Domestic and Family Violence Death Review and Advisory Board

Collaborative responses to risk, safety, and dangerousness

Annual Report 2021-22

Queensland Government

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

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

Acknowledgment

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

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

About this report

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(1) of the Act, which outlines that the Board must, within three months of the end of the financial year, provide a report to the Attorney-General in relation to the performance of the Board's functions during that financial year.

Under section 91ZB(2) of the Act the Annual Report must also include information about the progress made during the financial year to implement recommendations made by the Board during that year, or previous financial years.[1]

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

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

[1] Government Response to the *Domestic and Family Violence Death Review and Advisory Board 2020-21 Annual Report:* https://www.courts.qld.gov.au/__data/assets/pdf_file/0003/724089/dfvdrab-2020-21-government-response-final-updated.pdf Government's implementation updates to recommendations arising from the *Domestic and Family Violence Death Review and Advisory Board 2019-20 Annual Report:* https://www.courts.qld.gov.au/__data/assets/pdf_file/0005/707639/DRAB-2019-20-20220211-October-2021-implementation-update.pdf

Seek help

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

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

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

» DVConnect Womensline is a 24-hour crisis support line for anyone who identifies as female being impacted by domestic and family violence. DVConnect is contactable on 1800 811 811 or via www.dvconnect.org.

» DVConnect Mensline operates between 9am and midnight, 7 days a week, and is a crisis support line for anyone who identifies as male who is experiencing or using domestic and family violence. DVConnect Mensline is contactable on 1800 600 636 or via www.dvconnect.org.

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

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

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

» Beyondblue can be contacted on 1300 22 4636 or via www.beyondblue.org.au.

The Queensland Government's 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 during the 2021-22 financial year.

In 2021-22 the Board committed to focusing on cases that occurred in an area where a High-Risk Team and Integrated Service Response was operating, and the deceased was known to the Team or participating agency representatives. Integrated Service Responses and High-Risk Teams are a key focus in this report. This report also seeks to build upon the Board's prior findings and recommendations, exploring opportunities to more effectively protect victims and their children as well as hold persons who use violence to account *across* agencies and *over time*.

Cases profiled in this report clearly demonstrate that we can, and must, do more to understand risk and swiftly and effectively respond to protect victims of intimate partner violence and their children.

This report is intended to assist in the implementation of reforms associated with the Women's Safety and Justice Taskforce's First (2021) and Second (2022) reports. Significantly, the Taskforce also acknowledged the Board's findings and recommendations over the past six years and described that the Board's work contains a '*wealth of information about how domestic and family violence is being responded to across the service system and, importantly, where there are deficits that need to be addressed.*' It is my hope that this Annual Report will add to this wealth of information and contribute to meaningful reform in this area.

Reviewing and learning from domestic and family violence deaths can be both challenging and confronting, and I would like to take this opportunity to recognise the commitment and dedication of Board members and the Domestic and Family Violence Death Review Unit. I would also like to acknowledge the lives lost to violence profiled in this report and reinforce that we seek to learn from victims' stories to reduce the prevalence of domestic and family violence in our community and prevent future deaths.

Domestic violence in all its forms is unacceptable and the death of adult victims and children should not be seen as inevitable or unpreventable.

Many domestic violence deaths have predictive elements to them.

If this tragic cost in human life is to be stopped, we need to learn from such events.[2]

[2] Taylor, B. (2008). *Dying to be Heard: Domestic and Family Violence Death Reviews Discussion Paper.* Brisbane: Domestic Violence Death Review Action Group.

Board members

Mr Terry Ryan
State Coroner of Queensland
Chairperson

Dr Kathleen Baird RM, Ph.D., SFHEA
Deputy Chairperson
Professor of Midwifery; Director of Midwifery, Maternal and Child Research Centre
School of Nursing and Midwifery, Faculty of Health
University of Technology Sydney
Adjunct Professor, Griffith University

Ms Rosemary O'Malley
Non-government member
Chief Executive Officer
Gold Coast Domestic Violence Prevention Centre

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

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

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

Dr Jeanette Young PSM
Chief Health Officer of Queensland
Queensland Health (to October 2021)

Mr Paul Stewart
Commissioner, Queensland Corrective Services

Mr Brian Codd
Assistant Commissioner, Domestic, Family Violence and Vulnerable Persons Command
Queensland Police Service

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

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

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

Facilitator
Ms Helen Ferguson, PSM

Secretariat
Domestic and Family Violence Death Review Unit
Coroners Court of Queensland

Acknowledgements

The Board respectfully acknowledges the victims of domestic and family violence whose lives are discussed in this report and those who have lost a loved one to domestic and family violence.

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

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 no one agency or person has access to all available information prior to a death occurring. Reviews are conducted by the Board with the benefit of hindsight and, for this reason, it is necessary to share learnings from these reviews and effect systems change via those learnings.

The Board would like to take this opportunity to extend our considerable gratitude to Ms Helen Ferguson PSM, who assisted the Board in its focused discussions on Integrated Service Responses and High-Risk Teams.

During 2021-22, the Board was also supported by Special Advisors from Queensland Government agencies who stepped in to assist the Board when Board members were unavailable to attend. The Board acknowledges the contributions of:

- Mr Pete Brewer, A/Assistant Commissioner, Domestic, Family Violence and Vulnerable Persons Command, Queensland Police Service;
- Mr David Harmer, Senior Director, Social Policy and Legislation Branch, Queensland Health;
- Dr Keith McNeill, Assistant Deputy Director-General and Chief Clinical Information Officer, Queensland Health;
- Ms Samantha Newman, A/Deputy Commissioner, Queensland Corrective Services; and
- Ms Carly Bolhuis, A/Manager, Community Operations, Queensland Corrective Services.

The Board has also been fortunate to hear from a range of experts, government agencies and community members regarding key issues that were identified throughout the Board's 2021-2022 review process. In particular, the Board would like to acknowledge the contributions of:

- Professor Patrick O'Leary, School of Human Services and Social Work, Griffith University;
- Judge Eugene Hyman, retired Judge of the Superior Court of Santa Clara County, U.S.A.;
- Carmel O'Brien, Psychrespect;
- Dr Chris Sarra, Director-General, Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships;
- Ms Natalie Lewis, Commissioner, Queensland Family and Child Commission;
- Dr Emma Buxton-Namisnyk, Senior Research Associate, Office of the Pro Vice-Chancellor Indigenous and the Indigenous Law Centre, University of New South Wales/Lecturer, School of Law, Society and Criminology, University of New South Wales;

- Ms Amanda Shipway, Director, Integrated Service Responses, Office for Women and Violence Prevention, Department of Justice and Attorney-General;
- Ms Michelle Potter, Integrations Manager, Office for Women and Violence Prevention, Department of Justice and Attorney-General;
- Ms Kylie Mathewson, A/Manager, Service System Reform, Office for Women and Violence Prevention, Department of Justice and Attorney-General;
- Ms Amanda Medew, Director, Investment and Reform, Office for Women and Violence Prevention, Department of Justice and Attorney-General; and
- Ms Trudi Peters, Integration Manager, Office for Women and Violence Prevention, Department of Justice and Attorney-General.

Contents

Overview

Section 1 discusses recent domestic and family violence reforms in Queensland and contextualises the work of the Board (Chapter 1). It then outlines relevant literature about Integrated Service Responses and High-Risk teams (Chapter 2) and provides an overview of the status of these reforms in Queensland (Chapter 3). Chapter 4 outlines the approach taken by the Board throughout 2021-22 which has focused on domestic and family violence deaths that occurred where a High-Risk Team or Integrated Service Response was operating.

Section 2 the Board's findings from this reporting period, and outlines identified opportunities for improvement, with a focus on:

- Developing our knowledge and awareness of domestic and family violence (Chapter 4), including to build our understanding of key indicators of potentially lethal risk, and the intersections between domestic and family violence and suicide, to better respond to underlying patterns of risk and harm.
- Developing our practice and responses to domestic and family violence (Chapter 5), through improving safety planning and management, supported by effective record-keeping and strong information sharing. This will ensure that the system can better identify patterns of violence perpetration across relationships and over time. Developing our workforce, systems, and evidence about domestic and family violence (Chapter 6), including embedding specialisation into practice, focusing on the person using violence (PUV) disruption and management, and protecting children.

Chapters 7 and 8 outline the data in relation to homicides that occurred in an intimate partner or family relationship in Queensland from 2016 to 2022.

Monitoring our progress

Key Findings

- The Board was 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 65 recommendations. Of these, all but one has been accepted (in full, in part or in principle) by the Queensland Government. Implementation is on-going for 36.9% of recommendations made by the Board and 61.5% of recommendations being completed, with the remaining being considered.
- 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 65 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 1, most recommendations were within the portfolio responsibility of the former Department of Child Safety, Youth and Women (21), followed by Queensland Health (17) and the Department of Justice and Attorney-General (15). 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.[3]

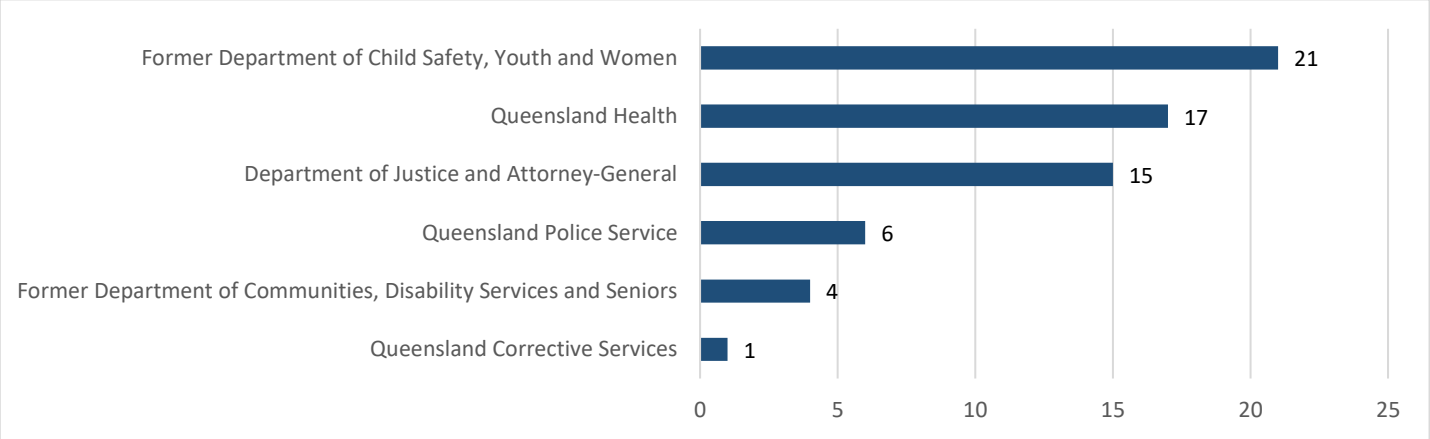

Figure 1. Original lead agency with responsibility for recommendations made by the Board from 1 July 2016 to 30 June 2021[4]

[3] 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

[4] 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

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 2). 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).

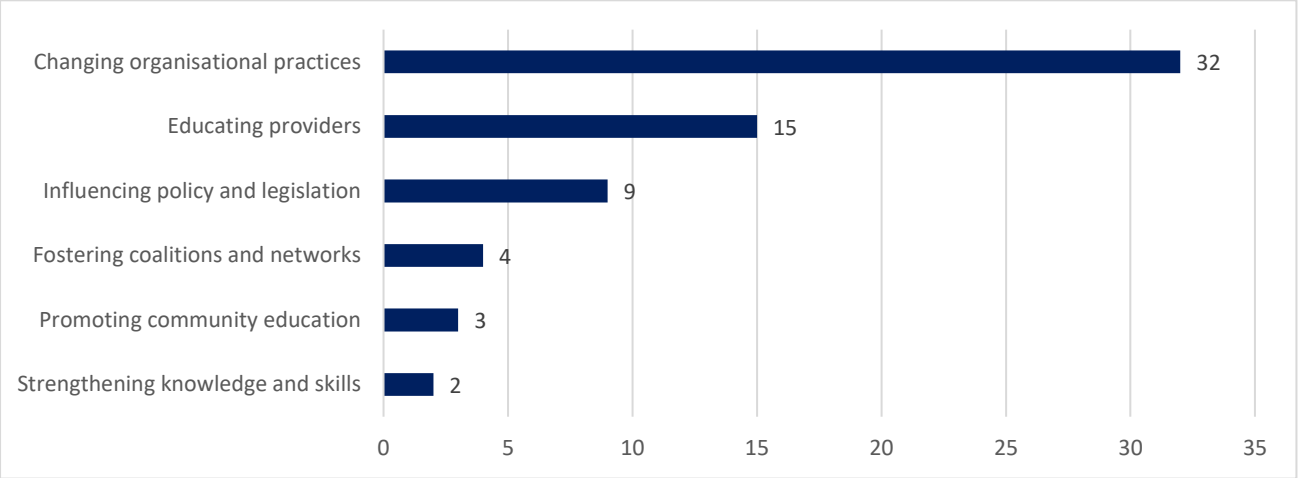

Figure 2. Level of recommendations made by the Board from 1 July 2016 to 30 June 2021

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 3 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.

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.

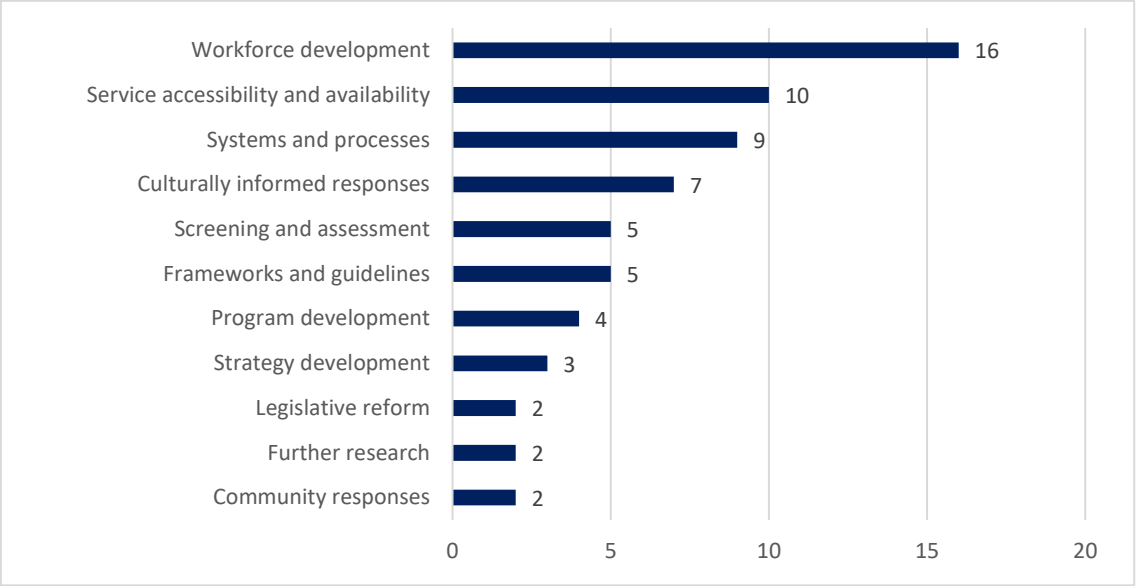

Figure 3. Main areas of focus of recommendations made by the Board from 1 July 2016 to 30 June 2021

Recommendations

2021 and 2022 have been milestone years in Queensland's response to domestic and family violence.

In particular, the Board acknowledges and recognises the significant work undertaken by the Women's Safety and Justice Taskforce (the Taskforce). The Taskforce, across two reports, has made 277 recommendations, comprehensively covering legislative, policy, program and practice changes aimed at improving system responses to domestic and family violence. Those recommendations recognise the community's role in responding to domestic and family violence and promote significant enhancements in our violence response.

The Queensland Government has accepted or accepted in principle the Taskforce's recommendations from the *Hear Her Voice* (Report 1) and the Board commends and is encouraged by the Queensland Government's ongoing commitment to address and reduce domestic and family violence in our communities.

In the context of the considerable body of existing recommendations and ongoing reform, 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.

Recommendation 1

That the Queensland Government commission research in relation to formal and informal help-seeking behaviours by people affected by domestic and family violence in intimate partner relationships, and the key influences in decisions to contact particular services, including perceptions about which services are the most helpful.

Recommendation 2

That the Queensland Government, in implementing recommendation 9 from the Women's Safety and Justice Taskforce relating to the plan for the primary prevention of violence against women, provide visible resources for family and friends to obtain information and support. This might be modelled on Ontario's Neighbours, Friends and Families campaign, recognising that many victims of domestic violence tell someone in their informal network about the violence before approaching service providers.

Recommendation 3

That in the roll out of High-Risk Teams and Integrated Service Responses, practice guidelines and protocols emphasise the need for safety planning based on the specific role that each agency can play in supporting effective safety planning, rather than locating responsibility for safety planning solely with victim-survivors.

Recommendation 4

That in implementing recommendation 64 from the Women's Safety and Justice Taskforce relating to the admissibility of expert evidence about domestic and family violence, the Queensland Government give consideration to the need for the accreditation of private practitioners, such as psychologists, working within the domestic and family violence system, particularly those completing reports for court proceedings.

Recommendation 5

That in implementing recommendation 22 from the Women's Safety and Justice Taskforce relating to the practice framework and tools for Child Safety staff to work to support victims of domestic and family violence to care protectively for their children and to hold perpetrators to account, the Queensland Government notes that the Board has identified that a significant onus can be placed on mothers to protect their children from domestic and family violence. The Board recommends that the Queensland Government prioritises research on how services can safely intervene when children are identified as high risk, particularly where they have ongoing contact with perpetrators, and that this research informs the Strengthening Families Protecting Children Framework for Practice and the Safe and Together Program.

Recommendation 6

That in implementing recommendation 24 from the Women's Safety and Justice Taskforce relating to evidence-based and trauma-informed ongoing training and education, the Queensland Government considers the establishment of an independent funded training body to develop and deliver ongoing training and education.

Recommendation 7

That in implementing recommendation 23 from the Women's Safety and Justice Taskforce relating to the development of a consistent, evidence-based and trauma informed framework to support training and education, the Queensland Government considers the importance of understanding, recognising and responding to escalation in risk.

Recommendation 8

That the Queensland Government review the implementation of the Suicide Prevention Framework for working with people impacted by domestic and family violence with a view to strengthening and enhancing its use across specialist domestic and family violence services.

Recommendation 9

That in implementing recommendation 18 of the from the Women's Safety and Justice Taskforce relating to the further rollout of High-Risk Teams, the Queensland Government ensure High-Risk Teams are able to meet the needs of Aboriginal and Torres Strait Islander people, including by considering an enhanced and formal role for Aboriginal and Torres Strait Islander organisations.

Recommendation 10

That the Queensland Government continue to support and establish High-Risk Teams (HRTs) across the State, and that agencies involved in the HRTs continue to enhance integration, protocols, assessments and responses to hold perpetrators to account and to support victim-survivors.

Section 1:
Setting the scene

SECTION 1

This section discusses recent domestic and family violence reforms in Queensland and contextualises the work of the Board (Chapter 1). It then outlines relevant literature about Integrated Service Responses and High-Risk Teams and provides an overview of the status of these reforms in Queensland (Chapter 2). Chapter 3 outlines the approach taken by the Board throughout 2021-22 which has focused on domestic and family violence deaths that occurred where a High-Risk Team or Integrated Service Response was operating and profiles cases examined by the Board in the course of its work.

Chapter 1: Reform in Queensland

This Chapter outlines recent reforms and initiatives in Queensland and contextualises the work of the Board.

This Annual Report represents the sixth such report produced by the Board since its establishment in 2016. It is produced at a time when there is an unprecedented focus on domestic and family violence in Queensland.

Reforms associated with the First Report (2021) of the Women's Safety and Justice Taskforce (the Taskforce)[5] have recently commenced in Queensland with the announcement of a $363 million in the 2022-23 State Budget to support victims of domestic and family violence.[6]

Focused on examining and reviewing coercive control and considering whether there was a need to create a new criminal offence, the Taskforce's First Report identified multiple opportunities to enhance responses to domestic and family violence in Queensland. The First Report made 89 recommendations which seek to:

- raise community awareness and understanding of domestic and family violence;
- improve primary prevention and service system responses with a particular focus on police, lawyers, judicial officers and the court;
- hold persons using violence (PUV) accountable to stop the violence; and
- progress immediate and longer-term legislative reforms addressing coercive control.

The Taskforce's Second Report (2022) considered opportunities to improve outcomes for women and girls who have experienced sexual violence and or have contact with the criminal justice system (as both victims and PUV). In this report, the Taskforce made a further 188 recommendations. That report explores intersections between domestic, family, and sexual violence further, including:

- community attitudes to sexual violence and consent, and barriers to reporting;
- responses to, and support for, victim-survivors within the criminal justice system; and
- the quality, accessibility and use of forensic evidence within legal proceedings.

In its second report, the Taskforce recommended that the Board undertake a review of past cases involving sexual violence to further enhance understanding in this area.[7] This will be a matter for further consideration by the Board in 2022-23.

In 2022, following the Taskforce's recommendations, an Independent Commission of Inquiry into Queensland Police Service responses to domestic and family violence was established. Under its Terms of Reference, the Commission will examine:

- whether there are any cultural issues within the Queensland Police Service that negatively affect police investigations of domestic and family violence;

[5] Women's Safety and Justice Taskforce (2021). *Hear Her Voice: Report 1 - Addressing Coercive Control and Domestic and Family Violence in Queensland.* Brisbane: Queensland Government, p xxxiii. Available at: https://www.womenstaskforce.qld.gov.au/__data/assets/pdf_file/0013/700600/volume-1-exectutive-summary-and-introduction.pdf.
[6] Queensland Government (2022). *Budget Measures – Budget Paper No. 4.* Brisbane: Queensland Government. Available at: https://budget.qld.gov.au/files/Budget_2022-23_BP4_Budget_Measures.pdf.
[7] Recommendation 17: The State Coroner as Chair of the Domestic and Family Violence Death Review and Advisory Board (the Board) consider the Board undertaking a one-off specific topic review of relevant past cases of domestic and family violence related deaths involving sexual violence, to examine and report matters within the Board's purpose and functions related to sexual violence within the context of domestic and family violence. See, Women's Safety and Justice Taskforce (2022). *Hear Her Voice: Report 2, Volume 1.* Brisbane: Queensland Government. Available at: https://www.womenstaskforce.qld.gov.au/__data/assets/pdf_file/0008/723842/Hear-her-voice-Report-2-Volume-1.pdf.

- if there are any cultural issues, whether they have contributed to the overrepresentation of First Nations people in the criminal justice system;
- the capability, capacity and structure of the Queensland Police Service to respond to domestic and family violence; and
- the adequacy of the current conduct and complaints handling processes against police officers.

It is anticipated that the Commission will report its findings later in 2022.

Given the Taskforce recommendations, the ongoing Independent Commission of Inquiry into the Queensland Police Service, as well as recommendations made in the recent Inquests into the deaths of Hannah Clarke and her children and Doreen Langham, the Board has elected in this Annual Report not to make any additional recommendations directed at the Queensland Police Service. The Board reiterates its support for the Taskforce's recommendations and affirms the importance of the ongoing Commission of Inquiry.

The Queensland Government recently responded to the Board's 2020-2021 Annual Report (outlined in Appendix C). This response describes that, of the previous recommendations made by the Board, implementation is ongoing for 34 recommendations.

The Government's response also confirms that all six recommendations made by the Board in its 2020-2021 report have been accepted in full or in principle, and will be delivered in tandem with the Queensland Government's response to the work of the Taskforce.

Further reforms relating to domestic and family violence are ongoing across related sectors such as child protection, suicide prevention and mental health. The recently released Queensland Mental Health Select Committee report, *Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders* (2022)[8] also recommended the development of a whole of government strategy to respond to people who have experienced trauma, including from domestic, family and sexual violence.

Implementation is ongoing as part of the *National Agreement on Closing the Gap* (National Agreement) with the Queensland Government agreeing to clear targets in July 2020 and to work together to overcome inequality experienced by Aboriginal and Torres Strait Islander people and achieve life outcomes equal to all Australians.

Target 13 of the National Agreement specifically commits to ensuring the rate of all forms of family violence against Aboriginal and Torres Strait Islander women and children is reduced by at least 50% by 2031, as progress towards zero.[9]

Action against Target 13 was also foreshadowed in the *Draft National Plan to End Violence Against Women and their Children 2022-2032,*[10] which is expected to be finalised by the end of the year.

An increased focus on domestic and family violence has not only resulted in increased funding and policy reform in Queensland, but greater community awareness.

During its discussions in this reporting period, the Board identified that, anecdotally, increased community awareness appeared to have resulted in increased demand for domestic and family violence services. Services report that they are struggling to cope not only with the volume and complexity of cases, but with challenges associated with recruiting, training and retaining an appropriately skilled workforce.

The Board also considers that Queensland's system responses continue to work most effectively where there are acts of physical violence

[8] Queensland Mental Health Select Committee (2022). *Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders*. Brisbane: Queensland Parliament. Available at: https://documents.parliament.qld.gov.au/tp/2022/5722T743-64F1.pdf.

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

[10] Australian Government Department of Social Services (2022). *Draft National Plan to End Violence Against Women and their Children*. Department of Social Services: Canberra. Available at: https://engage.dss.gov.au/draft-national-plan-to-end-violence-against-women-and-children-2022-2032/draft-national-plan-to-end-violence-against-women-and-children-2022-2032-document/.

or property damage. As the Board has observed in its previous Annual Reports, agencies continue to operate largely within this incident-based framework and in silos, with limited capacity for agencies to identify and respond to patterns of violence perpetration over time, and across relationships.

With the announcement of anticipated amendments to the Criminal Code to introduce a new stand-alone offence of coercive control in Queensland in late 2023 (further to the Taskforce's recommendations), now more than ever it is critical that the Board pauses and reflects on what works, when and why in responding to domestic and family violence.

