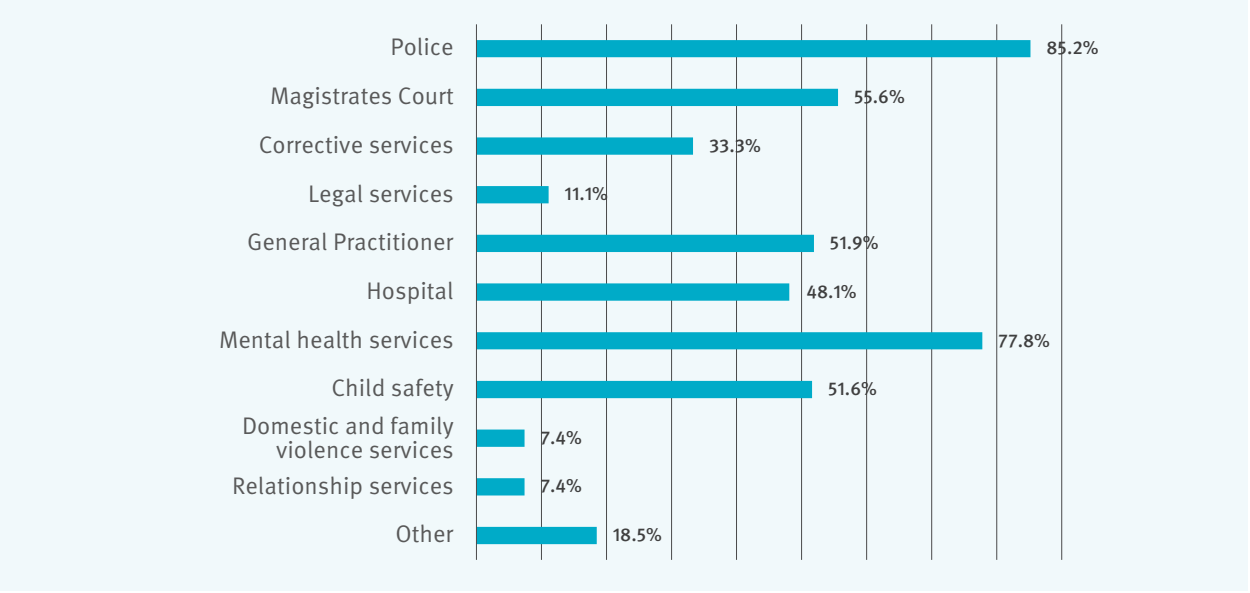
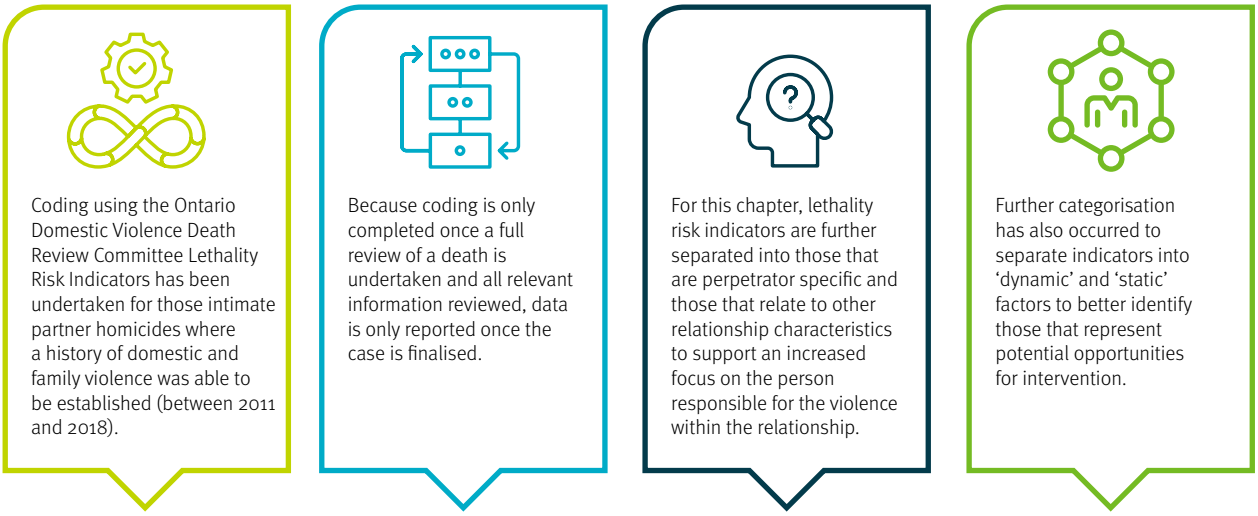


Figure 33. Service system contact, family violence suicides, deceased (2015–16 to 2019–20)



Intimate partner homicide lethality risk indicators

The Ontario Domestic Violence Death Review Committee's (Canada) coding system has been utilised to identify lethality risk indicators associated with intimate partner homicides where a history of domestic and family violence was able to be established. The Ontario Domestic Violence Death Review Committee, through its review of hundreds of cases and examination of the evidence base, have identified 39 factors prominent in intimate partner homicides.

The Ontario coding system is the most comprehensive available for use within a death review process as it has been directly developed from the review of these types of fatalities.[56] It has also been adopted for use by the Board due to similarities in basic population demographics between Queensland and Canada.

While not a risk assessment tool that is validated to assess domestic and family violence risk more broadly, because of its comprehensive nature, most indicators within this coding system also align with those captured in the *Common Risk and Safety Framework* and the *Domestic Violence Protective Assessment Framework (DV-PAF)*. Significantly, many of these indicators relate to non-physical acts of coercive control, which contributes to enhancing system understandings of the broader patterns of behaviour that may be characteristic of coercive control outside of physical abuse.

Given the nuanced analysis required to identify lethality risk indicators, this dataset is only completely finalised and publicly reported once all information about a case has been gathered and analysed. This coding system is also based on the prior history of domestic and family violence and therefore indicators are coded based on the primary victim-primary perpetrator relationship, which, as discussed previously, is not always the same as the homicide deceased-homicide offender relationship.

While still a developing area of practice, there is increasing recognition that a more nuanced understanding can be achieved through differentiating between 'static' risk factors that reflect past behaviours or actions, and 'dynamic' risk factors that change over time. This is because outcomes may be improved through targeting responses to those risk factors that can change (dynamic risk factors) as a means to reduce overall risk.

Accordingly, for the purposes of this chapter, lethality risk indicators have been further separated into static and dynamic risk indicators, as well as those that are perpetrator specific (e.g. prior suicide attempts or threats to kill), and those that reflect broader relationship characteristics (e.g. actual or pending separation).

The Ontario Domestic Violence Death Review Committee lethality coding system has been applied to 92 intimate partner homicides that have occurred in Queensland between 2011 and 2018 where a prior history of domestic and family violence was established. Of these 92 cases:

- 1-13 lethality risk indicators were recorded in 59 cases (64.1% of 92).
- 14-26 lethality risk indicators were recorded in 30 cases (32.6% of 92).
- 27-39 lethality risk indicators were recorded in 3 cases (3.3% of 92).

The average number of lethality risk indicators identified in these cases was 12. The largest number of lethality risk indicators identified in a case was 28, and the lowest number identified in a case was one.

56 The coding sheet and definitions are provided in Appendix B: *Domestic Violence Death Review Committee, 'Domestic Violence Death Review Committee 2018–2019 Annual Report', Office of the Chief Coroner, Ontario, Canada,* (2015), https://open.alberta.ca/dataset/9f534972-af61-44fe-8449-9d894e335bec/resource/75a7297c-1d39-4f27-b8a5-6a75a3862892/download/css-family-violence-death-review-committee-annual-report-2018-2019.pdf.

As shown in Figure 34, for perpetrator specific characteristics, the most common static risk indicator present among intimate partner homicide cases was a history of domestic and family violence in the current relationship, with this being present in 83.6% (77 of 92) of cases. The following lethality risk indicators were also common:

- perpetrator's attempts to isolate the victim in 42.4% (39 of 92) of cases.
- history of violence outside the family in 41.3% (38 of 92) of cases.
- failure to comply with authority in 41.3% (38 of 92) of cases.
- prior threats to kill the victim in 35.9% (33 of 92) of cases.

In addition, age disparity and youth of a couple as static risk factors (other characteristics) relevant to the relationship were present in 16.3% (15 of 92) of cases and 4.3% (4 of 92) of cases, respectively.

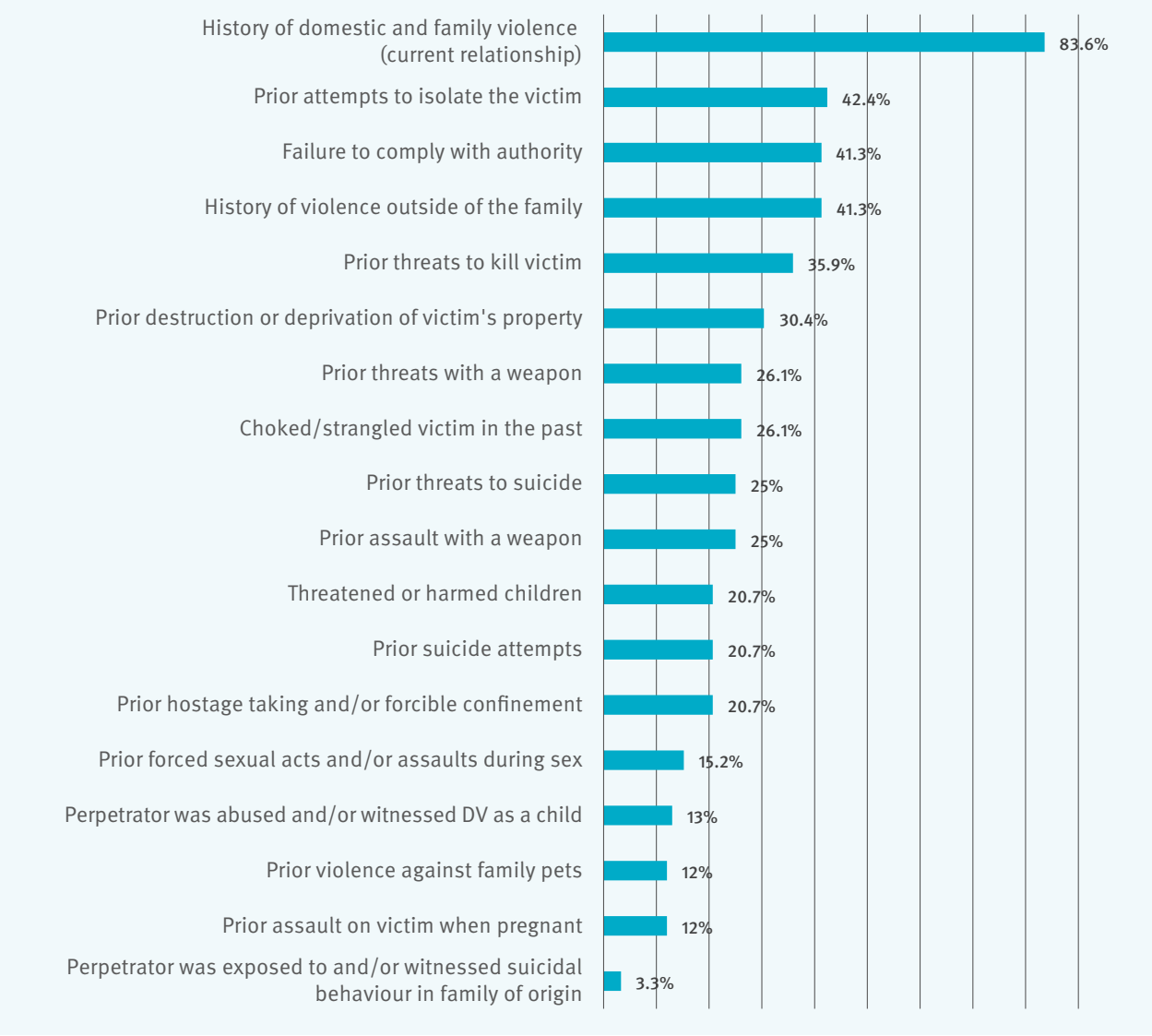


Figure 34. Prevalence of static risk factors among intimate partner homicides (perpetrator specific) (2011–2018)

Figure 35 outlines the dynamic lethality risk factors for intimate partner homicides that specifically related to the perpetrator.

Of these, the most prevalent dynamic risk factor among intimate partner homicides was excessive alcohol and other drug use by the perpetrator in 57.6% (53 of 92) of cases. This was followed by sexual jealousy in 49% (45 of 92) of cases, unemployment in 47.8% (44 of 92) of cases, and controlling most or all of victim's daily activities in 40.2% (37 of 92) of cases.

