Domestic and Family Violence
Death Review and Advisory Board

Domestic and Family Violence Death Review and Advisory Board

Annual Report 2023–24

Queensland Government

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

Our efforts remain with ensuring 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.

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

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

About this report

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

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

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

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

Support Services

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

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

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

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

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

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

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

- **Triple Zero (000)** is a 24-hour emergency response call service to the police for anyone requiring assistance in life-threatening or time-critical emergency situations.
- **Policelink (131 444)** is a 24-hour service for non-urgent incidents, crimes or police inquiries.
- **DVConnect Womensline** is a 24-hour crisis support line for anyone who identifies as female being impacted by domestic and family violence. DVConnect is contactable on **1800 811 811** or via www.dvconnect.org
- **DVConnect Mensline** operates between 9am and midnight, 7 days a week, and is a crisis support line for anyone who identifies as male who is experiencing or using domestic and family violence. DVConnect Mensline is contactable on **1800 600 636** or via www.dvconnect.org
- **Lifeline** is a 24-hour telephone counselling and referral service and can be contacted on **13 11 14** or via www.lifeline.org.au
- **13YARN** is a 24-hour telephone counselling and referral service run by Aboriginal and Torres Strait Islander peoples and can be contacted on **13 92 76** or via www.13yarn.org.au
- **Rainbow Sexual, Domestic and Family Violence Helpline** is a 24-hour telephone counselling and referral service for anyone from the LGBTQ+ community who has experienced sexual, domestic or family violence. This service also assists those who support the LGBTQ+ community (family, friends

and professionals). Rainbow Sexual, Domestic and Family Violence Hotline can be contacted on **1800 497 212**.

- **Kids Helpline** is a 24-hour free counselling service for children and young people (5–25 years of age) and can be contacted on **1800 55 1800** or via www.kidshelpline.com.au
- **Suicide Call Back Service** can be contacted on **1300 659 467** or via www.suicidecallbackservice.org.au
- **Beyondblue** can be contacted on 1300 22 4636 or via www.beyondblue.org.au

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

- **Queensland Homicide Victim Support Group (QHVSG)** is a community support group which offers 24-hour support, personal advocacy and education to all people affected by homicides in Queensland. QHVSG is contactable on **1800 774 744** or via www.qhvsg.org.au
- **Queensland Indigenous Family Violence Legal Service (QIFVLS)** is a free legal service for Aboriginal or Torres Strait Islander people affected by family violence or sexual assault. If you, or your family, need legal support or more information, you can contact QIFVLS on **1800 887 700** or via www.qifvls.com.au
- **Women's Legal Service Queensland (WLSQ)** is a community legal centre that provides free, statewide legal and social work help to Queensland women. WLSQ provides assistance in domestic violence, family law and sexual violence matters. Contact the statewide Legal Advice Helpline on **1800 957 957** or via https://wlsq.org.au/
- Aboriginal and Torres Strait Islander peoples can access culturally appropriate health services through your local Aboriginal and Torres Strait Islander Community Health Service https://www.qaihc.com.au/about/our-members
- **The Queensland Government's Domestic and Family Violence Media Guide** provides information for journalists about responsible reporting of domestic and family violence at https://www.publications.qld.gov.au/dataset/domestic-and-family-violence-prevention/resource/c9ed71ec-74e6-48b0-8894-e5de6d5cf290
- Guidelines for safe reporting in relation to substance use, suicide and mental illness for journalists are available at www.mindframe.org.au

Chair's message

This Annual Report reflects my first full year as Chair of the Domestic and Family Violence Death Review and Advisory Board (the Board). The Board has reflected on its purpose and the important contribution it can make to the Queensland domestic and family violence (DFV) reform environment. Maintaining the momentum of change requires ongoing commitment and dedication from the sector and the Queensland community.

The victims of DFV remain at the centre of the Board's work. Their deaths have a devastating impact on the families, friends and communities who grieve their loss.

This year, the Board reviewed 50 deaths arising from 35 DFV-related cases where there was evidence of intimate partner sexual violence (IPSV). This review was conducted in response to Recommendation 17 of the Women's Safety and Justice Taskforce Report 2, which was based on the Board's previous findings about the prevalence of sexual assault and sexual jealousy in DFV-related deaths.

The review identified significant gaps and needs in addressing IPSV within the context of DFV. Current risk assessments lack nuanced measures for detecting IPSV, often limited to single questions about sexual assault, which fail to capture behaviours like image-based sexual abuse, reproductive coercion, and sexual coercion. To improve identification, assessments should incorporate multiple, behaviourally specific, and open-ended questions. Community awareness of DFV and IPSV remains low despite ongoing research, with prevalent misconceptions about sexual violence hindering recognition and reporting. Education campaigns must be culturally relevant and co-designed with local communities. Data sharing and integration across systems are crucial for preventing DFV-related homicides and suicides, yet current injury data focuses primarily on physical injuries, overlooking non-violent forms of IPSV. Health practitioners are pivotal in detecting high-risk DFV cases, necessitating suitable risk assessment tools and training. High-risk perpetrators require intensive, multiagency interventions, but victims often face challenges in navigating protection systems. Finally, more research is needed to understand why some DFV perpetrators complete suicide, especially post-separation, highlighting the need to examine the role of suicidal ideation and controlling behaviours in these cases. Recommendations resulting from these findings are discussed in greater detail within this report.

The Board has continued to monitor the implementation of its 75 recommendations. It has also reflected on how improving the framing of recommendations and supporting evidence can assist lead agencies to effectively implement the changes needed to prevent DFV related deaths in Queensland.

I acknowledge the tireless work of Ms Betty Taylor who retired from the Board this year. Betty was appointed to the Board upon its inception in 2016 and had advocated for its establishment. For over three decades, Betty has fought against DFV. Her pioneering efforts have not only drawn attention to the urgent need for effective responses but have also catalysed tangible change at both local and

national levels. She leaves a legacy in the DFV sector in Queensland, and I wish her well in her retirement.

I also acknowledge the resignation of Dr Kylie Stephens from the Board this year. Dr. Stephens joined the Board in 2021 and made substantial contributions to its work throughout her tenure. I extend my best wishes to her in her new role as the Assistant Director-General of the Justice Reform Office, Department of Justice and Attorney-General and express my gratitude for her dedication and efforts while serving on the Board.

I welcome Dr Julia De Boos, Assistant Commissioner Christopher Jory, Dr Brian Sullivan, Ben Bjarnesen, Aletia Twist and Belinda Drew who were appointed as members of the Board this year. Their experience and insight complement that of existing members as we work together to continue to enhance the value of the Board and its work.

I would also like to recognise the commitment and dedication of the Domestic and Family Violence Death Review Unit, Coroners Court of Queensland, which provides secretariat support for the Board, and the support of Dr Hayley Boxall, Professor Kyllie Cripps, Ms Adelaide Bragias and Associate Professor Marlene Longbottom who supported the Board with the review of sexual violence cases this year.

It is my privilege to chair the Board as it continues to lead meaningful change.

Stephanie Gallagher
Deputy State Coroner

Acknowledgements

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

The Board also acknowledges the significant efforts of individuals, services and government agencies working across Queensland to prevent and respond to DFV.

Responding to DFV is complex and multilayered. There are no simple solutions, and it will take time to enact change. Until then, we acknowledge all persons working in pursuit of this shared goal.

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.

During 2023–24, the Board was supported by Expert Advisors in its review of DFV-related deaths involving intimate partner sexual violence.

The Board would like to acknowledge the contributions of:

- Dr Hayley Boxall, Australian National University
- Professor Kyllie Cripps, Monash University
- Ms Adelaide Bragias, Australian National University
- Associate Professor Marlene Longbottom, James Cook University.

Board members

CURRENT

Ms Stephanie Gallagher
Deputy State Coroner of Queensland
Chairperson

Ms Nadia Bromley
Non-government member
Chief Executive Officer, Women's Legal Service
Deputy Chairperson

Ms Kristina Deveson
Assistant Director-General, Magistrates Courts Service, Department of Justice and Attorney-General

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

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

Mr Paul Stewart
Commissioner, Queensland Corrective Services

Mr Christopher Jory
Assistant Commissioner, Domestic, Family Violence and Vulnerable Persons Command, Queensland Police Service

Dr Brian Sullivan
Non-government member
Chief Executive Officer, Red Rose Foundation

Dr Julia De Boos
Staff Specialist – Emergency Department, Regional Forensic Coordinator for the North West Hospital and Health Service, Queensland Health

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

Mr Ben Bjarnesen
Police Officer, Queensland Police Service
Founder and Managing Director of the LGBTQ Domestic Violence Awareness Foundation

Ms Aletia Twist
Non-government member
Chief Executive Officer, Mura Kosker Sorority Inc.

FORMER

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

Dr Kylie Stephen
Assistant Director-General, Justice Reform Office, Department of Justice and Attorney-General

SECRETARIAT
Domestic and Family Violence Death Review Unit, Coroners Court of Queensland, Department of Justice and Attorney-General

Contents

Overview

The 2023–24 Annual Report of the Domestic and Family Violence Death Review and Advisory Board comprises four sections:

- **Section One** describes the performance of the Board's functions.
- **Section Two** reports on new recommendations and the progress made towards implementing previous recommendations made by the Board since its establishment in 2016.
- **Section Three** outlines the Board's proposed focus for 2024–25.
- **Section Four** presents data about domestic and family violence-related homicides in Queensland between 1 July 2016 and 30 June 2024.