This includes being mindful of the risks of unintended consequences, including around the introduction of new laws.[11]

The Taskforce acknowledged that before introducing criminal sanctions for coercive control, there is a need for increased community and practitioner understanding of domestic and family violence, including coercive control. This includes understanding that domestic and family violence is a pattern of behaviour that occurs over time in the context of a relationship as a whole. This pattern of abuse can include physical and non-physical violence.

A widespread lack of understanding of domestic and family violence, and in particular that it is a gendered phenomenon, is perhaps most apparent with the increase in women being charged or convicted for domestic and family violence related offences in Queensland.[12] The impact of misidentification and criminalisation is greatest for First Nations women. In responding to domestic and family violence against First Nations women, First Nations women and allies have argued that the structures established to respond to domestic and family violence should focus on social programs designed and controlled by the communities they are intended to serve, rather than expansions of the criminal law.[13]

Finally, while the COVID-19 pandemic provided opportunities to explore diverse methods of domestic and family violence related service delivery (such as service delivery online or via phone), the Board has been advised that the pandemic has increased demand for services. The challenges associated with service delivery during the COVID-19 pandemic was identified by the Board as an issue in a number of cases it reviewed in this reporting period. The Board notes that while the pandemic created opportunities for more flexible service delivery, working from home arrangements may have impacted practice discussions that, pre-pandemic, may have occurred spontaneously in the workplace.

There is evidence that the COVID-19 pandemic resulted in domestic and family victims and their children becoming exposed to increased violence. The Australian Institute of Criminology recently reported that the pandemic appears to have coincided with the onset of physical or sexual violence or coercive control for many women, and for women already experiencing domestic and family violence, it has coincided with an increase in the frequency or severity of ongoing abuse.[14]

Notably, these messages are discussed in a 2012 analysis examining 33 years of recommendations made in relation to violence against women and

[11] Women's Safety and Justice Taskforce (2021). *Hear Her Voice: Report 1 - Addressing Coercive Control and Domestic and Family Violence in Queensland.* Brisbane: Queensland Government, p xxxiii. Available at: https://www.womenstaskforce.qld.gov.au/__data/assets/pdf_file/0013/700600/volume-1-exectutive-summary-and-introduction.pdf.

[12] Women's Safety and Justice Taskforce (2021). *Discussion Paper 1: Options for Legislating Against Coercive Control and the Creation of a Standalone Domestic Violence Offence.* Brisbane: Queensland Government, p 44.

[13] Sisters Inside and Institute for Collaborate Race Research (2021). *Joint Submission on Discussion Paper 1 of the Women's Safety and Justice Taskforce.* Brisbane: Queensland Government, p 14. Available at: wsjt-submission-sisters-inside-and-institue-for-collaborative-race-research.pdf; Buxton-Namisnyk, E. (2021). 'Domestic Violence Policing of First Nations Women in Australia: 'Settler' Frameworks, Consequential Harms and the Promise of Meaningful Self-Determination' *The British Journal of Criminology* (advance). Available at: https://academic.oup.com/bjc/advance-article/doi/10.1093/bjc/azab103/6430028.

[14] Boxall H, Morgan A & Brown R (2020). 'The Prevalence of Domestic Violence Among Women During the COVID-19 Pandemic', *Statistical Bulletin no. 28.* Canberra: Australian Institute of Criminology, p 16. Available at: https://doi.org/10.52922/sb04718.

their children in British Columbia, Canada.[15] That research determined that to keep women and children in that jurisdiction safe, there needed to be:

- access to specialised support for women experiencing violence, including in small communities, supported by effective referrals, and for women who are reluctant to engage with the justice system;
- better coordination and (risk-related) information sharing, at all levels of government and including community agencies;
- services to better meet the needs of marginalised women;
- consistent risk assessment and coordinated safety planning, including sufficiently resourced and trained staff;
- clear, effective, state-wide policies, including policy that holds police and courts responsible for the consistent application of predominant aggressor frameworks;
- expert legal assistance and representation for women who experience violence (including family law court);
- PUV accountability, particularly enforcement of protection orders and access to effective behavioural change programs (which are coordinated with other victim specialist support services);
- effective use of specialisation, which includes highly trained and experienced specialists to assist generalist responders;
- domestic and family violence training for all generalist and specialist responders, which is developed and delivered cross-sectorally;
- comprehensive prevention and coordinated community education to improve awareness; and
- system accountability through systematic data collections, public access and state-wide monitoring to ensure adherence to agreed policies and frameworks.[16]

The Board's recommendations over the past six years have largely mirrored these key areas. Recommendations of the Taskforce (2021, 2022), and those previously made by the Special Taskforce on Domestic and Family Violence (Special Taskforce) in *Not Now, Not Ever* (2015) also cover very similar terrain. As is so clearly articulated within this analysis:

> *'We know what needs to be done. The challenge is to do it.'*[17]

[15] Light, L (2012). *Violence Against Women and Their Children in BC - 33 Years of Recommendations*. Vancouver: The Ending Violence Association of BC. Available at: 33_Years_of_VAW_Recs_Updated_November_2012.pdf.

[16] Ibid.

[17] Ibid, p 4.

Chapter 2: Integrated service responses – Best practice evidence and current approaches in Queensland

This chapter focuses on the literature concerning interagency collaboration, and outlines the current approach taken in Queensland. It considers findings from an evaluation of Integrated Service Responses in Queensland undertaken in 2019.

This chapter lays a framework for considering issues identified by the Board in this reporting period with respect to the Integrated Service Response, High-Risk Teams and Common Risk and Safety Framework. These issues are specifically discussed in Section 2 of this report.

Our approach in this report

This year the Board undertook a focused review of domestic and family violence deaths that occurred in an area where:

- a High-Risk Team or Integrated Service Response was operating;
- the primary victim and/or primary PUV was identified as high risk;
- the primary victim and/or primary PUV were known to the team and/or participating representatives; or
- the primary victim/person using violence was not referred into the High-Risk Teams despite being assessed as '*high risk*'.

This included the deaths of five women, four men, and four children who died by homicide or apparent suicide in the context of domestic and family violence between 2018 and 2021.

Three of the deaths the Board examined occurred in 2018, two in 2019, six in 2020 and two in 2021.

The review process undertaken by the Board throughout 2021-22 was unique within the context of domestic and family violence death review processes more broadly, in that all of the reviews focused on the identification of common systemic failures, gaps or issues within the context of an Integrated Service Response. This enabled the Board to focus on how agencies are working together to:

- share information;
- assess risk;
- manage safety; and
- provide longer-term support to victims and PUV.

Service collaboration, and coordination

It has long been recognised that effective responses to domestic and family violence require strong collaboration and partnerships.

No agency or entity is able to solely respond to domestic and family violence in Queensland, and most victims and their children benefit from coordinated, multi-agency partnerships.

Since the report of the Special Taskforce (2015) was released there has been considerable focus on establishing and expanding Integrated Service Responses in Queensland. These are supported by the *Common Risk and Safety Framework* ('CRASF') and High-Risk Teams.[18] The Board acknowledges, however, that there are a range of other

[18] Special Taskforce on Domestic and Family Violence (2015). *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland*. Brisbane: Queensland Government. See Recommendations 9, 74, 75, 76 ,77, 78 ,79, 80, 82 and 83. Available at: https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/533db62b-b2c9-43cc-a5ff-f9e1bc95c7c7/dfv-report-vol-one.pdf?ETag=c69c3ef47071a137ddbaedb49f7fe468.

established and emerging networks and cross-agency groups operating in Queensland who seek to achieve this aim. This includes the Gold Coast Integrated Service Response (established in 1996)[19] and Partnership Response at Domestic Occurrences (PRADO) (established in 2012).[20]

Since its establishment, the Board has recognised the importance of focused system responses and has continued to call for increased information sharing, collaboration and coordination across sectors in its reports and recommendations. Previous findings by the Board, relevant to the cases reviewed in this reporting period, have highlighted:

- fragmentation in-service provision, even in cases where an Integrated Service Response was operating;[21]
- concerns with the capacity of the system to monitor recidivist PUV once people are stepped down from a High-Risk Team into a broader Integrated Service Response;[22]
- a need for services to be engaged at an earlier point, to increase system effectiveness and minimise the risk of future serious harm or lethality;[23] and
- the importance of adequate training and support for private health practitioners, to ensure they are involved in an Integrated Service Response. [24]

In recognition of the need for ongoing improvement in this area and to strengthen cross-sectoral partnerships, the Board has recommended:

- that the Queensland Government fund and facilitate cross-professional training and relationship building between mental health, drug and alcohol, and domestic and family violence services to enhance collaboration, shared understanding and information sharing (2016-17);[25]
- increasing the availability, accessibility and integration of services that support young mothers and their families experiencing, or at risk of experiencing, domestic and family violence (2018-19);[26]
- that Primary Health Networks throughout Queensland play a leadership role in training and workforce development initiatives that seek to improve cross-agency responses to domestic and family violence within primary health care settings. This should focus on enhancing local partnerships between specialist domestic and family violence support

[19] The Gold Coast Integrated Service Response (established 1996) is a community-based multi-agency response to domestic violence. Under this response agencies work together to provide co-ordinated, appropriate and consistent responses to women and children affected by domestic and family violence and to men who perpetrate domestic violence.

[20] A specialist domestic and family violence worker facilitated program (established in 2012) in partnership with police, community corrections and child safety delivering case management and early intervention to families identified as high risk and in contact with the Queensland Police Service.

[21] Domestic and Family Violence Death Review and Advisory Board (2018). *2017-18 Annual Report*. Brisbane: Queensland Government, p 10. Available at: domestic-and-family-violence-death-review-and-advisory-board-annual-report-2017-18.pdf.

[22] Domestic and Family Violence Death Review and Advisory Board (2020). *2019-20 Annual Report*. Brisbane: Queensland Government, p 71. Available at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0008/663632/domestic-and-family-violence-death-review-and-advisory-board-annual-report-2019-20.pdf.

[23] Ibid.

[24] Domestic and Family Violence Death Review and Advisory Board (2018). *2017-18 Annual Report*. Brisbane: Queensland Government, p 121. Available at: domestic-and-family-violence-death-review-and-advisory-board-annual-report-2017-18.pdf.

[25] Domestic and Family Violence Death Review and Advisory Board (2017). *2016-17 Annual Report*. Brisbane: Queensland Government, recommendation 8. Available at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0003/541947/domestic-and-family-violence-death-review-and-advisory-board-annual-report-2016-17.pdf.

[26] Domestic and Family Violence Death Review and Advisory Board (2019). *2018-19 Annual Report*. Brisbane: Queensland Government, recommendation 1. Available at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/630159/domestic-and-family-violence-death-review-and-advisory-board-annual-report-2018-19.pdf.

services and primary health care providers (2017-18);[27]

- 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 (2020-21).

While service integration is increasingly recognised as the best way to improve responses to domestic and family violence, mental health, alcohol and other drug use, and child protection concerns, there are a range of definitions and understandings of what an 'integrated response' means in practice.[28]

An Integrated Service Response has been previously described by the Board as: '*an innovative approach that ensures coordination of services and supports across government, nongovernment and other community organisations.*[29]

The Board has described that the aim of an Integrated Service Response is to '*have all relevant services work together in a timely, structured, collaborative way to ensure people affected by domestic and family violence receive quality and consistent support*'[30] wherever they may present.

This type of cross-agency collaboration and coordination is intended to protect victims and their children, and hold the PUV to account regardless of the level of risk identified (low, medium, high or extreme) or where someone presents for assistance (e.g. police, health, courts, private practitioners or domestic and family violence services).

Integrated Service Responses require:

- all services across the service system to take a domestic and family violence-informed approach;
- a common understanding of domestic and family violence;
- collaboration between services and sectors;
- formal and informal communication and partnerships;
- strong leadership and a strong "authorising environment"; and
- practices, partnerships, and decision-making processes that are shared by all partners.[31]

To be effective, service integration needs to be the 'business as usual' approach to service delivery.

Strong governance and accountability

A meta evaluation of Integrated Service Responses undertaken by ANROWS in 2015 concluded that clearly defined governance is central to effective integrated service implementation.[32] Strong governance helps agencies stay focused by:

[27] Domestic and Family Violence Death Review and Advisory Board (2018). *2017-18 Annual Report*. Brisbane: Queensland Government, recommendation 13. Available at: domestic-and-family-violence-death-review-and-advisory-board-annual-report-2017-18.pdf.

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

[29] Domestic and Family Violence Death Review and Advisory Board (2021). *2020-21 Annual Report*. Brisbane: Queensland. https://www.courts.qld.gov.au/__data/assets/pdf_file/0011/699230/domestic-and-family-violence-death-review-and-advisory-board-annual-report-2020-21.pdf.

[30] Domestic and Family Violence Death Review and Advisory Board (2021). *2020-21 Annual Report.* Brisbane: Queensland Government. Available at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0011/699230/domestic-and-family-violence-death-review-and-advisory-board-annual-report-2020-21.pdf.

[31] Department of Justice and Attorney-General (2022). *Integrated Service Responses*. Available at: Integrated service responses | Department of Justice and Attorney-General

[32] Breckenridge, J, Rees, S, Valentine, K & Murray, S. (2015). 'Meta-evaluation of Existing Interagency Partnerships, Collaboration, Coordination and/or Integrated Interventions and Service Responses to Violence against Women'. *Landscapes: State of Knowledge Papers.* Sydney: ANROWS, p 19. Available at: https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2019/02/Integrated-Responses-Meta-Evaluation-Landscapes-State-of-knowledge-Issue-Eleven.pdf.

- creating opportunities for effective and efficient decision making;
- providing structured lines of authority to facilitate escalation and resolution of issues; and
- guiding the direction of the team.

To be effective, a robust authorising environment is also required. This ensures agencies, and the broader system, remain accountable to shared goals and commitments. It also ensures that structures are in place to prevent and respond to issues where they may arise.

The Victorian *Royal Commission into Family Violence* (2016) highlighted the critical importance of a strong authorising environment and whole of government commitment to risk management, including high level, multi-departmental endorsement and support, as well as formalised guidelines.[33] At the very least, for any multi-team response, governance structures and processes are necessary to support the capacity to measure and monitor results.[34] The absence of appropriate governance arrangements or supportive administrative infrastructure has also been found to contribute to an implementation gap in collaborative ventures.[35]

There are opportunities to learn from approaches in other sectors to continue to develop practices in the domestic and family violence response space.

For instance, the *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse* (2018) identified that having clear roles and cross-agency leadership, training and professional development, a protocol or formal inter-agency agreement, and ongoing cross-agency review with procedures for conflict resolution, were necessary to support an effective multi-disciplinary team response.[36]

A 2013 review by Healey and Humphreys also found that effective governance arrangements to have the capacity to provide a framework for accountability and longevity for a multi-agency system.[37] The authors determined that local level governance could be enhanced by:

- strengthening community partnerships;
- ensuring clarity in function and diversity in representation;
- focusing on developing cross-sectoral pathways;
- establishing regular joint planning and review processes;
- developing practice across the service system; and
- supporting ongoing evaluation and research.[38]

Importantly, that review also identified that dedicated and sustained resourcing is required to ensure that strong governance is established and operates as intended.

That review found that agencies need to be accountable for their involvement in integrated responses and retain responsibility for their actions within a multi-agency partnership. Key elements such as strong governance and accountability, shared commitment and understanding of purpose, and clear roles and responsibilities, should be embedded into practice and consistently reinforced.

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[33] Royal Commission into Family Violence (2017). *Report and Recommendations.* Available at: http://rcfv.archive.royalcommission.vic.gov.au/Report-Recommendations.html.

[34] Healey, L & Humphreys, C (2013). 'Governance and Interagency Responses: Improving Practice for Regional Governance – A Continuum Matrix'. *Australian Domestic & Family Violence Clearinghouse.* Sydney: UNSW, p 3. Available at: https://www.nifvs.org.au/wp-content/uploads/2016/03/Governance-and-interagency-responses-Improving-practice-for-regional-governance-%E2%80%93-a-Continuum-Matrix-2013.pdf.

[35] Ibid.

[36] Herbert, J & Bromfield, L (2018). *National Comparison of Cross-agency Practice in Investigating and Responding to Severe Child Abuse*. Melbourne: Australian Institute of Family Studies, p 4. Available at: https://apo.org.au/sites/default/files/resource-files/2018-02/apo-nid133036.pdf.

[37] Healey, L & Humphreys, C (2013). 'Governance and Interagency Responses: Improving Practice for Regional Governance – A Continuum Matrix'. *Australian Domestic & Family Violence Clearinghouse.* Sydney: UNSW, p 3. Available at: https://www.nifvs.org.au/wp-content/uploads/2016/03/Governance-and-interagency-responses-Improving-practice-for-regional-governance-%E2%80%93-a-Continuum-Matrix-2013.pdf.

[38] Ibid.

Shared commitment and understanding of the purpose

In its meta-evaluation, ANROWS (2015) also found that an integrated service system should be primarily client centred and must retain a focus on its purpose to best meet the needs of victims and ensure safety for women and their children.[39]

Some criticisms of, and development areas for, Integrated Service Responses include where conflict arises in the purpose and intervention goals of different service providers.[40] The *Victorian Royal Commission* also found that a lack of accountability, oversight and clear and shared goals for the system contributed to a lack of collective ownership and created uncertainty and dislocation in the service sector.[41]

A recent study examining the complexities of working together across organisational and disciplinary boundaries to address the 'wicked' problem of domestic and family violence went so far as to question the assumption that interagency collaboration is good practice. The practice was questioned on the basis of issues including pre-existing power disparities, interagency tension and conflicting discourse.[42] The author determined that trust, mutual positive regard and professionalism, supported by formalised agreements and protocols, are key ways to navigate these issues.[43]

Clear roles and responsibilities

A final important characteristic of an effective Integrated Service Response is a clear cross-agency protocol, which outlines each agency's roles and responsibilities, as well as those of the broader group.

The aforementioned *National Comparison of Cross-Agency Practice in Investigating and Responding to Severe Child Abuse* (2018)[44] concluded that without a clear understanding of the process and the roles of individuals, cross-agency conflict can arise. Significantly, it noted that without the means to manage or respond to cross-agency conflict, teams and processes may disintegrate.

This can lead to a lack of support for the process from agencies, which further impacts adherence to previously agreed processes.[45]

Clear roles and responsibilities reduce confusion and help representatives understand what is required of them and their agency. This clarity assists participants to understand how each agency can work together within an Integrated Service Response, and work within the strengths and limitations of each agency.

Greater clarity concerning the capacity of each agency can also assist agencies to know how to refer most effectively.

The establishment of Integrated Service Responses in Queensland

Although, as previously discussed, Integrated Service Responses have organically developed in different locations in Queensland, their widespread establishment was first recommended by the Special Taskforce (2015). The Special Taskforce identified that integrated responses were a '*best practice*' approach to respond to domestic and

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[39] Breckenridge, J, Rees, S, Valentine, K & Murray, S. (2015) 'Meta-evaluation of Existing Interagency Partnerships, Collaboration, Coordination and/or Integrated Interventions and Service Responses to Violence against Women'. *Landscapes: State of Knowledge Papers.* Sydney: ANROWS, p 14. Available at: https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2019/02/Integrated-Responses-Meta-Evaluation-Landscapes-State-of-knowledge-Issue-Eleven.pdf.

[40] Ibid, 20.

[41] Royal Commission into Family Violence (2016). *Summary and Recommendations, Parliamentary Paper No. 132.* Melbourne: Victoria Government, p 40. Available at: http://rcfv.archive.royalcommission.vic.gov.au/MediaLibraries/RCFamilyViolence/Reports/RCFV_Full_Report_Interactive.pdf.

[42] Stuart, S. (2017). 'Enacting Entangled Practice: Interagency Collaboration in Domestic and Family Violence Work', PhD thesis. Sydney: University of Technology Sydney. Available at: https://opus.lib.uts.edu.au/bitstream/10453/116827/7/02whole.pdf.

[43] Ibid.

[44] Herbert, J & Bromfield, L (2018). *National Comparison of Cross-agency Practice in Investigating and Responding to Severe Child Abuse.* Melbourne: Australian Institute of Family Studies, p 32. Available at: https://apo.org.au/sites/default/files/resource-files/2018-02/apo-nid133036.pdf.

[45] Ibid.

family violence. An Integrated Service Response provides opportunity for coordinated approaches to ensuring safety and responding to episodes of domestic and family violence.

In recommending the establishment of Integrated Service Responses the Special Taskforce specifically acknowledged recommendations made in the Inquest into the death of Noelene Beutel: that the Queensland Government establish an interagency model for responding to victims of domestic and family violence, supported through implementation of a common risk assessment tool.[46]

In 2017, following the Queensland Government's acceptance of the Special Taskforce's recommendations, an Integrated Service Response incorporating High-Risk Teams was established as a trial in three locations:

- Logan/Beenleigh;
- Mount Isa/Gulf; and
- Cherbourg.

Each of the trial sites shared a common risk assessment tool, information sharing guidelines, and governance protocols. High-Risk Teams established in each location were managed and overseen at the regional level and each Team was responsible for developing its own protocols and processes to manage high risk domestic and family violence cases in their local areas. Co-design processes informed by the local context, existing local networks and services, and the needs of the local community, were undertaken to develop these protocols and processes.[47] In 2018 and 2019, the trials were made permanent and High-Risk Teams were established in a further five locations:

- Brisbane;
- Ipswich;
- Cairns;
- Mackay; and
- Caboolture.

The High-Risk Teams Statewide Guidelines 2022 recognise that one of the strengths of the High-Risk Team model is its ability to adapt and respond to local needs and trends. Each community and accordingly each High-Risk Team will have unique challenges, trends, and distinct demographics that would be difficult to address through a one-size-fits all approach. However, while flexibility is required to support local responses, a consistent, state-wide approach is important to support improved system responses.

The High-Risk Teams are one component of a much broader integrated service system which are a formalised, place-based coordinated response model. High-Risk Teams have specified funded positions across Queensland Government agencies and an appointed lead domestic and family violence Specialist Service Provider to deliver multi-agency responses. Cases are referred to the High-Risk Teams only when there is evidence to suggest escalating or imminent risk of serious bodily harm or lethality to the victim and existing agency and/or Integrated Service Responses have been unable or are insufficient to manage the level of risk.

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[46] Findings into the death of Noelene Marie Beutel. Available at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0020/330653/cif-beutel-nm-20141117.pdf.

[47] Special Taskforce on Domestic and Family Violence (2015). *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland*. Brisbane: Queensland Government, recommendation 86. Available at: https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/533db62b-b2c9-43cc-a5ff-f9e1bc95c7c7/dfv-report-vol-one.pdf?ETag=c69c3ef47071a137ddbaedb49f7fe468; Department of Child Safety, Youth and Women (2019). *Evaluation of the Integrated Service Response and High-Risk Teams Trial.* Brisbane: Queensland Government; Women's Safety and Justice Taskforce (2021). *Hear Her Voice: Report 1 - Addressing Coercive Control and Domestic and Family violence in Queensland.* Brisbane: Queensland Government. Available at: https://www.womenstaskforce.qld.gov.au/__data/assets/pdf_file/0013/700600/volume-1-exectutive-summary-and-introduction.pdf.

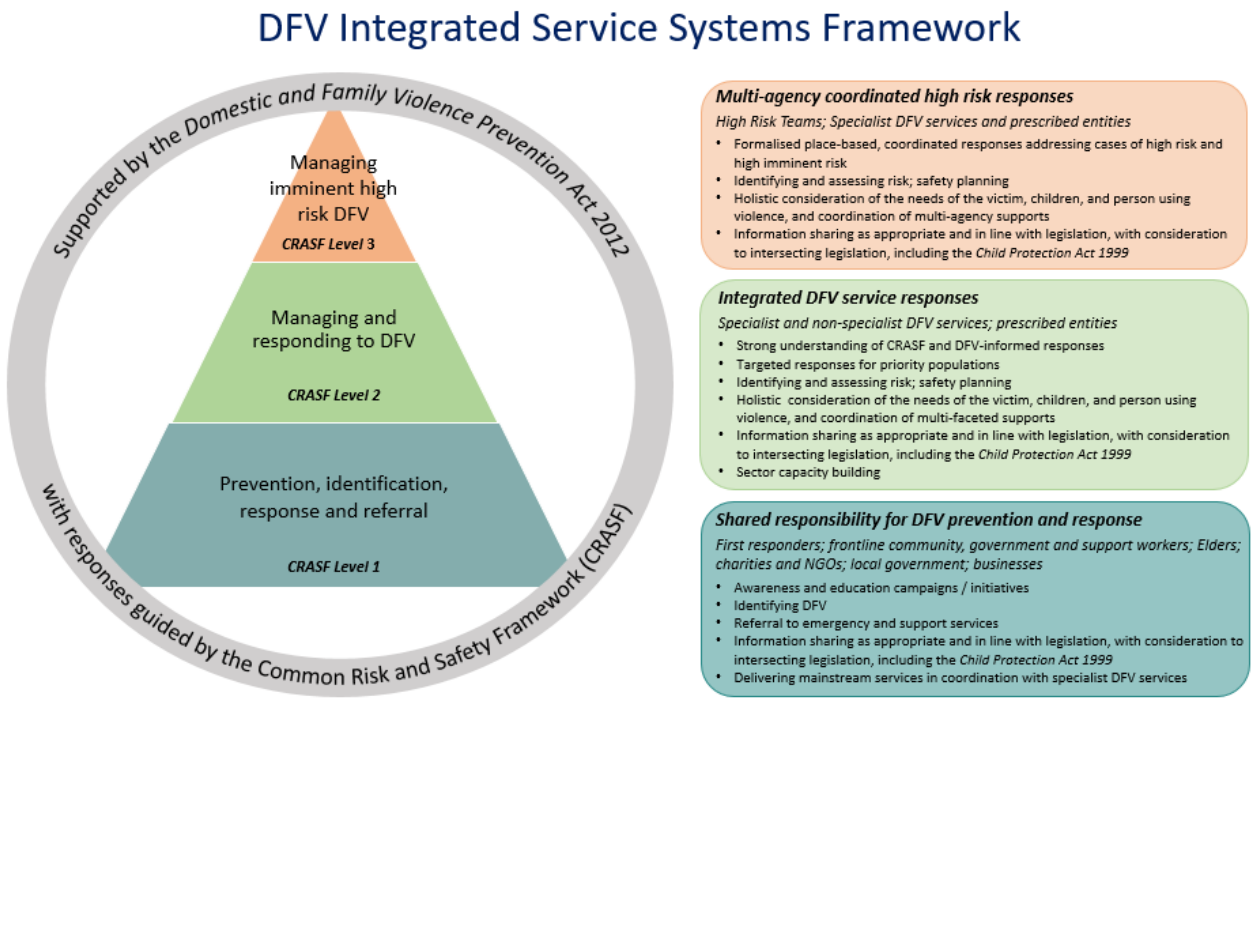

Figure 4. DFV Integrated Service Systems Framework Queensland.