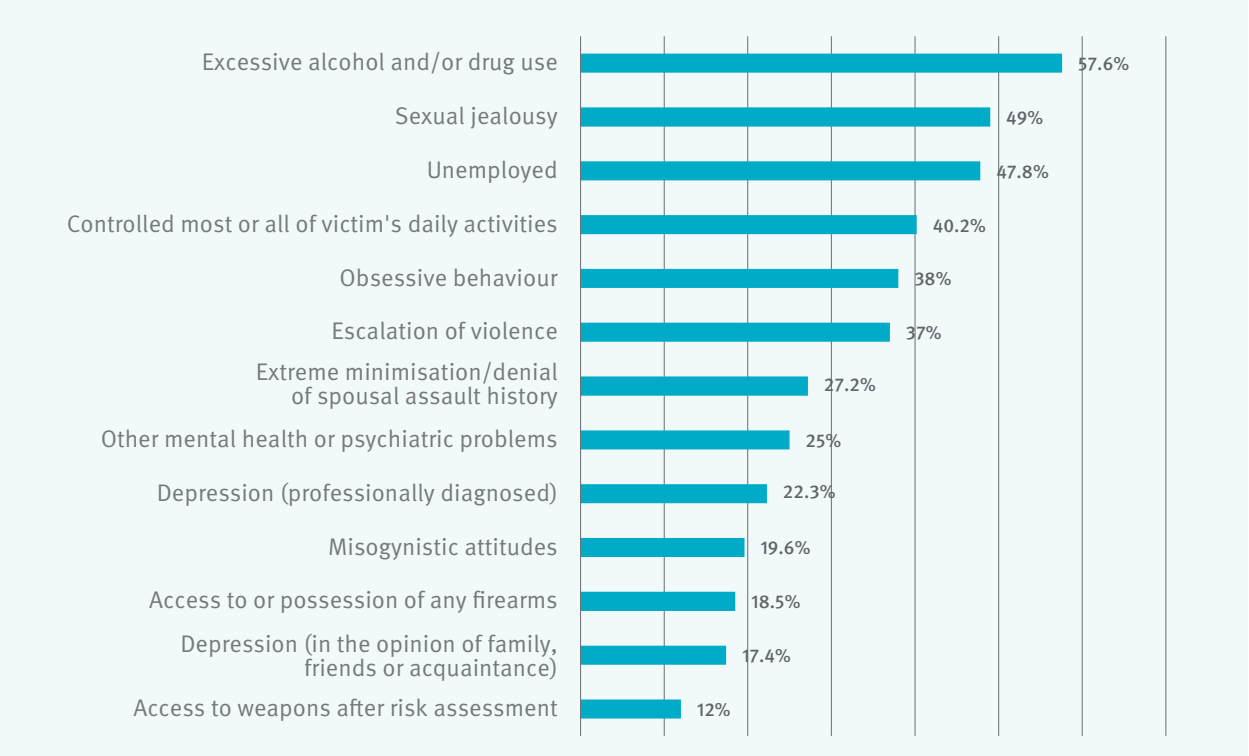


Figure 35. Prevalence of dynamic risk factors among intimate partner homicides (perpetrator specific) (2011–2018)

As shown in Figure 36, the most prevalent dynamic risk factors (other characteristics) were the primary victim and primary perpetrator being in a de-facto relationship in 58.7% (54 of 92) of cases, followed by actual or pending separation in 52.2% (49 of 92) of cases, and the victim's intuitive sense of fear of the perpetrator in 53.2% (48 of 92) of cases.

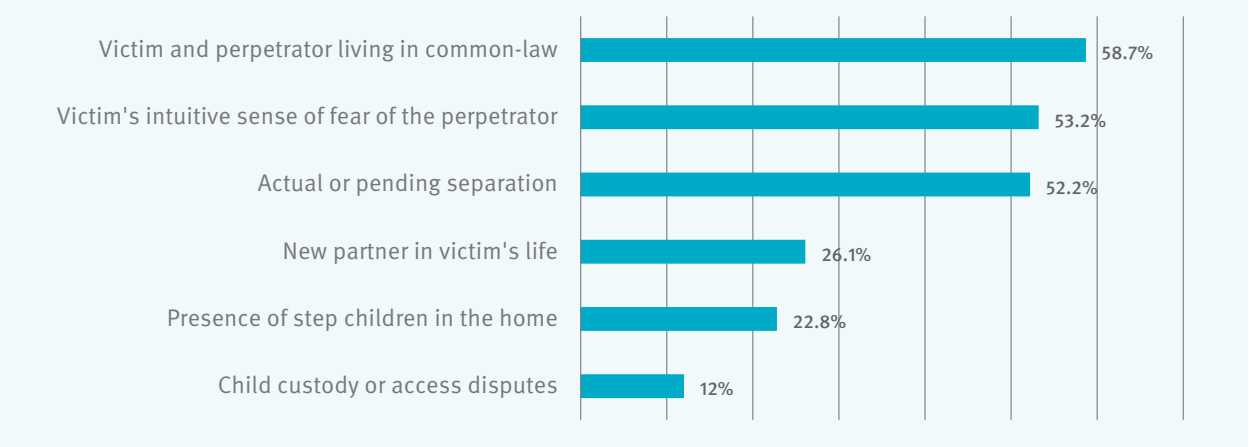
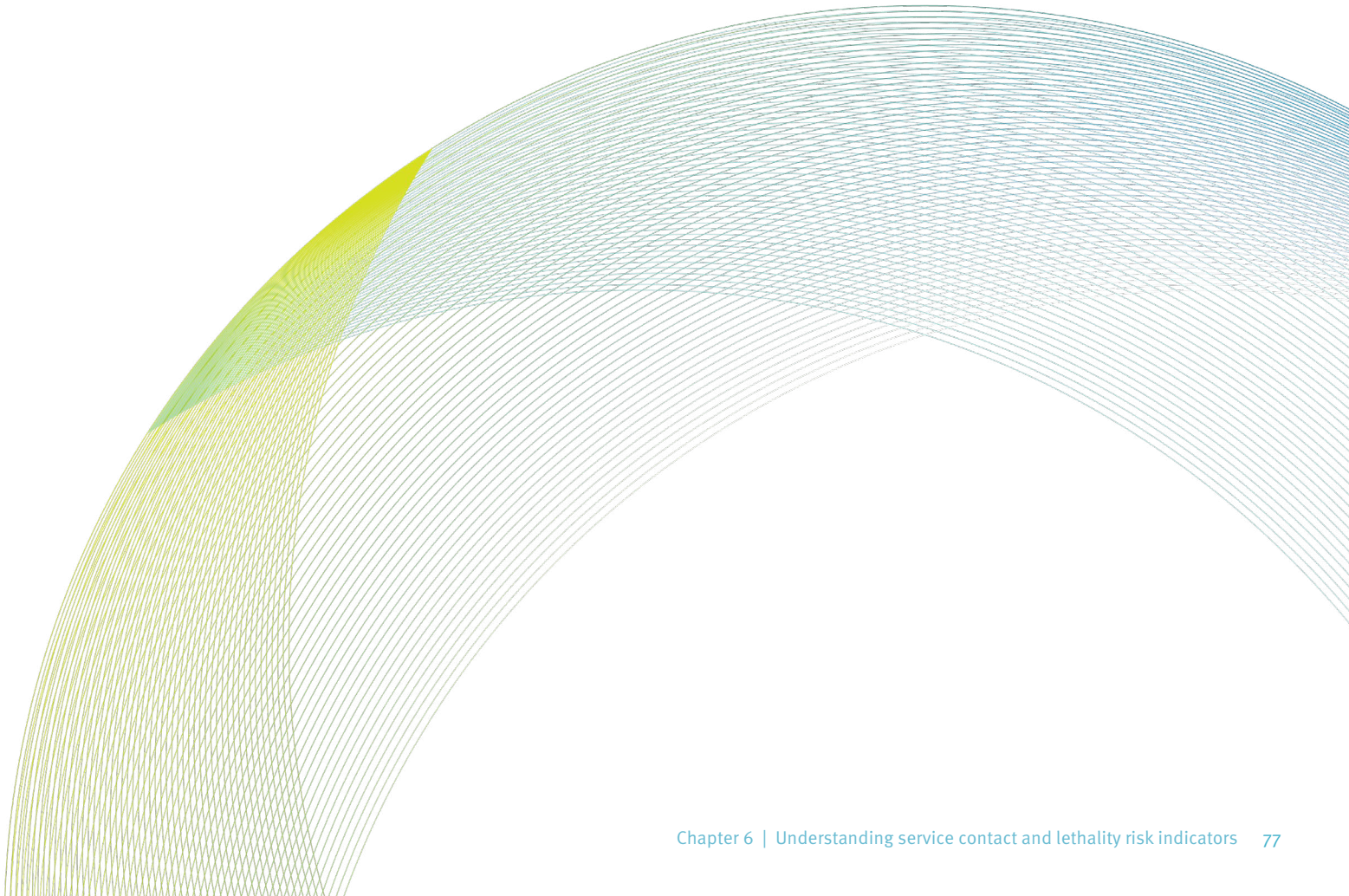


Figure 36. Prevalence of dynamic risk factors (other characteristics) among intimate partner homicides (2011–2018)



Chapter 7: Our system challenges

Key findings

- During the 2020–21 reporting period, the Board conducted in-depth systemic reviews of the deaths of 12 people who died by homicide or apparent suicide in the context of domestic and family violence.
- There were varying levels of contact with different services for the deceased and other relevant persons (such as the homicide offender) in these cases. This included contact with the criminal justice system (e.g. police, courts and corrective services), health services (e.g. public and private practitioners as well as non-government agencies), child safety services, and specialist domestic and family violence services.
- Across the cases reviewed in the current reporting period, the Board observed a number of challenges in appropriately recognising and responding to domestic and family violence that were consistent across agencies and systems.
- These include that Queensland is diverse and regionally distinct; service models are rigid, crisis oriented and not always accessible; services are not domestic and family violence informed or tailored to consider safety; service delivery is fragmented both within and across agencies; and service responses are inconsistent within and across agencies.
- The identification of these broader system issues highlights the importance of all agencies working together to address domestic and family violence. The issues identified are complex and cross-sectoral and require the shared commitment of all people working across government, community organisations and in the private sector to effectively address.

As highlighted in Chapter 6, it is apparent that victims, their children, and perpetrators present to a range of systems and services in relation to domestic and family violence and other co-occurring needs. While this contact is not always directly related to domestic and family violence, these contact points represent potential opportunities to recognise and respond to underlying patterns of violence and abuse.

In 2019–21, the Board conducted in-depth, systemic reviews of the deaths of 12 people who died by homicide or apparent suicide in the context of domestic and family violence.

In the lead up to the death/s, victims, their children and perpetrators had contact with a wide range of generalist and specialist services, including:

- police and/or other criminal justice system agencies (e.g. corrective services and court services) in relation to domestic and family violence or other related calls for service where there were indicators of domestic and family violence (e.g. welfare checks, or acts of self-harm that result in police making an application for an Emergency Examination Authority)[57] (in 12 cases).
- child safety services in relation to domestic and family violence and other child protection concerns (e.g. parental mental health) (in two cases).
- health services (e.g. psychologists, psychiatrists, ambulance services, and public and private hospital services) and other support service providers[58] in relation to presentations for assault-related injuries; mental ill-health, suicidal and/or self-harming behaviour; substance use; and maternity and antenatal care (in 11 cases).
- specialist domestic and family violence service providers, including women's refuges and perpetrator intervention programs (in three cases).

In its review of these cases, the Board identified five main challenges across the service system in appropriately responding to domestic and family violence (as outlined in Figure 37). This chapter will explore these challenges within the context of specific case examples from the current reporting period; however, these findings are not new and have been discussed in depth within previous Annual Reports.

In discussing the issues identified, it is important to be mindful that not one agency had a full picture of the patterns of risk and harm that characterised these relationships prior to the death/s.