The 2023–24 Annual Report also includes several appendices, which include supporting information to the annual report.

Section One: Performance of the Board's functions

About the Board

The Domestic and Family Violence Death Review and Advisory Board (the Board) was established in 2016 following Recommendation 8 of the *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland* report.[1]

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

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

a) identify preventative measures to reduce the likelihood of domestic and family violence deaths in Queensland
b) increase recognition of the impact of, and circumstances surrounding, domestic and family violence and gain a greater understanding of the context in which domestic and family violence deaths occur
c) make recommendations to the Minister for implementation by government entities and non-government entities to prevent or reduce the likelihood of domestic and family violence deaths.

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

Generally, the Board looks to emerging issues and data trends to decide what types of cases will be reviewed. However, the Women's Safety and Justice Taskforce's second report identified a need for greater service system leadership and coordination.[2] In particular, the Taskforce noted the need to better understand how sexual violence in the context of DFV is being responded to across the service and criminal justice systems.[3]

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

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

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

The Taskforce recommended (Recommendation 17) the Board undertake a focused review of cases involving sexual violence to further enhance understanding in this area, given its expertise in reviewing DFV-related deaths:[4]

> *'The [Deputy] 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.'*

This review has been the focus of the Board for this year, producing a report about its review of intimate partner sexual violence in the context of DFV.

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

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

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

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

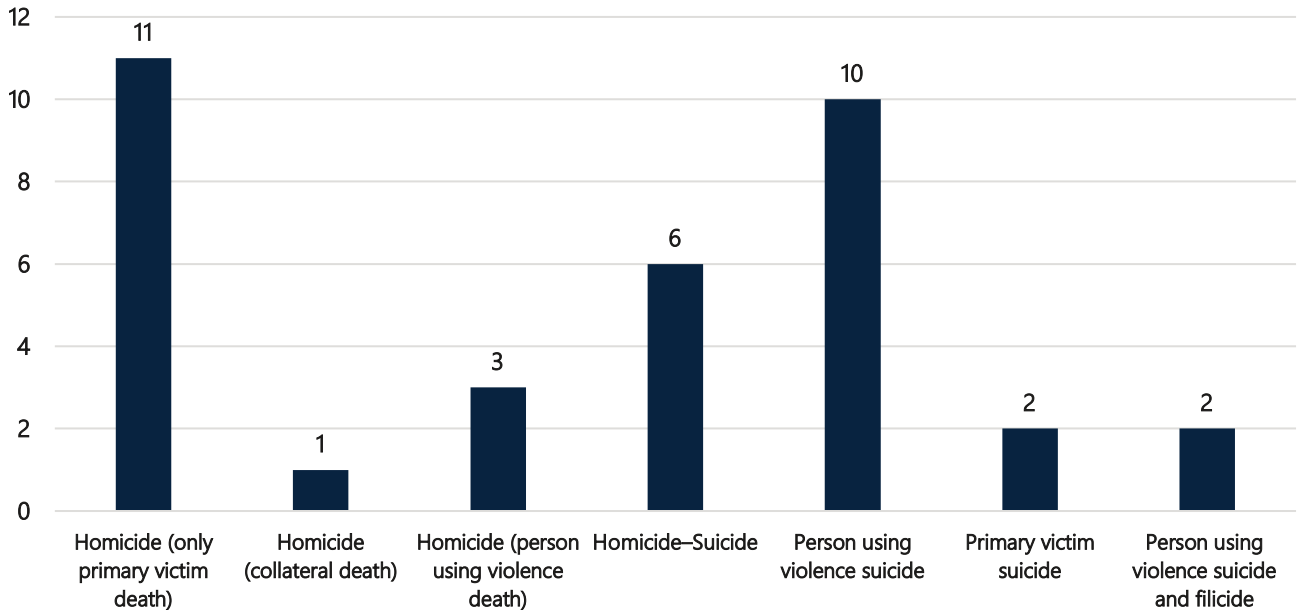
Section 91D(1)(a): Review domestic and family violence deaths

The Board has previously noted the prevalence of sexual assault and jealousy lethality indicators in DFV homicides[5] and devastating impacts of intimate partner sexual violence (IPSV) on victims.[6]

Drawing on the Board's findings, the Women's Safety and Justice Taskforce acknowledged the need to better understand how sexual violence in the context of DFV is being responded to across the service and criminal justice systems. The Taskforce recommended the Board review '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.' [7]

In response to this recommendation, the Board reviewed 35 DFV-related cases involving IPSV resulting in 50 deaths. As the focus of the review was on the presence of IPSV, the primary victim (PV) and the person using violence (PUV) were the focus of the data analysis. As a result, nine collateral or apparent filicide deaths were excluded from analysis. Eighteen of the 35 cases had previously been reviewed by the Board. However, the current review focused on the experiences of, and responses to, IPSV. Figure 1.1 describes the cases reviewed.

Figure 1.1: Reviewed domestic and family violence related cases involving Intimate partner sexual violence.



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

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

[7] Recommendation 17 of Women's Safety and Justice Taskforce (2022). *Hear Her Voice: Report 2, Volume 1.* (p. 14). https://www.womenstaskforce.qld.gov.au/__data/assets/pdf_file/0008/723842/Hear-her-voice-Report-2-Volume-1.pdf

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

The Board's data and research functions in 2023–24 complemented the review of DFV-related deaths involving IPSV.

Prevalence of IPSV

Australian data shows that one in five (22%) women have experienced sexual assault and 17% have experienced physical and/or sexual assault by a co-habiting partner.[8] These statistics likely underestimate the true prevalence of IPSV, given the stigma associated with IPSV, issues in identifying IPSV,[9] and pervading cultural norms and differing ways IPSV is defined in research and operationally.[10]

IPSV disproportionately affects First Nations women and girls

Aboriginal and Torres Strait Islander women and girls are disproportionately affected by the prevalence and severity of DFV perpetrated by men against women. Alarmingly, Aboriginal and Torres Strait Islander women and girls are more likely to experience IPSV than any other population group,[11] with over 90% of victims not reporting IPSV to services.[12]

Literature review

A scan of the relevant literature was conducted to inform the approach to the case reviews. This scan helped the Board define the types of sexual violence behaviours to be examined, and the individual and relationship risk factors for IPSV.

The literature shows that IPSV and DFV co-occur. Research indicates that IPSV frequently occurs in the context of violent arguments (i.e. forced sexual activity after a violent argument)[13] and out of fear to prevent violent escalation and repercussions of sexual refusal.[14]

As with all forms of gender-based violence, IPSV is associated with various adverse outcomes, both for those who experience it and for their children. This includes an elevated risk of

[8] Australian Bureau of Statistics. (2023). *Personal Safety, Australia*. https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/2021-22

[9] Cox, P. (2015). *Sexual assault and domestic violence in the context of co-occurrence and re-victimisation: State of knowledge paper* (ANROWS Landscapes, 13/2015). Sydney, NSW: ANROWS. https://www.anrows.org.au/publication/sexual-assault-and-domestic-violence-in-the-context-of-co-occurrence-and-re-victimisation-state-of-knowledge-paper/

[10] Tharp, A. T., DeGue, S., Valle, L. A., Brookmeyer, K. A., Massetti, G. M., & Matjasko, J. L. (2012). A systematic qualitative review of risk and protective factors for sexual violence perpetration. *Trauma, Violence, & Abuse, 14*(2), 133–167. https://doi.org/10.1177/1524838012470031

[11] Guggisberg, M. (2018). Aboriginal women's experiences with intimate partner sexual violence and the dangerous lives they live as a result of victimization. *Journal of Aggression, Maltreatment & Trauma, 28*(2), 186–204. https://doi.org/10.1080/10926771.2018.1508106

[12] Prentice, K., Blair, B., & O'Mullan, C. (2016). Sexual and family violence: Overcoming barriers to service access for Aboriginal and Torres Strait Islander clients. *Australian Social Work, 70*(2), 241–252. https://doi.org/10.1080/0312407x.2016.1187184

[13] Logan, T. K., Walker, R., & Cole, J. (2015). Silenced suffering: The need for a better understanding of partner sexual violence. *Trauma, Violence, & Abuse, 16*(2), 111–135. https://doi.org/10.1177/1524838013517560

[14] Hamilton, G., Ridgway, A., Powell, A. & Heydon, G. (2023). *Family violence and sexual harm: Research report*. RMIT University.

experiencing shame, Post Traumatic Stress Disorder, depression, problematic substance use, and suicidality compared with exposure to other forms of interpersonal violence.[15]

IPSV victimisation is also associated with higher risk of physical and sexual health consequences such as sexually transmitted infections, pregnancy (possibly unintended), specific physical injuries and death by homicide.[16]

Community perception of sexual violence

Cultural myths about 'real rape' and cultural norms about DFV as 'private' continue to strongly influence societal responses to IPSV. These myths provide a very narrow definition of what constitutes 'real' or 'legitimate' rape,[17] incorrectly stereotyping 'real rape' as being committed by a 'deviant perpetrator,' often a stranger, against an unsuspecting, 'genuine victim,' in a dark, secluded area, often using physical violence, force or the threat of a weapon in the attack.[18]

These myths contradict empirical evidence from Australia and overseas, where most sexual assaults are perpetrated by an intimate partner or someone else known to the victim. Like DFV, IPSV tends to occur in private. If it is witnessed, it is usually by people known to the couple.[19]

IPSV case review process

The Board also commissioned the services of a consortium of IPSV experts to support the case review process. The consortium included the following experts:

- Dr Hayley Boxall, Australian National University
- Professor Kyllie Cripps, Monash University
- Ms Adelaide Bragias, Australian National University
- Associate Professor Marlene Longbottom, James Cook University.