Common Risk and Safety Framework

A key element of an Integrated Service Response is a common risk assessment framework (CRASF) and tool which is intended to assist in:[48]

- establishing a shared understanding and language for risk;
- case triaging;
- helping to identify high risk cases;

[48] Special Taskforce on Domestic and Family Violence (2015). *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland*. Brisbane: Queensland Government. Available at: https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/533db62b-b2c9-

- identifying whether thresholds for information sharing have been met; and
- developing the appropriate response in each case.

The CRASF was developed by ANROWS in 2017 for use by government and non-government agencies to support the identification of high risk cases and the appropriate services needed for all victims seeking support.

The CRASF has three key components:[49]

- a shared understanding and definition of domestic and family violence, key principles and risk factors;
- foundations for practice; and
- a common, tiered approach to risk assessment, risk management, and safety action planning.

The CRASF was first introduced in Queensland in 2017, and serves the critical function of supporting people to identify domestic and family violence so risks can be recognised early, and swift action can be taken to prevent harm. It outlines a shared understanding and common approach to recognising, assessing, and responding to domestic and family violence, and offers clear practical guidance for undertaking risk assessment and safety planning for victim-survivors of DFV and their children.

On 15 July 2022, the Queensland Government released a revised CRASF following a 12-month review. The revised CRASF includes a new child screening tool, additional factors relating to coercive control, a greater focus on children, priority populations and the victim-survivor's voice, technology-facilitated abuse, improved cultural considerations and an increased focus on the PUV. Agencies across the integrated service system will be supported to understand more about the CRASF and how it can benefit their work.[50] The Board will continue to monitor use of the revised CRASF tool in subsequent reporting periods.

The Board reaffirms that for risk assessment to be effective workers must be supported to gain a robust understanding of risk, lethality and dangerousness, including how to identify and respond to changes in risk levels. The Board identified in this reporting period that, in some cases, risk assessments were not conducted effectively or consistently and this impacted not only agency responses, but the prospects of a successful integrated response to domestic and family violence.

High-Risk Teams

As noted previously, another key element of integrated service responses in Queensland has been the development of High-Risk Teams.

In Queensland, High-Risk Teams comprise staff from both non-government agencies including domestic and family violence services, and government agencies including Queensland Police Service; Queensland Corrective Services; the Department of Children, Youth Justice and Multicultural Affairs; Queensland Health; the Department of Communities, Housing and Digital Economy, the Department of Justice and Attorney-General (Courts) and the Department of Disability, Seniors and Aboriginal and Torres Strait Islander Partnerships.

Victims who have been assessed as being at high risk of serious harm or lethality through the CRASF are referred to High-Risk Teams. High-Risk Team members collaborate to share information and develop multi-agency safety plans to support victims and their children.

When a case is accepted by a High-Risk Team, High-Risk Team members will manage that case through a series of weekly meetings in which each agency provides the information it holds about the case to the High-Risk Team, the Team discusses

43cc-a5ff-f9e1bc95c7c7/dfv-report-vol-one.pdf?ETag=c69c3ef47071a137ddbaedb49f7fe468.

[49] Department of Justice and Attorney-General (2022). *Domestic and Family Violence Common Risk and Safety Framework*. Brisbane: Queensland Government. Available at: https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/c927ea9b-6973-4912-966e-dc11d1d46a67/common-risk-safety-framework-2022.pdf?ETag=35140347bed403b480f9c6ce89c6b99a.

[50] Queensland Government (2022). *Launch of the revised CRASF*. Available at: https://www.vision6.com.au/em/message/email/view?a=33521&id=1641741&k=DxlUlhKUJmea5nPs0n5Lh_OZQ5gquO7dvpJcvDLplkE.

what response options are available, and determines what actions need to be taken.

The High-Risk Team aims to:

- increase the safety of victims and their children and help prevent serious harm or death;
- manage the high risk posed by the PUV, increase their accountability, and reduce reoffending;
- prevent systems abuse; and
- increase agency understanding and accountability, and deliver coordinated, consistent, and timely responses.

Evaluation of the Integrated Service Response and High-Risk Teams

In 2019, an independent evaluation of the Integrated Service Response trial sites was completed by Griffith University.[51] The evaluation found there was evidence of promising improvements in service coordination and, overall, the Integrated Service Response/High-Risk Team model was in a state of '*emerging practice*'. It was found that the model delivered many benefits including better information sharing, enhanced accountability, and increased awareness and monitoring of the PUV.

One of the key findings of the evaluation was that there are blurred boundaries between the Integrated Service Response and High-Risk Teams, with the separate roles not being well-defined in practice. The fact that the High-Risk Team is just one component of the broader Integrated Service Response was not well understood by stakeholders.

The evaluation also identified opportunities to further develop and enhance the Integrated Service Response model in Queensland, including to further clarify the purposes and roles of the Integrated Service Response and High-Risk Teams.[52] Opportunities for improvement included:

1 Critically reflecting on the key purpose of the Integrated Service Response and developing strategies to strengthen this role, within the context of each site.
2 Developing a structured set of clear referral pathways for early intervention and lower risk cases among the Integrated Service Response agencies at each site.
3 Narrowing the focus of the High-Risk Teams to become a brief temporary intervention, focusing on immediate PUV risk mitigation and short-term risk management.
4 Considering the nature of the risk mitigation practices available to assist in PUV risk management and victim safety planning management, including the cultural, social and geographical appropriateness of these practices.
5 Developing further guidelines for the role of the Integrated Service Response once High-Risk Team intervention is completed.

While the First Report of the Taskforce did not assess the effectiveness of the current Integrated Service Response and High-Risk Teams, it did observe that the approach shows real promise by providing sophisticated, multi-agency and multi-sector responses to high risk PUV and vulnerable victims.[53] It recommended that:

- the Queensland Government continue to roll out integrated service system responses and High-Risk Teams in additional locations;[54]
- the Department of Health and each Hospital and Health Service ensure that health, drug and alcohol and mental health services each play an active role in integrated service system responses and High-Risk Teams;[55]
- the Department of Justice and Attorney-General review the *Domestic and Family Violence Information Sharing Guidelines* to

[51] Department of Child Safety, Youth and Women (2019). *Evaluation of the Integrated Service Response and High-Risk Teams Trial.* Brisbane: Queensland Government.

[52] Women's Safety and Justice Taskforce (2021). *Hear Her Voice: Report 1 - Addressing Coercive Control and Domestic and Family Violence in Queensland.* Brisbane: Queensland Government. Available at: https://www.womenstaskforce.qld.gov.au/__data/assets/pdf_file/0013/700600/volume-1-exectutive-summary-and-introduction.pdf.

[53] Ibid, p xvi.

[54] Ibid, Recommendation 18

[55] Ibid, Recommendation 19

ensure they provide a plain English and easy to use guide for agencies involved in integrated service system responses and High-Risk Teams and support integrated approaches between agencies and services across the state;[56] and

- the Department of Justice and Attorney-General strengthen the whole-of-system approach to risk assessment and safety planning by developing a whole-of-system risk assessment framework and requiring use of risk assessment processes across all parts of the domestic and family violence service system and justice system that are consistent and aligned with this framework.[57]

[56] Ibid, Recommendation 20.

[57] Ibid, Recommendation 21.

Chapter 3: Understanding dangerousness

This chapter provides a brief overview of each of the cases reviewed by the Board in this reporting period. Further details about relevant service contact are discussed in Section 2 of this report.

This chapter seeks to acknowledge the journeys of people who have lost their lives to, or been otherwise impacted by, domestic and family violence; and enhance understanding of the context in which these types of deaths occur. The Board acknowledges the strength and resilience of victims of domestic and family violence.

The Board is established under the *Coroners Act 2003* to identify systemic issues, make preventative recommendations and increase awareness of the context in which domestic and family violence deaths occur.[58]

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

This chapter provides a brief summary of each of the cases the Board reviewed within the 2021-22 reporting period. This information is provided to enhance understanding of the complex dynamics of domestic and family violence and highlight the personal, familial, and community impact of these deaths.

In total, the Board reviewed 13 deaths, five women, four men, and four children who died by homicide or apparent suicide in the context of domestic and family violence between 2018 and 2021. Including five First Nations People. Three of these deaths occurred in 2018 with one victim being 20 weeks pregnant at the time of death. Two in 2019 again, with one victim being 25 weeks pregnant. Six were reviewed occurring in 2020 and two in 2021.

All deaths occurred where an Integrated Service Response was operating, and all deceased persons and/or their intimate partners were either known to the High-Risk Team operating within their locality, or they had been identified as high risk by a participating agency.

While distressing and tragic, these are also stories of strength and resilience, often in the face of relentless and enduring violence. The courage of the victims in these cases as well as those bereaved by their loss should not go unacknowledged.

While this material may be confronting for some readers, the Board trusts that we can learn from these tragedies to enhance our understanding of domestic and family violence and prevent further deaths from occurring in the future.

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.

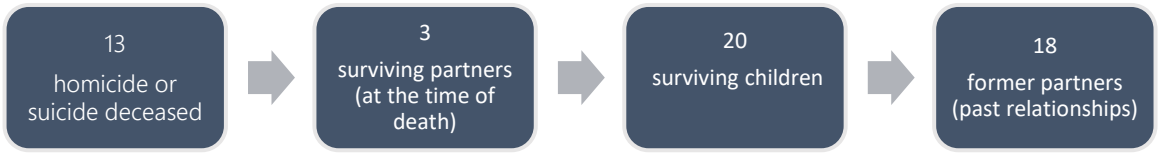

Figure 5. People impacted by a domestic and family violence death reviewed by the Board in 2021-22.

[58] *Coroners Act 2003* (Qld) s 91A.

Ellie

Ellie, a First Nations woman in her 20s, died by suicide. Ellie had an extensive history of suicidal and self-harm ideation, which was directly linked to her experiences of domestic and family violence. Domestic and family violence was a feature in all of her intimate partner relationships and many of her familial relationships.

In the 12 months prior to her death, Ellie was in a relationship with a partner, Sonny, for approximately eight months. At the time of her death, Ellie had separated from Sonny, and had commenced a new relationship with Jayden.

Sonny had an extensive history of using violence in his relationships and was the respondent in several protection orders naming his former partners and his sister as aggrieved persons. Violence had been a dominant feature in Sonny's family.

Sonny had attempted suicide several times in the past. His sister and her son had also died in a homicide-suicide which was perpetrated by Sonny's father.

Ellie had been referred into a High-Risk Team by Youth Justice during her relationship with Sonny. This referral was made due to Youth Justice having concerns about her safety. During their relationship, Sonny sought to control Ellie by using behaviours including non-lethal strangulation, physical violence and threats to kill. Ellie disclosed to services that she had visited Sonny's house one day and he had prevented her from leaving.

After Ellie and Sonny separated, she began dating Jayden, who also had an extensive history of perpetrating domestic and family violence against intimate partners and family members. Ellie's relationship with Jayden was also characterised by his use of domestic violence behaviours against her, which included: non-lethal strangulation (to the point of unconsciousness), biting her face, sexual violence (including forcing her to have sex with other men), assaulting and threatening her family members.

When services became aware of Ellie's relationship with Jayden, Ellie was referred to a High-Risk Team as Jayden was known to be a high risk recidivist PUV.

At the time of her death Ellie's case at the High-Risk Team remained open.

Ellie had been in contact with multiple services in the two years prior to her death including Queensland Police Service, Queensland Corrective Services, Queensland Courts, Queensland Ambulance Service, two High-Risk Teams, two domestic and family violence services, a Hospital and Health Service, and general practitioners at an Aboriginal health service.

Maeve

Maeve, a woman in her thirties, died by suicide.

When she died, Maeve was pregnant to her former partner of approximately 12 months, Jaxon. Maeve was the primary carer for her two young children from a previous relationship.

Jaxon had perpetrated domestic and family violence towards Maeve throughout their relationship, including physical assault, rape, sexual violence (physically restraining her during sex), financial abuse, non-lethal strangulation, and verbal abuse. Jaxon also had a history of using violence against his family members and other intimate partners.

Maeve had a history of self-harm and suicidal ideation and this was directly linked to her experiences of domestic and family violence. She had also experienced violence in past intimate partner relationships and had been exposed to violence in her childhood.

Maeve had a complex medical and psychiatric history and she had been diagnosed with anxiety and depression since her early teenage years.

In the lead up to her death, Maeve was supported by a domestic and family violence service, who had assisted her with safety planning. She was referred to a High-Risk Team on the basis she was assessed as experiencing several high risk lethality factors. However, Maeve's case was stepped down by the High-Risk Team three weeks before her death, as her risks were considered to be sufficiently managed through the Integrated Service Response.

In the years prior to her death, Maeve had contact with Queensland Health, several private hospitals,

Queensland Police Service, Queensland Court Services, a specialist domestic and family violence service, Legal Aid Queensland, Women's Legal Service, and the Family Court.

Johnny

Johnny, a man in his forties, died by suicide. At the time of his death, he was on parole for violent offences against his ex-partner, Eloise. Johnny had a violent criminal history which commenced when he was just 15 years old.

Johnny had served numerous terms of imprisonment, including six months for two counts of indecent treatment of a child under 16. Johnny perpetrated violence against members of his family and his former intimate partners, and he had been named as the respondent on six protection orders involving five different intimate partners. Johnny was known to child protection services as an adult due to his history of perpetrating domestic and family violence and child sexual abuse.

Johnny was in a relationship with Eloise for a little over 18 months and they had a son together. He perpetrated significant domestic violence against her during this time, including verbal abuse, physical abuse, threats to kill and other coercive controlling behaviours such as stalking, threats of suicide, sexual abuse (demanding sex and intimidating her into saying yes), extreme jealousy, constant calling and texting, and preventing Eloise from contacting her daughters after he assaulted her to hide her injuries from her ex-partner.

Eloise was in contact with a domestic and family violence support service who referred her to the High-Risk Team. Eloise was eventually stepped down from the High-Risk Team as her risks were considered managed. When Eloise's case was stepped down, Johnny was still serving time in prison for another domestic and family violence related offence.

In the lead up to his death, Johnny had been known to a range of different services including Queensland Police Service, Queensland Court Services, Queensland Corrective Services, a High-Risk Team, Queensland Health and Mental Health services, a men's behaviour change program, and a general practitioner.

Ryan

Ryan, a First Nations man in his thirties, died by suicide. Ryan had been in a relationship with his First Nations partner Clara, for over two decades and they had children together. All of Ryan and Clara's children were subject to child safety intervention, and none of them lived with Ryan and Clara at the time of his death. Ryan and Clara had separated and reconciled several times during their relationship but were separated when Ryan died by suicide.

Ryan experienced significant domestic and family violence during his childhood from his mother and father. His history of criminal offending began when he was an adolescent.

Ryan had a history of problematic substance use and had been diagnosed with paranoid schizophrenia and experienced hallucinations and depressive symptoms throughout his life. Records indicate that Ryan had attempted suicide and self-harmed in the past.

Both Ryan and Clara used domestic violence during their relationship, although the evidence suggested that Ryan was the primary PUV. Both Clara and Ryan were identified as respondents on different protection orders. Ryan perpetrated verbal abuse, threats to kill, sexual violence, non-lethal strangulation and other acts of coercive control against Clara throughout the course of their relationship. There is evidence that Clara used verbal abuse, sent abusive and sexually explicit text messages and 'attempted to provoke' Ryan to act violently.

Clara was referred to a High-Risk Team without her consent in relation to Ryan's use of domestic violence against her, and a Safety Management Plan was prepared for her. Ryan was separately referred to the High-Risk Team without his consent as a victim of violence (with Clara as the PUV). Both High-Risk Team cases were open at the time of Ryan's suicide.

The suicide of Ryan's son, Isaiah (see below), was also considered by the Board during this reporting period. Relevant, proximal service contact with the following agencies was also considered for Ryan:

Queensland Police Service, Queensland Corrective Services, and a family relationship service.

Isaiah

Isaiah, a First Nations adolescent male, died in an apparent suicide. The suicide of Isaiah's father, Ryan, was considered by the Board during this reporting period (see above).

Isaiah was regarded as a high risk PUV in both his intimate partner and familial relationships. He had been exposed to significant domestic and family violence while growing up.

Isaiah had extensive service system contact relating to his criminal offending, problematic substance use, mental illness and domestic and family violence. He had been subject to child safety intervention throughout his life, but at the time of his death was living with his family and girlfriend Eliza (who was under the age of consent at the time).

Eliza was subject to long-term child safety intervention, but she was described by child safety services to have *'self-placed'* with Isaiah and his family at the time of Isaiah's death.

Isaiah perpetrated physical, verbal and emotional abuse against Eliza. Isaiah was sentenced to juvenile detention several times in relation to non-domestic and family violence related offences. He was held on remand for approximately five months and was granted conditional bail.

Isaiah had a history of expressing suicidal ideation and self-harm and had attempted suicide several times. Both Eliza and Isaiah were separately referred to the local High-Risk Team and these cases were open at the time of Isaiah's death.

In the month before Isaiah's death, he was assessed as high risk for suicide. Isaiah had significant contact with youth justice programs along with several services in the years prior to his death.

Keira

Keira, a First Nations woman in her early thirties, was killed by her male intimate partner, Warren, who was also First Nations. Keira was 25 weeks pregnant at the time of her death.

Keira had a criminal record of mostly minor, non-violent offences. She had a history of mental illness. Medical records suggested that Keira had been suicidal in the past. In addition to being pregnant, Keira had other children who were in the care of child safety services when she died.

Warren had a significant criminal history that began when he was an adolescent. He had a history of both non-violent and violent offending, including assault and a sexual offence against the daughter of his previous de-facto partner. Warren experienced problematic substance use throughout his life.

Warren had perpetrated domestic violence against Keira throughout their relationship, and Keira had been involved with various services, including domestic and family violence services in relation to his abuse.

Warren's violent behaviours included verbal abuse, physical assaults, threats to kill, sexual violence, financial abuse and other coercive controlling behaviours.

Prior to her death, Keira was connected with domestic and family violence services, one of which had assessed her as being at a high risk due to the violence that had been perpetrated by Warren. A High-Risk Team referral was attempted but was not completed before her death because the referral system was not working at the time.

In the lead up to her death, Keira had significant contact with the Court Link programs and Murri Court, where she was being managed in relation to several minor criminal offences at the time of her death.

Keira had been identified as high risk by a specialist phone service in the months before her homicide and had relevant service contact with the Queensland Police Service, an employment service and the Aboriginal and Torres Strait Islander Legal Service.

Flora and Russell

Flora, a woman in her late 50s, was killed by her ex-partner, Russell, who subsequently died by suicide.

Russell had used significant domestic and family violence in at least three past intimate partner relationships and his abusive behaviours consistently escalated post-separation. Russell had been found guilty of various offences against his previous partners, including assault, stalking, destruction of property, and larceny.

Russell used violence against Flora from early in their relationship. Flora's children had told their mother that they were concerned about Russell's violence towards her and were concerned that she would adjust her behaviours to avoid upsetting Russell.

At the time of Flora's death and Russell's suicide, there was a temporary protection order in place which prohibited Russell from having any contact with Flora or attending her home. Russell had breached this temporary protection order many times in the weeks leading up to Flora's death. These breaches were reported to the police and to a specialist domestic and family violence service that was working with Flora.

Flora was not referred to a High-Risk Team, although a worker at the domestic and family violence service she was involved with had noted that a referral 'may need to be considered' if Russell continued to breach the temporary protection order. A Magistrate at a specialist court had previously identified that her case may need to be referred to a High-Risk Team. No referrals were made prior to Flora's death.

Charlotte and her children

Charlotte, a woman in her 30s, and her children, were killed by her ex-partner and the children's father, Mark. Mark died by suicide immediately after the homicides.

Charlotte and Mark were in an intimate partner relationship for ten years, and their relationship was characterised by Mark's violence against Charlotte. Violence behaviours Mark used included physical assault, sexual violence (rape) and non-lethal strangulation. Mark also had a history of perpetrating domestic and family violence against previous intimate partners and his violence would escalate post-separation.

Charlotte was in contact with a domestic and family violence service in the months leading up to her death. While Charlotte was not referred to a High-Risk Team by either police or specialist support services, both entities identified her as being at high risk (using their own agencies' respective risk assessment tools).

Relevant service contact had also occurred with Queensland Police Service, Department of Child Safety, two domestic and family violence services, family mediation services, two general practitioners, legal practitioners and a 24-hour men's phone support service. The Board noted that none one of these services specifically explored the safety of the children.

Section 2: Understanding responses to risk, safety and dangerousness

SECTION 2

This section outlines the Board's findings from this reporting period and identified opportunities for improvement, with a focus on:

- Developing greater knowledge and awareness of domestic and family violence (Chapter 4), including understanding key indicators of potentially lethal risk, and the intersections between domestic and family violence and suicide, to better respond to underlying patterns of risk and harm;
- Developing practice and responses to domestic and family violence (Chapter 5), through improving safety planning and management, supported by effective record-keeping and strong information sharing. This will ensure that the system can better identify patterns of violence perpetration across relationships and over time; and
- Developing Queensland's workforce, systems, and evidence about domestic and family violence (Chapter 6), including embedding specialisation into practice, focusing on PUV disruption and management, and protecting children.

Chapter 4: Developing our knowledge and awareness

This chapter discusses the need to build our shared understanding of key indicators of potentially lethal risk, such as a victim's intuitive sense of fear of the PUV, and an escalation in violence. When considering opportunities to improve responses to domestic and family violence it is not only important to enhance community awareness, including through improved media reporting It is also necessary to consider how to improve understanding of the intersections between domestic and family violence and suicide, to better understand underlying patterns of risk and harm.

In several cases the Board reviewed in this reporting period there was a lack of understanding of, and response to, disclosures made by people experiencing domestic and family violence. This resulted in key risk indicators being missed, or not adequately responded to, including:

- non-lethal strangulation;
- non-consensual sexual acts (sexual violence);
- escalation of violence;
- threats to kill;
- the PUV's history of violent behaviours; and
- the victim's sense of being in danger.

As outlined in Figure 6, these key lethality indicators have been prevalent in intimate partner violence-related homicides in Queensland where risk indicators have been collated (between 2011 and 2019).

For example, in the months prior to Keira's death, she was subjected to intensive monitoring by her intimate partner Warren. While at an employment service, she had passed a note to staff which asked them to call the police for her. When police attended, this matter was recorded as a DV – No Offence on the basis that Warren had told police that there had been no altercation between the couple, and he did not know why police had been called.

During that callout, Keira told the responding officers that she wanted to go to a family member's home and wanted Warren to provide her with the key to this residence. She told police that she believed Warren '*would get angry if she told him that she wanted to leave*' with officers recording that the victim was fearful.

Police ultimately determined that there was no evidence of domestic violence on this occasion. They transported Keira to her family member's house, which may have provided an opportunity for officers to ask her additional questions. There is nothing recorded to indicate this occurred.

Body worn camera footage shows that Warren was agitated while speaking to police, and Keira was quiet and apologised to officers for the call. It appeared that police were strategically empathising with Warren as a means of de-escalation, as they also made statements such as *'you don't need the drama mate'* which appeared to diminish Keira's help-seeking.

Warren had previously been subject to an order under the *Dangerous Prisoners Sexual Offenders Act 2003* as he had been convicted of sexual offences against a very young child and had also severely assaulted that child's siblings. He had a history of domestic and family violence perpetration in other intimate partner relationships. This information would have been available to police if they had undertaken QPRIME checks at the time. There is no evidence that this occurred prior to police attending.

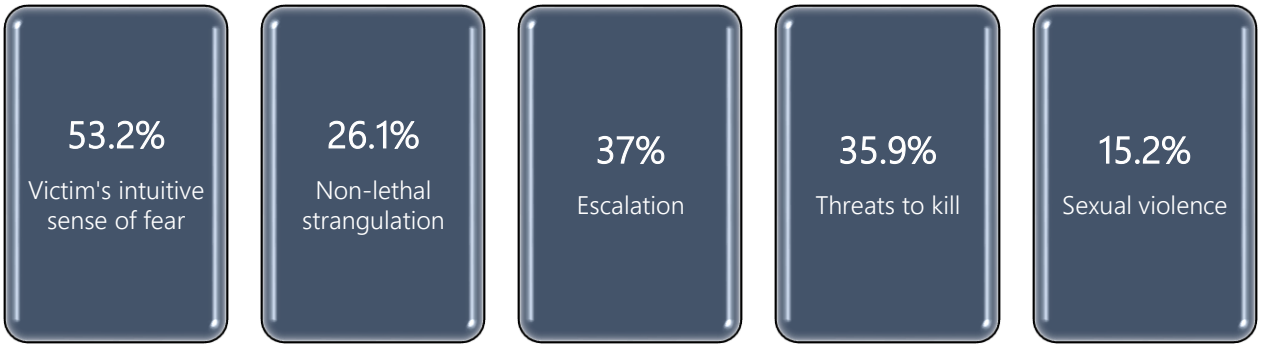

Figure 6. Presence of key lethality risk indicators in intimate partner violence related homicides between 2011 and 2018 (where recorded).