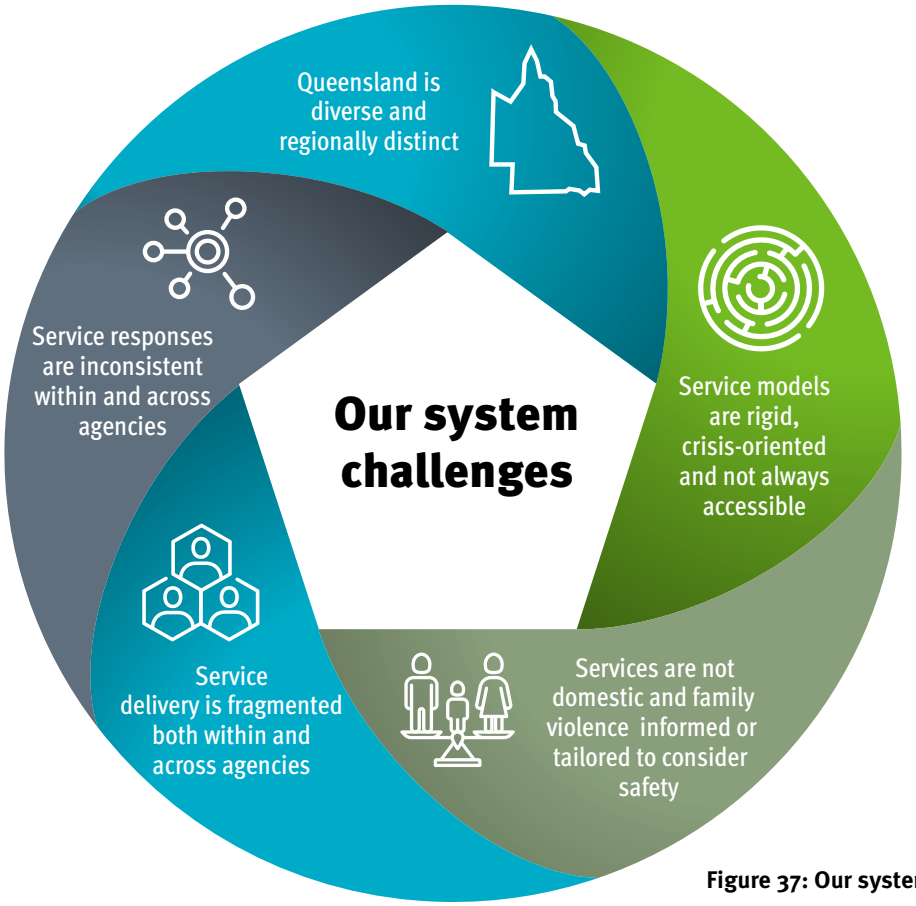


Figure 37: Our system challenges

57. An Emergency Examination Authority (EEA) is a legal mechanism by which a person whose behaviour indicates that they (the person) are at immediate risk of serious harm, which appears to be a result of a major disturbance in the person's mental capacity, may be taken against their will (involuntarily) to a public sector health service facility, usually a hospital. Under Chapter 4A of the *Public Health Act 2005* (Qld), Queensland Ambulance Service officers or Queensland Police Service officers may detain and transport a person to a treatment facility or place of care under an EEA.

58. A non-government entity, other than a specialist domestic and family violence service provider, that provides assistance or support services to persons who may include persons who fear or experience domestic violence or who commit domestic violence (pt 5A div 1 s 169C(1) of the *Domestic and Family Violence Protection Act 2012* (Qld)).

Queensland is diverse and regionally distinct

Domestic and family violence is prevalent across all Australian communities, but some groups face additional challenges when seeking help for their experiences of abuse. This includes:

- Aboriginal peoples and Torres Strait Islander peoples, including those living in regional or remote communities.
- culturally and linguistically diverse people.
- people living with a disability.
- people who identify as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+).
- older people.
- people who are socially or geographically isolated.
- women in pregnancy or early motherhood.

Because of this, responses need to be tailored to the needs of a particular community or cohort. For example, supporting women during pregnancy and early motherhood requires a different response than for older Australians using and experiencing domestic and family violence.

In addition, the Board has continued to identify issues with the way in which services respond to victims and perpetrators who have complex life circumstances. This includes people living with a mental illness, trauma, substance use, and people who have histories of suicidal ideation or attempts.

Issues have also been identified with the accessibility of services outside of metropolitan areas and major regional cities.

For example, in one case considered by the Board, the victim's family called police with concerns that she was experiencing domestic and family violence from her partner. Due to her regional location, police initially called the victim via telephone. The victim reported to police that she had been verbally and physically abused by her partner, who had then left the home with her car and young child.

The Board considered this to be an example of coercive controlling behaviour, where the perpetrator's actions were intended to isolate the victim from her young child and support systems.

This is a common theme that has emerged across the Board's case reviews, where perpetrators have taken or threatened to take children as a powerful means of eliciting fear and controlling the victim.

On this occasion, the victim told police that she was frightened of her partner but had no immediate safety concerns because he had left to stay with family in a neighbouring regional community.

Records indicate that police consulted with the victim about an appropriate course of action and made a protection order application naming her as the aggrieved. Police also requested officers in the neighbouring community conduct a 'welfare check'[59] and ensure the victim's child was safe in the perpetrator's care. Police proactively attended the victim's address the following day to further assess her level of risk, ensure she was safe, and to provide referrals to specialist support services, which were accepted.

The Board considered that, despite the challenges encountered with the regional location, this was a positive service response, where police:

- recognised the domestic and family violence risk, including to the child.
- assessed the victim's risk, with consideration of her immediate safety needs, and responded by making a protection order application to protect the victim.
- liaised with police outside of their station to ensure the child was safe and not at risk of immediate harm.
- proactively followed up with the victim to further assess her risk and ensure her immediate safety.
- offered the victim appropriate referrals to specialist support services.

However, this case also highlights the challenges faced by many services working in a regional or remote location, and the importance of flexible and tailored responses to individual needs.

When considering diversity, the Board also reflected on the need for services to be equipped to respond to complexity, regardless of how this presents, and to keep victim safety at the forefront of all responses; including being mindful of unintended consequences.

In another case considered by the Board, the perpetrator and victim (and homicide deceased) were both Aboriginal and lived in a remote community.

In this case, the perpetrator had an extensive history of violence perpetration across multiple intimate partner and familial relationships. He also had a history of sexual offending against a child.

At the time of the homicide, the perpetrator was supervised by Community Corrections on a probation order for domestic and family violence related offences perpetrated against the deceased, which had involved assaulting her and damaging her property.

As a condition of his probation order, the perpetrator was mandated to attend a men's behavioural change program to address his use of violence. Due to challenges with the regional location and long waiting lists for the only available program, the perpetrator did not commence a men's behavioural change program until nine months after his

59. As discussed in Chapter 5, the Board raised concerns with the term 'welfare check' and discussed whether 'safety and risk assessment' may be more appropriate, as this reinforces the actions which must be undertaken, rather than just confirming that someone is still alive. However, overall, the Board considered that this was a positive service response to the domestic and family violence risk at this point in time.

probation order commenced. He killed the victim around a week after completing the program.

The Board noted that while geographical isolation can create structural barriers to accessing support and intervention, this is a simplistic explanation that fails to hold perpetrators accountable for their violence.

In this case, the Board observed that there were other opportunities for the perpetrator to access culturally appropriate support and intervention; however, the perpetrator's supervision primarily focused on his risk of child sexual offending. As a result, Community Corrections staff rarely assessed and/or responded to the perpetrator's risk to his intimate partner, despite his significant history of perpetrating violence against her.

Service models are rigid, crisis oriented and not always accessible

Currently, service responses are primarily incident-based and focused on reacting to reported episodes of violence or immediate presenting issues. Since its establishment, the Board has continued to note this as a persistent issue identified in many cases, which inhibits an effective response.

In one case considered by the Board in the current reporting period, the perpetrator threatened his partner with a knife, slashed at his wrist and disclosed suicidal intent. The victim called Triple Zero for help and paramedics transported the perpetrator to hospital where he denied suicidal ideation or intent, stating that he had been using methamphetamines and cannabis for several days and that he had become *'upset'* with his partner. The perpetrator was discharged into the victim's care on the same day with no further follow up or mental health support.

Although the perpetrator disclosed that he had cut himself during a *'verbal dispute'* with his partner, the service response narrowly focused on treating his immediate medical needs arising from his self-inflicted injury, and the treating team did not explore or consider the underlying context in which his self-harming behaviour occurred.

While self-harm and suicidal ideation/attempts may be indicative of significant emotional distress, they can also be used as a tactic of coercive control by a perpetrator towards a victim of domestic and family violence.

Self-harming behaviour in the context of domestic and family violence is a high risk indicator of lethality, and the Board identified that this was a missed opportunity for health services to have recognised the perpetrator's domestic and family violence risk and initiate appropriate referrals to help him address his self-harming behaviour and use of violence. There was also no enquiry as to the victim's safety, given that he was discharged into her care by the hospital. The perpetrator later died by suicide.

The Board observed a common pattern across cases where medical and/or health practitioners responded narrowly to the clinical components in front of them (whether they were physical injuries or responding to acute psycho-social issues), without examining the broader context in which these events occurred or conducting any screening for domestic and family violence.

Although the extent to which health practitioners are able to address underlying psycho-social issues may be somewhat limited in acute or crisis-focused settings (e.g. emergency departments), there are still opportunities to recognise domestic and family violence, as well as underlying patterns of risk and harm, and initiate appropriate referrals. For example, social workers are often attached to emergency departments and other hospital departments (although they do not always operate on a 24-hour basis).

Even when circumstances have reached a point of crisis, the Board has continued to observe that services are not always available or accessible.

For example, in another case reviewed by the Board, the victim called Triple Zero requesting police assistance, stating that her partner had grabbed her, ripped her clothes, and locked her out of their home. After around two hours police had not arrived and the victim called back, stating that she did not need further assistance.

Police did not arrive until the afternoon of the following day, more than 12 hours after the victim's call for service. At that time, the victim did not wish to provide any further information about what had occurred, and police concluded that they were '*unable to obtain the facts of the incident*'. This victim was later seriously assaulted in an attempted homicide, which involved the victim being repeatedly stabbed and bludgeoned with an object. The perpetrator died by suicide shortly after the assault.

Systems are not domestic and family violence informed or tailored to consider safety

When victims disclose domestic and family violence, or when it is recognised by services, this always carries an element of risk. Victims (and their children) may be at an elevated risk from the perpetrator or other family members, or they may be at risk from negative or unwanted service intervention (e.g. child removal), particularly if they have previously experienced poor service responses.

In its case reviews, the Board has regularly observed a lack of awareness by agencies of crucial indicators of risk and/or a corresponding lack of tailored responses to address that risk and keep victim and children's safety at the forefront of all responses.

For example, in one case reviewed within this reporting period, the victim had experienced many years of (unreported) domestic and family violence perpetrated against her by her partner, including verbal, emotional, financial, sexual, and physical abuse.

Shortly before her death, the victim called police to report her partner's violence. She disclosed multiple behaviours exhibited by her partner that are high risk indicators of future harm or lethality, including sexual proprietariness, property damage, and non-lethal strangulation. The victim explained that she wanted to separate from her partner and that she had previously been too frightened of him to call police.

Initially, police took no action to respond or investigate the victim's allegations of domestic and family violence or non-lethal strangulation and recorded the matter as a *'street check'*,[60] rather than a domestic and family violence related occurrence.[61] After police left the home, the perpetrator's violent and abusive behaviour towards the victim continued to escalate. The victim locked herself in a room and again called police for help.

The same officers who attended the first call for service attended the address again the second time.

Records indicate that the perpetrator was intoxicated and belligerent towards the responding officers. He was detained and taken to the local watchhouse where he was served with a PPN on the victim's behalf and then released with a high blood alcohol reading.[62]

Police did not tell the victim that the perpetrator had been released,[63] that a PPN had been issued, or that the perpetrator had been made aware of her allegations of domestic and family violence (as recorded on the PPN).

There were also no records to indicate that police took steps to assess the victim's risk or safety needs, although there were multiple high risk indicators identifiable. In particular, non-lethal strangulation is strongly associated with attempted homicide, completed homicide,[64] and intimate partner sexual assault.[65] It may also be an indicator that coercive control and other well-established risk indicators for lethal violence are present in a relationship.

The Board identified that this case represented a missed opportunity for police to have consulted with the victim or other specialist support services to conduct risk assessment and safety planning. This case also highlights the need to put victim safety front and centre of all service responses, regardless of whether there may be limited/no prior service contact. Given the known underreporting of domestic and family violence, a lack of prior service system contact is not necessarily indicative of low risk.

In this case, when the perpetrator returned home from the watchhouse he violently assaulted, strangled and raped the victim over a significant period of time. She later died from her injuries.

Philip's story

Philip had an extensive history of perpetrating domestic and family violence within his intimate partner relationships and exhibited a range of behaviours that are indicators of domestic and family violence lethality, including: threats to kill, threats with weapons, sexual assault, self-harm and suicide attempts in the context of coercive control, non-lethal strangulation, obsessiveness, extreme sexual jealousy, and substance use.

At the time of his suicide, Philip was subject to court ordered parole for two counts of choking, suffocation or strangulation in a domestic setting (among other charges). The victim was his current intimate partner, Leah. During supervision, Community Corrections received information that Philip had threatened Leah with a knife. Information suggested that Philip was also using illicit substances and living with Leah in contravention of his parole conditions.

In response, Community Corrections considered that electronic monitoring would *'reduce his risk of re-offending' and 'reinforce compliance*' with the residential conditions of his parole order. However, it was not articulated within Philip's Community Corrections records how electronic monitoring would mitigate his elevated risk towards Leah and ensure her immediate or long-term safety.