The experts drew on the published research as well as their own research with victim–survivors and conducting death reviews to guide the work of the Board.

The Board noted that all issues highlighted by the experts could be observed in the cases reviewed. Experts identified a research gap exists in relation to understanding why a PUV would choose to kill their partner rather than themselves.

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[15] Vatnar, S.K.B., Bjørkly, S. (2008). An interactional perspective of intimate partner violence: An in-depth semi-structured interview of a representative sample of help-seeking women. *Journal of Family Violence, 23*, 265–279. https://doi.org/10.1007/s10896-007-9150-7

[16] McFarlane, J., Malecha, A., Gist, J., Watson, K., Batten, E., Hall, I., & Smith, S. (2005). Intimate partner sexual assault against women and associated victim substance use, suicidality, and risk factors for femicide. *Issues in mental health nursing*, *26*(9), 953–967. https://doi.org/10.1080/01612840500248262

[17] Bagwell-Gray, M. E. (2019). Women's experiences of sexual violence in intimate relationships: Applying a new taxonomy. *Journal of Interpersonal Violence*, *36*(13–14), 13–39. https://doi.org/10.1177/0886260519827667

[18] Clark, H., & Quadara, A. (2010). *Insights into sexual assault perpetration: Giving voice to victim/survivors' knowledge (*Research Report No. 18). Melbourne: Australian Institute of Family Studies.

[19] Hamilton, G., Ridgway, A., Powell, A. & Heydon, G. (2023). *Family violence and sexual harm: Research report*. RMIT University.

The Board reflected on the available data, research and findings of the case reviews and produced a report about a systemic matter, as authorised by section 91ZC of the *Coroners Act 2003*.

This report has been provided to the Minister, with a recommendation to table it in the Legislative Assembly.[20]

Other research projects supported by the Board

The Board, through the Domestic and Family Violence Death Review Unit (DFVDRU), contributes to national research projects conducted as part of the Australian National Research Organisation for Women's Safety (ANROWS) and Australian Domestic and Family Violence Death Review Network (ADFVDRN) partnership.

In 2023–24, the partnership finalised a project to create a national minimum dataset of filicides that occur within a DFV context. The report was launched on 2 July 2024.[21]

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

As a result of the activities in 2023–24 focusing on DFV-related deaths involving IPSV, the Board identified five key findings resulting in five recommendations to the Minister. Recommendations are detailed in section two of this report.

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

In the 2022–23 Annual Report, the Board stated it planned to increase its focus on monitoring the implementation of its recommendations to ensure progress continues in the crowded reform environment.[22]

The Department of Justice and Attorney-General's Legal Services Coordination Unit seeks status updates from lead agencies implementing the Board's recommendations. These updates are published on the Board's website.[23]

In 2023–24, the Board also requested information directly from agencies to better understand implementation progress, as permitted under section 91Y of the *Coroners Act 2003*. Queensland Health and Queensland Police Service responded to the Board's requests for information. The

[20] Sections 91ZC(4) and 91ZC(5) of the *Coroners Act 2003 (Qld).*

[21] Australian National Research Organisation for Women's Safety. (2024). *Australian Domestic and Family Violence Death Review Network Data Report: Filicides in a domestic and family violence context 2010–2018* (1st ed.; Research report, 06/2024), ANROWS. https://www.anrows.org.au/publication/australian-domestic-and-family-violence-death-review-network-filicides/

[22]Domestic and Family Violence Death Review and Advisory Board (2023). *2022-23 Annual Report*. https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0006/781719/domestic-and-family-violence-death-review-and-advisory-board-annual-report-2022-23.pdf

[23] https://www.coronerscourt.qld.gov.au/dfvdrab/annual-reports-and-government-responses

Board will continue to use this method to monitor implementation of recommendations periodically, and as required.

A detailed analysis of implementation progress is included in section two of this report.

Section Two: Board Recommendations

Recommendations

In the context of the considerable body of existing recommendations and ongoing reform, and in accordance with section 91D(1)(e) of the *Coroners Act 2003*, the Board makes the following recommendations to the Attorney-General and Minister for Justice and Minister for the Prevention of Domestic and Family Violence.

The Board makes these recommendations based on the findings of the IPSV case review. This separate report will be available on the Board's website and provides more detailed context for these recommendations.

Recommendation 1

Relevant risk assessment that includes more nuanced measure of IPSV

Practitioners in the DFV sector, including health professionals such as General Practitioners, community nurses and those working in emergency departments have an opportunity to identify and address high-risk DFV and IPSV. Equally, practitioners from the sexual violence sector also have an opportunity to identify and address high-risk DFV and IPSV. As such, there is an identified need for specific training in DFV and IPSV for health practitioners and those working in the sexual violence sector.[24]

The Board recognises that current risk assessment tools and frameworks used in Queensland may not be nuanced enough to identify the risk of IPSV. There is a need to review current risk assessments to identify the adequacy and appropriateness of questions related to IPSV. Additional support is also needed to guide practitioners to ask these questions in a manner that ensures that the PV or PUV can identify any IPSV present in the relationship. A review of supporting guidelines for practitioners is therefore required.

The Board suggests resources that could be used to guide the review and the development of practitioner guidelines include:

- Archambault, J., Lonsway, K.A. (2020). Interviewing the Victim: Techniques based on the realistic dynamics of sexual assault. End Violence Against Women International. https://evawintl.org/wp-content/uploads/Module-6_Interviewing-the-Victim-8.20.2020.pdf
- IACP's Sexual assault incident reports investigative strategies https://www.theiacp.org/resources/document/sexual-assault-incident-reports-investigative-strategies; and

[24] Queensland Government (2024). *Broadening the Focus: Queensland's strategy to strengthen responses to people who use domestic and family violence 2024 to 2028*. https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/fad6a8d8-b3be-47ad-a6d9-5ba181f28c05/strengthen-responses-to-people-using-dfv-strategy-202428.pdf?ETag=6c5d47e721a38ac636f12e0051cf1579

- IACP's Successful trauma informed victim interviewing guide https://www.theiacp.org/sites/default/files/2020-06/Final%20Design%20Successful%20Trauma%20Informed%20Victim%20Interviewing.pdf

The Board acknowledges the Queensland Government's *Broadening the Focus* strategy to strengthen responses to people who use DFV, which articulates the importance of equipping services to identify, respond and refer a PUV. The Board agrees with this priority and would emphasise the importance of specifically including IPSV, sexual violence and sexual respect into training, assessments and interventions for PUVs.

Recommendation 2

Place-based and culturally relevant community education on IPSV

Within communities there are commonly held misconceptions about IPSV, and there is a clear need for community awareness and education campaigns to improve understanding and knowledge of IPSV. These community awareness and education campaigns should be underpinned by a public health model and be co-designed with local community groups and organisations to ensure they are relevant and resonate with local communities.

The Board welcomes the recent release of the *Broadening the Focus* strategy to strengthen responses to people who use DFV.[25] One of the four priority areas in this strategy aims to increase community awareness of DFV.

The case review undertaken shows a clear need to include IPSV in this awareness program. The Board is aware of other successful community awareness campaigns that involve local, well respected community members participation. It is also important that the language that is used in the campaigns is adapted and relevant for context within each local community.

Recommendation 3

Accessible and linked datasets to identify IPSV

The finding that information sharing and data integration across systems in contact with PVs and PUVs is crucial for preventing DFV-related homicide and suicide has been a persistent finding across various reviews. The Board acknowledges that health practitioners hold a crucial piece of the puzzle as they have opportunities to detect and respond to high-risk cases of DFV and IPSV. When data from the health system is inaccessible or missing, it can be a barrier to preventing violence.

[25] Queensland Government (2024). *Broadening the Focus: Queensland's strategy to strengthen responses to people who use domestic and family violence 2024 to 2028*. https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/fad6a8d8-b3be-47ad-a6d9-5ba181f28c05/strengthen-responses-to-people-using-dfv-strategy-202428.pdf?ETag=6c5d47e721a38ac636f12e0051cf1579

The Board also acknowledges and encourages the progress Queensland Health has made in replacing paper-based medical records with Integrated Electronic Medical Record (ieMR). There are 16 sites with ieMR, with a further 14 future sites noted on the department website.[26]

Across Queensland, health services are at various stages of technological improvement in record keeping, particularly in relation to the ieMR. The provision of timely and accurate records is possible through the ieMR system which is available in larger health services. Regional, rural, and remote services typically have paper-based health records which are required to stay on the main campus with the patient. This technological gap between services may result in challenges to the provision of timely and accurate records. Further, it can create inconsistencies in data collection.

Information about injuries in Queensland can be recorded by the type of physical injury with which a patient presents to the emergency department or upon admission. Current injury data records the classification of diseases, injury and related health problems by the type of injury for a patient admission to hospital in accordance with ICD-10-AM codes – X85-Y09 [Assault]. The ICD records illness and injury but not the context in which it occurred. Domestic abuse is not an ICD diagnosis (although physical and sexual abuse are).

There is a need to ensure that data about the context of injury is consistently recorded to allow the system to better understand the prevalence and impact of DFV and IPSV. Further, as paper-based systems are replaced, embedding triggers to consistently flag referrals and in-depth risk assessments for patients presenting with injury in context of DFV or IPSV is needed.