Although there was little police-recorded evidence of Warren using violence against Keira, she had disclosed to a service that Warren had threatened to kill her and her unborn child and this information was reported to the police. That episode had been finalised as a 'No DV/DV other action', with Warren similarly appearing to be highly agitated in available body worn camera footage. On this occasion, officers again appeared to empathise with Warren, perhaps to also strategically de-escalate the situation.

When the officers questioned Warren about his threats to kill Keira and her unborn child, he told them Keira had threatened him and that he did not mean to threaten her.

One of the officers suggested to Warren that perhaps he was just *'mouthing off'*. Available footage shows that while officers separated the parties, the parties were spoken to within hearing distance of each other. At one point Warren followed Keira into a bedroom as she was attempting to collect her belongings, and he continued to verbally abuse her in front of police.

In their discussions of this case and others, the Board observed that a victim's intuitive level of fear of the PUV is a key indicator of future harm/lethality. This highlights the importance of believing a victim where they express concerns about their safety or concerns about their children's safety, irrespective of their presentation. The Board was of the view that expectations in relation to how victims present shaped how agencies responded where such disclosures were made. The Board reinforces that this should not be the case.

The Board noted that within the same case a risk assessment was completed by one service and this deemed the victim, Keira, to be *'high risk'*. However, this risk assessment was not shared with other services Keira was working with. Nor did the risk assessment result in Keira being referred to the local High-Risk Team. This demonstrated low levels of agency collaboration and ultimately put the victim, Keira, at further risk. This was a missed opportunity for greater agency collaboration.

Understanding risk and victimisation

The concept of the 'ideal' victim has been discussed previously by the Board in successive Annual Reports and, in this reporting period, the Board again raised this concern.

This arose particularly in Ryan's case, in the context of an event that occurred some years before his death. In the episode of concern, Clara interceded to protect a child from being sexually assaulted by Ryan and was herself raped by Ryan as a result. Both Clara and Ryan were charged and convicted of exposing a child to an indecent act, and Ryan was also convicted of indecent treatment of a child under 16. There was no consideration of the sexual assault that Ryan had perpetrated against Clara in this episode. The Board was concerned that Clara had been convicted of this offence, especially after attempting to help the child and being raped herself as a consequence. As a long-term victim of Ryan's violence, Clara's criminalisation in this context was concerning and indicative of a lack of understanding of her victimisation.

Similarly, the fear experienced by Flora was not taken seriously by agencies because she presented as *'jovial'* and *'happy'* despite articulating clear threats to her safety, expressing being fearful of

her former intimate partner Russell, and describing a range of other behaviours that were indicative of a high risk of lethality (threats to kill, separation, stalking and previous domestic violence protection orders). Flora was killed by Russell within weeks of seeking assistance from police and domestic and family violence services. The Board was concerned that Flora's victimisation was not well understood by agencies who appeared to expect her to present differently as a victim.

System expectations of how victims present when reporting domestic and family violence can impact the way services respond when victims do not fit within predetermined perceptions.

The Board considers that agencies need to better demonstrate to victims that they believe them. This includes agencies acting on the information that victims provide and responding accordingly.

The Board reinforces that it is not the responsibility of women in need of protection to self-organise and seek help. In the cases reviewed, the Board emphasised that victims of violence had *'done enough'* to attempt to secure safety for themselves and it was the systems and services responding to those women that let them down.

In the cases considered, the agencies miscalculated the actual level or risk and potential for future harm within the relationship and the management of victims safety could have been better managed.

Understanding escalation

From its review process, the Board observed that across responding agencies there needs to be better understanding and identification of escalation to improve victim safety, particularly where victims may present to agencies on multiple occasions.

For example, when a victim takes further protective action such as seeking to vary a protection order by strengthening its conditions, this likely indicates that there has been a change of circumstances, or that the current conditions are ineffective. This should be understood as the victim taking additional protective actions and should be interpreted as reflecting an escalation of PUV behaviour, or is indicative of the victim being at heightened risk of harm.

Services need to be mindful that certain actions the victim or the service takes may heighten the potential risk of violence to the victim. Actions that heighten risk may include the victim taking steps to secure the safety of children through mediation and legal processes. Services should regularly revisit safety plans and discuss additional protective steps that can be taken with victims, as these are likely key to effective risk management.

On this basis, the Board considered that further specific training around understanding and identifying risk escalation may be beneficial for specialist domestic and family violence practitioners and other agencies engaged in the domestic and family violence response. Adequate training for all service providers (frontline agency workers, lawyers and psychologists) about how to identify and respond to escalating risk needs to focus on:

- static and dynamic risk factors;
- patterns of risk escalation;
- constellations of risk; and
- how best to respond to risk.

After consideration of these cases and taking into account the entirety of the evidence across the system, it was clear that imminent risk was not recognised by the agencies and professionals involved.

If a referral to a High-Risk Team had been made, acceptance and prioritisation of a referral takes into account:

- protective factors which may be present and are considered sufficient to manage the identified risks;
- whether information sharing and collaborative safety planning has occurred within the broader Integrated Service Response; and
- whether existing Integrated Service Response processes and interventions are in place or could be enacted, to monitor and respond to changes in risk.

In accordance with the High-Risk Team Statewide Guidelines 2022, a referral will only be accepted by a High-Risk Team if it meets the following criteria:

- there is evidence to suggest escalating or imminent risk of serious bodily harm or lethality to the victim; and
- existing service responses have been unable or are insufficient to manage the level of risk.

While domestic and family violence related homicides remain a statistically rare event, the Board considered current research that looks at pathways to homicides, to learn more about *'what works'* in trying to prevent or disrupt these types of deaths particularly where there are clear signs of escalation (as was the case for three intimate partner homicides the Board reviewed in this reporting period).

Recent research in this area has focused on the characteristics of intimate partner homicide offenders. Although approaches taken do not always differentiate between domestic violence context deaths and those in which other precipitating characteristics may be present, it is important to be mindful that research informed by interviews with PUV or sentencing decisions can also prioritise the perspectives of the PUV and minimise the victim's experiences, due to methodologies.

Eriksson, McPhedran, Mazerolle & Wortley (2022) recently considered whether there were any differences between men convicted of intimate partner femicides, and those who had been convicted of killing people who weren't intimate partners (both male and female).[59] This study found that:

- both homicide offender cohorts shared similar developmental and socio-economic characteristics;
- men convicted of non-intimate partner femicides had extensive criminal histories and serious substance dependency issues compared to intimate partner femicide offenders;
- not unsurprisingly, men convicted of intimate partner femicides were more likely to have previously perpetrated partner violence; and
- both cohorts were similar with respect to 'jealousy' and 'marital role attitudes', although men convicted of intimate partner femicides were more likely to condone intimate partner violence, and 'behaviourally control' their partners.[60]

The Australian Institute of Criminology recently explored three PUV trajectories to intimate partner homicide. While this study did not consider the domestic violence context of these deaths, it summarised three different pathways, in 149 homicide cases, that led to intimate partner homicides (see Figure 7).

[59] Eriksson, L, McPhedran, S, Mazerolle, P, and Wortley, R. (2022). 'Gendered Entitlement or Generally Violent? Sociodemographic, Developmental, and Gender-Based Attitudinal Characteristics of Men Who Commit Homicide'. *Homicide Studies* (advance). Available at: https://doi.org/10.1177%2F10887679221079801.

[60] Ibid.

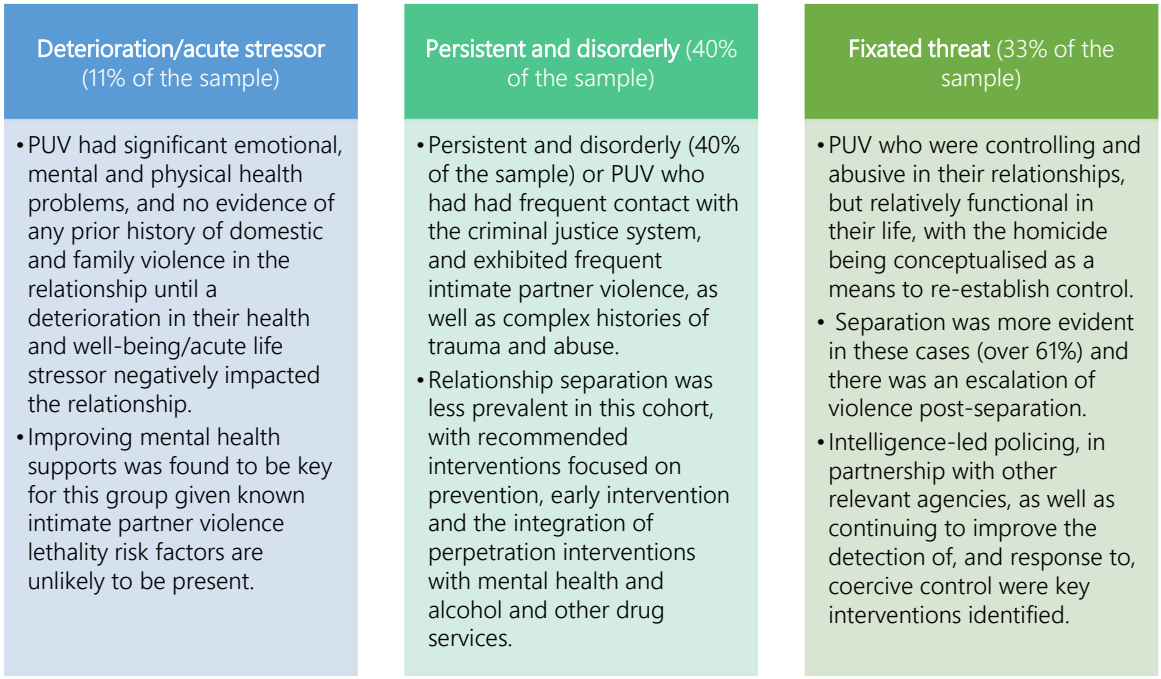

Figure 7. Pathways to intimate partner homicide (2022) Australian Institute of Criminology[61]

Jane Monckton-Smith (2019) has focused on the issue of escalating risk in intimate partner homicides, positing that there are eight stages of intimate partner femicide (as per Figure 8). While not necessarily directly lineal or definitive, Monckton-Smith's model recognises that there are opportunities for intervention across each of the different stages preceding intimate partner femicide, and at all stages steps can be taken to prevent a fatality.

While some of these stages are familiar in cases reviewed by the Board, it is important to be mindful that for services required to respond to domestic and family violence it is unlikely there will be sufficient information about the relationship history to be able to meaningfully predict a lethal outcome based on any theoretical model. The Board was of the view instead that all opportunities for intervention must be seized, and services delivered to victims and PUV. Across cases it was often ineffective or incomplete interventions that raised particular concern.

For example, Keira, who was a First Nations victim of an intimate partner homicide, had reported her experiences of violence from her partner Warren to multiple services including the police, a specialist state-wide domestic and family violence phone line, and Court Link. Keira was referred to support services by Court Link as she had said she was going to leave Warren. The support service undertook a risk assessment determined that Keira was at high risk. They arranged temporary accommodation for her. Keira elected not to utilise the accommodation and returned to stay with family. The service subsequently closed the file and marked Keira as 'disengaged'. There was no safety planning completed with her about what would

[61] Australia's National Research Organisation for Women's Safety (2022). *Pathways to Intimate Partner Homicide: The "Fixated Threat" Offender Trajectory (Fact Sheet).* Sydney: ANROWS. Available at: https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2022/02/PIPH-Fixated-threat-trajectory-fact-sheet.pdf; Australia's National Research Organisation for Women's Safety (2022). *Pathways to Intimate Partner Homicide: The "Persistent and Disorderly" Offender Trajectory (Fact Sheet).* Sydney: ANROWS. Available at: https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2022/02/PIPH-Persistent-disorderly-trajectory-fact-sheet.pdf; Australia's National Research Organisation for Women's Safety (2022). *Pathways to Intimate Partner Homicide: The "Deterioration/Acute Stressor" Offender Trajectory (Fact Sheet).* Sydney: ANROWS. Available at: https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2022/02/PIPH-Deterioration-acute-stressor-trajectory-fact-sheet.pdf.

happen if the PUV, Warren was to locate her and no referral was made to the High-Risk Team.

Warren had used violence against Keira which included:

- verbal abuse;
- physical assaults;
- threats to kill;
- sexual violence;
- financial abuse;
- non-lethal strangulation;
- stalking; and
- other acts of coercive control.

Warren had attempted to cut off Keira's ear with scissors and kept custody of all of Keira's important documents as a way of controlling her. Keira's Centrelink payments were also sent directly to Warren's bank account. Records showed that Warren was consistently present during appointments and court events, which further impacted Keira's ability to seek or receive support in relation to the violence she was experiencing.

There is limited information available about the violence Keira experienced from Warren in the months prior to Keira's homicide, which is likely to be partially accounted for by Warren's highly controlling and socially isolating behaviours. In the months before her death, Keira had been exited from Court Link which meant she had no access to ongoing case management support about the violence she continued to experience.

In addition, from reviewing Keira's case and other cases, the Board considered that the victim '*disengaging*' from programs or support services should in itself be considered a key indicator of risk particularly within the context of coercive control. The Board observed that, like in Keira's case, the term '*disengaged*' is often recorded on notes when a victim has not taken up a referral or attended follow-up appointments, suggesting that the victim is unwilling when there may be a range of reasons why engaging is not appropriate or safe for the victim. This language and assumption is particularly problematic when a PUV engages in intensive monitoring and surveillance of the victim making it unsafe for the victim to engage with services.

In Keira's case, Court Link notes were inconsistent, stating in some places that Keira was participating effectively, and then recording her as '*not engaging*' and being '*limited*' in her engagement in other locations on the file. In summaries Court Link had prepared about Keira's case, no reference was made to discussions that the service had with Keira in respect of her relationship with Warren or the homelessness she was experiencing. Court Link did not appear to consider how these factors may have impacted her ability to engage with the service, nor did it appear to recognise culture or connect to culturally appropriate or safe organisations.

Court Link files described Keira as being '*anti-intervention*'. The Board considered that this was an incorrect assessment given the coercive controlling behaviours Keira was experiencing from Warren. Further to this point, the Board considered that victims' reluctance to participate or engage with services may also reflect their low expectations of receiving quality service or the need to consider the cultural safety of organisations for First Nations victims.

The Board identified that services did not routinely assess a victim's capacity to stay engaged with a service. A range of factors affects a victim's, or indeed a PUVs', ability to meaningfully engage with a service or support. These challenges must be identified, understood and responded to in the context of effective service provision. Challenges that can affect a person's capability to remain engaged may include mental illness, problematic substance use or competing life priorities (such as having a child in care). This highlights the need for more inquisitive and person-centred approaches to understanding victim and PUV engagement, and more holistic responses anchored in the real-life experiences of victims and PUV.

Figure 8. Monckton-Smith's Eight stage relationship progression to intimate partner homicide.[62]

[62] Monckton-Smith, J. (2020). 'Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Relationship Progression to Homicide'. *Violence Against Women,* 26(11). Available at: https://eprints.glos.ac.uk/6896/1/6896%20Monckton-Smith%20(2019)%20Intimate%20Partner%20Femicide%20using%20Foucauldian.....pdf.

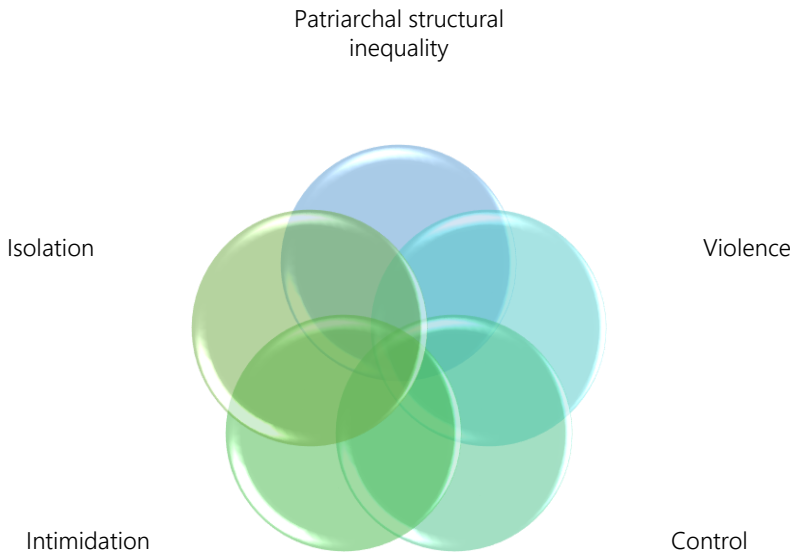

Figure 9. Diagram of the elements of coercive control, derived from Stark.[63]

Understanding coercive control

A recent study of femicides in Australia found that all femicide victims studied had experienced coercive control and most were trying to regain a level of independence when they were killed by their intimate partner.[64]

From the review of cases in this reporting period, the Board considers that there continues to be a limited understanding of coercive control and the gendered nature of domestic and family violence among domestic and family violence responders and the general public.

While the Taskforce's First Report (2021) made a suite of recommendations aiming to strengthen community and system responses to coercive control, including the introduction of a stand-alone criminal offence and the development of a communication strategy to increase community understanding and awareness of coercive control, it is critical that the gendered nature of coercive control is recognised.

According to Stark, coercive control is an ongoing pattern of physical, sexual, or non-physical abuse against current or former intimate partners in which male abusers leverage social and structural gender inequality to effectively restrict women's liberty.[65]

In coercive control, the combination of persistent micromanagement via non-physical techniques, credible and sometimes executed threats of physical and sexual violence, gendered relationship norms, and structural gender inequality disproportionately entraps women in relationships with abusive men (as per Figure 9).

Acts calculated to maintain control are often intensely personal within the context of the relationship. Coercive and controlling behaviours

[63] Dragiewicz, M. How Children and Technology-Facilitated Abuse in domestic and Family Violence. Plenary address. *Domestic and Family Violence Hurts Kids Too Symposium*, Children's Health Queensland. 18 May 2022.
[64] Eriksson, L, Mazerolle, P and McPhedran, S. (2022). 'Giving Voice to the Silenced Victims: A Qualitative Study of Intimate Partner Femicide'. *Trends & Issues in Crime and Criminal Justice, (645)*. Canberra: Australian Institute of Criminology. Available at: https://www.aic.gov.au/sites/default/files/2022-03/ti645_giving_voice_to-the_silenced_victims_v2.pdf.
[65] Stark, E & Hester, M. (2019). 'Coercive Control: Update and Review'. *Violence against Women*, 25(1). Available at: https://doi.org/10.1177/1077801218816191.

are accordingly unlikely to present as 'textbook' behaviours. The Board considers there are opportunities for agencies to better understand this and tailor their responses accordingly.

For example, in Ellie's case, Ellie's abusive ex-partner Sonny, in the course of his coercive controlling behaviour, had forced Ellie to get his name tattooed on her body. Sonny had forced Ellie's sister to get his name tattooed on her body. This behaviour indicates, Sonny saw both Ellie and her sister as a possession, and had similarly forced his former partner to have his name tattooed on her. When his former partner had removed that tattoo from her arm, Sonny had threatened to assault her.

When Ellie became involved with the High-Risk Team, the Team considered ways to support Ellie to safely remove the tattoo. While Ellie wanted the tattoo removed so she would no longer be recognised as Sonny's *'wife'*, she was worried about his reaction if he was asked to pay for the removal as he was already *'furious'* with her. The High-Risk Team applied for Victims Assistance money to have the tattoo removed.

Other victims reported acts of coercive control by their abusive partners which were highly personalised to themselves and their relationship, including:

- forcing her to look into a coffin, knowing that this would bring back traumatic memories of her mother's death;
- not allowing her to wear certain colours or clothes;
- timing how long it would take her to complete tasks to ensure he always knew her movements (intense surveillance);
- insisting that all of her phone calls were conducted with the speaker activated and not allowing her to have a phone when he was not present;
- discouraging her from taking her prescribed anti-depressant medicine;
- not allowing her to carry a handbag or wallet;
- taking photos of the victim as she slept and later showing these to her as an act of intimidation and demonstration of control;
- demanding they have 'family time' with their child, while excluding her from spending time with her children from another relationship.

The Board is of the view that, while gendered, responders should be better equipped to understand the manifestations and effect of coercive control in other relationships, including family and carer relationships and same-sex intimate partner relationships.

The Board seeks to reiterates the importance of enhanced capabilities in this area, especially to support the progress of anticipated criminal law reform in this area.

Informal supports

It is clear that family and friends played a significant role in supporting victims in the cases the Board reviewed in this reporting period. Supports that friends and family provided included:

- encouraging their loved ones to report the violence they were experiencing to police;
- supporting victims by attending the police station with them;
- providing accommodation and other forms of practical support (for instance, childcare) to victims who had separated, or were in the process of separating from, their abusive partners;
- liaising with support services on the victim's behalf; and
- providing statements to police about their concerns for the victim and in support of relevant proceedings.

In some cases, those family members had themselves experienced abuse from the victim's partner.

The Board recognises acknowledge the importance of family and friends continuing to be supported through general education about domestic and family violence. The Board considers that this will be particularly important to support to the progress of anticipated criminal law reform in the area of coercive control.

Media reporting

In this reporting period, the Board considered opportunities to improve community and practitioner understanding of coercive control. It noted that there had been significant media attention in relation to domestic and family violence within this reporting period and considered that improved media reporting around coercive control could enhance public understanding in this area.

Although enhanced media reporting has increased the visibility of domestic and family violence in Queensland, the Board expressed concerns that frequent and graphic discussions of domestic and family violence may elevate risk to people experiencing domestic and family violence. For instance, Board members discussed anecdotal concerns it was appraised of regarding increased use of accelerants, or threats to use accelerants, in episodes of domestic and family violence following the high-profile deaths of Hannah Clarke and her children.

Studies have shown that media reporting can increase suicide rates, particularly where there is an increase in the frequency of stories about suicide, or prominent reporting on this issue.[66] It is possible this type of contagion may occur with domestic and family violence related homicides, particularly where there is a focus on the circumstances of the death.

While there are existing media guidelines for domestic and family violence, the Board considered there may be an opportunity to enhance these through consideration of the Mindframe guidelines for suicide and mental ill-health – noting that when reporting on suicide, guidelines suggest effective measures such as:

- using safe, inclusive language;
- only presenting confirmed information;
- removing method and location details; and
- including help-seeking pathways.[67]

Guidelines also exist in the United Kingdom to support appropriate media reporting around domestic violence deaths and these recognise that insensitive reporting has lasting traumatic impacts on the victim's family and describe that every article is an opportunity to help prevent future deaths.[68]

According to those guidelines,[69] best practice in media reporting includes ensuring:

- that accountability is placed on the person who caused the death;
- that there is accuracy in terms of naming the behaviour as domestic violence;
- that dignity is upheld through avoiding sensationalising language, invasive or graphic details;
- that there is equality by avoiding insensitive or trivialising language or images; and
- that there is sensitivity to culture or religion.

As part of the implementation of the Taskforce reforms, the Queensland Government has agreed in principle to review its existing Domestic and Family Violence Media Guide and agreed to advocate for nationally consistent media standards similar to those for suicide, which emphasise the need for a trauma-informed approach.

There is a need to ensure that consideration is given to highlighting the need for sensitive and appropriate media reporting for domestic and family violence deaths in line with the principles outlined above.

[66] Monckton-Smith, J. (2020). 'Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Relationship Progression to Homicide'. *Violence Against Women*, 26(11). Available at: https://eprints.glos.ac.uk/6896/1/6896%20Monckton-Smith%20(2019)%20Intimate%20Partner%20Femicide%20using%20Foucauldian.....pdf.

[67] Mindframe (2020). *Mindframe Guidelines*. Available at: https://mindframe.org.au/suicide/communicating-about-suicide/mindframe-guidelines.

[68] Starling, J. (2018). *Dignity for Dead Women: Media Guidelines for Reporting Domestic Violence Deaths.* London: Level Up. Available at: https://static1.squarespace.com/static/5741ba638a65e2e0809f8d25/t/5c8f7f1015fcc04d1f249d84/1552908055603/Guidelines-Report.pdf.

[69] Ibid.

Understanding the intersections between domestic and family violence and suicide

While intimate partner homicides and homicide-suicides continue to attract considerable media attention, the Board's authority extends to the consideration of opportunities to prevent and reduce domestic and family violence related suicides.

Since its establishment, the Board's reviews of domestic and family violence related suicides have shown clear similarities with, and opportunities for prevention similar to, homicides and homicide-suicide cases. Broadly speaking, the Board has, in recent years, identified that:

- suicide threats and attempts are used by PUV to control victims within relationships characterised by domestic and family violence;
- both PUV and victims may have a complex history of prior suicidal behaviour or be otherwise impacted by suicide (such as through bereavement);
- PUV are at risk of harming both themselves and others where they make disclosures of suicidal intent or ideation, particularly within the context of relationship separation; and
- some PUV suicides are perhaps better conceptualised as attempted homicide-suicides where they are precipitated by a near fatal assault against a current or former intimate partner.

While the Board questions the extent to which High-Risk Teams or other services such as men's behavioural change programs should be expected to identify and respond to suicide risk, the need for additional support and safety planning, particularly for those at risk of self-harm or suicide who have been stepped down from a High-Risk Team, is evident.

The Board is of the view that specific consideration should be given to each person's individual circumstances in exit planning from services or High-Risk Teams, particularly where suicide risk or mental ill-health concerns have been identified.

In the Board's review of five, suicide cases that had contact with a High-Risk Team, three cases had been stepped down at the time of the death. In two of these cases the High-Risk Team was aware the victim or PUV had a history of suicidal behaviour and had expressed an intent to suicide proximal to the death, but there were no supports put in place to support the victim prior to the case being stepped down.