Philip was fitted with an electronic monitoring device and directed to reside at his current residential address, which was also known by Community Corrections staff to be Leah's address. Philip claimed that Leah had moved out, though there were no records to suggest that staff took steps to confirm this, and it appears that Philip's report was taken at face value.

When Community Corrections staff later conducted a home visit to Philip's approved address, Leah was also present. The Board observed that records from other agencies showed that Philip was continuing to live with Leah, elevating her risk of further violence and abuse.

As an example, during the same period, Leah called police and sought advice about applying for a protection order, as Philip had verbally abused her and damaged property during a further episode of violence. Leah told police that Philip was living with her.

The Board considered that, in this case, Philip's risk towards Leah was likely elevated by the decision of Community Corrections to mandate Philip to reside at her address, with an apparent lack of proactive follow up action to determine Leah's whereabouts, or to consider the potential for any unintended consequences or risks in relation to Philip living with Leah, who he had a significant history of violence perpetration towards.

In the months prior to the death, records indicate that Leah experienced ongoing and, at times, escalating domestic and family violence from Philip including verbal, emotional, physical and sexual abuse. Records indicate that Leah was attempting to separate from Philip, and he died by suicide after Leah ended the relationship.

60. This was in breach of the Queensland Police Service Operational Procedures Manual in place at the time. This was also in breach of section 100 of the *Domestic and Family Violence Protection Act 2012* (Qld), which requires police to investigate allegations of domestic and family violence.
61. An occurrence is a record created on the Queensland Police Service Information Management Exchange (QPRIME) in response to a policing incident (i.e., a response to a report of domestic and family violence is recorded as a type of 'occurrence').
62. Although the perpetrator was released with a high blood alcohol reading, this was in accordance with the Queensland Police Service Operational Procedures Manual in place at the time.
63. This was in breach of the Queensland Police Service Operational Procedures Manual in place at the time.
64. Nancy Glass, Kathryn Laughon, Jacquelyn Campbell, Anna Wolf Chair, Carolyn Block, Ginger Hanson, Phyllis Sharps, and Ellen Taliaferro, 'Non-fatal Strangulation is an Important Risk Factor for Homicide of Women', The Journal of Emergency Medicine 35/3 (2008), 329–335. doi:10.1016/j.jemermed.2007.02.065.
65. Grace McKee, Kathy Gill-Hopple, Daniel Oesterle, Leah Daigle, and Amanda Gilmore, 'New Perspectives on Risk Factors for Non-fatal Strangulation and Post-assault Imaging', Journal of Interpersonal Violence 13 October 2020. https://doi.org/10.1177/0886260520966673.

Service delivery is fragmented both within and across agencies

Throughout its case reviews, the Board has continued to observe fragmented and isolated service responses to people using and experiencing domestic and family violence.

Victims and perpetrators (and their children) are often forced to navigate a system where most services are funded to address particular issues or concerns, and generally at the point of crisis. However, many people using or experiencing domestic and family violence have other needs that span multiple different portfolios.

In one victim suicide case considered by the Board, the victim had contact with a specialist domestic and family violence service and multiple public and private health services in relation to suicidal ideation, mental illness, polysubstance use, and her experiences of domestic and family violence perpetrated against her by her partner of several years.

Overall, the Board identified that there was a lack of information sharing within and across agencies that could have helped to develop a shared understanding of the victim's domestic and family violence and suicide risk. This could have assisted in developing collaborative responses to keep her safe from the perpetrator and address her complex, interconnected issues.

For example, on one occasion the victim attempted suicide after her partner had verbally abused, mocked and belittled her for seeking treatment for her substance use (an example of coercive controlling behaviour in the context of this relationship).

Following her suicide attempt, the victim sought help from hospital services. Although the victim's treating clinicians were aware that she was regularly engaged with an alcohol and other drug counsellor for support, there were no records to indicate that her counsellor was contacted to inform a thorough assessment of risk or to deliver holistic and integrated responses to the victim's co-occurring needs.

Over the next few months, the victim experienced escalating verbal, emotional and physical abuse from her partner. She continued to engage with her counsellor and hospital services for mental health and substance use support, and also sought assistance from a specialist domestic and family violence support service. However, each service was inherently siloed in their approach, and worked with the victim in isolation.

A few months after her suicide attempt, the victim texted her alcohol and other drug counsellor and explicitly stated her intention to suicide. The counsellor noted that she had not acted on suicidal thoughts before and waited several hours before initiating an emergency response, which involved the counsellor contacting police and reporting the victim as a missing person. She was located deceased shortly thereafter.

The Board identified this case as a compelling example of how fragmented service delivery can lead to poor outcomes and, at times, elevate risk to victims. This case also highlights the critical importance of well-trained, resourced, and interconnected mental health and alcohol and other drug services to address the needs of clients experiencing multiple psycho-social issues in the context of domestic and family violence.

The *Domestic and Family Violence Capability Assessment Tool: for Alcohol and other Drug Settings* (DFVCAT)[66] is a benchmarking tool, designed to help alcohol and other drug services to assess their current responses to clients who use or experience domestic and family violence and plan for future improvements. The DFVCAT[67] was specifically developed for alcohol and other drug services and can be applied across a diverse range of practice settings, including counselling services and long-term residential or community-based programs.

Assessment of program/service capacity can be conducted through self-assessment or by an independent, external assessor. Capacity is scored across six domains for good practice, including program structure; physical environment and organisational culture; screening, safety planning and assessment; interventions; continuity of care; and staffing considerations.

While DFVCAT is not yet validated, it is currently used as an indication of program/organisational capacity to respond to clients using or experiencing domestic and family violence.

In considering this case, and the data outlined in Chapter 6 that shows that excessive alcohol and other drug use by perpetrators was a prevalent lethal risk indicator in intimate partner homicides, the Board considered that there may be benefits to undertaking a trial of the DFVCAT tool in Queensland. This will help to embed previous recommendations made by the Board in earlier reports[68] that aim to improve responses in this area.

Recommendation 4:

That the Queensland Government trial and evaluate the use of the Domestic and Family Violence Capability Assessment Tool for Alcohol and Other Drug Settings in alcohol and other drug treatment and harm reduction services in multiple trial sites across Queensland.

This should include both government and non-government organisations with input from the peak body for alcohol and other drug services and domestic and family violence services within the trial sites.

66. Nicole Lee and Linda Jenner, *Domestic and Family Violence Capacity Assessment Tool: for Alcohol and Other Drug Settings* (2017), http://www.atoda.org.au/wp-content/uploads/2018/04/CapabilityTool_Online.pdf.
67. The tool can be used in conjunction with other resources to help guide alcohol and other drug services practice when working with clients using or experiencing domestic and family violence, including the *Practice Guide: for Responding to Domestic and Family Violence in Alcohol* and *Other Drug Settings* and *Scope of Practice: for Working with Service Consumers in Alcohol* and *Other Drug Settings Who Experience or Use Domestic and Family Violence.*
68. For example, the Board has previously recommended that the Queensland Government fund and facilitate cross professional training and relationship building between mental health, drug and alcohol and specialist domestic and family violence services to enhance collaboration, shared understandings and information sharing. The Queensland Government accepted this recommendation in full: Recommendation 8 of the 2016-17 Annual Report of the Domestic and Family Violence Death Review and Advisory Board.

Service responses are inconsistent both within and across agencies

The Board has continued to observe significant variability in the way agencies respond to people using and experiencing domestic and family violence. This includes inconsistent approaches to the same victim by the same agency (but different staff) over time, and varying responses by different agencies during similar time periods.

In one case, the victim had contact with police and health services in relation to mental ill-health (depression, anxiety and suicidal ideation) and experiences of domestic and family violence perpetrated against her by her former partner. Across these contacts, she continued to receive inconsistent responses when she sought support.

For example, on one occasion the victim attended hospital in relation to heightened anxiety. Positively, she was referred to a social worker who recognised that she was experiencing domestic and family violence, and the social worker took appropriate steps to assess the victim's level of risk and initiate referrals to specialist support services.

However, some months later, the victim had contact with the same hospital service in relation to escalating anxiety and insomnia associated with her ongoing experiences of domestic and family violence. Although she disclosed experiencing domestic and family violence, and this was also clearly reflected on her clinical file, the victim was noted by her treating clinician to *'appear a bit histrionic'* about her situation, which the Board considered was a misunderstanding of the ongoing and cumulative effects of domestic and family violence and coercive control.

The victim also received inconsistent responses from police when she sought help for her experiences of domestic and family violence and, at times, police identified her as the primary aggressor in the relationship. The Board observed that the perpetrator in this case actively engaged in systems abuse and was able to successfully portray the victim in a negative light.

For example, on one occasion the perpetrator verbally abused the victim and then took her children to a family member's address without her permission. When the victim went to collect her children, she *'lunged'* at the perpetrator because he was filming her behaviour. The victim told police that she was struggling with how the perpetrator *'mentally abuses her'*.

Police noted that while her allegations of mental abuse *'may be true'*, her threatening behaviour appeared *'way out of proportion'*. Although the perpetrator had a documented history of physically assaulting the victim and there was a protection order in place naming her as the aggrieved, police responded by making an application for a protection order naming her as the respondent.

While acknowledging the difficulties police encounter when faced with contradictory evidence or conflicting versions of events, the Board considered that this demonstrated a lack of understanding of how and when women use physical force to resist domestic and family violence and the need for services to be better equipped to recognise patterns of coercive control, impression management and systems abuse.

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

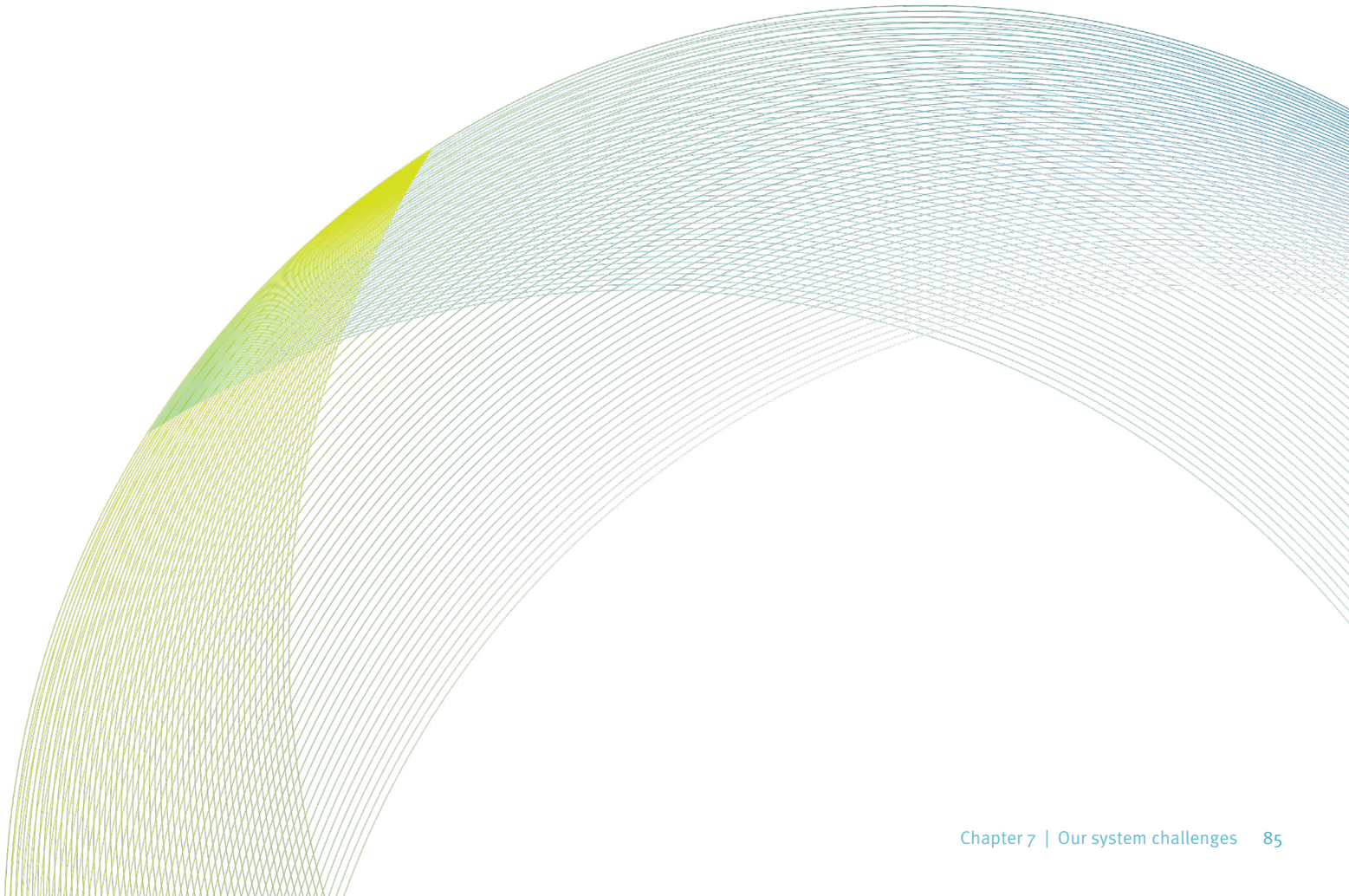
Emerging practice: Queensland Police Service initiatives

On 1 March 2021, police established a dedicated Domestic and Family Violence and Vulnerable Persons Command (the Command) to deliver sustainable, effective and innovative policing strategies to drive the prevention, response and investigation of domestic and family violence and other matters involving vulnerable persons.