There is also a need to embed these triggers to support the health service beyond the hospital setting, as General Practitioners and community nurses have opportunities to detect the presence of DFV and IPSV.

Recommendation 4

Review of current models for intensive and escalated responses to high-risk cases of DFV

The Board identified a need for programs focusing on stopping sexual violence by men. Such programs could also present opportunities for enhanced risk assessment and the provision of education on sexual respect. Programs currently funded dealing with sexual violence should be bolstered, with extended sessions that focus on sexual respect, sexual violence and sexual abuse. Programs should also provide extensive and ongoing support to effectively address and mitigate sexual violence in these interventions.

It is evident there is a need to engage with high-risk PUVs through intensive, proactive, and multiagency responses. The Board acknowledges the trial of the High-Risk Response Team model, and the work done to date. It is important to note that the practice model is a significant component when engaging high-risk PUVs. The Board is aware there may be other emergent

[26] https://www.health.qld.gov.au/clinical-practice/innovation/digital-health-initiatives/queensland/integrated-electronic-medical-record-iemr

models in this area of work. The Board recommends the expansion and evaluation of engagement of high-risk PUVs through High-Risk Response Teams or other emergent models. However, it is essential to note that some PVs may express hesitancy engaging with multiagency teams, fearing impacts on housing, support payments, and custody arrangements.

The cases reviewed by the Board demonstrated the significance of non-policing service contacts as an opportunity to identify and respond to IPSV, and DFV more broadly. Structured guidance and escalation avenues for private practitioners who engage with PUVs is a particular need, as cases demonstrated a high degree of practitioner discretion (for example, when a PUV was recommended to undertake marriage counselling with the PV).

Recommendation 5

Greater research on suicide in the context of domestic and family violence

The findings from the IPSV case review undertaken by the Board highlighted areas for further research. These include:

- In this case review there were several similarities between homicide and suicide cases, however there were a few differences highlighted too. In the cases reviewed all PUV who ended their life, did so post-separation, while half the homicide cases occurred post-separation. Understanding this difference, and if ideation relates to emotional distress or is related to the interplay between suicidality and the use of death as a tool of control, would allow practitioners to provide appropriate intervention and support to a PUV with suicidal ideation.
- While there is international research relating to sexual violence in a DFV context for both women and children, there is a gap in knowledge about the Australian context.

Monitoring progress

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

In addition to making recommendations to the Minister to prevent or reduce the likelihood of DFV deaths, the Board is required to monitor the implementation of its recommendations[27] and include information about progress in its annual report.[28]

Of the 75 recommendations made by the Board between 2016–17 and 2021–22, all but one has been accepted (in full, in part or in principle) by the Queensland Government.

[27] Section 91D(1)(f) of the *Coroners Act 2003*
[28] Section 91ZB(2) of the *Coroners Act 2003*

The Board's recommendations relate to multiple portfolio areas. While in some instances multiple secondary agencies were nominated to support the lead agency in delivering recommendations, most of the Board's recommendations have been directed towards the departments with responsibility for child safety, DFV reform and service delivery, women's safety, health and justice.[29]

The Board acknowledges the intent of the recommendations is to take incremental steps towards full system change, hence recommendations have had a broad focus, with the majority aiming to enhance workforce development, enhance systems and processes, and enable greater service accessibility and availability (see Figure 2.1).

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

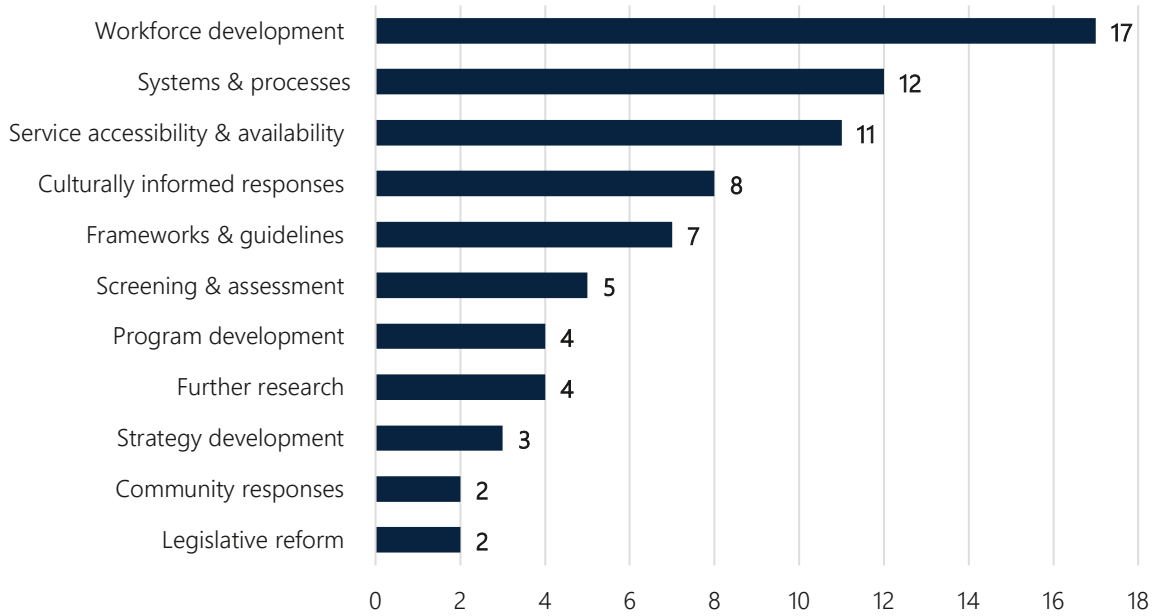

Figure 2.1: Focus of recommendations made by the Board between 2016–17 and 2022–23.

In response to the Board's recommendations, lead agencies contribute to an initial whole-of-government response, and then regular progress updates throughout implementation are provided. All responses are published on the Board's webpage.[30]

[29] Machinery of government changes have meant that the implementation of recommendations have been reported upon by different agencies over time.
[30] Please see: https://www.coronerscourt.qld.gov.au/dfvdrab/annual-reports-and-government-responses

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

Implementation of death review recommendations from New South Wales and Queensland was examined by researchers from the University of New South Wales. They found that despite most (95.2%) recommendations being accepted by governments initially, there was a gap between acceptance and implementation. They also found:[31]

> *'the NSW and Queensland Governments took a more favourable position on the implementation of domestic violence death review recommendations [government described 37.6% of recommendations as implemented] than our independent analysis of the implementation materials suggested was warranted [16.0% described as implemented]. This raises serious questions about the desirability of government self-assessment with respect to the implementation of domestic violence death review reforms.'*

The researchers noted it was sometimes difficult to determine implementation status from the information provided by government, and 'in some cases, it was unclear how the information provided in implementation materials even related to the original recommendation.'[32]

These findings are consistent with observations previously made by the Board. For example, in its 2021–22 Annual Report, the Board noted it was not clear in some reports provided by agencies what new actions had been taken to implement recommendations made in addition to work already underway.

Figure 2.2 shows implementation progress based on information provided to the Board prior to this report being finalised.[33] It shows that 60 (80%) recommendations are considered implemented by the Queensland Government, and 15 (20%) are in progress.

However, of the updates provided for the 15 open recommendations, all were current as at 25 June 2024. The Board is concerned that the significant delays between lead agencies providing updates and the publication of these documents inhibits its ability to effectively monitor the progress of implementing its recommendations.

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[31] Buxton-Namisnyk, E. & Gibson, A. (2024). The contribution of domestic and family violence death reviews in Australia: From recommendations to reform? *Journal of Criminology*, https://doi.org/10.1177/26338076231223580 (pp. 11, 19–20).

[32] Buxton-Namisnyk, E. & Gibson, A. (2024). The contribution of domestic and family violence death reviews in Australia: From recommendations to reform? *Journal of Criminology*, (p. 10). https://doi.org/10.1177/26338076231223580

[33] The information in this section was correct as at 25 June 2024.

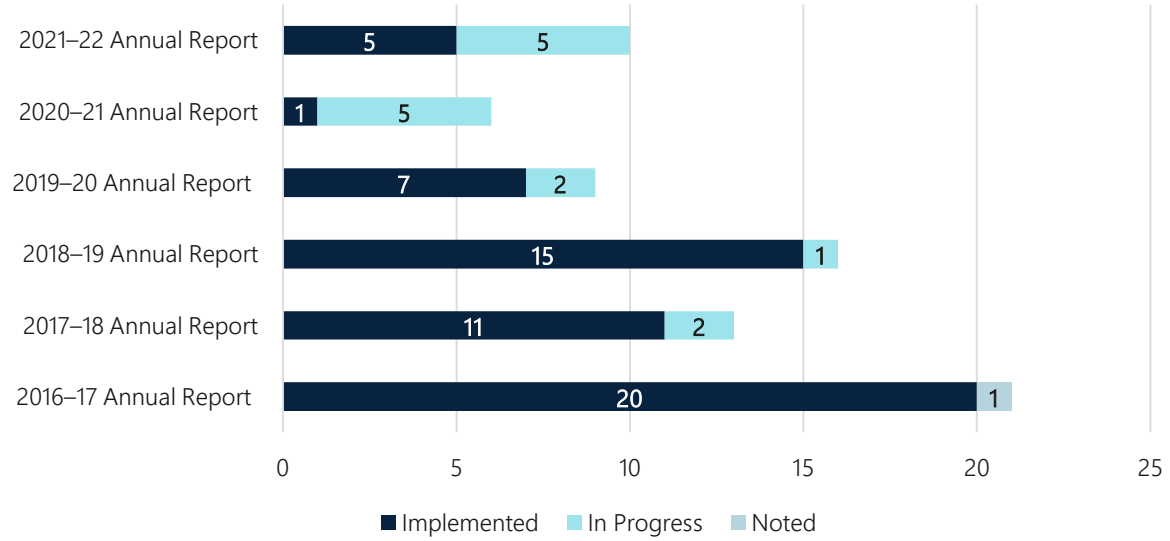

Figure 2.2: Implementation status of recommendations made by the Board between 2016–17 and 2021–22.