There was clear evidence the male PUV had urged the female victim to suicide in two cases where the female victim then died by suicide. This evidenced a continuation of the PUV's abusive behaviours and likely an escalation prior to the domestic violence related suicide death.

An example of the complexity of domestic and family violence related suicide cases, and the need for sustained interventions, is evident from the case of Ellie. In Ellie's case, while her ex-partner Sonny was incarcerated for a significant proportion of their relationship, he continued to maintain contact with Ellie from prison, calling her up to 70 times a day. In these calls Sonny was frequently verbally abusive and threatening. He urged Ellie to kill herself several times.

Shortly before Sonny was released on parole, police applied for a protection order naming Ellie as the aggrieved. The order included an additional no contact condition. Even with this protection order in place, Sonny would often utilise family members and new partners to contact and threaten Ellie. Whilst subject to parole, Sonny was fitted with an electronic monitoring device which monitored his movements by GPS. It was identified by Queensland Corrective Services; Sonny was attempting to locate Ellie as he was found within proximity to her location. They determined that he had asked associates to locate and stalk her on his behalf. Subsequently his parole order was suspended and he was returned to custody as a result of his behaviours towards Ellie.

Sonny had an extensive history of violence in his relationships and had been listed as the respondent in three protection orders with former intimate partners and his sister. Violence had been a dominant feature in his family of origin, and he had made several suicide attempts in the past.

Throughout his relationship with Ellie, he was physically and verbally abusive to Ellie, and threatened to kill her on several occasions. He also viewed her younger sister as his property and had begun controlling her.

A month before her death, Ellie was assaulted in her home and it was believed that Sonny, who was gang affiliated, had orchestrated this attack from within prison.

Ellie had been referred twice to a High-Risk Team in relation to Jayden and Sonny's violence against her, but as she had relocated as part of separating from Sonny, the High-Risk Teams were in different locations and did not share information due to the client data base being location-specific. It is understood that the High-Risk Team Coordinators did communicate and attempt to coordinate services to Ellie as she moved between the two locations, but information sharing was limited.

The Board observed in this case that across the service system Ellie's experiences of domestic and family violence were not considered as being relevant to her mental health needs. Her domestic and family violence issues were considered to be separate to her mental ill-health when it was apparent that both issues were complex and intertwined. While health services provided Ellie with support for suicidal ideation and depression, her underlying history of trauma and domestic and family violence were not explored. This was a missed opportunity, as a more complex understanding of Ellie's mental ill-health issues would have been likely to improve her outcomes. This echoes previous findings made by the Board in relation to the need for services to be better equipped to respond to a person's presenting and underlying needs.

The Board identified similar issues in Maeve's case. Maeve had been identified by police as a PUV in the months prior to her death, although other police and service records confirm that she experienced significant abuse from her current male intimate partner including:

- physical assault;
- sexual violence;
- non-lethal strangulation; as well as
- verbal and financial abuse.

Maeve's case had been stepped down by a High-Risk Team a month before her death, as her risks were considered to be managed through the broader Integrated Service Response. It was noted that that in the event of an escalation in the threat to her safety, she could be re-referred to the High-Risk Team. There was no re-referral prior to her death even though there is evidence that her risk level escalated during this time.

Just three days before Maeve died by suicide, a current police application for a protection order listing Maeve as the respondent was eventually dropped. When this occurred, Maeve attempted suicide and disclosed to police that Jaxon had told her to kill herself.

Police transported Maeve to hospital and the hospital treated her immediate injuries. However, Maeve left the hospital prior to a mental health assessment being undertaken. An Authority to Return was prepared, but it appears this was not recorded accurately within police systems, and was not followed up.

A police officer who had attended an earlier episode of violence between Maeve and her partner spoke to Maeve after this particular event and advised hospital staff, based upon his own individual, informal assessment, that she was not at risk to herself or others. This officer again made an application for a protection order listing Maeve as the respondent on the basis that "*exposing her ex-partner and her unborn child to threats (in this case actual) self-harm would seem to fall within the broad definition of DV*".

Concerningly, on both occasions where police had contact with Maeve, the police officers turned off their body worn camera mid-interview with her. On the first occasion, the pregnant Maeve had tried to explain that she had accidently hit the respondent - who was significantly taller than her – in self-defence, as she was trying to free herself from his restraint and to stop herself being thrown against the wall. She told the officer that she was trying to get her property back from Jaxon and showed the officer property damage that she reported occurred when Jaxon *'head-butted the wall'*.

This officer said to Maeve: *'Oh ok. It's a difficult situation for us…Maybe I can explain to you how*

things work'. The officer then gestured to his partner to stop recording. The footage stopped immediately, which appears to have been a breach of police policy.[70]

The details of the conversation this police officer had with Maeve also do not appear to be reflected in the occurrence report.

In this case, Maeve had a history of self-harm and suicidal ideation that was directly linked to her past experience of domestic and family violence. She had a complex medical and psychiatric history, and she had been diagnosed with anxiety and depression since her early teenage years. This appeared not to be appreciated by the police and her police interactions proximal to her death appeared to augment her mental health concerns. There was no attempt to re-refer Maeve to the High-Risk Team despite the evident change in her risk level at this time.

Based on its discussions, the Board considers that there is an opportunity to strengthen responses for people known to High-Risk Teams who have mental ill-health or who are identified as being at risk of suicide. This could occur as a parallel process to the High-Risk Team's management of that person's domestic and family violence concerns. This is especially important given the heightened risk of suicide for people experiencing or using domestic and family violence.[71]

Given intersections between mental ill-health and domestic and family violence, the Board is of the view that safety planning should extend to managing suicide risk in addition to domestic and family violence risk where these issues co-occur.

In response to recommendations made by the Board in its 2016-17 Annual Report,[72] the Queensland Government developed a *Suicide prevention framework for working with people impacted by domestic and family violence* (2021).[73]

While the Board's recommendation focused on domestic and family violence specialist refuges, the framework is designed to be used by all frontline workers who may come into contact with people impacted by domestic and family violence, including victims, PUV and witnesses.

This framework recognises that domestic and family violence specialist workers are not expected to be experts in suicide prevention. Rather, it acts as a guide to inform best practice suicide prevention responses and covers risk screening and assessment; response and referral pathways; and providing ongoing support.

Use of the framework is discretionary but strongly recommended for funded domestic and family violence services, with it being recommended that all such services have explicit policies and procedures in place to support people at risk of suicide.

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[70] Queensland Police Service (2021). *Digital Electronic Recording of Interviews and Evidence Manual (DERIE).* Brisbane: Queensland Government, section 4.4: When an officer commences a body worn camera recording, the officer should continue recording until: i) the incident is finalised; ii) the officer has entered an area where the Service has CCTV installed and operating (e.g. a watchhouse); iii) the need to record the incident is no longer required (e.g. guarding a crime scene overnight); or iv) a senior officer or incident commander directs that a BWC recording can be ceased. Prior to ending a recording, the officer should clearly state the recording will be stopped and the reasons for doing so. Available at: https://www.police.qld.gov.au/sites/default/files/2021-03/DERIE%20-%20Section%204%20-%20Field%20Audio%20and%20Video%20Recordings.pdf.

[71] Australian Institute of Health and Welfare (2019). *The Health Impact of Suicide and Self-inflicted Injuries in Australia, 2019.* Canberra: Australian Government. Available at: https://www.aihw.gov.au/getmedia/c504923e-e81d-411b-9ec9-c212d626cbfc/The-health-impact-of-suicide-and-self-inflicted-injuries-in-Australia-2019.pdf.aspx?inline=true.

[72] Domestic and Family Violence Death Review and Advisory Board (2017). *2016-17 Annual Report*. Brisbane: Queensland Government, Recommendation 1. Available at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0003/541947/domestic-and-family-violence-death-review-and-advisory-board-annual-report-2016-17.pdf.

[73] Queensland Government (2021). *Suicide Prevention Framework for Working With People Impacted by Domestic and Family Violence.* Brisbane: Queensland Government. Available at: https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/ac6ec5c6-3746-4022-a845-5c192e958255/suicide-prevention-framework-for-working-with-people-impacted-by-domestic-and-family-violence.pdf?ETag=0cec79475423d4b3e79d440aac2c840c.

Chapter 5: Developing our practice and responses

This Chapter considers opportunities to further develop our practice and responses to domestic and family violence through improving system understanding of safety planning and management. Effective record-keeping and strong information sharing, preferably with consent, are key to ensuring that the system can better identify patterns of violence perpetration across relationships and over time.

Across the cases the Board reviewed in this reporting period there was often a lack of understanding among responders of clear indicators of escalating risk and harm. The Board continues to identify issues with the way in which risk assessments are completed by agencies, noting that there are inconsistencies in the approach taken across agencies. Risk assessments are often not conducted dynamically and some risk assessment processes are very poor. These issues are considered in further detail in regard to workforce development in Chapter 6.

Persistent, compounding risk assessment issues were particularly evident in Flora's case. In this case, the PUV Russell had an extensive interstate criminal history, including serious domestic and family violence offences. Despite Flora disclosing this information to multiple agencies, this risk was never adequately assessed or responded to.

Flora contacted police on five separate occasions to report that Russell had breached the temporary protection order that was in place to protect her. On each occasion police took no action beyond recording information in their database. No risk assessment was ever carried out by police and no attempts were even made to speak to Russell about the reported breaches.

On another occasion, while a specialist domestic and family violence court magistrate determined that Flora was high risk based on the information Flora provided when applying privately for a protection order, no referral was made to the High-Risk Team operating in the area. No other attempts were made to assist Flora to manage this risk.

On another occasion, Flora also sought support from a specialist domestic and family violence service, and while a brief risk assessment was undertaken as part of the intake before she was placed on a wait list for counselling, key risk indicators were missed in that assessment. It does not appear that specialist domestic and family service workers asked qualifying questions, and this assessment was not informed by the protection order that was in place protecting Flora from Russell at the time.

In this case, available information about Flora's level of risk, such as Russell's extensive interstate domestic and family violence history and his previous attempt to burn down an ex-partner's home, was also not adequately appreciated by police nor was it shared across agencies.

In this case, Flora was flagged as potentially needing to be referred to a High-Risk Team after she re-contacted a specialist domestic and family violence service for support when Russell continued to breach the current protection order (police did not take action to these breach reports).

The Board was of the view that the management of Flora's case demonstrated considerable challenges in risk assessment across agencies and over time. Flora's case demonstrated numerous missed opportunities to intervene effectively prior to her death.

The review of Flora's case, the Board discussed the need for domestic and family violence services to actively manage wait lists, and for services to update victim's risk assessments and safety planning when there is a change in circumstances, or where victims seek further support, including where they report potential breaches of protection orders.

The Board was of the view that the police should undertake comprehensive checks to determine a PUV's prior history of violence and this should inform risk assessment processes. With respect to Flora's case, it was observed that the Queensland Police Service's increased focus on reducing

inappropriate access to records by officers may have had an unintended consequence of reducing officers' willingness to undertake additional checks of a PUV's history on police systems.

In recognition of the importance of policing domestic and family violence effectively and protecting vulnerable people across our communities, the QLiTE NextGen functionality was fast-tracked by the Mobile Capability Centre and released state-wide on 31 March 2022. The focus on the relationship provides a central point from which to access all available information between involved persons, resulting in faster information for officers and a focus on the current incident.

In discussing how agencies identified and responded to risks in this reporting period, the Board discussions focused on:

- the way in which risk screening and assessment tools were utilised by practitioners;
- if and how information was shared across agencies about any risks identified (particularly outside of a High-Risk Team); and
- the level of risk currently being managed across the domestic and family violence sector.

While in all three intimate partner homicides the Board reviewed in this reporting period the victim had been identified as being at high risk on at least one occasion in the lead up to their death, none of those victims were ever referred into a High-Risk Team.

In addition, while agencies are required to complete the CRASF to assess the level of risk experienced by the victim, it is also the mechanism for referring a case to a High-Risk Team in Queensland. The Board recognised that at no point was the CRASF completed with any of the intimate partner homicide victims; even when those victims had been assessed as being at high risk by a participating agency.

There were also considerable issues of delay identified in some cases. In Charlotte's case, for instance, both police and domestic and family violence services identified Charlotte to be at high risk at different points in time, although there were clear delays in the risk assessment being completed by the specialist domestic and family violence service in this case. These delays occurred despite Charlotte continuing to have contact with this service in relation to her concerns that the PUV Mark was stalking her and that she believed he had the capacity to kill her and the children.

In other cases there were considerable information sharing issues identified. For instance, in Keira's case, Keira was identified as high risk by a specialist state-wide phone service, although information about this risk was not shared back to the referring agency.

In Queensland, domestic and family violence risk assessment tools predominantly include a checklist of risk factors that are based on women's risk from men. In practice, professionals also use these tools to assess risk to men. As these tools are not validated for this purpose, using them in this way can also overstate the risk women present to their male partners, including in circumstances of defensive or resistive violence.

The Board emphasises that just because a risk number is relatively 'low' when compared to other cases being managed by an agency, this does not mean that:

- a case does not require a high risk response;
- the risk should not be actively managed; and
- the risk cannot escalate suddenly and rapidly.

In accordance with the *National risk assessment principles for family and domestic violence* (2018)[74] risk must be assessed at the very first point of engagement/contact and at every point of contact thereafter to align with best practice standards. For every risk identified during an assessment, there

[74] Toivonen, C and Backhouse, C. (2018). *National Risk Assessment Principles for Domestic and Family Violence.* Sydney: ANROWS. Available at: https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2018/07/ANROWS_NRAP_National-Risk-Assessment-Principles.1.pdf.

must also be a corresponding safety or management measure developed.

This aligns with the new Department of Justice and Attorney-General's '*Practice standards for working with victims and PUV of domestic and family violence* (2021) (Practice Standards),[75] which more clearly outline the roles and responsibilities of domestic and family violence services. Service compliance with the Practice Standards is now monitored in Queensland through the Human Services Quality Framework audit process.

Relevant to the issues identified by the Board, the revised Practice Standards require all staff to be competent in dealing with risks around safety and implementing effective strategies to maintain victim safety, including the specific needs of children.

Importantly the Practice Standards require that:

- a risk assessment is undertaken by staff at first contact, and that this risk assessment is managed and updated throughout the provision of interventions (Standard 1.3.1);
- staff are trained to recognise and identify the variety of risk factors present for both adult victims and their children and maintain a contemporary knowledge of emerging risk factors (Standard 1.3.2); and
- staff are trained to recognise and identify risk factors for PUV, and use these to inform risk assessment, management and the development of safety plans for victims (Standard 1.3.3).

While the Board's primary focus in this reporting period was on the practices of domestic and family violence services in assessing and managing risk, it was noted that actions taken by private practitioners[76] (including psychologists and lawyers) may, inadvertently, escalate a victim's level of risk.

For example, in Charlotte's case, Charlotte's solicitor wrote to the PUV Mark after he breached the temporary protection order protecting Charlotte. The solicitor advised Mark that Charlotte would no longer be complying with the parenting agreement, citing Charlotte's concerns about Mark's continued abuse and deteriorating mental ill-health.

Charlotte had expressed to the specialist domestic and family violence service she was engaged with that her solicitor's action may escalate Mark's violence. However, it does not appear that this information was incorporated into that service's risk assessment processes nor was the risk assessment updated to reflect the change in risk level (for both Charlotte and the children). There was also no management of risk during this period of change.

The Board noted that not all agencies involved with a victim will have the full picture of risk or have the specialist knowledge to effectively manage risk, which is why appropriate and effective information sharing between agencies is critical to help to inform effective, accurate and dynamic risk assessment.

Information sharing

Since its establishment the Board has continued to identify that existing information sharing provisions in relation to domestic and family violence are underutilised in Queensland.

Within this reporting period, issues were identified with:

- a lack of information sharing between police and domestic and family violence services, even where workers were co-located within a police station and/or services were aware the victim had sought assistance from each respective service. This was observed in multiple cases;
- a lack of follow-up once information had been shared by an agency. There was an apparent presumption that once information was shared by a referring

[75] Department of Child Safety, Youth and Women (2020). *Domestic and Family Violence Services: Practice Principles, Standards and Guidance.* Brisbane: Queensland Government. Available at: https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/e75875e0-50a9-4fa2-acde-121dc4a3a804/dfv-services-practice-principles-standards-and-guidance.pdf?ETag=8465906b55ef511a2a2db9721f74b69a.

[76] Including general practitioners, psychologists, psychiatrists etc.

agency, it was now the other agency's responsibility;
- a lack of understanding of the need for ongoing case management and collaboration, and for responses to extend beyond the sharing of information (particularly outside of High-Risk Teams); and
- inconsistent levels of information sharing by High-Risk Teams about the background of the victims and the PUV, and the history of violence within each relationship. Agency representatives typically shared only what they subjectively considered to be relevant or appropriate.

In its 2019-20 Annual Report, the Board recommended that the Queensland Government increase the awareness and consistent use of the existing information sharing provisions in Part 5A of the *Domestic and Family Violence Protection Act 2012* (the Act) by all agencies empowered to share or receive information under the Act including:

- ensuring that all prescribed entities under the Act have internal guidelines, processes and procedures in place;
- exploring opportunities to ensure that non-government organisations who are empowered to share or receive information under the Act have processes and procedures in place;
- developing standardised processes and procedures that can be provided to organisations as a template; and
- liaising with the relevant peak professional bodies of services who are empowered to share information under the Act.

This recommendation was accepted with the Queensland Government response stating that following the completion of the Integrated Service Response Trial Evaluation Report in 2019, a multi-agency work plan would be developed to guide implementation of the evaluation's recommendations.

The Queensland Government response also noted that to further support this work, the Department of Justice and Attorney-General will develop standard template processes and procedures to share with agencies who are empowered to share or receive information under Part 5A of the Act.

The Queensland Government noted that standard templates will be designed as resources that could be adapted as required to individual agency contexts. Peak bodies for key non-government organisations and other peak professional bodies will also be encouraged to promote relevant resources and use of the information sharing provisions to their memberships.

In its first report, the Taskforce (2021) also recommended that the Domestic and Family Violence Information Sharing Guidelines[77] be reviewed to ensure they provide a plain English and easy to use guide for agencies involved in Integrated Service Responses and High-Risk Teams (Recommendation 20).

When considering the use of the existing information sharing guidelines and the relevant provisions under the Act, it is important to acknowledge that the Part 5A provisions were intended to be enabling provisions for use in circumstances where there is a serious threat to a person's life, health or safety because of domestic violence.

Their use is not mandated and this is for good reason. It is preferable that information is shared with a victim's consent. This is preferable for many reasons, not least because a victim is often best able to anticipate the PUV's response to any actions taken. Victims may be reluctant to have information about their experiences of violence shared with others. When decisions are made about victims without taking into account their knowledge of risk, this can expose victims to further danger or unwanted, dangerous state intervention.

For instance, in Charlotte's case, Charlotte had initially expressed to police and domestic and family violence services that she did not want a protection order to be sought as she considered it

[77] Department of Communities, Child Safety and Disability Services (2017). *Domestic and Family Violence Information Sharing Guidelines*. Brisbane: Queensland Government. Available at: https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/06796d15-6f8a-4556-b0ba-ea7a16cdbf1e/info-sharing-guidelines.pdf?ETag=f1f3173ae89e1fe1e9737316e4da732d.

would upset the PUV, Mark. Mark had previously threatened that if she was to leave and take the children with her, he would make sure she regretted that action.

In Keira's case, she had expressed to a Statewide specialist domestic and family violence service that *'she felt strongly about not wanting the police involved in her case;* [Keira] *stated her grandparents and* [her partner's] *grandparents were a part of the stolen generation and she knows her and* [her partner] *are both Aboriginal and she hates that Aboriginal's* [sic] *have a bad name to them* [the police] *in relation to violence and doesn't want to bring shame to her family or his as the elders would view this as disrespectful.'*

In considering these cases, the Board recognised the challenges of information sharing across agencies including the Queensland Police Service and domestic and family violence services. However, the Board was of the view that in each of these cases individual agencies held critical pieces of information and had information been shared, this may have affected the case outcomes.

The Board recognised that while stronger and more proactive information sharing between agencies can help to hold PUV to account and support victims, it is critical that information is shared with victims to facilitate their own protective actions. Sharing information with victims helps to build trust and demonstrate that services are able to provide assistance and support to keep victims safe.

For instance, in Johnny's case, the primary victim of violence, Eloise, was not provided with relevant information about Johnny's imminent release from prison, despite the fact he continued to use domestic violence against her while in custody. Although Eloise had relocated, all agencies and the High-Risk Team involved in the case were aware that Johnny would be easily able to find Eloise when he was released.

In discussing this issue, the Board observed that victims are not always aware when a PUV is/may be released from custody, which may place them at an increased risk. The Board noted that while there is a Victims Register operating in Queensland, it can only be used when a person has been convicted, and not when they are on remand.

In Johnny's case, Johnny was on remand for a serious domestic and family violence related assault against Eloise. As he was on remand, Eloise was ineligible to gain information about when he was going to be released even though this was likely to increase her risk of further victimisation.

Record-keeping

In addition to deficiencies in information sharing, the Board identified apparent inconsistencies in record-keeping within agencies and by High-Risk Team representatives. This was most evident in Ellie's case where she had contact with two different High-Risk Teams in relation to the violence she was experiencing.

In the year prior to her suicide, Ellie was actively, concurrently managed by two different High-Risk Teams in relation to two separate relationships. In presenting to High-Risk Team meetings, some agencies recorded 'nil' updates in relation to Ellie, even though records from the other High-Risk Team confirm that Ellie had presented to those agencies during the relevant period. Accordingly, the Board were aware that there was information available and an update should have been provided by agencies reporting to the High-Risk Team.

The Board identified that there was a significant difference in the quality and detail of information agencies provided to each of the High-Risk Teams Ellie was involved with. For instance, in one of the High-Risk Teams, agencies appeared to share much more information and this resulted in a more nuanced overview of the experiences of the victim and the PUV.

Further, based on the record-keeping issues affecting the High-Risk Teams in Ellie's case, the Board considered that the different levels of information sought by High-Risk Teams and provided by agencies may result in problematic information gaps when someone moves from one team to another (for example, when a victim changes location, or the case is stepped down from a High-Risk Team and re-referred to a different team).

The Board notes, however, when reflecting on other cases reviewed in this reporting period that there appear to have been improvements in record-keeping by High-Risk Teams over time. The Board will continue to monitor this in its ongoing work.

Record keeping issues also affected individual services in a number of cases the Board considered during the reporting period.

For some cases, while there was apparent contact with a service, no records were available to inform the review suggesting that no records had been kept. In Ellie's case, for instance, a prisoner support service had been vocal in highlighting its engagement with the victim prior to her suicide. However, when the Board requested its records, that service was unable to produce any record of this engagement.

Similarly, in Charlotte's case, the Board was aware that Charlotte provided significant information to a specific police officer: she disclosed escalating violence; stalking; non-lethal strangulation; suspected child grooming and forced sexual acts. However, the officer did not record this information in police systems. This officer was preparing a brief of evidence to support an application for a protection order to support Charlotte at the time.

Poor record-keeping was also evident in the practice of a psychologist who had worked with the PUV in the lead up to an intimate partner homicide-suicide. The Board expressed concern in this case that the psychologist's records appeared to have been altered after the death.

Effective record-keeping within the context of domestic and family violence service provision is essential, as it helps those with whom information is shared better identify and understand patterns of violence perpetration over time, improves the assessment and management of risk, and provides greater consistency in service provision where multiple people may be working with the same victim or PUV. Effective record-keeping is an important way to prevent future violence.

Safety planning and management

When considering how risk is identified and responded to across agencies, the Board discussed the need for a more nuanced understanding of 'high risk' and 'high harm' cases across services. This includes greater clarity about what steps can be taken by an agency that has screened a victim as high risk, and how an agency can manage the victim's safety in the longer term.

While safety planning was undertaken by agencies and High-Risk Teams in the cases reviewed by the Board in this reporting period, many of the agreed actions appeared to be a list of things that the victim was required to do to keep themselves safe, with limited follow-up or actions required from the agencies involved. As outlined by ANROWS:

Safety planning is different to, though often linked with, risk, danger or lethality assessments. It is a practice framework and a practice tool. Safety planning is not done to a woman but with her. It is less about expert assessment and more of a collaboration. It is a union of expertise.

Safety planning is ongoing, dynamic, and responsive. It should not be viewed as a plan that is static. It is not a contract between a woman and a service in which she is made responsible (for protecting herself or others).

Safety planning works to understand the personal and family connections a woman lives with, is sustained by, or may wish to escape from. These connections may, at different times and in different contexts, produce risk and may also be protective. Therefore, checking and re-checking with her about these connections is vitally important.

In discussing limitations in safety planning, the Board considered the term *'safety management'* was more appropriate terminology, as it highlights the need for agencies to take action and proactively manage victims' risk. The Board considered that safety management should extend beyond the provision of phone numbers and to the consideration of how each identified risk factor can be managed.

The Board identified deficiencies in safety management that put victims at increased risk. For instance, in Charlotte's case, there were considerable delays in the completion of the tasks agreed to by domestic and family violence services, including conducting a technology sweep on Charlotte's phone (necessary due to Charlotte's concerns she was being stalked/intensively monitored by the PUV Mark). The delay was attributed to:

- one service provider taking three weeks to complete a referral;
- difficulties in trying to find a mutually suitable time for the engagement;
- the provider being away for a few days; and
- Charlotte's phone being turned off, even though it was part of current safety planning for her phone to be turned off.

The Board considered the perspective that had Charlotte's matter been managed by the High-Risk Team, issues with her and her children's safety management may not have occurred.

Given issues with safety planning in this particular case, the Board discussed the importance of services having 'safe contacts' in place so that where victims are uncontactable services can communicate with a trusted friend/family member.

The Board also observed in this reporting period that there are important opportunities to further consider the role of safety planning outside of the High-Risk Team including by other more generalist services. The Board identified that there is a lack of knowledge of how other agencies can undertake this work with victims.