The Command provides a domestic and family violence and vulnerable persons lens to police systems, training and processes to strengthen service capability and better respond to the needs of people using and experiencing domestic and family violence.

The Command is working toward improving police responses to domestic and family violence by developing a standalone domestic and family violence manual to guide and shape frontline policing responses; conducting a system-wide review of current police responses to domestic and family violence; delivering training to frontline officers, including dedicated training and resources on coercive control; and strengthening referral pathways and information sharing capabilities to enhance victim safety.

The Command builds upon the State Domestic and Family Violence and Vulnerable Persons Unit that was established in 2015 to guide and shape policing responses across several portfolio areas, including domestic and family violence, elder abuse and mental health and suicide prevention.



Chapter 8: Consolidating our approach

Key findings

- Queensland is continuing to progress reforms that aim to better respond to domestic and family violence, including those that seek to address community attitudes and beliefs; and ensure that agencies are equipped with the necessary tools to appropriately recognise domestic and family violence and safely respond.
- This type of reform requires an improved awareness and understanding of domestic and family violence across multiple sectors, professions, and workforces. It is complex and takes time to embed into practice, with the Board continuing to identify issues with the way services recognise and respond to domestic and family violence in the cases reviewed.
- Domestic and family violence does not occur in isolation and victims, perpetrators and their children present to a range of services for other needs like mental illness and substance use, where domestic and family violence may be an underlying issue.
- Repetitive patterns of violence experienced by victims and perpetrators across relationships is an issue that has repeatedly been identified by the Board in its case reviews, as has the impacts of cumulative trauma.
- This highlights the need for longer term support, in addition to strengthening immediate crisis responses, to help victims and their children rebuild their lives, and to embed longer term behavioural change for perpetrators.

As outlined in more detail in Chapter 3, since the final report of the *Special Taskforce on Domestic and Family Violence in Queensland* (the Special Taskforce), significant work has been undertaken to improve responses to domestic and family violence in our community. Core policy frameworks include:

- The *Third Action Plan of the Queensland Domestic and Family Violence Prevention Strategy 2019–20 to 2021–22*.
- *Queensland's plan to respond to domestic and family violence against people with a disability.*
- *Queensland's Framework for Action: Reshaping our Approach to Aboriginal and Torres Strait Islander Domestic and Family Violence.*

Under these strategies, there has been substantial investments to address community attitudes and beliefs that support or condone domestic and family violence and convey strong messages to the community that domestic and family violence is never tolerated or acceptable.

There have also been ongoing reforms to ensure services are equipped with the necessary tools to appropriately recognise and respond to acute crisis and/or elevated risk. This includes implementing processes to support routine screening for domestic and family violence in public health settings and strengthening criminal justice responses to perpetrators.

This type of reform is complex and takes time to embed into practice, with the Board continuing to identify issues with the way in which services recognise and respond to domestic and family violence. As such, in the 2020–21 reporting period, the Board reflected on what more may be required to overcome these challenges.

To disrupt underlying patterns of violence and abuse more effectively, the Board discussed the need to work together to prioritise the safety of victims and their children at every point of contact with services, regardless of the level of risk identified.

People experiencing domestic and family violence should be able to present to any point in the service system (e.g. police, child safety, health or legal services) and receive person-centred, tailored responses that focus on their immediate and long-term safety. While the specific actions an individual agency takes will depend on their individual roles and responsibilities, all responses should take into account the potential for unintended consequences with respect to a person's individual circumstances.

The current legislative framework for responding to domestic and family violence in Queensland is outlined in the *Domestic and Family Violence Protection Act 2012* (DFVPA 2012), which was established to:

- maximise the safety, protection and wellbeing of people who fear or experience domestic and family violence, and to minimise disruption to their lives.
- prevent or reduce domestic and family violence and the exposure of children to domestic and family violence.
- ensure that people who commit domestic and family violence are held accountable for their actions.[69]

Direct pathways (perpetrators, victims and their children present to a range of systems and services in relation to domestic and family violence (the presenting issue))
Criminal justice system
Police, court services and corrective services
Specialist services
Specialist domestic and family violence service providers
Child protection
Child safety services
Other pathways (victims, perpetrators and their children present to a range of systems and services in relation to other issues, and domestic and family violence may not be immediately identifiable (the underlying issue))
Support service providers (gateway organisations)[70]
Examples may include, but are not limited to: counselling, disability, health,[71] housing, legal services (including solicitors and barristers), youth justice, family support services and sexual assault service providers.

The DFVPA 2012 also outlines the varying roles and responsibilities of agencies in achieving these objectives by appropriately recognising, referring and responding to people using and experiencing domestic and family violence (as outlined above).

Domestic and family violence does not occur in isolation and victims, their children, and perpetrators present to a range of systems and services for other needs like mental illness and substance use (as highlighted in Chapters 6 and 7), where domestic and family violence may not be immediately identifiable (the underlying issue).

Under Part 5A of the DFVPA 2012, these agencies are broadly referred to as support service providers.[72]

69. *Domestic and Family Violence Protection Act 2012* (Qld) div 2, s 3.
70. A non-government entity, other than a specialist domestic and family violence service provider, that provides assistance or support services to persons who may include persons who fear or experience domestic violence or who commit domestic violence (pt 5A div 1, s 169C(1) of the *Domestic and Family Violence Protection Act 2012* (Qld)).
71. Including ambulance services and public and private hospital services, psychologists, and psychiatrists.
72. In 2017, the Queensland Government made amendments to the *Domestic and Family Violence Protection Act 2012* (Qld) to enable prescribed government organisations, specialist domestic and family violence service providers, and support service providers, to exchange confidential information without consent to assess or manage serious damage and family violence threats. These amendments were intended to enhance the ability of services to work together and share information to better assess and manage domestic and family violence risk.

Support service providers play an important role as gatekeepers who are in a critical position to recognise domestic and family violence and respond by referring to other services who are able to take action, or who have a primary role in responding to domestic and family violence (e.g. specialist service providers), even where it may not be their only responsibility (e.g. police, courts, corrective services, and child safety services).

This chapter seeks to extend upon the Board's prior findings and recommendations in previous reports and explore the opportunities to ensure all points of the service system are equipped to appropriately recognise and respond to domestic and family violence within the context of a framework that prioritises safety (Figure 38).[73]

During the current reporting period, the Board also considered what a future system that prioritises victim and children's safety, extends on current reforms and invests in continuous improvement, would look like.

Throughout this chapter, the Board broadly discusses domestic and family violence related risk; however, it is acknowledged that risk varies over time. Acts of abuse are commonly considered across a spectrum of severity ranging from low to high, and at times, extreme risk. This report does not seek to quantify this terminology and recognises more work needs to be done to improve responses to perceived or actual risk within the context of domestic and family violence relationships. This was discussed by the Board in detail within its 2017–18 Annual Report.

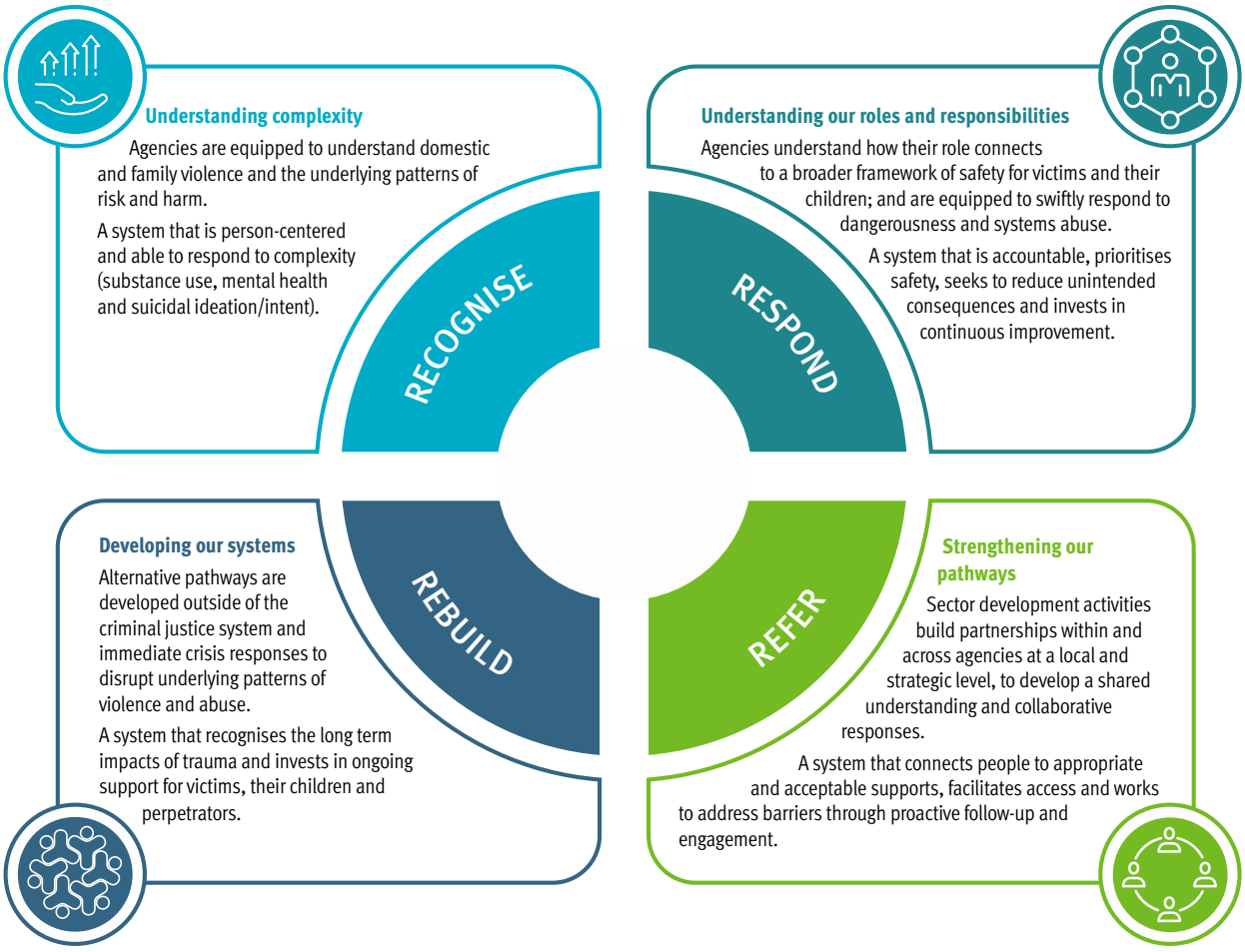


Figure 38: A framework for prioritising safety

73. This diagram is based on the 'Recognise, Respond, Refer' model highlighted in Australia's Fourth Action Plan (2019–22) of the National Plan to Reduce Violence Against Women and Their Children (2010-2022), which aims to ensure that health care professionals are equipped to appropriately recognise, refer and respond to domestic and family violence. The Board sought to extend upon this model and discussed its application across the service system more broadly, within the context of the *Domestic and Family Violence Protection Act* (2012) (Qld), and the need to move toward a system that also recognises the long-term impacts of trauma and abuse, and that people using and experiencing domestic and family violence require long-term support to rebuild their lives.

Recognise

The first step in any response to domestic and family violence is to recognise that it is occurring. Domestic and family violence is an enduring pattern of coercive controlling behaviour. Actual risk fluctuates over time and is influenced by a complex interplay of risk and protective factors.

There is a significant body of research to suggest that women and children are most at risk of serious harm and homicide following separation, as the perpetrator perceives a loss of control over the primary victim and family unit.[74] Similarly, women experiencing domestic and family violence are at a heightened risk during pregnancy, with research indicating that women often experience their first assault during pregnancy, or an escalation in the form or intensity of violence.[75]

Without first recognising that it is occurring, agencies cannot take action to respond or refer people using and experiencing domestic and family violence for intervention or support. Where there is a failure by one agency to recognise domestic and family violence, there are implications for the way in which other services respond and engage with victims, their children, and perpetrators.

For example, in one case reviewed by the Board in this reporting period, the perpetrator was subject to a community-based supervision order for domestic and family violence related offences perpetrated toward his current partner (which involved assault, non-lethal strangulation and threats with weapons).