There were no recommendations made by the Board in the 2022–23 Annual Report.

The Board took a proactive approach to monitoring its recommendations in 2023–24, using its legislative powers to request specific information from lead agencies about the implementation status of recommendations.

The Board further acknowledges the challenges obtaining timely progress updates for recommendations led by multiple agencies with distinct approval processes. In the future the Board is interested in understanding the impact of the implementation of recommendations and may take a deep dive approach. To continue to drive the systems shared goal, the Board may invite agencies to a meeting to discuss the implementation of recommendations.

The Board is eager to support agencies with implementation and identifying opportunities for collaboration, as well as streamlining the provision of timely updates about implementation.

For example, the Board's updated Procedural Guidelines[34] describe how the Board develops quality recommendations and provides information to support agencies with implementation. It is expected that by clearly defining the problem or issue a recommendation is designed to address and defining the desired outcomes (including outcome implementation progress measures the Board intends to monitor), agencies can provide timely, succinct and relevant implementation progress updates.

[34] Please note: https://www.coronerscourt.qld.gov.au/dfvdrab

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

The DFVDRU delivered six presentations in 2023–24:

1. Child Death Review Board Secretariat
2. Child Safety Systems and Practice Review team
3. Mt Gravatt Child Safety Service Centre
4. South East Region DFV Champions Forum
5. Youth Justice Systems Quality Review and Supports team
6. Toowoomba Community Corrections.

Section Three: Focus for 2024–25

The Board's upcoming work

In 2023–24, the Board reflected on the way it performs its functions and identified opportunities to increase its influence. These strategies will continue to be implemented in 2024–25, including enhanced recommendation development and monitoring guidelines, and broadening the communication of Board findings.

The Board looks forward to continuing its work to analyse data and conduct research to identify patterns, trends and risk factors relating to DFV-related deaths in Queensland. It will also continue to identify key lessons and good practice, making recommendations to the Minister to improve legislation, policies, practices, services, training, resources, and communication to prevent or reduce the likelihood of DFV-related deaths in Queensland.

To achieve this, the Board will maintain efforts to strengthen relationships with agencies to ensure effective collaboration and understanding of how the Board can support rather than duplicate work underway across the sector.

The Board remains committed to continuing its quality assurance review of Queensland data about DFV-related homicides and suicides and contributing to national research and data projects with a focus on DFV-related deaths.

Proposed focus areas for case reviews

When considering the focus areas for case reviews, the Board scans existing research, work undertaken by various taskforces and recent data to support its decision-making. The Board also considers factors when considering cases for review, including whether the Board has reviewed the case previously. There are several areas of focus the Board is considering in 2024–25.

Filicides

Analysis of Australian filicides[35] found that filicides commonly occur in a DFV context (86 of 113 cases, 76%). Of the DFV filicide cases, there was identifiable history of violence against the children (78% of cases) and intimate partner violence (88% of cases). Most filicides were perpetrated by male offenders (68%) and the deceased children were typically very young (in 46% of cases, the deceased child was less than two years old at death).

A high proportion of cases (60%) had contact with child protection services. The report highlighted child protection services as a key intervention point for potentially preventing filicides. It further stated that the high rates of intimate partner violence against women prior to

[35] Australian National Research Organisation for Women's Safety. (2024). *Australian Domestic and Family Violence Death Review Network Data Report: Filicides in a domestic and family violence context 2010–2018* (1st ed.; Research report, 06/2024). ANROWS. https://www.anrows.org.au/publication/australian-domestic-and-family-violence-death-review-network-filicides/

the DFV context filicides indicates that risk of violence to mothers should be seen as a risk to their children.[36]

The Board is considering plans to review filicides of young children which occurred in a DFV context to examine whether DFV was adequately considered in risk assessment processes.

Use of arson in the context of DFV

There is increased media and research attention on the use of fire to coerce, control and punish current or former partners.[37] Some in the DFV sector have suggested this is due to an increase in the behaviour,[38] while others caution that media representations of DFV can be sensationalist and favour extreme, multiple fatality cases.[39]

Professor Heather Douglas reviewed the (limited) literature on the use of, or threats to use, fire in the context of DFV, along with a sample of reported cases where fire or threat of burning was used in the DFV context.[40] While Professor Douglas drew tentative conclusions based on the information available, she stressed the need for further systematic research on the issues raised.

In recognition of the limited research and an apparent increase in the use of arson in intimate partner homicides in Queensland since the deaths of Hannah Clarke and her children, and Doreen Langham, the Board is considering plans to review these types of deaths in 2024–25.

Women experiencing mental health concerns

In the research synthesis *Violence against women and mental health*,[41] ANROWS note that women experiencing mental health concerns are among the groups least likely to be believed when reporting sexual assault,[42] and that persons using violence may 'weaponise' mental health to prevent victims from accessing justice.

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[36] Australian National Research Organisation for Women's Safety. (2024). *Australian Domestic and Family Violence Death Review Network Data Report: Filicides in a domestic and family violence context 2010–2018* (1st ed.; Research report, 06/2024). ANROWS. https://www.anrows.org.au/publication/australian-domestic-and-family-violence-death-review-network-filicides/

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

[38] Lelliott, J., Lim, P., & Lu, M. (2021). Dousing threats and the criminal law in Queensland: Do we need a new offence? *Alternative Law Journal*, *46*(4), 282–287. https://doi.org/10.1177/1037969X211029961

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

[40] Douglas, H. (2023). The use of fire and threats to burn in the context of domestic and family violence and coercive control, *Current Issues in Criminal Justice*, *35*(1), 27–47. https://doi.org/10.1080/10345329.2022.2095794

[41]https://www.anrows.org.au/publication/violence-against-women-and-mental-health/

[42] Kelly, L. (2010). The (in)credible words of women: False allegations in European rape research. *Violence Against Women*, *16*(12), 1345–1355. https://doi.org/10.1177/1077801210387748

People who experience mental illness may face barriers to accessing supports due to pervasive stereotypes that accounts provided by people with mental illness are unreliable.[43]

The Board is considering plans to explore the impact of mental illness on service responses provided to women experiencing DFV in a review of suicides of mothers.

[43] Overton, S. L., & Medina, S. L. (2008). The stigma of mental illness. *Journal of Counseling & Development, 86*(2), 143–151. https://psycnet.apa.org/doi/10.1002/j.1556-6678.2008.tb00491.x

Section Four: Domestic and family violence-related homicides 2016–24

Identifying domestic and family violence-related homicides

The DFVDRU, working closely with the Queensland Police Service Coronial Support Unit, identified all homicides occurring in an intimate partner or family relationship in Queensland during 2023–24. The DFVDRU considered all available information to further identify homicides and homicide–suicides occurring in the context of DFV. This includes:

Relationship	Context
Intimate partner, family or informal care relationship	Evidence of a prior history of DFV, whether or not this was reported to police
Child or young person	A child/ren is killed by a parent and there was history of the parent as a perpetrator or victim of DFV
Young person	A young person is killed by an intimate partner where there was evidence of a prior history of DFV
No relationship - collateral or bystander	The person is killed as a result of DFV between others (such as new partner of a former victim–survivor or a person intervening in an episode of DFV)

The DFVDRU adopts the definition of 'homicide' used by the ADFVDRN, which includes 'all circumstances in which an individual's intentional act, or failure to act, resulted in the death of another person, regardless of whether the circumstances were such as to contravene the provisions of the criminal law' (see Appendix B).[44] To account for the specifics of Queensland criminal law, the DFVDRU includes cases in which the charges related to the death are listed as a domestic violence offence, whether or not the DFVDRU holds evidence of prior DFV within the relationship.[45]

There is no universally agreed definition of the behaviours that comprise DFV. Australian definitions include a spectrum of physical and non-physical behaviours including physical assault, sexual assault, threats, intimidation, psychological and emotional abuse, social isolation and economic deprivation. Primarily, DFV is predicated upon inequitable relationship dynamics in which one person exerts power over another. This accords with the definition of family violence contained in the *Family Law Act 1975 (*Cth*)*, which is adopted by the ADFVDRN. The definition of

[44] Australian Domestic and Family Violence Death Review Network (2022), Australian Domestic and Family Violence Death Review Network Data Report: Intimate partner violence homicides 2021–2018, Australia's National Research Organisation for Women's Safety Limited (ANROWS): Sydney, p. 8. https://www.anrows.org.au/publication/australian-domestic-and-family-violence-death-review-network-data-report-intimate-partner-violence-homicides-2010-2018/

[45] Under Queensland's *Criminal Code Act 1899*, a 'domestic violence offence' is an offence under an act which also constitutes an act of domestic violence as defined by the *Domestic and Family Violence Protection Act 2012*; or represents a breach of a domestic violence protection order.