For example, in Keira's case, Keira had attended a Court Link case management appointment with injuries that were suspected to be related to domestic and family violence. Staff supported Keira to exit from the back of the courthouse and flee with the support of brokerage (a Go Card). However, beyond those immediate actions, no safety planning was conducted and Court Link staff did not follow up to ensure that Keira returned home safely. The Board was of the view that enhanced safety management actions may have helped keep Keira safe.

While Court Link records indicate that safety planning was conducted with Keira at a later point, that safety planning was not documented on any Court Link records. The Board identified that this is another challenge that may undermine accountability and result in inadequate service responses to victims of violence.

Resource limitations were identified as a key factor impacting both risk identification and safety management in the cases reviewed. For example, in Ellie's case, Ellie's former partner Sonny was able to continue to abuse Ellie via the Prisoner Telephone System while he was incarcerated. This included arranging for associates to assault and/or threaten her, and phoning Ellie relentlessly. Telephone records indicated that Sonny called Ellie 955 times from the Prisoner Telephone System between 2 March 2018 and 24 May 2018, a period of 3 months.

While the Prisoner Telephone System has the capacity to monitor such calls (and agencies can intervene accordingly), the Board was advised that enhanced monitoring would require an expansion of existing intelligence capabilities within Queensland Corrective Services.

In its 2019-20 Annual Report, the Board recommended the Queensland Government, in conjunction with Queensland Corrective Services, review the mechanisms through which prisoners who are subject to a domestic violence protection order may contravene these orders while in custody in Queensland correctional centres, such as through the Prisoner Telephone System, mail and visits with a view to identifying and addressing existing gaps that allow this to occur.

The latest implementation update for this recommendation indicates that Queensland Corrective Services is:

- reviewing and amending existing operational policies to ensure considerations are in place to reduce the risk of prisoners contravening domestic and family violence orders; and
- continuing to consider options for legislative amendments to minimise the risk of prisoners contravening domestic and family violence orders while detained in a Queensland Corrective Services facility.

The Board will continue to monitor implementation of this recommendation in light of issues observed in this reporting period, specifically Ellie's case.

Collaborative responses

While acknowledging that there is high demand and waitlists for domestic and family violence services including counselling services, the Board

was of the view that there are potential opportunities for multiple government agencies, such as Queensland Corrective Services, Health and Hospital Services, Housing and Police, to be in regular contact with victims of violence to reassure and proactively manage risk and safety concerns, particularly where the victim recontacts the domestic and family service and reports further episodes of violence.

The Board recognises that a victim may decline service response options offered to them at one point in time, and then decide to take those options up at a later point. The Board noted that when this occurs, service providers should ask the victim whether something has changed, as this may prompt the victim to seek additional supports and should trigger a risk re-assessment recognising that a change in circumstances may reflect an escalation of risk.

Case management and ongoing support

The Board determined from its review of cases in this Annual Report that greater clarity is needed about the different roles and responsibilities of agencies working in an Integrated Service Response. The Board is of the view that there needs to be greater clarity around the role of the High-Risk Team within the broader system response. The Board considers that this is important to ensure that all agencies and individuals better understand their individual, team and agency responsibilities within the Integrated Service Response framework.

The High-Risk Team Statewide Guidelines 2022, highlight that there may be times when a case is stepped down even though the risk to the victim remains high. This may occur when there are no other actions that can be taken to reduce risk, or the High-Risk Team is unable to engage with the victim of PUV despite numerous and varied attempts do so. This does not apply where there has been escalation.

The Board recognises that High-Risk Teams do not work in isolation, they do not offer case management services and are not the only answer to domestic and family violence. The broader domestic and family violence Integrated Service Response system continues to hold ongoing responsibility for safety and accountability within localised responses including when cases are stepped down from High-Risk Teams.

High-Risk Teams and Mental Illness

During its case review process, the Board questioned the extent to which High-Risk Teams should be expected to manage the mental health risks of PUV, and whether this was too complex a task for High-Risk Teams to undertake while also looking after the safety needs of victims. Complex mental ill-health issues concurrent with domestic and family violence use were evident in several cases where the PUV suicided and were known to the High-Risk Team. These complexities were evident for some victims of violence, including Maeve.

In considering how mental illness was managed by High-Risk Teams, the Board was mindful that the High-Risk Team model is not a case management response nor a provider of long-term interventions. The Board acknowledges that the role of High-Risk Teams is instead to intervene where there is escalating or imminent risk of serious bodily harm or lethality as a consequence of domestic and family violence.

However, the Board considered that an ongoing case management role in complex cases was important, even though this was not clearly within the remit of the High-Risk Team. It was not evident to the Board which, if any agencies currently provide this type of resource-intensive and cross-agency support to victims or PUV. The general guidance provided to High-Risk Teams around case closure procedures also outlines that a lead agency should be established to undertake ongoing risk assessment and safety planning in the stepped down case to ensure all relevant agencies are connected and ongoing support is provided to the victim and/or PUV. However, the Board identified that this did not appear to be clearly happening in practice across High-Risk Teams.

The Board identified that both victims and PUV in the cases it reviewed would have greatly benefitted from a lead coordinator or central point of contact after the case was stepped down, given that many services often continued to be involved in the case, but none appeared to be the main point of contact for the victim or PUV. This also meant that many victims were required to advocate for themselves after the case was stepped down from a High-Risk Team.

For example, in Isaiah's case, Isaiah was engaged with multiple services, including child safety, police, youth justice, behaviour change programs,

and speech pathology in respect of his criminal offending and youth justice order requirements. There was a lack of clarity regarding which agency was taking a lead role in his case management. The lack of information sharing across agencies indicated a mixed approach in responding to the multiple risk factors facing Isaiah and appeared to focus on different aspects of his case management rather than a collaborative response to risk, safety and dangerousness.

In Isaiah's case, the Board noted that the High-Risk Team had a duty to both the victim of violence and the PUV, recognising that the PUV was still a child himself and his underage partner Eliza was also a child. This was missed by all services but in particular Child Safety. The Board considered that there had been a lack of response within the broader system to Isaiah as a victim of childhood domestic and family violence.

Isaiah appeared to be most engaged with his Speech Pathologist who was neither connected to a High-Risk Team nor had capacity to assist him with his mental ill-health, co-occurring substance use, past history of trauma and use of violence. The Speech Pathologist was linked with the Youth Justice Service, but not with the High-Risk Team.

There was a lack of clear, helpful involvement by Child Safety in this case; while removal was not an option for Isaiah it was an option that could have been taken in respect of his young victim. Ongoing exposure to domestic and family violence also harmed both children.

The Board considered that greater holistic practice was needed within High-Risk Teams to deal with multiple, concurrent and co-occurring issues including mental illness and domestic and family violence against children. It considered that greater co-ordination was required at the point of step down to ensure the continuation of safe and effective interventions in complex cases.

First Nations victims and Persons Using Violence

Of the cases considered by the Board in this reporting period, four involved the deaths of First Nations people. Two of the suicides considered in this reporting period occurred within a regional/remote discrete community where a High-Risk Team was operating. This led the Board to consider how High-Risk Teams engage with and provide services to First Nations peoples and communities. The Board acknowledged the importance of having representatives from First Nations communities and services as core members of High-Risk Teams.

This discussion also renewed the Board's ongoing concerns about how the system as a whole responds to First Nations victims and PUV.

The Board determined that there likely is scope to improve practice in High-Risk Teams' engagement with First Nations people, noting that there was limited evidence of Aboriginal community-controlled organisation involvement with High-Risk Teams across cases.

Within this context, the Board considered the importance of community healing, including community driven solutions and High-Risk Teams connecting with community members who have cultural authority to discuss any identified issues or proposed solutions. From its review of cases, the Board considered that there was greater scope to enhance community involvement with the practice of High-Risk Teams, noting the importance of this being done safely for victims and PUV.

In accordance with the High-Risk Teams Statewide Guidelines 2022, the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships employs Positive Relationship Cultural Connectors who have key a role in encouraging collaboration with local communities, to co-lead the development of a place-based, culturally appropriate integrated service system in an attempt to address this practice gap.

The Positive Relationship Cultural Connectors' role is to:

- help facilitate strategic communications between local community, service providers, High-Risk Teams, and the Queensland Government;
- work closely with local service providers to ensure services are culturally appropriate and targeted to meet local community needs;
- identify appropriate pathways for services to obtain cultural advice;
- work with communities to identify and develop culturally appropriate local solutions to enhance service provision;
- work with community organisations and communities to ensure a level of understanding of domestic and family

violence and the referral pathways to support;

- ensure whole of population domestic and family violence initiatives are inclusive of First Nations populations; and
- identify and report on current trends related to domestic family violence in each of the High-Risk Team locations.

While the Positive Relationship Cultural Connector role is predominantly focused on the broader Integrated Service Response outside the High-Risk Team context, they can also support cultural capability development within the High-Risk Team.[78]

The evaluation of the Integrated Service Response and High-Risk Teams by Griffith University in 2019, also identified that increased availability of culturally appropriate processes and services for First Nations participants, and those from culturally and linguistically diverse backgrounds was a key area for improvement.

The Board is aware that work is underway to deliver a Statewide, systemic approach to enhancing culturally-led domestic and family violence responses for First Nations, informed by local cultural protocols. The Board urges that this work consider how to enhance practices and processes within the Integrated Service Response and High-Risk Teams.

This work will include the development of a series of resources to support practitioners to improve their understanding and awareness of culturally-led domestic and family violence responses, and to adopt a strengths-based approach when engaging with First Nations people who are experiencing or using domestic and family violence.

The Board noted advice from invited experts that, while it is commendable for services and systems to try and operate in culturally safe ways, this does not mean ignoring a person's needs or presenting risks.

The Board acknowledges that there is a need to understand the totality of a person's experiences, including the totality of needs of First Nations peoples, and seek to work in a holistic way with individuals, families and communities.

In July 2019, the Queensland Government committed to commencing discussions on *Tracks to Treaty*, to reframe the relationship between First Nations people and the Queensland Government.

It is intended that *Tracks to Treaty* will progress a shared agenda built on mutual respect, recognition and a willingness to speak the truth about shared history.

The Queensland Government, through initiatives such as Local Thriving Communities, is also seeking to improve service delivery to Aboriginal and Torres Strait Islander discrete communities. These initiatives seek to embed significant long-term change and progress a visibly different way of working alongside communities across the state.

Local Thriving Communities seeks to partner and support Aboriginal and Torres Strait Islander communities to:

- make decisions about their own future;
- build on their strengths as a community;
- invest in the things that will make communities stronger and make a difference in people's lives; and
- create thriving communities.

In its discussions, the Board noted the first report of the Taskforce (2021), specifically Recommendation 1. This recommends that the Queensland Government work in partnership with Aboriginal and Torres Strait Islander peoples to co-design a specific whole-of-government and community strategy to address the overrepresentation of First Nations peoples in Queensland's criminal justice system and meet Queensland's *Closing the Gap* justice targets.

[78] High-Risk Team Statewide Guidelines, 2022.

Chapter 6: Developing our workforce, systems and evidence

This Chapter discusses Queensland's ongoing need to focus on workforce capacity, capability and development as well as the need to develop our system response to domestic and family violence.

In discussing issues around information sharing, risk identification and safety management practice identified within this reporting period, the Board considered ways to develop the domestic and family violence workforce. The Board notes that there are currently no set pre-requisite qualifications or base level training required of people who work specialist domestic and family violence service delivery in Queensland.

Since its establishment, the Board has made multiple recommendations to build workforce understanding, capacity, and capability through the introduction, expansion and evaluation of specialist domestic and family violence response training for health, police, child safety services, and private practitioners. In its 2019-20 Annual Report, the Board recommended that domestic and family violence training be embedded in relevant undergraduate and postgraduate courses in Queensland universities.[79]

Implementation is ongoing for previous recommendations the Board has made in this area. The Board also notes that the Taskforce (2021) made other relevant recommendations which seek to develop a consistent evidence-based and trauma-informed framework to support training, education and change management across all parts of the domestic and family violence, and justice, system.

In 2019, WorkUp Queensland was also established to help develop a strong and skilled workforce across the sexual violence, women's health, and domestic and family violence specialist sector.

WorkUp Queensland delivers training across Queensland, prioritising organisations receiving funding from the Queensland Government (including Domestic Violence, Sexual Assault Services and Women's Health and Wellbeing Services). The Board notes, however, that this training is not delivered without cost to services.

The Board notes that, under the Community Service Training Package, there are competency trainings that could be mandatorily required and delivered free for community organisations. However, these competency trainings are not currently available or delivered in this way.

The Board acknowledges that there is a paucity of permanently funded, independent, and accredited training packages concerning domestic and family violence capabilities available for all agencies. This means that even where training is available, the approach taken across the service sector is not always consistent.

The Board raised concerns around the accessibility of domestic and family violence response training and noted that while online training may improve information accessibility, it may not be as effective as face-to-face learning or other more comprehensive training packages.

The Board identified that workforce stability is important, particularly in regional and remote communities, noting that instability can disrupt service provision and result in a loss of critical skills, experience and knowledge.

[79] The Board recommended that universities and peak professional bodies incorporate evidence-based domestic and family violence education into professional undergraduate courses in key frontline areas such as psychology, social work, law, criminology and health. See, Domestic and Family Violence Death Review and Advisory Board (2020). *2019-20 Annual Report*. Brisbane: Queensland Government, Recommendation 4. Available at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0008/663632/domestic-and-family-violence-death-review-and-advisory-board-annual-report-2019-20.pdf.

This was evident in one case the Board reviewed during this reporting period, where public holidays and then the COVID-19 pandemic impacted the ability of services to effectively respond to the disclosures of suicide risk that had been made by a PUV. These issues were identified as possibly impacting service delivery in another case.

The Board discussed that continuity of victim support during holiday periods can be achieved through agencies focused joint planning but noted that in small community organisations this may be more difficult to achieve.

The Board identified that effective joint planning was evident in Isaiah's case in particular, where in light of an upcoming holiday period, Youth Justice took steps to notify the Child Safety After Hours Service that Isaiah had screened at 'high risk' of suicide. This enabled Isaiah's suicide risk to be adequately managed during the holiday season, despite reduced staffing levels.

The Board noted that while COVID-19 has created opportunities for more flexible service delivery, it has also had some detrimental impacts on victims and PUV who may prefer, or need, to access services face-to-face.

This was particularly evident in Isaiah's case, where Isaiah did not want to access mental health services via telehealth, and accordingly did not access these services at all. Isaiah identified that telehealth was inappropriate for him as he would not be able to see the person on the other end of the phone and this was an important aspect of safe service delivery for him. He also expressed that he only felt comfortable participating in therapy in person, but this was unable to be accommodated at the time due to restrictions associated with the COVID-19 pandemic.

Embedding specialisation into practice

In addition to undertaking general workforce development to improve responses to domestic and family violence in Queensland, the development and embedding of specialist roles within police, health, corrections and Child Safety has been another initiative progressed to improve service responses across agencies.

The Board considers that based on cases reviewed in this reporting period, the establishment of specialist roles appears to have had varying levels of effectiveness.

In some cases, specialisation appeared to improve the response to victims and PUV. For instance, in Ellie's case the Specialised Clinical Services Unit within Queensland Corrective Services worked with Community Corrections to suspend Sonny's parole after he threatened and intimidated Ellie. This demonstrated knowledge of the dynamics of domestic and family violence and was assessed by the Board to be an appropriate, and safe, response.

However, in Maeve's case the Board considered that specialisation within the police did not enhance that agency's response to the victim of violence. In this case, specialised officers within the Victim Protection Unit (VPU) had identified that a Police Protection Notice naming Maeve as the respondent was inappropriate as she was the victim of violence and the Notice protected a long-term, known PUV. Yet, when the VPU recommended to responding officers that the Police Protection Notice protecting the PUV be withdrawn, both the responding officer and the Officer in Charge rejected the VPU's advice.

Based on these responses, the Board questioned the capacity of specialist units to provide oversight and intervene in systemically-embedded poor practices around domestic and family violence.

In relation to Maeve's case, the Board specifically queried whether there is an escalation process when there are differences in opinion between police officers. The Board noted that currently there is no formal escalation process, and more senior supervisors at each location are expected to resolve issues such as differences of advice between responding officers and the VPU.

While the Board noted that Maeve's case occurred early on in the implementation of the VPU and considered that processes are likely to have improved since, it observed other issues with the VPU in Charlotte's case, which occurred the following year.

In Charlotte's case, VPU officers assessed Charlotte as being at high risk and noted her *'increasing fear levels'* in relation to the PUV, Mark. Officers from the VPU also conducted a joint home visit with a worker from the local specialist domestic and family violence service to make referrals and discuss support options with her.

Despite VPU involvement, Mark's use of violence continued to escalate and less than a month after this home visit the police charged him with breaching the temporary protection order that was in place protecting Charlotte.

The Board was concerned that no further risk assessment was undertaken by the VPU at this time despite the change in circumstances. While the VPU reviewed the occurrence details and requested officers follow up with Mark and offer him a referral to a support service, the VPU ceased involvement once these tasks had been completed. No risk re-assessment of Charlotte was completed.

In that case, the Board identified that Charlotte had been previously supported by another specialist police officer who seemed unsure of the support options available for Charlotte and also appeared unaware of what evidence was required to pursue an application for a Police Protection Notice with additional conditions. This police officer sought advice from the VPU in this instance, although it is unclear what advice was ultimately provided. That officer also did not appear to respond to Charlotte's assessments of her own risk and proceeded to apply for a protection order against her wishes. That officer was also delayed in responding effectively despite being aware of ongoing violence by Mark against Charlotte.

The Board raised concerns about a specialised psychologist working with the PUV, Mark, in Charlotte's case. In that case, the psychologist, who claimed to have specialisation in domestic and family violence, did not assess Mark's domestic and family violence behaviours and also wrote him a letter of support to be used in family court matters, including to support him to have contact with his children.

The Board discussed how the psychologist's letter may have been given significant weight in future family court proceedings, especially due to the psychologist purporting to be a specialist in domestic and family violence. The Board raised concerns about this specialist designation, noting that it did not appear to be accompanied by sufficient knowledge of domestic and family violence, including how to work with a PUV.

Accordingly, the Board considered that there are additional needs for specialisation, accreditation, and training of private practitioners working within the domestic and family violence system, particularly for those completing reports for the court, as those reports can carry significant weight in judicial decision making.

The Board reiterates that if the Queensland system is to move towards a specialisation model, this must be achieved through evidence-based, education focused on core competencies around domestic and family violence. Specialisation must also be accorded weight in all professional practice settings.

Persons Using Violence disruption and management

In most of the cases the Board reviewed in this reporting period, the PUV had a history of perpetrating violence across multiple relationships. This highlights the need for focused responses to PUV, including for supporting engagement with behaviour change programs as soon as domestic and family violence behaviours are identified.

Behavioural change programs were a feature of several cases in this and prior reporting periods. The Board has concerns about these programs.

For instance, in Johnny's case, the Board noted that Johnny had been mandated to attend a men's behaviour change program shortly before his death. By this time, however, Johnny had a significant history of domestic and family violence perpetration and had previously been subject to protection orders involving multiple partners. He also continued to use violence while undertaking the behavioural change program.

The Board acknowledges that some aspects of the response to Johnny as a PUV worked well in this case. Johnny was held accountable for an assault on Eloise through being imprisoned and he was mandated to attend a men's behavioural change program where he attended seven sessions while on supervised release. However, the Board considered that behavioural change was sought too late in Johnny's perpetration history.
The Board does note, however, that the behavioural change program Johnny undertook was likely the most extended period of reflection and engagement he had ever had around his use of violence.

Records indicate that at his final behavioural change session, Johnny spoke about *'how difficult and upsetting the impact of his domestic and family violence in his relationships has been'*. The records describe that he was able to *'articulate the beliefs he held that led him to be violent and how if he held different beliefs he would have behaved in a different manner'*. They also describe that Johnny *'appeared remorseful and wanted to reflect on his own values and beliefs are what needed to change to ensure that he could be the role model for his children (and future partner) that he wanted to be'*.

The Board noted that there are clear issues with the availability and accessibility of men's behavioural change programs across Queensland.

The Board considers that there is a greater need for accountability for non-attendance or participation by the PUV in these programs, especially if engaging for the purpose of court proceedings.

However, the Board noted that behavioural change programs are not the only way to manage or respond to a PUV.

Regarding the issue of recidivist PUV, the Board reflected on the role of the High-Risk Team and the context of the Integrated Service Response.

While there are provisions for High-Risk Teams to consider PUV across relationships, with a requirement that safety planning must take into account the broader pattern of abuse and previous High-Risk Team actions and decisions, it is unclear to what extent this occurs in practice.

The Board discussed a range of potential strategies that could be used to disrupt PUV where they present across systems. The Board found that there was a need to enhance understandings of what this may look like within the context of each agency's roles and responsibilities.

For instance, within the criminal justice response, the Board identified that across several cases the police hesitated to commence investigations into apparent offences such as stalking, non-lethal strangulation and sexual violence. Prosecuting these offences could lead to strong bail conditions such as GPS monitoring, which could help disrupt some patterns of a PUV's behaviour, at least in the short term, especially when accompanied by strong collaboration across the integrated service system.

ANROWS has recommended that the concept of PUV intervention systems should be broadened to include a wide range of human services agencies. ANROWS identified that this would increase capacity across systems to identify PUV and manage risk earlier.[80]

ANROWS recommended the system consider other forms of PUV intervention beyond group-based men's behavioural change programs.[81]

While the first report of the Taskforce (2021) made multiple recommendations to improve the way PUV intervention programs are delivered across Queensland,[82] the Board notes that recent research by ANROWS has determined that there is limited evidence for the long-term effectiveness of men's behavioural change programs. This is because behaviours may already be highly entrenched, highlighting the importance of early intervention.

Research suggests that to better respond to men's use of violence, there is a need to:

- address trauma and inequality;
- provide early and holistic support for any co-occurring issues;
- support community-led initiatives;
- integrate service systems; and

[80] Chung, D, Upton-Davis, K, Cordier, R, Campbell, E, Wong, T, Salter, M, Austen, S, O'Leary, P, Breckenridge, J, Vlais, R, Green, D, Pracilio, A, Young, A, Gore, A, Watts, L, Wilkes-Gillan, S, Speyer, R, Mahoney, N, Anderson, S and Bissett, T. (2020) *Improved Accountability: The Role of Perpetrator Intervention Systems*. Sydney: ANROWS, p. 14-16. Available at: https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2020/06/Chung-RR-Improved-Accountability.pdf

[81] Ibid.

[82] For example, Recommendations 14, 22, 25-29, 52, 59, 74, 80. Women's Safety and Justice Taskforce (2021). *Hear Her Voice: Report 1 - Addressing Coercive Control and Domestic and Family Violence in Queensland*. Brisbane: Queensland Government. Available at: https://www.womenstaskforce.qld.gov.au/__data/assets/pdf_file/0013/700600/volume-1-exectutive-summary-and-introduction.pdf.

- build workforce capacity.[83]

The Board identified a need for greater recognition of PUV behaviour across the service response, including systems abuse. There are certain 'textbook' behaviours of PUV, such as image management and manipulation, that are not widely understood.

In several cases the Board identified that the PUV would manipulate processes and systems to strengthen their position and diminish that of the victim, causing systems to become implicated in perpetrating the violence and abuse.

For example, records indicate that in Charlotte's case, the PUV Mark sought advice from at least three different legal practitioners over the space of two months in relation to child access and domestic and family violence victimisation.

At the first hearing relating to a protection order naming him as a respondent, Mark was also represented by two barristers and a solicitor, which appeared to be a manoeuvre designed to intimidate Charlotte.

Shortly before the deaths in this case, Mark also attempted to access a men's behavioural change program on the advice of his lawyer. This appeared to be an exercise in image management calculated to improve his position around accessing his children. It did not appear to demonstrate a genuine commitment to stop using domestic and family violence.

The Board reiterates the importance of agencies being aware of systems abuse and notes that this further demonstrates the need for whole-of-workforce competency around domestic and family violence.

Trans-generational patterns of violence

In cases in this reporting period the Board again identified that across both intimate partner and family relationships there continued to be patterns of inter-generational violence victimisation and perpetration. This included:

- in six of the eight cases reviewed, the primary PUV being exposed to, or experiencing, domestic and family violence in their family of origin;
- in two of the eight cases, the primary PUV experiencing other forms of child abuse/neglect in their family of origin;
- in three of the eight cases, the primary victim being exposed to, or experiencing, domestic and family violence in their family of origin;
- in one of the eight cases, the primary victim of violence experiencing other forms of child abuse/neglect in their family of origin;
- in seven of eight cases, the primary PUV having a history of violence perpetration in previous intimate partner relationships
- in seven of eight cases, the primary PUV having a history of violence perpetration within family relationships;
- in two of eight cases, the primary victim having past experiences of domestic and family violence in previous intimate partner relationships; and
- in one of eight cases, the primary victim of violence having past experiences of domestic and family violence within family relationships.

Significantly, in this reporting period the Board considered the cases of Ryan and Isaiah, who were a father and son who both died by suicide within two years of each other. Both Ryan and Isaiah had a history of violence perpetration within their family and intimate partner relationships, and Isaiah had also been a victim of Ryan's violence during his childhood.

In these two cases, the Board observed that multiple family members had come to the attention of the local High-Risk Team within a short period of time and, at one time, there were multiple, separate open cases for different family members. The Board considered that this highlights the importance of High-Risk Teams

[83] Australia's National Research Organisation for Women's Safety (2021). *Interventions for Perpetrators of Domestic, Family and Sexual Violence in Australia*. Sydney: ANROWS Insights. Available at: https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2021/06/Intervenions-for-perpetrators-od-DFSV-Synthesis-Insights.pdf.

taking a holistic approach to risk assessment and decision making, including examining at broader familial dynamics and understanding, individual cases in context.

Ryan's former partner Clara had been referred to a High-Risk Team because Ryan was returning to the area in which she lived and her corrections officer had concerns for her safety.