In this case, the perpetrator was mandated by Community Corrections to engage with a private psychologist for treatment of his co-occurring mental illness.

While the psychologist provided the perpetrator with strategies to manage his anxiety, the Board observed that his psychologist failed to recognise or understand his impression management tactics or the extensive and severe nature of the violence he was using in his intimate partner relationship. This contributed to ongoing assessments by the psychologist that the perpetrator *'was doing really well'* and was of *'much less risk'* to the victim than he was before. This also appeared to have influenced assessments made by Community Corrections that the perpetrator was not at an elevated risk to the victim.

However, upon review of the available records from multiple agencies involved with the perpetrator and/or victim, the Board observed that the perpetrator had continued to use ongoing, and, at times, escalating domestic and family violence toward the victim that included verbal, emotional, physical and sexual abuse.

To recognise domestic and family violence, all service providers must have some understanding of the context and patterns of violence (both physical and non-physical acts of abuse), its underlying motivations, and indicators of heightened lethality (such as suicide threats, non-lethal strangulation or sexual proprietariness), to respond and refer appropriately and safely.

As discussed by the Board in previous Annual Reports, this also includes an understanding of the immediate and cumulative impacts on children who are exposed to, or experiencing, domestic and family violence. This extends to young people who are themselves experiencing intimate partner and/or sexual violence.

For example, in two cases considered by the Board in the current reporting period, the victims experienced sexual violence perpetrated against them by their partners, which commenced when they were under the age of consent (in both cases the victim was around 14 years old).[76]

In one of these cases, the victim became pregnant to the perpetrator at the age of 15. Records indicate that this victim experienced extreme and escalating violence associated with her pregnancy, which involved the perpetrator assaulting her so *'she would abort the unborn child'* because her pregnancy *'would prove he committed carnal knowledge offences'*.

Although in both cases police investigated unlawful carnal knowledge offences[77] against the perpetrator, the victims did not wish to speak to police who ultimately declined to pursue criminal charges.

The Board observed that in both cases, once the young person had reached the legal age of sexual consent, services involved with the perpetrator and/or victim appeared to accept that they were in a relationship.

The long-term impacts of sexual abuse are substantial, with research showing that victims of sexual violence are more likely to experience depression and higher rates of suicidal ideation and attempts.[78]

Research also suggests that victims experiencing intimate partner sexual violence are at a heightened risk of homicide.[79] In one of the cases mentioned earlier, the victim was later killed by her partner. Her young child was present during the homicide event and also suffered serious, physical injuries.

74. Holly Johnson and Tina Hotton, 'Losing Control: Homicide Risk in Estranged and Intact Intimate Relationships', *Homicide Studies* 7/1 (2003), 58-84. https://doi:10.1177/1088767902239243.
75. Deborah Walsh, 'The Hidden Experience of Violence During Pregnancy: A Study of 400 Pregnant Australian Women', *Australian Journal of Primary Health* 14/1 (2008), 97-105. https://doi.org/10.1071/py08013.
76. Section 215(1) of the *Criminal Code Act 1899* (Qld) stipulates that the legal age of sexual consent in Queensland is 16 years.
77. It is an offence in Queensland under section 215 of the *Criminal Code Act 1899* (Qld) to have intercourse with a child under 16 years of age. Section 6 of the *Criminal Code Act 1899* (Qld) stipulates that carnal knowledge is sexual penetration of any kind and to any extent.
78. Australia's National Research Organisation for Women's Safety, *Intimate Partner Sexual Violence: Research Synthesis (2nd Ed.; ANROWS Insights* (2019), https://www.anrows.org.au/publication/intimate-partner-sexual-violence-research-synthesis/.
79. Ibid.

Respond and refer

The way in which agencies respond to domestic and family violence is dependent on and informed by the discrete functions each agency or practitioner fulfils.

However, at a minimum, all services can respond to domestic and family violence, by:

- identifying impression management tactics and systems abuse to avoid colluding with perpetrators in their efforts to excuse, minimise, or justify their violence.
- appropriately documenting and contextualising domestic and family violence in records and sharing this information with other agencies to better inform and assess domestic and family violence risk.[80]
- working proactively with other agencies to ensure victims, their children and perpetrators receive consistent, tailored, and culturally appropriate responses that focus on safety, and consider unintended consequences.
- working with perpetrators, victims and their families to make supported and appropriate referrals, whether it be to specialist service providers or other support service providers.

On reflection of the cases reviewed in the current reporting period, the Board was concerned about the apparent lack of referrals provided to perpetrators and victims of domestic and family violence, particularly from police, child safety and health services.

Although referrals can form part of an effective response to domestic and family violence, the Board noted that the way in which referrals are offered is critical to the likelihood of them being taken up. Therefore, it is vital for services to take steps to understand why someone may decline a referral to another agency or choose not to engage with a service they have been referred to.

In one case considered by the Board, the victim declined a referral to a social worker from a health service because of past negative experiences with social workers that had resulted in her children being removed from her care. If the health service had understood her reluctance to engage with a social worker, there may have been an opportunity to offer an alternative referral or help clarify her concerns.

Upon reflection of the cases reviewed in this reporting period, the Board identified that even when a referral was made, there was no follow up to confirm engagement or support the person to access the new service. It appears that many services assumed an accepted referral was taken up. The Board considered this to be a flawed assumption that can result in significant consequences for victims and their children.

The Board noted that, for some agencies, referral processes appear to be more of a 'tick box' requirement where the focus is on whether a referral is made, rather than whether a referral is beneficial. Where possible, services should consider making 'warm' referrals, as opposed to providing someone with a number to call or arranging for a service to call the person at another time. Warm referrals may involve contacting the relevant agency, providing information about the person's support needs (with consent), facilitating access, and seeking feedback or following up when appropriate.

It is also important for frontline workers to have a sound understanding of appropriate referral pathways within and across agencies to ensure that all services that encounter victims, perpetrators and/or their families are interconnected and consistent in their responses. Beyond the provision of referrals, there is an increasing focus on integrated service responses to domestic and family violence where there is a shared understanding of domestic and family violence risk and management, and all agencies work together to prioritise safety for victims and their children.

The importance of collaborative and integrated service responses was highlighted in the final report of the Special Taskforce, *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland* (2015), which recommended the development and implementation of integrated service response models. Three pilot sites commenced in 2017 and there are now eight High Risk Teams (HRT) operating across Queensland. HRTs consist of dedicated staff from government and non-government agencies, who collaborate and share information to support victims and their children assessed to be at a high risk of serious harm or homicide.[81]

However, it is clear that all services play a role in recognising and responding to domestic and family violence, regardless of the level of risk identified or whether there is an integrated response operating where they live. Each agency needs to understand how their role connects to a broader framework of safety for victims and their children, and accountability for perpetrators. In this way, services need to be accountable for how they engage (or fail to engage) with people using and experiencing domestic and family violence. In reflecting on this issue, the Board considered that an accountable service system prioritises victim safety and invests in continuous improvement.

Currently, the service system is largely crisis oriented and based on responding to immediate domestic and family violence related risk. To put an end to domestic and family violence in our community, we must also move toward an accountable system that recognises that people using and experiencing domestic and family violence require long-term support to disrupt underlying patterns of violence and abuse.

80. In 2017, the Queensland Government made amendments to the *Domestic and Family Violence Protection Act 2012* (Qld) to enable prescribed government organisations, specialist domestic and family violence service providers, and support service providers, to exchange confidential information without consent to assess or manage serious damage and family violence threats. These amendments were intended to enhance the ability of services to work together and share information to better assess and manage domestic and family violence risk.

81. High Risk Teams (HRT) consist of dedicated staff from both government and non-government agencies (e.g. Queensland Police Service, Queensland Corrective Services, the Department of Child Safety, Youth Justice and Multicultural Affairs, Queensland Health and specialist domestic and family violence services).

Emerging practice: partnership approaches

To enhance responses to domestic and family violence, a number of local partnerships have been established between police and domestic and family violence support services state-wide. Commencing in 2011, the Partnership Response to Domestic Occurrences (PRADO) is a joint initiative between the Centre Against Domestic Abuse (CADA) and the Queensland Police Service (QPS), which was developed to improve the uptake of police referrals and information sharing across agencies. Through PRADO, social workers are co-located with police to advocate and facilitate an integrated service response to domestic and family violence across the Moreton Bay Region and surrounding areas.

In November 2020, the Domestic Violence Prevention Centre (DVPC) commenced a nine-month pilot program with the QPS, whereby women's advocates were co-located (at Coomera and Southport) police stations two days per week.

The objective of this program was to work together in a co-located space to provide the best possible support for women experiencing domestic and family violence. This pilot aimed to help staff from both DVPC and police to observe, reflect and utilise shared learnings to further develop innovative and collaborative strategies that will strengthen responses to both victims and perpetrators of domestic and family violence. The pilot concluded on 30 June 2021 and is currently being evaluated by Griffith University.

Rebuilding lives

The Board has previously discussed the repetitive patterns of violence that can occur across relationships for both victims and perpetrators in earlier Annual Reports. The need for an expanded service system that recognises the impacts of trauma, and that people experiencing or using domestic and family violence require long-term support, is becoming increasingly evident.

Without this investment, services will continue to re-encounter and re-assess the same perpetrators and/or victims across their life course.

Death reviews consistently show that people using or experiencing domestic and family violence (and who have co-occurring needs) have multiple points of contact with the service system, each of which provide an opportunity to recognise and respond. In many cases, regardless of the death type, contact with services commenced many years before the death.

As discussed in Chapter 3, this highlights the need for a greater understanding across the service system of the profound, traumatic and long-lasting impact of repeated abuse and exposure to domestic and family violence in childhood.

Services must not only be accessible, but they must also be acceptable to victims so they feel safe, supported, and that their lived experiences of violence are validated.

In one case considered by the Board in the current reporting period, the victim called police after her partner had assaulted and non-lethally strangled her. Police issued a PPN naming the victim as the aggrieved, and the order contained a *'cool off'* condition that prohibited the respondent from returning to the address for 24 hours.

A few days later, the victim called police again for help after the perpetrator had threatened to assault and kill her. The perpetrator denied making threats but acknowledged that he had been verbally abusive towards his partner and had called her derogatory names. On this occasion, police told the victim that they were unable to take further action due to the perpetrator providing a different version of events.

The responding officers encouraged the victim to call police again if future violence occurred; however, the victim questioned, *'what's the point?'* She referred to the PPN in place to protect her, stating that she had already been told to call police again *'if he threatened me and I've done that'*. The victim stated that when police had attended the address a few days before, they *'just believed what I said... they believed me'*.

The Board observed that the victim did not appear to have felt safe or supported by police on this occasion, or that her experiences of violence were appropriately validated and understood. This was clearly reflected in the police records, which contextualised the victim's experiences of violence, including threats to assault and kill her, as a *'communication issue'* in the relationship. Police did not take any further action in response to the victim's allegations or offer her referrals to specialist support services. The victim died by suicide the following day.

Currently, safety plans and strategies tend to focus on a list of actions that victims should or should not take to keep themselves and their children safe. However, this places an unreasonable burden on victims to manage their own safety (and that of their children and/or other family members), overlooks the perpetrator's choice to use violence, and shifts the responsibility away from services to take action to ensure victim safety and perpetrator accountability.

This approach also fails to consider the nature and dynamics of coercive control that characterises domestic and family violence relationships. Coercive control can

break down a woman's autonomy and personhood, the very things needed to leave a violent relationship.[82]

In one case considered by the Board in the current reporting period, the victim contacted a domestic and family violence support service in relation to her experiences of violence from her de-facto partner, including concerns that the perpetrator *'may kill her'*.

This service assisted the victim to develop a safety plan, which involved her putting money and a phone aside, looking into alternative housing and rental applications, and contacting a counselling service for support in relation to suicidal ideation associated with her experiences of intimate partner violence.

In this case, the Board observed that there was no proactive follow up or support provided to the victim following this contact, and she was told to return to the centre *'once she made a decision to stay…or relocate'*.

The Board noted that this response placed responsibility on the victim to act and manage her own safety. Ultimately, the safety plan was unable to protect the victim and keep her safe from the perpetrator. During the next month, the victim continued to experience escalating verbal, emotional, physical and sexual abuse from her partner. The victim died by suicide shortly after she attempted to leave the relationship and the perpetrator sexually assaulted her.

The Board identified this case to be a compelling example of the need to shift the focus away from victims being responsible for managing their own safety, to the services who have roles and responsibilities to recognise, respond and refer. This case also highlights the need for well-trained and resourced domestic and family violence services in supporting effective and holistic safety planning that addresses both the immediate and long-term safety needs of victims and their children.

In this regard, the Board discussed the potential for a peak body for domestic and family violence services in Queensland.