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

To identify DFV-related homicides, deaths flagged as 'domestic violence-related' and/or 'interpersonal violence/apparent homicide' in the Coronial Case Management System are reviewed against the Consensus Statement. Additional deaths identified by the Queensland Police Service Coronial Support Unit and Domestic, Family Violence and Vulnerable Persons Command are also reviewed against the Consensus Statement.

Aligning with the ADFVDRN Consensus Statement criteria, homicides *may* be excluded where there is no prior evidence of DFV, and other factors can be shown to contribute (such as an acute episode of mental illness or a suicide pact).

These processes resulted in the identification of 16 DFV-related homicide events in Queensland in 2023–24,[46] resulting in the deaths of 19 people. These events mostly occurred in metropolitan or inner regional areas of Queensland (6 homicide events in each), three homicide events occurred in outer regional Queensland, one in a remote area.

[46] It is acknowledged that as police and coronial investigations continue, additional cases may be identified for inclusion, and some cases may be excluded as more information becomes available (for example, from agency records, witness statements and police briefs of evidence). This data was correct based on the information available as of 15 July 2024.

Domestic and family violence-related homicides 2023–24

Between 1 July 2023 and 30 June 2024, there were 19 DFV-related homicides in Queensland. Table 4.1 describes the DFV-related deaths in an intimate partner or family relationship that occurred in 2023–24.[47]

Table 4.1: Domestic and family violence-related homicide deaths (2023–24), N=19, 2023–24.[48]

	Intimate partner	Family relationship	Collateral
DFV homicide deceased	**7**	**9**	**3**
Primary victim of DFV status			
Primary victim of DFV	7	6	0
Not primary victim of DFV	0	3	3
Gender			
Female	7	5	1
Male	0	4	2
First Nations status			
Identified as Aboriginal and Torres Strait Islander	1	1	0
Did not identify as Aboriginal and Torres Strait Islander	6	8	3

Two of the 19 homicide victims and one of the 16 homicide offenders identified as Aboriginal or Torres Strait Islander. Five victims and five offenders were from culturally and linguistically diverse backgrounds.

Three of the seven intimate partner homicide victims had been in the relationship for more than 10 years. One had been in the relationship for less than one year. In five of seven intimate partner homicides, the couples were cohabiting at the time of the homicide event. In four of the seven cases, there was actual or pending separation. In three of the separation cases the couple were still cohabiting at the time of the homicide. Planned or actual separation is a known risk factor for intimate partner homicides which has been documented in previous reports by the Board.

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

[48] It is acknowledged that as police and coronial investigations continue, additional cases may be identified for inclusion, and some cases may be excluded as more information becomes available (for example, from agency records, witness statements and police briefs of evidence). This data was correct based on the information available as of 15 July 2024.

Figure 4.1 describes the age of the deceased in DFV-related homicides for 2023–24, with nearly a third (32%, n=6) of the deceased aged 30–39 years.

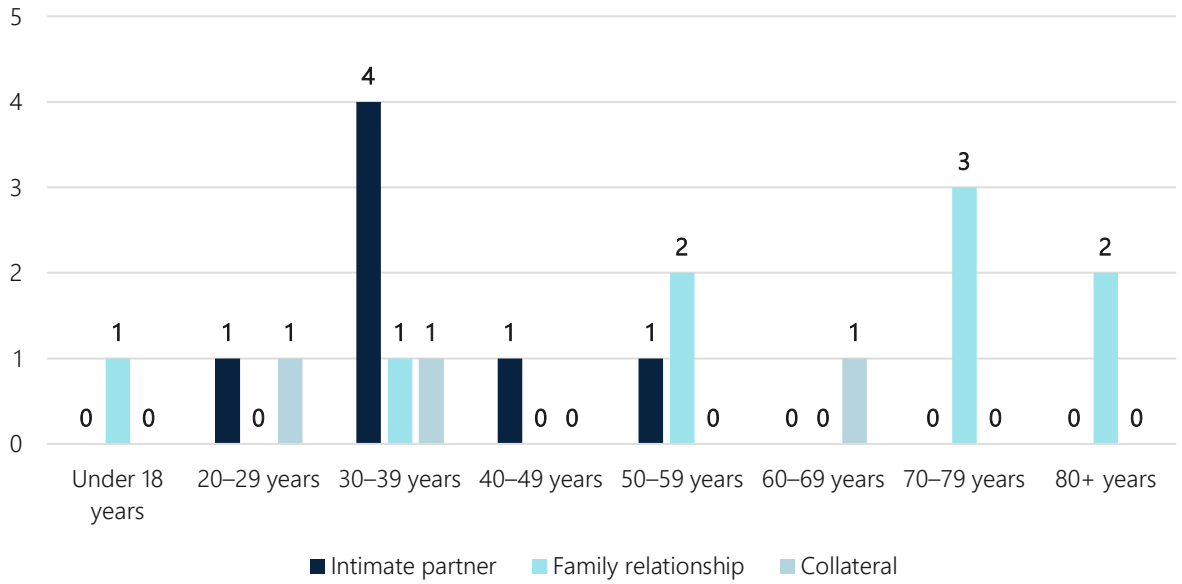

Figure 4.1 Age of primary victim deceased, by DFV-related homicide type, 2023–24.

The gender distribution of victims is different in intimate partner and other family homicide cases with a known history of DFV. Thirteen of the 19 homicide deaths (68%) in 2023-24 were primary victims in a known history of DFV. The other six deaths were either collateral or family member deaths who were not the primary victims of DFV. These included the primary victim's new partner (1), bystanders in a traffic incident (2), children of the primary victim (2), and an extended family member of the perpetrator (1).

One hundred percent of victims in intimate partner homicide cases with a known history of DFV were female.

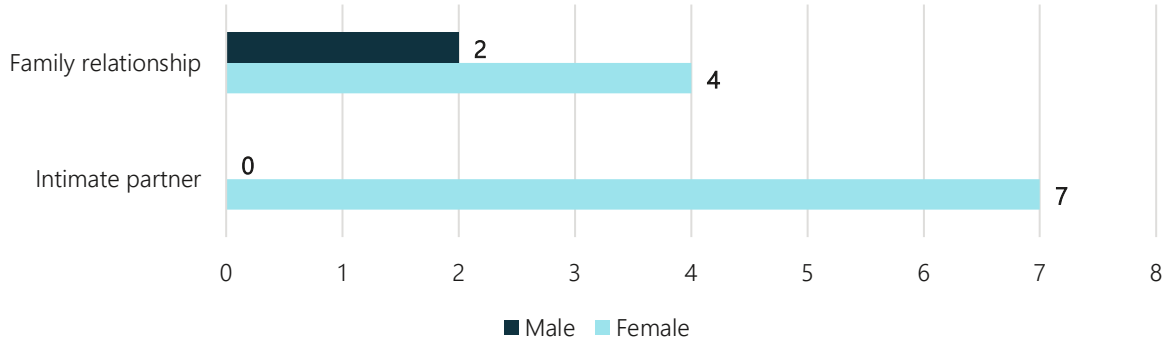

Figure 4.2: Gender of deceased primary victims of DFV by homicide type, 2023–24.[49]

[49] It is acknowledged that as police and coronial investigations continue, additional cases may be identified for inclusion, and some cases may be excluded as more information becomes available (for example, from agency records, witness statements and police briefs of evidence). This data was correct based on the information available as of 15 July 2024.

There were four female victims (66%) and two male victims (33%) in other family violence homicide cases with a known history of DFV. These victims included the sibling of the perpetrator (1), child/ren of the primary victim (4), and the extended family member of the perpetrator (1).

Table 4.2 describes the person using violence in an intimate partner or family relationship that occurred in 2023–24.[50]

Table 4.2: Domestic and family violence-related homicide offenders (2023–24), N=16, 2023–24.[51]

	Intimate partner	Family relationship
DFV homicide offender	**8**	**8**
Person using DFV status		
Persons using DFV	8	7
Persons not using DFV	0	1
Gender		
Female	0	2
Male	8	6
First Nations status		
Identified as Aboriginal and Torres Strait Islander	1	1
Did not identify as Aboriginal and Torres Strait Islander	7	7
Single offender		
Single deceased and single offender	5	7
Multiple deceased and single offender	2	0
Homicide/Suicide	1	1

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

[51] It is acknowledged that as police and coronial investigations continue, additional cases may be identified for inclusion, and some cases may be excluded as more information becomes available (for example, from agency records, witness statements and police briefs of evidence). This data was correct based on the information available as of 15 July 2024.

Homicide offenders ranged in age, but most were in their 30s (5 offenders) and 50s (5 offenders). Only 2 of the 16 homicide offenders were female.

Figure 4.3 shows all the homicide offenders for DFV-related intimate partner homicides were male (n=8). Most homicide offenders for DFV-related family relationship homicides were also male (n=5).