While Clara had an open case with the High-Risk Team, police subsequently identified her as a PUV after a callout, and police referred Ryan to the High-Risk Team as a victim.

These cases were managed separately and concurrently by the High-Risk Team.

The Board ascertained that for this family, five immediate family members had been referred into the High-Risk Team over two years.

In addition to Ryan and Isaiah's case, the Board reviewed another case in this reporting period which was related to a double homicide-suicide it had previously reviewed in an earlier report.

There is significant research on the impact of adverse childhood experiences on brain development and the importance of therapeutic support/intervention in this area.

Research on adverse childhood experiences is making it increasingly clear that toxic stress during childhood, including from domestic and family violence, can negatively impact the nervous, endocrine, and immune systems and may physically alter DNA structures, having flow on effects for a person's attention, impulsivity, decision making, emotion, learning, and future responses to stress.[84]

In the absence of protective factors that may mitigate the impact of exposure to adverse childhood experiences and associated stress, this may result in:

- difficulties in forming healthy and stable relationships;
- increased risk of engaging in high risk health behaviours, or criminal activities;
- increased likelihood of mental health illness and problematic substance use; and
- instability in the workforce and difficulties in completing education.[85]

When considering this research, it is important to be mindful that it is by no means definitive or determinative; as both adverse childhood experiences and their associated harms are preventable largely through addressing the broader social and cultural determinants of health.

The Board concluded that it is not useful to have a deficit-based narrative and it is important to have a forward looking, pragmatic approach to focus on how best to support people affected by adverse childhood experiences including domestic and family violence.

The Board noted that there is emerging research on how to intervene with young boys who use violence toward their mothers so that trajectories towards using intimate partner violence can be interrupted.[86]

The Board has made multiple recommendations in relation to trans-generational trauma and early intervention in previous Annual Reports including identifying the need for the Government to:

- consider what services or programs are available to support children who experience or witness domestic and family violence including early intervention and prevention services (2017-18 Annual Report);
- increase the availability, accessibility, and integration of primary prevention service responses and awareness campaigns to families, children and young people for the purposes of breaking the cycle of

[84] Center for Disease Control and Prevention (2019). *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence*. Atlanta: National Center for Injury Prevention and Control. Available at: https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf.

[85] Ibid.

[86] Ogilvie, J, Thomsen, L, Barton, J, Harris, D, Rynne, J and O'Leary, P. (2022). *Adverse Childhood Experiences Among Youth Who Offend: Examining Exposure to Domestic and Family Violence for Male Youth who Perpetrate Sexual Harm and Violence.* Sydney: ANROWS. Available at: https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2022/07/RP.20.07-RynneRR2-Young-men-HSB.pdf.

intergenerational trauma and violence (2018-19 Annual Report);
- develop a specialist model to identify and respond to intergenerational trauma and cumulative harm within Aboriginal and Torres Strait Islander families (2018-19 Annual Report);
- explore opportunities to improve service collaboration and the coordination of support provided to families, particularly children, bereaved by a domestic and family violence death, (2020-21 Annual Report); and
- 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, including considering the longer-term support needs of PUV to embed ongoing behavioural change and improve protective outcomes (2020-21 Annual Report).

Implementation is ongoing for many of the Board's recommendations in this area, with the latest Government update indicating that the Department of Child Safety, Youth and Women would engage the Centre for Domestic and Family Violence Research, through Central Queensland University, to: map existing responses to children and young people impacted by domestic and family violence, explore the strengths of existing responses; and identify service gaps. This work will specifically focus on responses commissioned through the department and explore evidence-informed approaches across the continuum of responses – from prevention through to therapeutic and recovery focused interventions.

The Department of Justice and Attorney-General has implemented a range of community awareness campaigns and primary prevention service responses to families, children and young people, and has contributed to national campaigns as well as those undertaken by funded organisations such as Our Watch, which target this cohort.

Protecting children within the context of domestic and family violence

While it is critical that steps are taken to disrupt patterns of violence over generations and across relationships, the Board discussed what role services and High-Risk Teams have, or should have, in responding to children who are at high risk within the context of domestic and family violence.

The Board observed that, across cases, significant responsibility was placed on mothers to protect their children from domestic and family violence. The Board considers there is a need to prioritise research on how services can safely intervene when children are identified as high risk, particularly where they have ongoing contact with the PUV.

With respect to Isaiah's case, the Board observed that the system struggles to respond to violence involving young people. It observed that, generally, young people do not appear to become engaged with domestic and family violence services until they have progressed through many other interventions first.

For instance, Isaiah was a young person who had both experienced and used violence in his relationships. In this case the Board discussed the role of Child Safety in overseeing long-term placements in respect of his girlfriend and victim of violence Eliza, who was under the age of 16 and whom Child Safety Services had a statutory responsibility to keep safe. In this case Child Safety Services enabled Eliza to self-place with Isaiah and his family, thereby exposing her to significant harm of domestic and family violence. The Board observed that there seemed to be limited assessment of the appropriateness of this placement, in light of the violence Eliza was experiencing from Isaiah, which was known to the High-Risk Team.

As in previous years, the Board questioned the effectiveness of the family law system in the protection of children, including ongoing challenges faced in negotiating safe parenting arrangements post-separation in the context of domestic and family violence. The Board observed that there are additional complexities associated with protecting children who have contact with their abusive father through formal/informal shared parenting arrangements, particularly as children may be at heightened risk if they speak about the violence with service providers or engage in counselling while still having contact with the PUV.

Positively, the Board noted that in this reporting period that there was an episode where police responded effectively to domestic and family violence against a woman, Charlotte, and her children. In this episode, the PUV Mark took one of Charlotte's children and Charlotte reported this to police. Police attempted to find Mark and the child multiple times and, after finding the child, returned them to Charlotte's care. This was done in the absence of any formal parenting orders.

After this episode of violence, Charlotte sought advice from her lawyer and began limiting contact with Mark. In this case, the Board observed that Charlotte took multiple steps to keep her children safe including seeking to negotiate safe parenting arrangements through a lawyer.

In its discussions around this case, and the way in which services responded to keep the children safe, the Board noted:

- that there was a lack of response to Charlotte's disclosures to the specialist domestic and family violence service that Mark had previously threatened and planned to kill a former intimate partner and their children, and her concerns about her and the children's safety;
- that Child Safety Services closed a child harm notification in relation to Charlotte and Mark's children, having assessed the children as having a parent willing and able to protect them. This did not take into account the risk of harm that Mark posed to Charlotte and the children; and
- that the children's school advised Charlotte that they would not be able to stop Mark from taking the children from the school as there was no family law order in place. This was despite the school being aware that a protection order was in place protecting Charlotte and the children from Mark. The Board acknowledges that legally the school could not prevent Mark from taking the children.

In Johnny's case, the Board observed that the risk to Eloise may have escalated if she had sought assistance from the family law court around child custody arrangements. In this case, a two-year protection order was granted, preventing Johnny having contact with the victim, except to facilitate contact with their child. There was no such support for Eloise's child, who had ongoing contact with Johnny.

While this order was in place, Eloise was seriously physically assaulted by Johnny, while facilitating contact with their child.

Section 3: Data

SECTION 3

Chapters 7 and 8 outline the data in relation to homicides that occurred in an intimate partner or family relationship in Queensland from 2016 to 2022. Data is disaggregated where possible to reflect domestic and family violence context.

Chapter 7: Understanding the data

This chapter presents key data on homicides that occurred in intimate partner or family relationships in Queensland from 2016-2022. Later in this chapter, homicides that occurred between 2016-2022 following an identifiable history of domestic and family violence are considered.

This chapter provides a statistical overview of homicides that occurred in an intimate partner or family relationship between 1 July 2016 and 30 June 2022 in Queensland.

Chapter 8 outlines the known history of service system contact for the homicides from this time period where there was an identifiable history of domestic and family violence.

In providing this data, Board members acknowledge the need to better understand and share data across systems and consider how it can be utilised to inform system responses and improvements.

This accords with the nationally agreed approach to data collation and reporting of these deaths, as outlined in the *Australian Domestic and Family Violence Death Review Network Homicide Consensus Statement*.

Homicides in an intimate partner or family relationship

Between 1 July 2016 and 30 June 2022, there were 129 homicides that occurred in an intimate partner or family relationship in Queensland. This included the deaths of 129 women, children and men who were killed by a family member or a current or former intimate partner.

As shown in Figure 10, of the 129 homicides that occurred during this period, 63 were intimate partner homicides and 66 were family homicides.

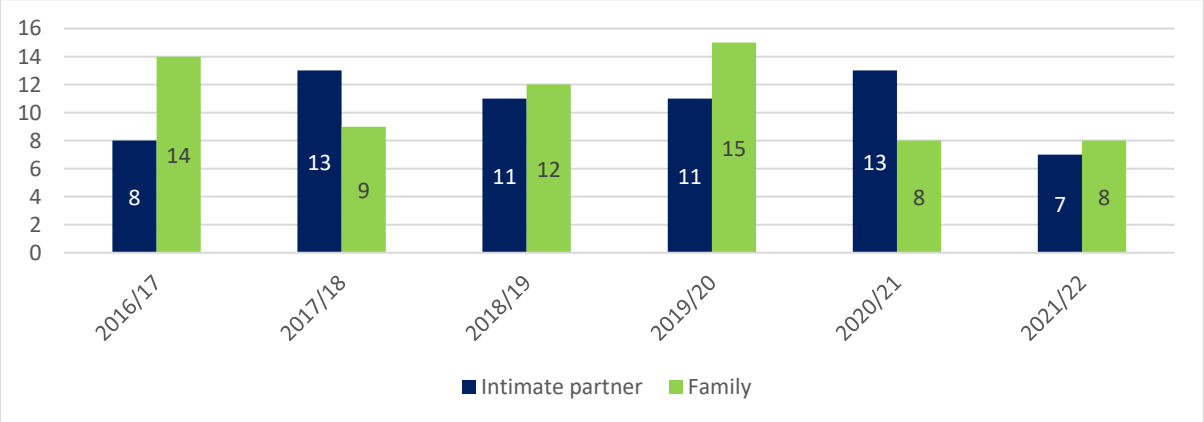

Figure 10. Homicides in an intimate partner or family relationship (1 July 2016 to 30 June 2022) N = 129.

Of the homicides that occurred in a family relationship, 50% (33 of 66 cases) involved the death of a child/ren. These children were all killed by a family member or caregiver (filicide). Of this number, 51.5% (17 of 33 cases) of the cases involved the death of a male child/ren and 48.5% (16 of 33 cases) involved the death of a female child/ren.

The remaining 33 homicides involved the deaths of adults who were killed by adult family members. Most adults killed by a family member were killed by their son or brother, but some were killed by their father, mother, daughter, nephew, son-in-law or brother-in-law.

As shown in Figure 11 below, of the 129 homicides that occurred in a domestic and family relationship between 1 July 2016 – 30 June 2022, the homicide offender was male in 65.89% (85 of 129) of cases and the homicide offender was female in 34.88% (45 of 129) of cases.[87]

Males were over-represented as the offender in all intimate partner and family relationship homicides.

For intimate partner homicides, the homicide offender was male in 61.9% (39 of 63) of cases and the homicide offender was female in 38.1% (24 of 63) of cases. As discussed below in the section on intimate partner homicides in a domestic and family violence context, the dynamics of male and female homicides are very different.

For homicides in a family relationship, the homicide offender was male in 69.7% (46 of 66) of cases and the homicide offender was female in 31.8% (21 of 66) of cases. In 1.5% (1 of 66) of cases, both a male and female were charged in connection with a family homicide.

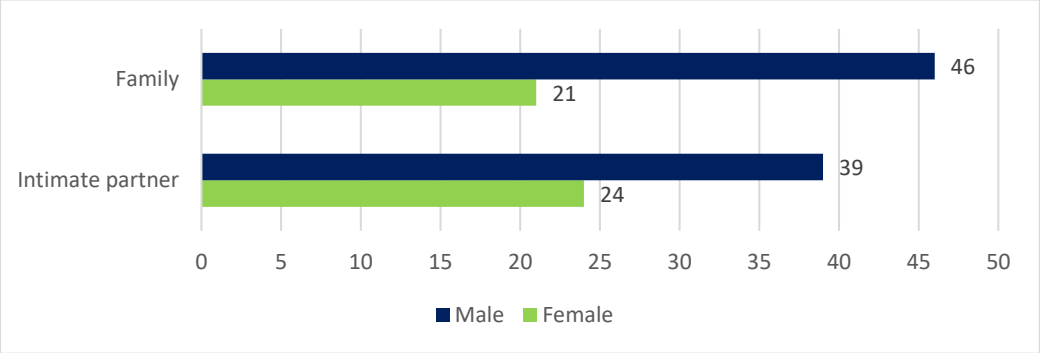

Figure 11. Homicides in an intimate partner or family relationship by type and sex of homicide offender (1 July 2016 to 30 June 2022) (N = 130).

The youngest person who died as a result of a family homicide was aged less than four years old, and the oldest person who died as a result of family homicide was 80-84 years old (see Figure 12).

As shown in Figure 12, almost 20% (N = 12, 19%) of persons who died as a result of intimate partner homicide were aged 45-49 years at the time of their death. For homicides in a family relationship, the majority of persons who died were children aged less than four years (N = 27, 40.9%).

[87] There are a total of 130 homicide offenders. This is because in one family relationship homicide, both a male and female were charged with homicide offences.

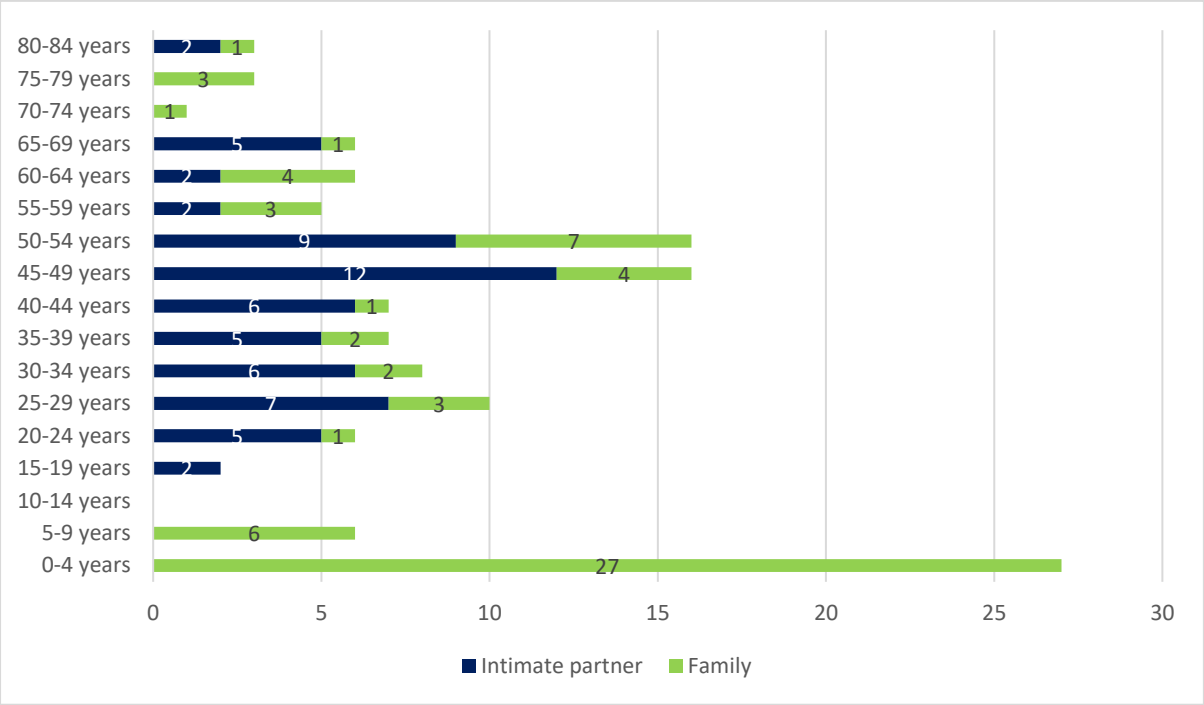

Figure 12. Homicides in an intimate partner or family relationship by type and age of deceased person (1 July 2016 to 30 June 22) (N = 129).

As shown in Figure 13, in around a quarter (N = 31, 25.2%) of all homicides in an intimate partner or family relationship where cultural background could be identified[88] (123 of 129), the homicide victim identified as Aboriginal and/or Torres Strait Islander.

Where cultural background could be identified, Aboriginal and Torres Strait Islander peoples represented 27.1% of intimate partner homicide victims (16 of 59) and 23.4% of family homicide victims (15 of 64).

There were 15 homicides in an intimate partner or family relationship where the deceased was from a culturally and linguistically diverse background, representing 12.2% (15 of 123) of all homicides in a domestic and family relationship in Queensland where cultural background was identifiable.

	Intimate partner	Family	Total
Aboriginal	15	11	26
Torres Strait Islander	1	2	3
Aboriginal and Torres Strait Islander	0	2	2
Culturally and linguistically diverse	7	8	15
Non-Indigenous and non-culturally and linguistically diverse	36	41	77
Unknown	4	2	6
Total	63	66	129

Figure 13. Homicides in an intimate partner or family relationship by cultural background of deceased (1 July 2016 to 30 June 2022) (N = 129).

Domestic and family violence context

Domestic and family violence context in intimate or family relationship cases

A history of domestic and family violence was identified in 61.24% (79 of the 129) of all homicides in an intimate partner and family relationship between 1 July 2016 and 30 June 2022.

This is a provisional figure as an underlying history of violence may be identified as a full review of a death is undertaken and as 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 acknowledged that these figures are likely to be an under-representation, particularly where violence histories were not known to services or family members.

For cases where a history of domestic and family violence was identified, the Board and Secretariat collates information about known case characteristics or risk factors, including relationship separation or the presence of a protection order.

[88] 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 6 cases. There are greater data gaps in relation to the cultural background of the homicide offender which is why this data is not presented in this report.

Intimate partner homicides in a domestic and family violence context

Between 1 July 2016 and 30 June 2022, there were 24 intimate partner homicides where a female was killed by a current or former intimate partner and a history of domestic and family violence was identified. Of these cases, the female homicide deceased was identified as the primary victim of violence in 95.8% (23 of 24) of cases and was identified as the primary PUV in one case (4.2%).

Between 1 July 2016 and 30 June 2022, there were 20 homicides where a male person was killed by a current or former intimate partner and a history of domestic and family violence was identified. The male homicide deceased was identified as the primary PUV in 100% (20 of 20) of these cases.

Presence of separation in intimate partner or family relationship homicides with an identified history of domestic and family violence

Actual separation was present in 40.5% (32 of 79) of intimate partner or family homicide cases with an identifiable history of domestic and family violence between 1 July 2016 and 30 June 2022. Intended separation was present in 10.1% (8 of 79) of these cases.

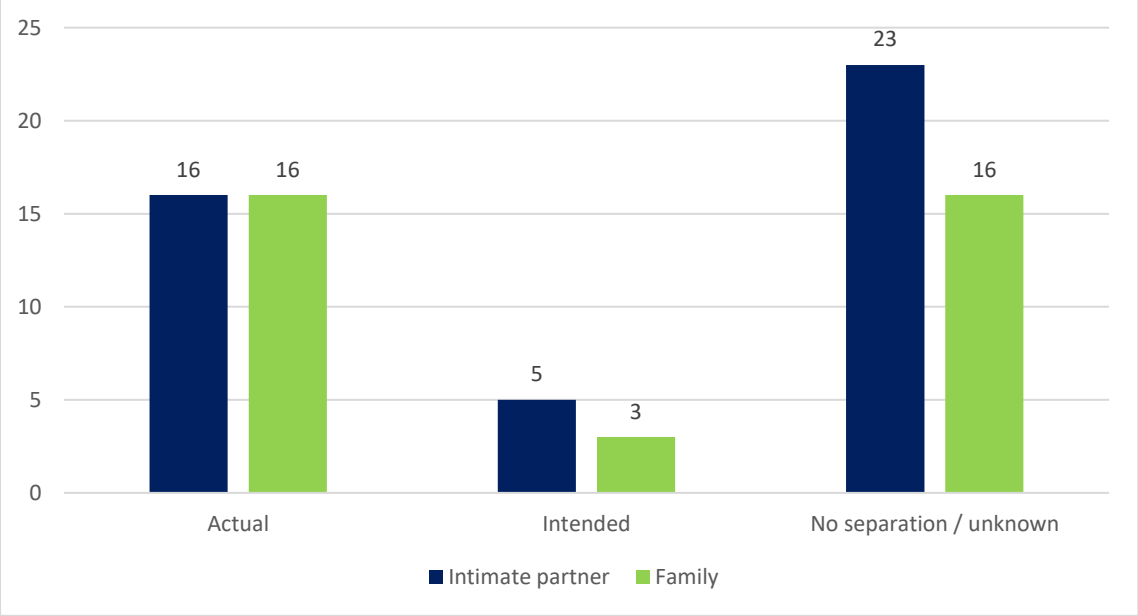

Figure 14. Presence of separation in homicides with an identified history of domestic and family violence (1 July 2016 to 30 June 2022) (N = 79)

Protection order history for intimate or family relationship homicides with a domestic and family violence context

In 45.6% (36 of 79) of the intimate partner or family homicide cases with an identifiable history of domestic and family violence that occurred between 1 July 2016 and 30 June 2022, a protection order was in place at the time of the death.

As shown in Figure 15, a protection order was in place at the time of the death in 45.5% (20 of 44) of intimate partner homicides following a history of domestic and family violence and 45.7% (16 of 35) of family homicides following a history of domestic and family violence. The primary DFV victim was respondent listed on the protection order in 5.6% (2 of 36) of these cases, and was the aggrieved in 63.9% (23 of 36) of these cases.

There was a cross-application for a protection order in 19.4% (7 of 36) of cases, and 11.1% (4 of 36) of these cases were family homicides where their parents were on a protection order.

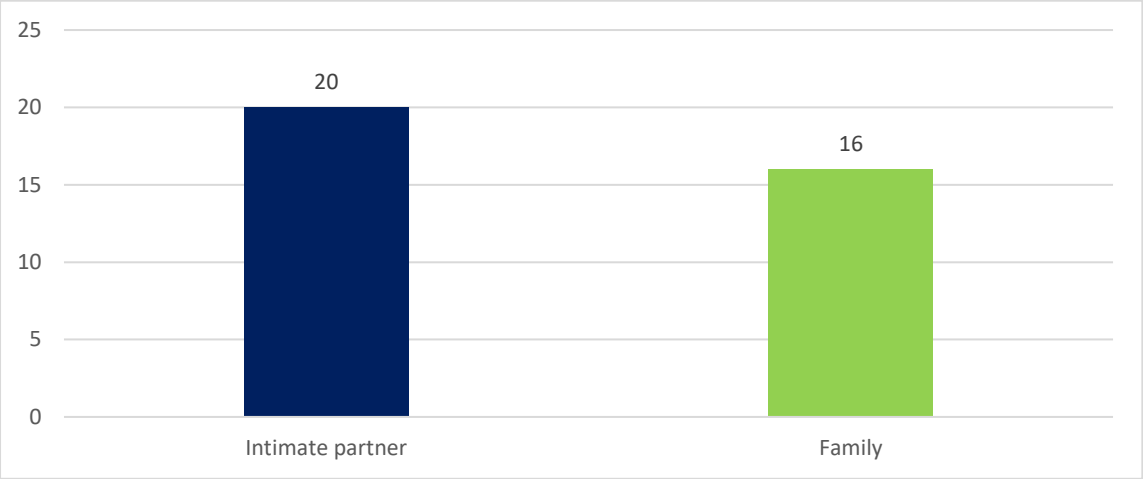

Figure 15. Presence of a protection order in intimate partner or family homicides with an identified history of domestic and family violence (1 July 2016 to 30 June 2022) (N = 36)

Chapter 8: Service contact in fatal cases

Following on from the data overview in Chapter 7, this section focuses on those homicides where a history of domestic and family violence was identified and profiles the pattern of service contact over time for intimate partner, and family relationships (adults and children).

Compared to intimate partner homicides following a history of domestic and family violence, this chapter highlights that there is less likely to be relevant service contact in family homicides following a history of domestic and family violence (particularly where the homicide occurs within an adult family relationship).

Queensland's data collection approach aligns with the Australian Domestic and Family Violence Death Review Network's agreed definition of a domestic and family violence related homicide (Appendix C).

This approach recognises that not all homicides in a domestic and family relationship are, upon review, '*domestic and family violence related*'.

The Homicide Consensus Statement takes into account:

- the case type (external causes);
- intent;
- the role of human purpose in the death;
- relationship; and
- domestic and family violence context.

This agreed alignment ensures a nationally consistent approach across all Australian states and territories, with the Network continuing to collaborate with the ANROWS to improve data and reporting of these types of deaths.

Publications utilising Queensland's data include the recently released *Australian Domestic and Family Violence Death Review Network Data Report: Intimate Partner Violence Homicides 2010-2018* (2022)[89] which determined that, at a national level, intimate partner violence context homicides:

- are highly gendered, and in the majority of cases domestic violence is perpetrated by a male against his female partner;
- occur across a broad age range (16-80) with the majority of PUV and victims born in Australia; and
- happen at any stage of a relationship, including during or after short relationships, as well as after many years of protracted violence by abusers.

This report identified the primary PUV would utilise a diverse range of abusive tactics in perpetrating intimate partner violence including physical, emotional, social, financial and sexual violence and stalking. This highlights that any intimate partner relationship characterised by domestic violence is embedded with a risk of lethality (irrespective of whether that violence is physical or non-physical).[90] The report highlights that there is a heightened risk of harm for women who separate or are intending to separate from their male intimate

[89] Australian Domestic and Family Violence Death Review Network & Australia's National Research Organisation for Women's Safety (2022). *Intimate Partner Violence Homicides 2010-2018.* Sydney: ANROWS. Available at: https://www.anrows.org.au/publication/australian-domestic-and-family-violence-death-review-network-data-report-intimate-partner-violence-homicides-2010-2018/.
[90] Ibid.

partners, with actual or intended separation being a feature in over half of male perpetrated intimate partner violence related homicides in Australia during this time period.[91]

To further enhance understanding of the nature and context of domestic and family violence related deaths, Queensland, through the National Network and in collaboration within ANROWS, has commenced work to establish a national minimum dataset for domestic and family violence context filicides.