Peak bodies are independent, non-government organisations that lead, organise and advocate for and on behalf of member organisations using an intersectional approach. In the domestic and family violence context, peak bodies advocate for victims and their children; support and build the capacity of domestic and family violence services; and lead innovation in policy development, and system and law reform.

There is a national peak body for women's services in Australia called the Women's Services Network (WESNET), which represents women's domestic and family violence services – a complex system of organisations that assist women and children experiencing or escaping violence.

Peak bodies for domestic and family violence also exist in other Australian jurisdictions including in Victoria, New South Wales, Western Australia and South Australia.

In Queensland, the Service and Practitioners for the Elimination of Abuse Queensland (SPEAQ) form a collective voice for member practitioners and services who work with men who use domestic and family violence. However, there is no dedicated peak body for domestic and family violence services supporting victims and their children.

The Board considered that the establishment of a peak body for domestic and family violence services would provide an essential platform to bring together specialist organisations state-wide to share information and develop innovative cross-sector strategies; support policy and workforce development; and advocate for greater integration and safer responses to domestic and family violence that will better support victims and their children.

Recommendation 5:

That the Queensland Government commit to designing a model for a peak body for domestic and family violence services to further the objective of increased integration, and workforce development, undertake broader sector advocacy, and support the successful implementation of government policies and reforms.

Victims are not responsible for the violence they experience. Stopping domestic and family violence can only result from the perpetrator's change in behaviour and/or agency or community intervention.[83]

As the Board has discussed previously, criminal justice system consequences[84] and men's behavioural change programs[85] are often seen as the primary mechanisms through which the service system responds to perpetrators and holds them accountable for their violence. However, as outlined in Chapter 5, many victims of domestic and family violence do not wish to pursue criminal justice system responses for a variety of reasons. Responses to domestic and family violence are generally also short-term and/or crisis orientated and not tailored to consider the long-term safety or support needs of victims, their children or perpetrators.

For example, there are few studies that have examined the long-term effectiveness of men's behavioural change programs, including the relationship between program completion and domestic and family violence recidivism.[86]

82. Australia's National Research Organisation for Women's Safety, *Defining and Responding to Coercive Control: Policy Brief* (2021), https://www.anrows.org.au/publication/defining-and-responding-to-coercive-control/.
83. Denise Wilson, Rachel Smith, Julia Rowena Tolmie, and Irene de Haan, 'Becoming Better Helpers: Rethinking Language to Move Beyond Simplistic Responses to Women Experiencing Intimate Partner Violence', *Police Quarterly* 11/1 (2015), 25-31. https://doi.org/10.26686/pq.v11i1.4529.
84. For example, through police responses to criminal acts of domestic and family violence by arresting, charging and prosecuting perpetrators; legal sanctions, including protection orders and consequences for breaching these orders; and court directed attendance at men's behavioural change programs.
85. Men's behavioural change programs aim to prevent violence by changing attitudes and behaviours through a range of strategies including individual counselling, case management and group work.
86. Australia's National Research Organisation for Women's Safety, *Perpetrator interventions in Australia: Part One – Literature Review* (2015), https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2019/02/Landscapes-Perpetrators-Part-ONE.pdf.

In 2020, ANROWS finalised and published research examining the role of perpetrator intervention strategies in Australia. With respect to men's behavioural change programs, ANROWS found that while they may play an important role in supporting men to reduce their use of violence, practitioners only have relatively short periods of time to address attitudes and behaviours that are highly entrenched.[87] This highlights the need for perpetrators to receive ongoing support over the longer term to help disrupt entrenched patterns of abuse.

There are also limited consequences for men who disengage with programs, with research suggesting that some perpetrators disengage when they believe they might not achieve the outcome they want, such as reunification with their partner and/or children.

ANROWS also found that the role of men's behavioural change programs in providing support to victims is often undervalued or not put in place at all. While programs/partner organisations should offer victims' information, support and safety planning, this is often not prioritised because it is labour-intensive, and resources are limited.[88] The failure to include victims of domestic and family violence in men's behavioural change programs can also increase risks to victims and even exacerbate abuse.

To better support victims and their children, services must not only see victim help-seeking as an indicator of heightened risk, but also as a form of resistance to abuse that they have, or are continuing, to experience.[89]

Victim help-seeking (like other forms of resistance discussed in Chapter 5) is varied and dependent on individual circumstances. This includes the severity of abuse experienced and the psychological impact on victims, quality of social connections, as well as access to, and availability of, social, financial, health and/or legal resources.[90] All touchpoints with the system provide opportunities to recognise and respond to domestic and family violence risk, but to also recognise and respond to underlying needs.

There is a need to ensure that victims' immediate safety needs from the perpetrator are assessed and addressed as well as other immediate and long-term needs like housing, financial, legal, parenting, and/or mental health support. This type of approach requires service collaboration at both a macro (system) and micro (individual) level, to better support victims and keep them safe during their experiences of domestic and family violence and points of crisis, as well as to help victims move forward and rebuild their lives after violence.

Recommendation 6

That the Queensland Government explore trauma informed options to improve the accessibility, availability and acceptability of longer term supports for victims and their children beyond the point of crisis to support them to rebuild their lives. There should also be consideration of the longer term support needs of perpetrators of domestic and family violence to embed ongoing behavioural change and improve protective outcomes for victims and their children.

87. Australian's National Research Organisation for Women's Safety, *Improved Accountability: The Role of Perpetrator Intervention Systems* (2020), https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2020/06/Chung-RR-Improved-Accountability.pdf.
88. Ibid.
89. Richardson, C. and A. Wade (2010) 'Islands of safety: restoring dignity in violence-prevention work with indigenous families', First Peoples Child and Family Review, 5 (1), pp.137-45
90. Denise Wilson, Rachel Smith, Julia Rowena Tolmie, and Irene de Haan, 'Becoming Better Helpers: Rethinking Language to Move Beyond Simplistic Responses to Women Experiencing Intimate Partner Violence', Police Quarterly 11/1 (2015), 25-31. https://doi.org/10.26686/pq.v11i1.4529.

Section 3
Appendix

Appendix A

Remuneration of the Board

Domestic and Family Violence Death Review and Advisory Board					
Act or instrument	*Coroners Act 2003*				
Functions	*Review domestic and family violence deaths*				
Achievements	*In 2020-21, the Board met on six occasions, including three case review meetings, two annual report planning meetings and a meeting that incorporated expert presentations. A total of 12 cases were reviewed in this period involving 12 deaths.*				
Financial reporting	*The Board is audited as part of the Department of Justice and Attorney-General. Accounts are published in the annual report.*				
Remuneration					
Position	Name	Meetings/sessions attendance	Approved annual, sessional or daily fee	Approved sub-committee fees if applicable	Actual fees received
Chair	*Terry Ryan*	*6*			
Deputy Chair	*A/Prof Kathleen Baird*	*6*	*$4500*		*$2400*
Member	*Betty Taylor*	*3*	*$4500*		*$1320*
Member	*Rosemary O'Malley*[91]	*2*	*$4500*		*$600*
Member	*Angela Lynch*	*5*	*$4500*		*$2310*
Member	*Barbara Shaw*[92]	*3*			
Member	*Angela Moy*	*3*			
Member	*Molly Dragiewicz*	*6*	*$4500*		*$2400*
Member	*Keryn Ruska*	*5*	*$4500*		*$600*
Member	*Ben Marcus*[93]	*1*			
Member	*Dr Jeannette Young*[94]	*0*			
Member	*Paul Stewart*[95]	*3*			
No. scheduled meetings/sessions	Six (inclusive of three case review meetings, two annual report planning meetings and a meeting that incorporated expert presentations).				
Total out of pocket expenses	N/A				

91. Rosemary O'Malley was appointed to the Board in January 2021.
92. Barbara Shaw's position with the Board ended in November 2020.
93. Assistant Commissioner Ben Marcus was appointed to the Board in January 2021 and his position with the Board ended in March 2021.
94. Dr Jeannette Young was excused from attending meetings of the Board due to her responsibility for responding to the COVID-19 pandemic and sent a proxy to four of the meetings.
95. Deputy Commissioner Paul Stewart was appointed to the Board in January 2021.

Appendix B

Intimate Partner Homicide Lethality Risk Coding Form

Perpetrator = The primary aggressor in the relationship

Victim = The primary target of the perpetrator's abusive/maltreating/violent actions

Risk factor	Descriptor
1. History of violence outside of the family by perpetrator	Any actual or attempted assault on any person who is not, or has not been, in an intimate relationship with the perpetrator. This could include friends, acquaintances, or strangers. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.).
2. History of domestic violence	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual, etc.) toward a person who has been in, or is in, an intimate relationship with the perpetrator. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family members; friends; neighbours; co-workers; counsellors; medical personnel, etc.). It could be as simple as a neighbour hearing the perpetrator screaming at the victim or include a co-worker noticing bruises consistent with physical abuse on the victim while at work.
3. Prior threats to kill victim	Any comment made to the victim, or others, that was intended to instil fear for the safety of the victim's life. These comments could have been delivered verbally, in the form of a letter, or left on an answering machine. Threats can range in degree of explicitness from 'I'm going to kill you' to 'You're going to pay for what you did' or 'If I can't have you, then nobody can' or 'I'm going to get you'.
4. Prior threats with a weapon	Any incident in which the perpetrator threatened to use a weapon (e.g., gun; knife; etc.) or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.) for the purpose of instilling fear in the victim. This threat could have been explicit (e.g., 'I'm going to shoot you' or 'I'm going to run you over with my car') or implicit (e.g., brandished a knife at the victim or commented 'I bought a gun today'). Note: This item is separate from threats using body parts (e.g., raising a fist).
5. Prior assault with a weapon	Any actual or attempted assault on the victim in which a weapon (e.g., gun; knife; etc.), or other object intended to be used as a weapon (e.g., bat, branch, garden tool, vehicle, etc.), was used. Note: This item is separate from violence inflicted using body parts (e.g., fists, feet, elbows, head, etc.).
6. Prior suicide threats by perpetrator	Any recent (past 6 months) act or comment made by the perpetrator that was intended to convey the perpetrator's idea or intent of committing suicide, even if the act or comment was not taken seriously. These comments could have been made verbally, or delivered in letter format, or left on an answering machine. These comments can range from explicit (e.g., 'If you ever leave me, then I'm going to kill myself' or 'I can't live without you') to implicit ('The world would be better off without me'). Acts can include, for example, giving away prized possessions.
7. Prior suicide attempts by perpetrator	Any recent (past 6 months) suicidal behaviour (e.g., swallowing pills, holding a knife to one's throat, etc.), even if the behaviour was not taken seriously or did not require arrest, medical attention, or psychiatric committal. Behaviour can range in severity from superficially cutting the wrists to actually shooting or hanging oneself.

8. Prior attempts to isolate the victim	Any non-physical behaviour, whether successful or not, that was intended to keep the victim from associating with others. The perpetrator could have used various psychological tactics (e.g., guilt trips) to discourage the victim from associating with family, friends, or other acquaintances in the community (e.g., 'if you leave, then don't even think about coming back' or 'I never like it when your parents come over' or 'I'm leaving if you invite your friends here').
9. Controlled most or all of victim's daily activities	Any actual or attempted behaviour on the part of the perpetrator, whether successful or not, intended to exert full power over the victim. For example, when the victim was allowed in public, the perpetrator made her account for where she was at all times and who she was with. Another example could include not allowing the victim to have control over any finances (e.g., giving her an allowance, not letting get a job, etc.).
10. Prior hostage-taking and/or forcible confinement	Any actual or attempted behaviour, whether successful or not, in which the perpetrator physically attempted to limit the mobility of the victim. For example, any incidents of forcible confinement (e.g., locking the victim in a room) or not allowing the victim to use the telephone (e.g., unplugging the phone when the victim attempted to use it). Attempts to withhold access to transportation should also be included (e.g., taking or hiding car keys). The perpetrator may have used violence (e.g., grabbing; hitting; etc.) to gain compliance or may have been passive (e.g., stood in the way of an exit).
11. Prior forced sexual acts and/or assaults during sex	Any actual, attempted, or threatened behaviour, whether successful or not, used to engage the victim in sexual acts (of whatever kind) against the victim's will. Or any assault on the victim, of whatever kind (e.g., biting; scratching, punching, choking, etc.), during the course of any sexual act.
12. Child custody or access disputes	Any dispute in regards to the custody, contact, primary care or control of children, including formal legal proceedings or any third parties having knowledge of such arguments.
13. Prior destruction or deprivation of victim's property	Any incident in which the perpetrator intended to damage any form of property that was owned, or partially owned, by the victim or formerly owned by the perpetrator. This could include slashing the tires of the car that the victim uses. It could also include breaking windows or throwing items at a place of residence. Please include any incident, regardless of charges being laid or those resulting in convictions.
14. Prior violence against family pets	Any action directed toward a pet of the victim, or a former pet of the perpetrator, with the intention of causing distress to the victim or instilling fear in the victim. This could range in severity from killing the victim's pet to abducting it or torturing it. Do not confuse this factor with correcting a pet for its undesirable behaviour.
15. Prior assault on victim while pregnant	Any actual or attempted form of physical violence, ranging in severity from a push or slap to the face, to punching or kicking the victim in the stomach. The key difference with this item is that the victim was pregnant at the time of the assault and the perpetrator was aware of this fact.
16. Choked/Strangled victim in the past	Any attempt (separate from the incident leading to death) to strangle the victim. The perpetrator could have used various things to accomplish this task (e.g., hands, arms, rope, etc.). Note: Do not include attempts to smother the victim (e.g., suffocation with a pillow).
17. Perpetrator was abused and/or witnessed domestic violence as a child	As a child/adolescent, the perpetrator was victimised and/or exposed to any actual, attempted, or threatened forms of family violence/abuse/maltreatment.
18. Escalation of violence	The abuse/maltreatment (physical; psychological; emotional; sexual; etc.) inflicted upon the victim by the perpetrator was increasing in frequency and/or severity. For example, this can be evidenced by more regular trips for medical attention or include an increase in complaints of abuse to/by family, friends, or other acquaintances.
19. Obsessive behaviour displayed by perpetrator	Any actions or behaviours by the perpetrator that indicate an intense preoccupation with the victim. For example, stalking behaviours, such as following the victim, spying on the victim, making repeated phone calls to the victim, or excessive gift giving, etc.
20. Perpetrator unemployed	Employed means having full-time or near full-time employment (including self-employment). Unemployed means experiencing frequent job changes or significant periods of lacking a source of income. Please consider government income assisted programs (e.g., O.D.S.P.; Worker's Compensation; E.I.; etc.) as unemployment.