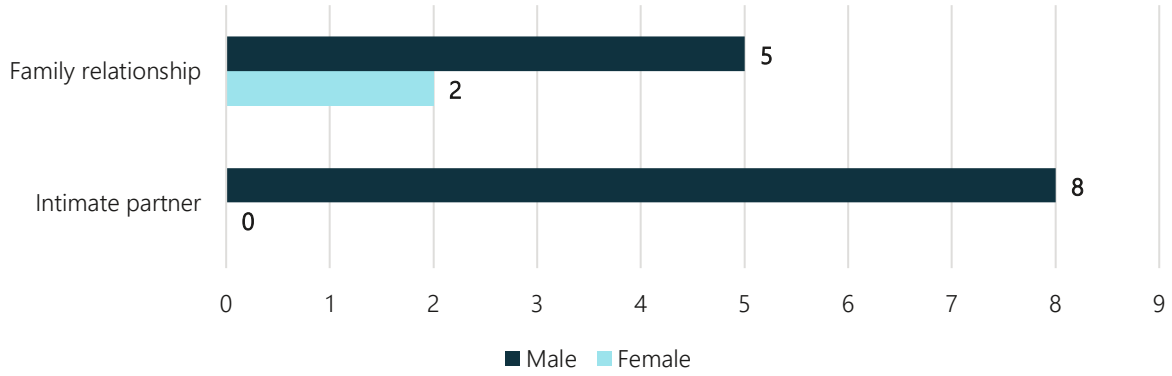

Figure 4.3: Gender of homicide offender by homicide type, 2023–24.

Assault with a sharp weapon was the most frequent mechanism of death for both male and female victims (8 deaths; 5 female victims and 3 male). Neglect-related deaths (failure to provide the necessaries of life) were the next most frequent mechanism (3 deaths). Three people were also killed in a single transport event (1 primary victim and 2 collateral deaths). Figure 4.4 notes mechanism of death, by gender of the homicide victim.

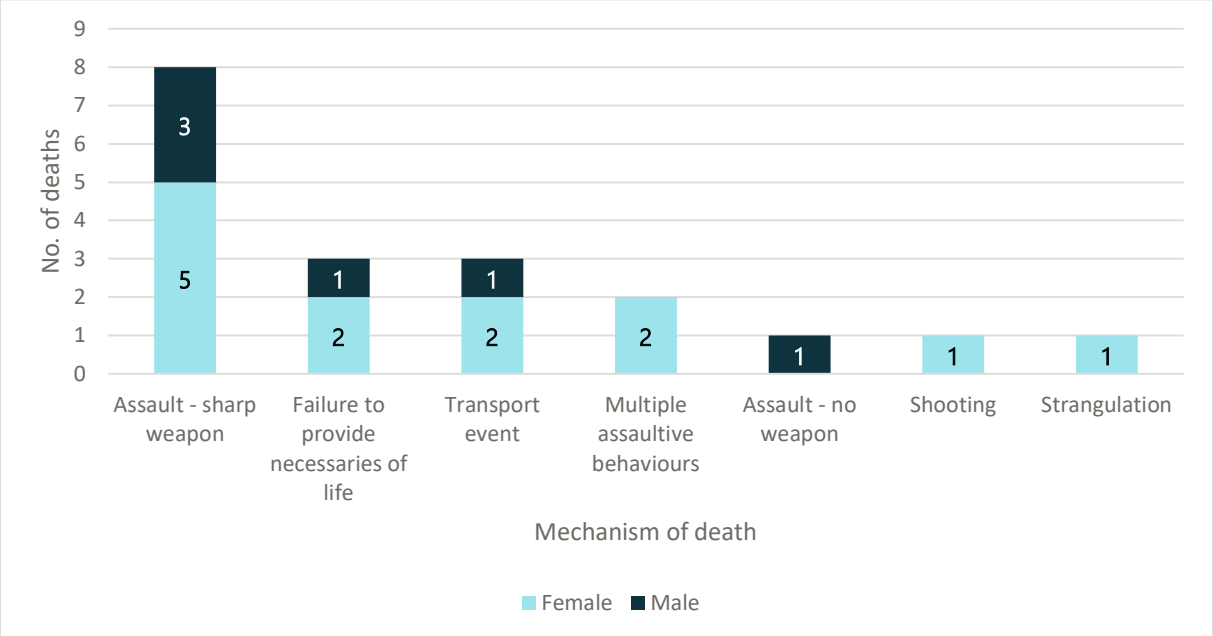

Figure 4.4: Homicide victims by gender and mechanism of death, 2023–24.

The 3 neglect-related deaths in 2023–24 occurred in informal care relationships, in which an elderly person (and/or person with a disability) was being cared for by a family member. In each case, the DFVDRU has identified concerns with the capacity of the carer to undertake this role.

Domestic and family violence-related homicides 2016–24

Between 1 July 2016 and 30 June 2024, there were 183 DFV-related homicides in Queensland. As shown in Figure 4.5, 79 occurred in an intimate partner relationship, 82 occurred in a family relationship and 22 occurred where there was no intimate partner or family relationship between the offender and the deceased, also known as a collateral death.

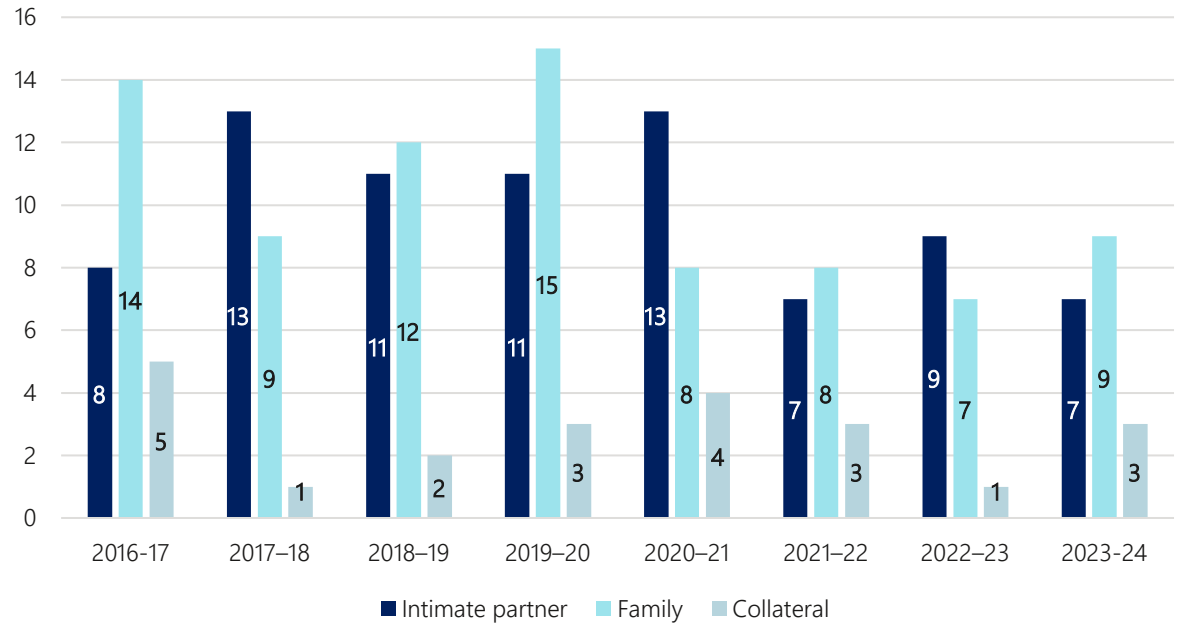

Figure 4.5: DFV-related deaths, by relationship (1 July 2016 to 30 June 24, N=183*)

** It is acknowledged that as police and coronial investigations continue, additional cases may be identified for inclusion, and some cases may be excluded as more information becomes available (for example, from agency records, witness statements and police briefs of evidence). This data was correct based on the information available as of 15 July 2024.*

What the data tells us about domestic and family violence-related homicides in Queensland

The Queensland data on DFV homicides reveals several important trends and features which correspond with current research and national data. The significant trends are highlighted below.

Prevalence

DFV-related homicides are a substantial contributor to homicides in Queensland. The data shows that many homicides in the state are linked to DFV, with a notable percentage of these deaths occurring within intimate partner relationships or family relationships. It is also worth noting that while numbers fluctuate year on year, there has not been a significant decrease in several years.

Gendered nature

Women and their children remain disproportionately affected by DFV-related homicides. Victims of DFV homicides are predominately women, often in an intimate partner relationship with the PUV. Several children were also victims of DFV-related homicides. Conversely, most DFV-related homicide offenders were men, who were often the current or former partners of the victims.

Lethality indicators

There are some consistent factors that are present and indicate a high risk of homicide, including:

- Previous history of DFV, including previous non-fatal violence or threat. There were often existing protection orders in place.
- In an intimate partner relationship context, the separation or threat of separation.
- Other factors such as substance abuse and mental health concerns.

Response and prevention

Queensland Government is currently implementing several strategies to address DFV, including legislative reforms, specialised response team and courts, an increase in funding to frontline services and workforce development. There is also an ongoing program of evaluation to assess the effectiveness of the strategies.

With the aim of shifting attitudes towards DFV, community awareness and education campaigns were implemented across Queensland. The campaign focussed on improving the detection of abuse, increasing support for victims, and holding perpetrators accountable.

Data collection and analysis

Continuous improvement in the collection of data relating to DFV-related homicides in Queensland remains important to build system improvement. The Board is committed to continuing the comprehensive data collection and analysis efforts, with the DFVDRU maintaining the databases about DFV-related deaths in Queensland. This data provides patterns and causes for homicides, to support system improvement.