For the purposes of this chapter, and other sections of this report, data 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
    - a homicide offender.

For collateral homicides[92] and domestic and family violence suicides, the primary victim may be otherwise connected to the death, such as the partner of the primary PUV who died by suicide.

- the *primary PUV*, 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 PUV may be:
    - a suicide deceased;
    - homicide offender, parent or caregiver of a deceased child (filicide cases); or
    - a homicide deceased.

For collateral homicides and domestic and family violence suicides, the primary PUV may also be otherwise connected to the death, such as the surviving partner of the primary victim of violence who died by suicide.

While known service system contact is recorded for all victims and PUV 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 PUV 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 PUV may have had contact with other entities or agencies, but this was not identified through the review process; and
- 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 in a period proximal to the death.

While much of the service contact recorded is directly related to domestic and family violence, service contact may also occur in relation to mental illness, 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. Just because a victim or PUV was experiencing violence and having service contact, does not mean that the service necessarily was aware of the domestic and family violence in the relationship, for example, if a person was attending a mental health service, they may not disclose the violence occurring in their relationship unless specifically asked.

Data does not reflect the number of contacts a victim or PUV had with a service nor the number of agencies that person was engaged with at any one time. Service contact can span from minimal contact with one or two agencies, to multiple, concurrent contacts across current and former relationships, and many agencies.

[91] Ibid.

[92] A collateral homicide occurs when a person dies in a domestic and family violence related homicide but is not a direct party to the relationship. This may include a third party who is killed intervening in an episode of domestic and family violence.

As part of the 2022-23 State Budget, additional funding has been allocated to the Coroners Court of Queensland to drive continued improvements in the existing Domestic and Family Violence Related Homicide and Suicides datasets, which will contribute to further understanding of these types of deaths.

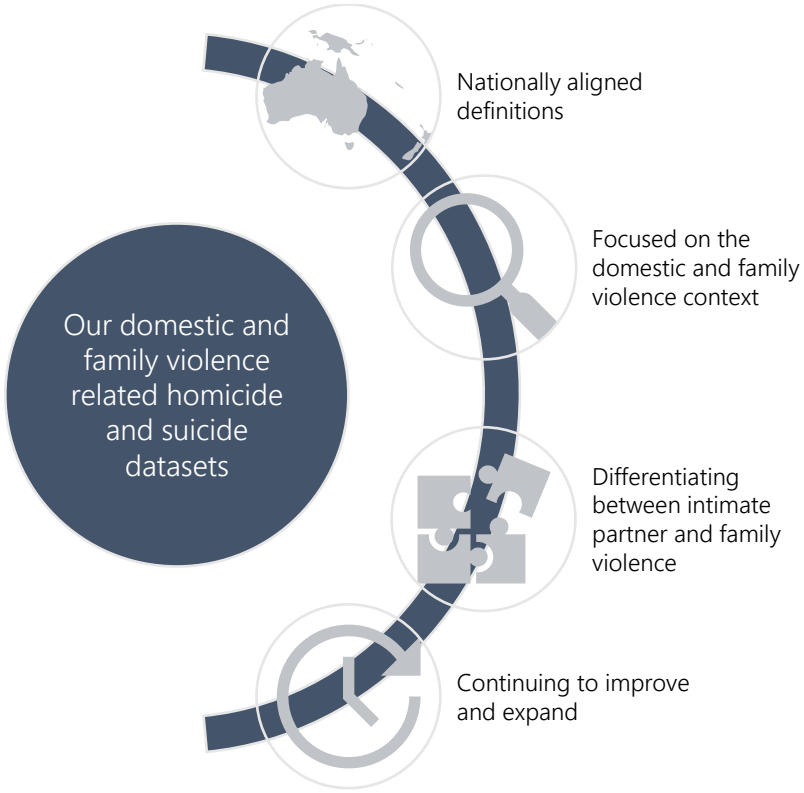

Figure 16. Our domestic and family violence related homicide and suicide datasets.

Intimate partner homicides that occurred in a domestic and family violence context

This section considers the patterns of service contacts for the primary victims and primary PUV in intimate partner violence related homicides from between 1 July 2016 and 30 June 2022 (Figures 17 to 20).

Key findings include that:

- The highest levels of contact for both primary victims and primary PUV was with the criminal justice system; and
- Primary PUV had more contact with mental health and corrective services than primary victims.

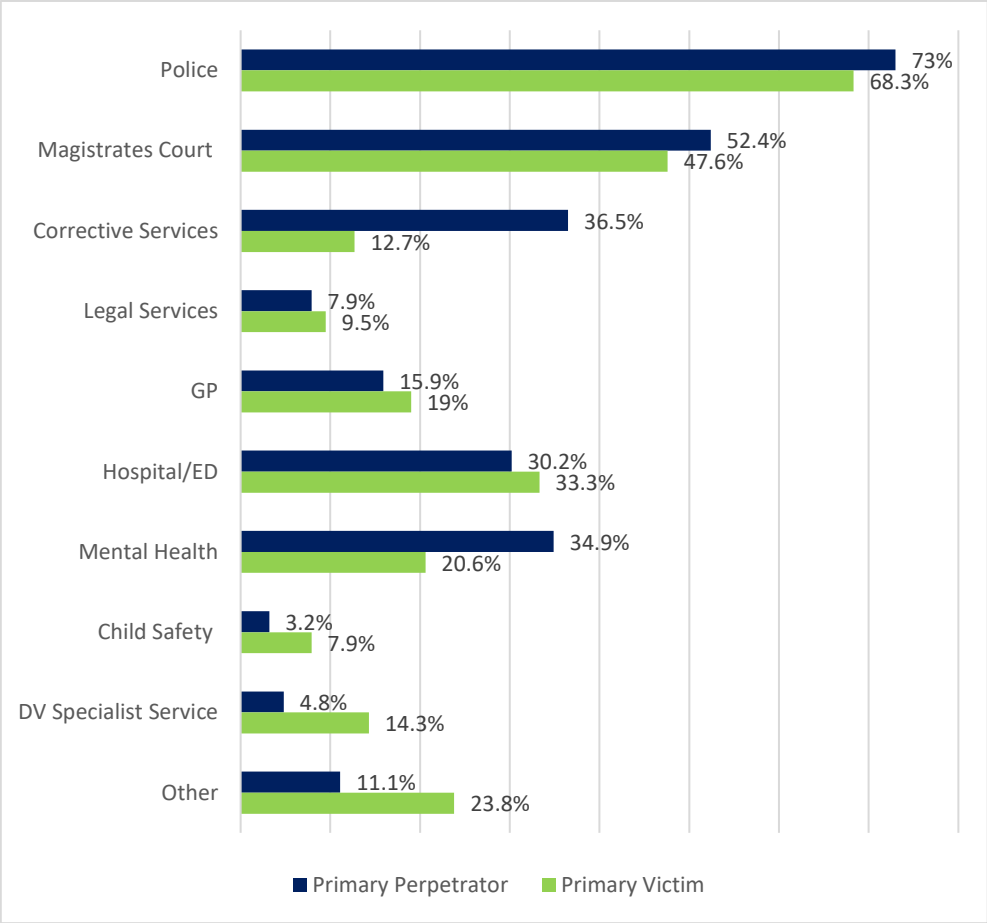

Figure 17. Known service contact in intimate partner violence related homicides by percentage of persons accessing services (1 July 2016 to 30 June 2022)

Family violence related homicides (children)

This section considers the service contact history for the primary victims and primary PUV in family violence related homicides of children who were killed by a parent or caregiver (filicides).

It is important to be mindful that the primary victim and primary PUV in these cases generally refers to the homicide offender and their current or former intimate partner. The application of this definition accords with relevant provisions within the *Domestic and Family Violence Protection Act 2012*, which outlines that children cannot be named as an aggrieved or respondent in protection orders or Police Protection Notices if there is a parental relationship.

While noting that there are fewer child homicides in family relationships than there are intimate partner violence homicides, key points include that:

- comparative to intimate partner and family violence homicides (adults) there was a higher level of contact with child safety services;
- there was less identifiable contact with the criminal justice system and health services comparative to intimate partner homicides but overall service contact remained higher than in the family homicides involving the deaths of adults; and
- primary PUV and primary victims had a higher level of known contact for specialist and legal service contact in family violence related child homicides comparative to intimate partner violence related homicides.

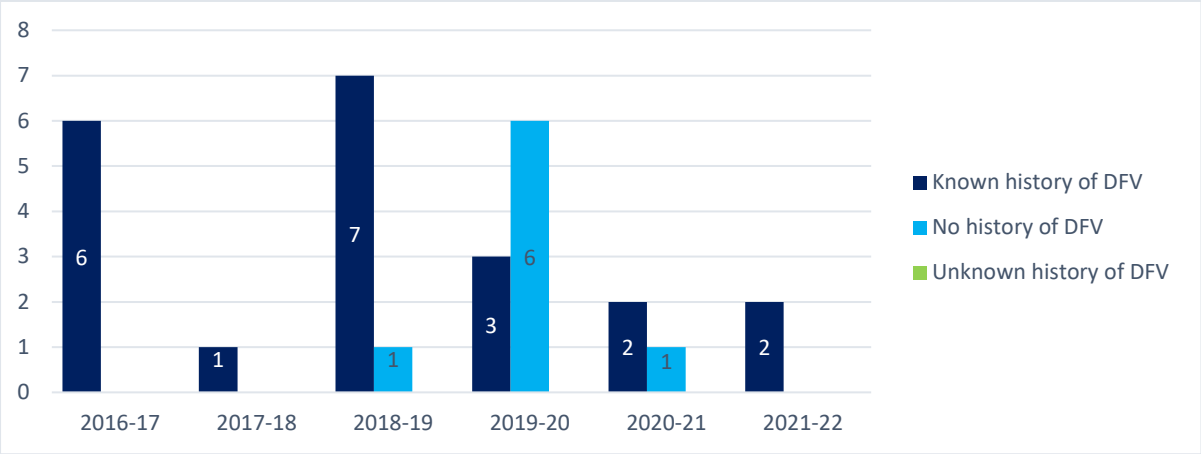

Figure 18. History of domestic and family violence between the primary victim and primary PUV (Family relationships - Child) (1 July 2016 to 30 June 2022) (N = 29).

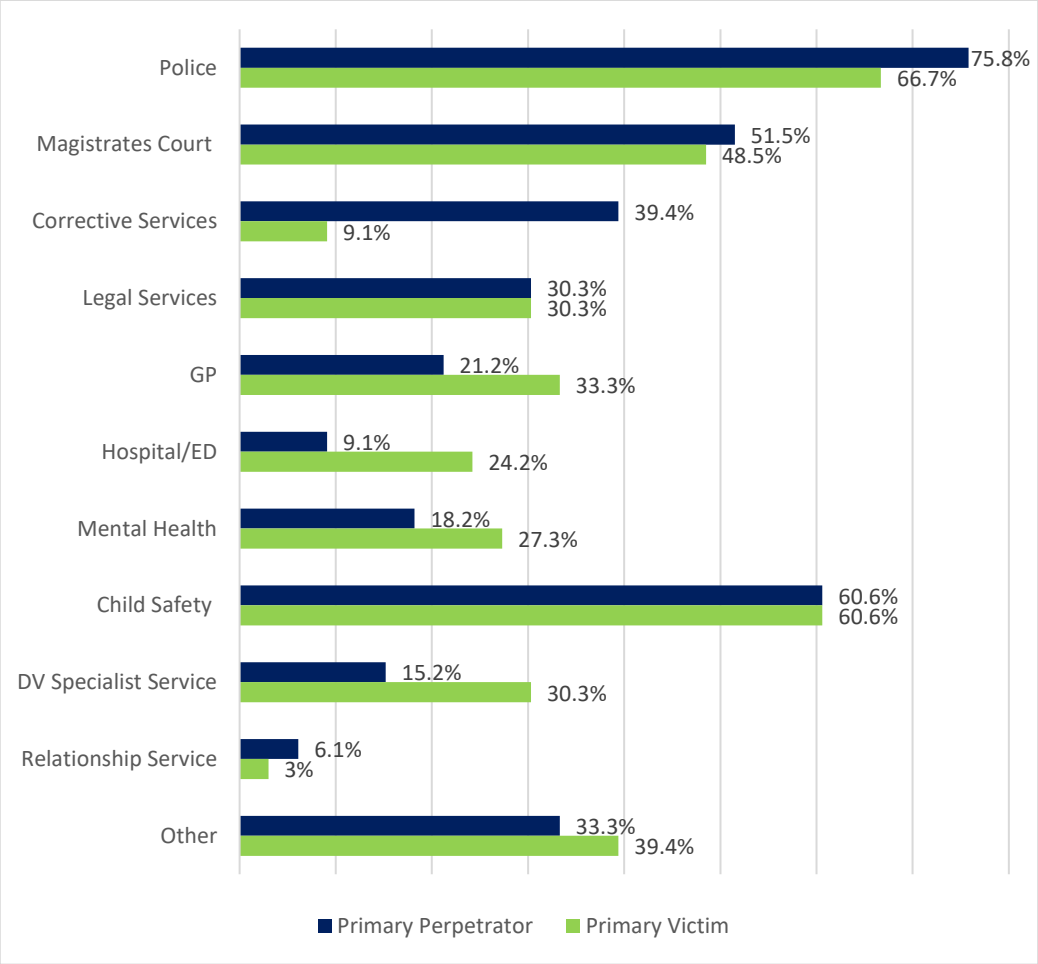

Figure 19. Known service contact in family violence related child homicides by percentage of persons accessing services (1 July 2016 to 30 June 2022).

Family violence related homicides (adults)

This section considers the different pattern of service contacts for the primary victims and primary PUV in family violence related homicides of adults. Relationships in this category were diverse and included family-like relationships and kin relationships. This includes: a child/stepchild who is over the age of 18 years; parent; step-parent; sibling; grandparent; aunt; nephew; cousin; half-brother or mother-in-law.

As discussed earlier, patterns of violence within this category of death tend to be far more heterogenous, with limited identifiable service contact compared to both intimate partner homicides and family violence related child homicides.

Data in this category is perhaps most compelling due to the relative absence of service contact.

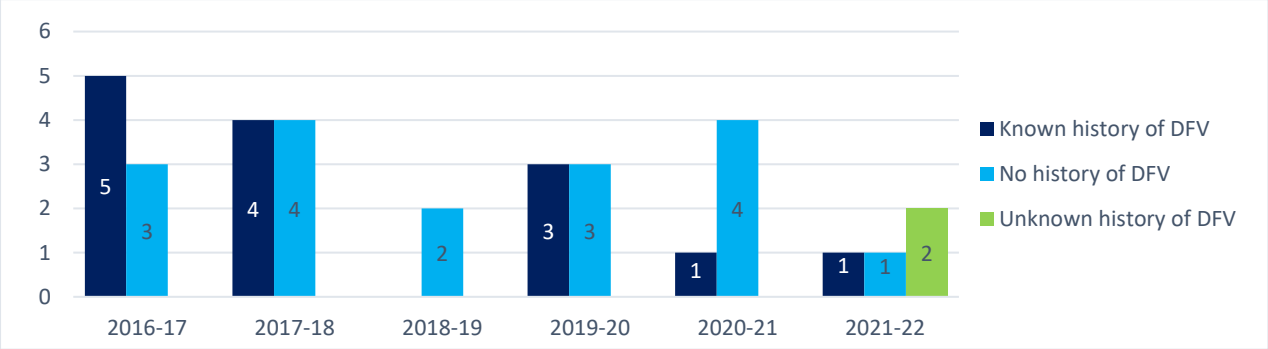

Figure 20. History of domestic and family violence between the primary victim and primary PUV (family relationships - adult) (1 July 2016 to 30 June 2022) (N = 33).

Section 4: 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 2021-22, the Board met on nine occasions, including five case review meetings and four annual report planning meetings. A total of eight cases were reviewed in this period involving thirteen 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*	*9*			
Deputy Chair	*A/Prof Kathleen Baird*	*9*	*$4500*		*$3600*
Member	*Betty Taylor*	*7*	*$4500*		*$3300*
Member	*Rosemary O'Malley*	*8*	*$4500*		*$3000*
Member	*Angela Lynch*	*7*	*$4500*		*$2760*
Member	*Dr Kylie Stephen*[93]	*9*			
Member	*A/Prof Molly Dragiewicz*	*8*	*$4500*		*$3300*
Member	*Keryn Ruska*	*7*	*$4500*		*$2700*
Member	*Brian Codd*[94]	*4*			
Member	*Paul Stewart*	*5*			
No. scheduled meetings/sessions	*Nine (inclusive of five case review meetings and four annual report planning meetings)*				
Total out of pocket expenses	*$1050.32*				

[93] Dr Kylie Stephen was appointed to the Board in July 2021.

[94] Assistant Commissioner Brian Codd was appointed to the Board in August 2021.

Appendix B: Intimate Partner Homicide Lethality Risk Coding Form

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

Risk factor	Descriptor
1. History of violence outside of the family by PUV	Any actual or attempted assault on any person who is not, or has not been, in an intimate relationship with the PUV. 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 PUV. 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 PUV 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 PUV 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 PUV	Any recent (past 6 months) act or comment made by the PUV that was intended to convey the PUV'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 PUV	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 PUV 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 PUV, whether successful or not, intended to exert full power over the victim. For example, when the victim was allowed in public, the PUV 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 PUV 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 PUV 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 regarding 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 PUV intended to damage any form of property that was owned, or partially owned, by the victim or formerly owned by the PUV. 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 PUV, 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 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 PUV 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 PUV 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. PUV was abused and/or witnessed domestic violence as a child	As a child/adolescent, the PUV 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 PUV 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 PUV	Any actions or behaviours by the PUV 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. PUV 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 PUV living common-law	The victim and PUV were cohabiting.
22. Presence of stepchildren in the home	Any child(ren) that is(are) not biologically related to the PUV.
23. Extreme minimisation and/or denial of spousal assault history	At some point the PUV was confronted, either by the victim, a family member, friend, or other acquaintance, and the PUV displayed an unwillingness to end assaultive behaviour or enter/comply with any form of treatment (e.g., batterer intervention programs). Or the PUV 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 PUV 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 PUV	Within the past year, and regardless of whether or not the PUV received treatment, problematic substance use that appeared to be characteristic of the PUV'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 PUV. For example, people described the PUV 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 PUV'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 PUV to terminate his substance use.
26. Depression – in the opinion of family/friend/acquaintance - PUV	In the opinion of any family, friends, or acquaintances, and regardless of whether or not the PUV received treatment, the PUV displayed symptoms characteristic of depression.
27. Depression – professionally diagnosed – PUV	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 PUV received treatment.
28. Other mental health or psychiatric problems – PUV	For example: psychosis; schizophrenia; bipolar disorder; mania; obsessive-compulsive disorder, etc.

29. Access to or possession of any firearms	The PUV 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 PUV'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 PUV perceived there to be a new intimate partner in the victim's life
31. Failure to comply with authority – PUV	The PUV 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. PUV exposed to/witnessed suicidal behaviour in family of origin	As a(n) child/adolescent, the PUV 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 PUV (e.g., caregiver) attempted or committed suicide.
33. After risk assessment, PUV 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 PUV still had access to the victim.
34. Youth of couple	Victim and PUV were between the ages of 15 and 24.
35. Sexual jealousy – PUV	The PUV 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 – PUV	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 PUV	The victim is one that knows the PUV best and can accurately gauge his level of risk. If the women discloses to anyone her fear of the PUV 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. PUV 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 control: an ongoing pattern of behaviour asserted by a PUV that is designed to induce various degrees of fear, intimidation and submission in a victim.[95] This may include the use of tactics such as social isolation, belittling, humiliation, threatening behaviour, restricting resources and physical abuse of the victim, children, pets or relatives. Coercive control also includes acts of physical and sexual violence.

Common Risk and Safety Framework (CRASF): The Domestic and Family Violence Common Risk and Safety Framework (CRASF) was developed by ANROWS in 2017 for use by government and non-government agencies to support the identification of high risk cases and the appropriate services needed for all victims seeking support. It was revised and relaunched in 2022.

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.

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)*.

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

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

Network is broader than the legal definition of the term, and includes all circumstances in which an individual's act, or failure to act, resulted in the death of another person, regardless of whether the circumstances were such as to contravene provisions of the criminal law.

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

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

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 who was under the age of 18 years at the time that they died.

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

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).

Government Response to the Domestic and Family Violence Death Review and Advisory Board 2020-21 Annual Report: https://www.courts.qld.gov.au/__data/assets/pdf_file/0003/724089/dfvdrab-2020-21-government-response-final-updated.pdf

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

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

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

Response' refers to the specific approach taken in Queensland as recommended by the Women's Safety and Justice Taskforce.

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

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

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

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

PUV Interventions: typically refers to specific programs (e.g. behaviour change programs) for PUV of domestic and family violence. These interventions generally seek to change men's attitudes, beliefs and behaviour in order to prevent them from engaging in violence in the future.[96]

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

Private 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.

QLiTE NextGen: Queensland Police Service launched a new mobile interface to enable frontline officers to respond to domestic and family violence (DFV) episodes with easily accessible information on the relationships between those involved.

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

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

that individual's cultural group. This includes: a child, stepchild, parent, step-parent, sibling, grandparent, aunt, nephew, cousin, half-brother, or mother-in-law.

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

Reporting period: 2021-22 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 DFVPA 2012.

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

Risk management: an approach to respond to and reduce the risk of violence. Risk management strategies should include safety planning, ongoing risk assessment, plans to address the needs of victims through relevant services (e.g. legal, counselling), and liaison between services utilising appropriate information sharing processes.[97]

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 domestic and family violence services.

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

Special Taskforce on Domestic and Family Violence in Queensland (the Special Taskforce): 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), which made 140 recommendations that have now been implemented.

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

[97] Department of Human Services (2012). *Family Violence: Risk Assessment and Risk Management Framework and Practice Guides 1-3*. Melbourne: Victorian Government. Available at: http://www.ncdsv.org/images/VGDHS_FVRiskAssessmentRiskManagementFrameworkAndPracticeGuides1-3_4-2012.pdf.

Systems abuse: the ongoing use of systems to continue to abuse victims by a PUV, typically after a relationship separation (e.g. child custody matters through family law court).

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.

VPU: Vulnerable Persons Unit. A specialist unit within the Queensland Police Service which is committed to the prevention, disruption, investigation and response to domestic and family violence (DFV) and other harms perpetrated to vulnerable Queenslanders and supports everyone's right to feel safe and respected and live a life free of violence and abuse.

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

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

Background and Purpose

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

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

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

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

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

Definitions

This Consensus Statement defines the inclusion criteria adopted by the Network for domestic and family violence homicide. While there is no universally agreed definition of the behaviours that comprise domestic and family violence, in Australia it includes a spectrum of physical and non-physical abuse within an intimate or family relationship. Domestic and family violence behaviours include physical assault, sexual assault, threats, intimidation, psychological and emotional abuse, social isolation, and economic deprivation. Primarily, domestic and family violence is predicated upon inequitable relationship dynamics in which one person exerts power and coercive control over another. This accords with the definition of family violence contained in the *Family Law Act 1975* (Cth), which is adopted by the Network.

The definition of 'homicide' adopted by the Network is broader than the legal definition of the term. 'Homicide', as used by the Network, includes all circumstances in which an individual's intentional act, or failure to act, resulted in the death of another person, regardless of whether the circumstances were such as to contravene provisions of the criminal law.

Surveillance

The World Health Organization defines surveillance as:

> "… systematic ongoing collection, collation and analysis of data and the timely dissemination of information to those who need to know so that action can be taken".[98]

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

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

Categorisation

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

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

Consideration 1: Case Type

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

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

Consideration 2: Intent

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

Intent	Definition	Inclusion
Assault*	Injury from an act of violence where physical force by one or more persons is used with the intent of causing harm, injury, or death to another person; or an intentional poisoning by another person. This category includes intended and unintended victims of violent acts (e.g. innocent bystanders).	Yes
Complications of Medical or Surgical Care	Death which occurred due to medical misadventure, accidents or reactions in the administration of medical or surgical care drugs or medication.	No
Intentional Self-Harm	Injury or poisoning resulting from a deliberate violent act inflicted on oneself with the intent to take one's own life or with the intent to harm oneself.	No

Legal Intervention/ Operations of War	Death which occurred due to injuries that were inflicted by police or other law-enforcing agents (including military on duty), in the course of arresting or attempting to arrest lawbreakers, suppressing disturbances, maintaining order or other legal action.	Yes (only where DV context present)
Still Enquiring	Death under investigation whereby the intent or case type is not immediately clear based on the level of information available.	No
Undetermined Intent	Events where available information is insufficient to enable a person to make a distinction between unintentional, intentional self-harm and assault.	No
Unintentional	Injury or poisoning that is not inflicted by deliberate means (that is, not on purpose). This category includes those injuries and poisonings described as unintended or "accidental", regardless of whether the injury was inflicted by oneself or by another person.	No
Unlikely to be Known	Upon case completion, the coroner was unable to determine whether the death was due to Natural or External causes, therefore unable to make a determination on intent.	No

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

Consideration 3: Relationship

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

- *Coroners Act 2009* (NSW);
- *Domestic and Family Violence Protection Act 2012* (Qld);
- *Family Violence Protection Act 2008* (Vic);
- *Intervention Orders (Prevention of Abuse) Act 2009* (SA);
- *Restraining Orders Act 1997* (WA) and *Parliamentary Commissioner Act 1971* (WA); and
- *Domestic and Family Violence Act 2007* (NT).

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

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

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

Consideration 4: Domestic and Family Violence Context

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

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

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