21. Victim and perpetrator living common-law	The victim and perpetrator were cohabiting.
22. Presence of stepchildren in the home	Any child(ren) that is(are) not biologically related to the perpetrator.
23. Extreme minimisation and/or denial of spousal assault history	At some point the perpetrator was confronted, either by the victim, a family member, friend, or other acquaintance, and the perpetrator displayed an unwillingness to end assaultive behaviour or enter/comply with any form of treatment (e.g., batterer intervention programs). Or the perpetrator denied many or all past assaults, denied personal responsibility for the assaults (i.e., blamed the victim), or denied the serious consequences of the assault (e.g., she wasn't really hurt).
24. Actual or pending separation	The partner wanted to end the relationship. Or the perpetrator was separated from the victim but wanted to renew the relationship. Or there was a sudden and/or recent separation. Or the victim had contacted a lawyer and was seeking a separation and/or divorce.
25. Excessive alcohol and/or drug use by perpetrator	Within the past year, and regardless of whether or not the perpetrator received treatment, substance abuse that appeared to be characteristic of the perpetrator's dependence on, and/or addiction to, the substance. An increase in the pattern of use and/or change of character or behaviour that is directly related to the alcohol and/or drug use can indicate excessive use by the perpetrator. For example, people described the perpetrator as constantly drunk or claim that they never saw him without a beer in his hand. This dependence on a particular substance may have impaired the perpetrator's health or social functioning (e.g., overdose, job loss, arrest, etc.). Please include comments by family, friend, and acquaintances that are indicative of annoyance or concern with a drinking or drug problem and any attempts to convince the perpetrator to terminate his substance use.
26. Depression – in the opinion of family/friend/acquaintance - perpetrator	In the opinion of any family, friends, or acquaintances, and regardless of whether or not the perpetrator received treatment, the perpetrator displayed symptoms characteristic of depression.
27. Depression – professionally diagnosed – perpetrator	A diagnosis of depression by any mental health professional (e.g., family doctor; psychiatrist; psychologist; nurse practitioner) with symptoms recognized by the DSM-IV, regardless of whether or not the perpetrator received treatment.
28. Other mental health or psychiatric problems – perpetrator	For example: psychosis; schizophrenia; bipolar disorder; mania; obsessive-compulsive disorder, etc.
29. Access to or possession of any firearms	The perpetrator stored firearms in his place of residence, place of employment, or in some other nearby location (e.g., friend's place of residence, or shooting gallery). Please include the perpetrator's purchase of any firearm within the past year, regardless of the reason for purchase.
30. New partner in victim's life	There was a new intimate partner in the victim's life or the perpetrator perceived there to be a new intimate partner in the victim's life.
31. Failure to comply with authority – perpetrator	The perpetrator has violated any family, civil, or criminal court orders, conditional releases, community supervision orders, or 'No Contact' orders, etc. This includes bail, probation, or restraining orders, and bonds, etc.

32. Perpetrator exposed to/witnessed suicidal behaviour in family of origin	As a(n) child/adolescent, the perpetrator was exposed to and/or witnessed any actual, attempted or threatened forms of suicidal behaviour in his family of origin. Or somebody close to the perpetrator (e.g., caregiver) attempted or committed suicide.
33. After risk assessment, perpetrator had access to victim	After a formal (e.g., performed by a forensic mental health professional before the court) or informal (e.g., performed by a victim services worker in a shelter) risk assessment was completed, the perpetrator still had access to the victim.
34. Youth of couple	Victim and perpetrator were between the ages of 15 and 24.
35. Sexual jealousy – perpetrator	The perpetrator continuously accuses the victim of infidelity, repeatedly interrogates the victim, searches for evidence, tests the victim's fidelity, and sometimes stalks the victim.
36. Misogynistic attitudes – perpetrator	Hating or having a strong prejudice against women. This attitude can be overtly expressed with hate statements or can be more subtle with beliefs that women are only good for domestic work or that all women are 'whores'.
37. Age disparity of couple	Women in an intimate relationship with a partner who is significantly older or younger. The disparity is usually nine or more years.
38. Victim's intuitive sense of fear of perpetrator	The victim is one that knows the perpetrator best and can accurately gauge his level of risk. If the woman discloses to anyone her fear of the perpetrator harming herself or her children, for example statements such as, 'I fear for my life', 'I think he will hurt me', 'I need to protect my children', this is a definite indication of serious risk.
39. Perpetrator threatened and/or harmed children	Any actual, attempted, or threatened abuse/maltreatment (physical; emotional; psychological; financial; sexual; etc.) towards children in the family. This incident did not have to necessarily result in charges or convictions and can be verified by any record (e.g., police reports; medical records) or witness (e.g., family; friends; neighbours; co-workers; counsellors; medical personnel, etc.).

Appendix C

Glossary of Terms

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

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

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

Coercive controlling violence: an ongoing and often relentless pattern of behaviour asserted by a perpetrator that is designed to induce various degrees of fear, intimidation and submission in a victim.[96] This may include the use of tactics such as social isolation, belittling, humiliation, threatening behaviour, restricting resources and abuse of children, pets or relatives. Coercive control also includes acts of physical and sexual violence.

Collateral homicides: includes a person who may have been killed intervening in a domestic dispute or a new partner who is killed by their current partner's former abusive spouse.

Collusion: the conscious or unconscious collaboration of two or more individuals to protect those engaged in unethical or illegal practices. This can involve friends, family or service systems, and can include the justification or minimisation of abusive behaviours, blaming the victim, and failing to intervene when violence is detected.

Cross-orders: where two protection orders have been made by the same court or by different courts, and a person named as a respondent in one of the protection orders (the first protection order) is named as the aggrieved in the other protection order (the second protection order).

Cumulative harm/trauma: harm experienced by a person as a result of a series or pattern of harmful events and experiences that may have occurred in the past or are ongoing.

Deceased: the person/s who died.

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

DV-PAF: the Domestic and Family Violence Protective Assessment Framework is a decision-making framework utilised by the Queensland Police Service to assist officers in assessing the protective needs of an aggrieved person and determining the required response. This is based on the identification of risk factors and an assessment of the aggrieved person's level of fear.

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

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

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

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

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

Exposed to domestic violence: a child or young person is exposed to domestic and family violence if the child or young person sees or hears domestic violence or otherwise experiences the effects of domestic and family violence.

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

Family violence: this term is commonly used when referring to violence that occurs within Aboriginal and Torres Strait Islander families and communities. This concept places a greater emphasis on the impact on the family as a whole and contextualises this type of violence more broadly, recognising the impact of dispossession, breakdown of kinship networks, child removal policies and entrenched disadvantage, as well as intergenerational trauma and grief on Aboriginal and Torres Strait Islander families and communities. This describes all forms of violence (e.g. physical, emotional, psychological, sexual, sociological, economic and spiritual), in intimate partner, family and other relationships of mutual obligations and support.

Filicide: the killing of a child/ren by a parent or caregiver.

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 second person is predominantly or entirely dependent on the first person financially.

Generalist services: services not specifically designed for, but in the course of their business, may be required to respond to issues associated with domestic and family violence (e.g. health, mental health, criminal justice, child safety, psychologists, general practitioners, and alcohol and other drug treatment services).

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

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

Ideal victim: a term used to refer to people who are victimised and may also experience stigma as a result of added complex psycho-social issues such as harmful substance use, mental illness, a background of complex trauma or a history of criminal offending.

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.

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

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

LGBTIQ+: an acronym used to collectively describe people of diverse sexual orientation, gender identity or intersex people. The acronym stands for lesbian, gay, bisexual, trans, intersex and queer/questioning. The + symbol recognises this acronym does not fully capture the entire spectrum of sexual orientations, gender identities and intersex variations, and is not intended to be limiting or exclusive of certain groups.

Offender: the person whose actions, or inaction, caused the person (the deceased) to die.

Perpetrator: the person who was the primary aggressor in the relationship prior to the death and who used abusive tactics within the relationship to control the victim.

Perpetrator Interventions: typically refers to specific programs (e.g. behaviour change programs) for perpetrators of domestic and family violence. These interventions generally seek to change men's attitudes, beliefs and behaviour in order to prevent them from engaging in violence in the future.[97]

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

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

Primary perpetrator: this is defined as the person most responsible for violence in the relevant relationship that preceded the domestic and family violence death. This could be the homicide offender, homicide deceased, suicide deceased, homicide-suicide offender/deceased, or surviving perpetrator.

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

97. Australia's National Research Organisation for Women's Safety, *Perpetrator Interventions in Australia: Part One – Literature Review* (2015), https://d2rn9gno7zhxqg.cloudfront.net/wp-content/uploads/2019/02/19024727/Landscapes-Perpetrators-Part-ONE.pdf.

Private health practitioner: general practitioners, psychologist, psychiatrist etc.

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

Queensland Child Protection Commission of Inquiry (the Carmody Review) – led by the Honourable Tim Carmody QC, this inquiry was established in 2012 to review the entire child protection system and to deliver a roadmap for a new system for supporting families and protecting children. The final report, *Taking Responsibility: A roadmap for Queensland child protection*,[98] released in 2013 outlined 121 recommendations to government to reform the child protection system; 116 of these recommendations were accepted fully and the remaining five were accepted in principle.

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

Relevant relationship: as defined by section 13 of the *Domestic and Family Violence Protection Act* 2012, includes an intimate partner relationship, family relationship or informal care relationship.

Reporting period: 2020-21 financial year.

Resistive violence: where one partner becomes controlling and violent, the other partner may respond with violence in self-defence. Within this typology, the violent resister does not engage in controlling behaviours.

Respondent: a person against whom a domestic violence protection order, or a police protection notice, is in force or may be made under the *Domestic and Family Violence Protection Act* 2012.

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

Risk management: an approach to respond to and reduce the risk of violence. Risk management strategies should include safety planning, ongoing risk assessment, plans to address the needs of victims through relevant services (e.g. legal, counselling), and liaison between services utilising appropriate information sharing processes.[99]

Risk screening: a routine process to determine if domestic and family violence occurs to inform further actions, including referral and intervention.

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

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

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

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

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

Systems abuse: the ongoing use of systems to continue to abuse victims by a perpetrator, typically after a relationship separation (e.g. child custody matters through Family Law Court).

The Act: within the context of this report refers to the *Coroners Act 2003*.

The National Plan to Reduce Violence against Women and their Children 2010-2022: explains what the Commonwealth, state and territory governments, in partnership with the community, are doing to reduce violence against women and their children in Australia. The National Plan focuses on two main types of violent crimes impacting women, specifically, domestic and family violence and sexual assault, and seeks to support initiatives that enhance prevention and early intervention, victim support and perpetrator accountability.

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

Victim-blaming: where the victim of a crime, or other negative act/s, is perceived to be partially or entirely at fault for their victimisation.

98. Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (2013), https://cabinet.qld.gov.au/documents/2013/Dec/Response%20cpcoi/Attachments/report%202.pdf.

99. Department of Human Services, *Family Violence: Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), http://www.ncdsv.org/images/VGDHS_FVRiskAssessmentRiskManagementFrameworkAndPracticeGuides1-3_4-2012.pdf.

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