Appendices

Appendix A: Remuneration of the Board

Domestic and Family Violence Death Review and Advisory Board					
Act or instrument	*Coroners Act 2003 (Qld)*				
Functions	Review DFV deaths				
Achievements	In 2023–24, the Board met on eight occasions, including two meetings to prepare the 2022–23 Annual Report, two meetings to reframe the role and focus of the Board, three case review meetings and one data meeting. A total of 35 cases were reviewed in this period involving 50 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	Meeting/ sessions attendance	Approved fee per meeting attended	Approved sub-committee fees if applicable	Actual fees received [52]
Chair	Stephanie Gallagher*	6	$300	N/A	N/A
Deputy Chair	Nadia Bromley	8	$300	N/A	$2,700
Member	Julia De Boos[53]*	3	$300	N/A	N/A
Member	Kristina Deveson*	7	$300	N/A	N/A
Member	Molly Dragiewicz	6	$300	N/A	$2,100
Member	Christopher Jory[54]*	3	$300	N/A	N/A
Member	Keryn Ruska	7	$300	N/A	$2,100
Member	Kylie Stephen*	6	$300	N/A	N/A
Member	Paul Stewart*	6	$300	N/A	N/A
Member	Brian Sullivan[55]	3	$300	N/A	$900
Member	Betty Taylor[56]	3	$300	N/A	$1,200
Member	Belinda Drew[57]*	0	$300	N/A	N/A
Member	Aletia Twist	0	$300	N/A	N/A
Member	Ben Bjarnesen*	0	$300	N/A	N/A
No. scheduled meetings/sessions	Eight (8)				
Total out of pocket expenses	$1,119.28 ex GST				

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

[52] Payments for the 29 June 2023 meeting were not processed until 2023–24 and are therefore reflected in remuneration expenses for 2023–24. Nadia Bromley, Molly Draiewicz and Betty Taylor received these payments.

[53] Dr De Boos was appointed to the Board in February 2024.

[54] Assistant Commissioner Jory was appointed to the Board in February 2024. Prior to his appointment, he attended two meetings as an expert advisor.

[55] Dr Sullivan was appointed to the Board in February 2024.

[56] Betty Taylor resigned from the Board in March 2024.

[57] Belinda Drew, Aletia Twist, and Ben Bjarnesen were appointed to the Board in July 2024 and did not attend a meeting this financial year.

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

Background and purpose

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

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

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

- improve knowledge regarding the frequency, nature, and determinants of domestic and family violence deaths;
- identify practice and system changes that may improve outcomes for people affected by domestic and family violence and reduce these types of deaths;
- identify, collect, analyse, and report data on domestic and family violence related deaths;[58]
- 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 2022–2032*.[59]

Definitions

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

[58] See: https://www.anrows.org.au/project/australian-domestic-and-family-violence-death-review-network-national-data-update/

[59] Commonwealth of Australia (2022). National Plan to End Violence against Women and Children 2022–32. https://www.dss.gov.au/ending-violence

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.'[60]

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 DFV homicide incidents is conducted both retrospectively and prospectively.

Categorisation

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

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

Consideration 1: Case Type

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

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

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

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 (for example, 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

Intent	Definition	Inclusion
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. It is acknowledged that the member jurisdictions operate within the following legislative frameworks:

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

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

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

Relationship type	Definition	Inclusion
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 DFV homicides and are subject to review by each jurisdiction.

Each jurisdiction can also review deaths where no direct domestic relationship exists between the deceased and PUV, but the death nonetheless occurs in a context of DFV. For example, this might 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 constitute a DFV homicide. In these deaths, other situational factors determine the fatal incident, such as the PUV experiencing an acute mental health episode. These deaths do not feature many of the characteristics known to define DFV, such as controlling, threatening or coercive behaviour; having previously caused the other person to feel fear; or evidence of past physical, sexual, or other abuse.

Appendix C: Glossary of terms

Term	Description
Aggrieved	The person for whose benefit a domestic violence protection order, or Police Protection Notice, is in force under the *Domestic and Family Violence Protection Act 2012* (Qld).
ANROWS	Australian National Research Organisation for Women's Safety.
Apparent suicide	In Queensland, only an investigating coroner can determine that a death is a suicide after considering all the information they have gathered as part of their investigation. Until a coroner has made their findings, these deaths are referred to as 'suspected' or 'apparent' suicides.
Coercive control	An ongoing pattern of behaviour asserted by a PUV that is designed to induce various degrees of fear, intimidation, and submission in a victim.[61] 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-law	When two adults live together in a marriage-like relationship but are not legally married. The couple can be either same sex or opposite sex. This is also known as a de facto relationship.[62]
Deceased	The person/s who died.
DFVPA 2012	*Domestic and Family Violence Protection Act 2012 (Qld)*.
Domestic and family violence (DFV)	DFV is 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

[61] Johnson, M. (2008). *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance and Situational Violence*. Boston: University Press of New England.
[62] Family Law Act 1975, section 4AA.

Term	Description
	recognises that although there is no universally agreed definition of the behaviours that comprise DFV, in Australia it includes a spectrum of physical and non-physical behaviours including physical assault, sexual assault, threats, intimidation, psychological and emotional abuse, social isolation and economic deprivation. Primarily, DFV is predicated upon inequitable relationship dynamics in which one person exerts power over another. This accords with the definition of family violence contained in the *Family Law Act 1975* (Cth), which is adopted by the Network. The definition of homicide adopted by the National Network is broader than the legal definition of the term, and includes all circumstances in which an individual's act, or failure to act, resulted in the death of another person, regardless of whether the circumstances were such as to contravene provisions of the criminal law.
Emotional or psychological abuse	Behaviour by a person towards another person that torments, intimidates, harasses or is offensive to the other person.
Episodes of violence	Describes the series of events characterising this type of violence. Referring to episodes of violence (as opposed to 'incidents', for example) allows practitioners to consider the repetitive nature of violence perpetration and victimisation, exposing the ongoing vulnerabilities of victims and cumulative risk that PUV pose both within, and across, relationships.
Filicide	The killing of a child/ren by a parent or caregiver who was under the age of 18 years at the time that they died.
Financial abuse	Behaviour by a person that is coercive, deceptive, or unreasonably controls another person without the second person's consent in a way that denies economic or financial autonomy, or by withholding or threatening to withhold financial support necessary for meeting reasonable living expenses if the first person is predominantly or entirely dependent on the first person financially.
High Risk Teams	Seek to support the delivery of coordinated, consistent and timely responses to prevent serious harm or death in cases where victims and their children are assessed as being at high risk. Participating agencies across the service system will work together to enhance victim safety, monitor the high risk posed by the PUV, and implement strategies that seek to hold the PUV to account through appropriate information sharing, comprehensive risk assessment and informed safety planning, and increased agency accountability. In Queensland, the funded High Risk Teams form part of the

Term	Description
	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.
Homicide offender	The person whose actions, or inaction, caused the person (the deceased) to die, also known as the person using violence.
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.
Intimate Partner Sexual Violence (IPSV)	Intimate partner sexual violence (IPSV) refers to sexual violence which occurs within an intimate partner relationship (current or former). Broadly, IPSV encompasses a broad range of sexually based violence that includes but is not limited to: • sexual assault, or rape as defined under Section 349 of the *Criminal Code*.[63] • sexual coercion used to manipulate a person into unwanted sexual penetration.

[63] *(1) Any person who rapes another person is guilty of a crime.*
Maximum penalty—life imprisonment.
(2) A person rapes another person if—
(a) the person engages in penile intercourse with the other person without the other person's consent; or
(b) the person penetrates the vulva, vagina or anus of the other person to any extent with a thing or a part of the person's body that is not a penis without the other person's consent; or
(c) the person penetrates the mouth of the other person to any extent with the person's penis without the other person's consent.
(3) For this section, a child under the age of 12 years is incapable of giving consent.
(4) The Penalties and Sentences Act 1992, section 161Q states a circumstance of aggravation for an offence against this section.
(5) An indictment charging an offence against this section with the circumstance of aggravation stated in the Penalties and Sentences Act 1992, section 161Q may not be presented without the consent of a Crown Law Officer.

Term	Description
	• sexual abuse, including the use of emotionally manipulative tactics aimed at controlling a women's sexuality, sexual health, or image-based abuse. • forced sexual activity, or physical violence that occurs within the sexual realm of a relationship, including forced non-penetrative sexual contact such as fondling, using or threatening to harm the primary victim's sexual organ (i.e., cutting a breast with a knife), and sexual violence with masturbation (i.e., being held down and masturbated on or focusing one's hand to assist in masturbation). • sexual jealousy.
Lethality risk indicators	DFV death review processes are based on the premise that there have been warning signs, and key indicators or predictors of harm, prior to the death. These indicators, such as a noted escalation in violence, non-lethal strangulation or real or impending separation, have been found to have been associated with an increased risk of harm in relationships characterised by DFV.
Person using violence (PUV)	The person who was the aggressor in the relationship prior to the death and who used abusive tactics to control the victim.
PUV interventions	Typically refers to specific programs (for example, behaviour change programs) for PUV of DFV. These interventions generally seek to change men's attitudes, beliefs, and behaviour to prevent them from engaging in violence in the future.[64]
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 DFV is occurring or has occurred. A PPN requires the respondent to be of good behaviour towards the aggrieved and may include other conditions stopping the respondent from having contact with the aggrieved. A PPN is taken to be an application for a protection order made by a police officer.

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

Term	Description
Primary victim (PV)	This is the person who was subjected to DFV in a relevant relationship prior to the homicide event. This could be the homicide deceased, homicide offender, homicide–suicide offender/deceased, and surviving victim.
Protection order	As defined by Part 3 of the *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 DFV.
Relative	Individuals, including children, related by blood, a domestic partnership or adoption. This includes family-like relationships and explicitly includes extended family-like relationships that are recognised within that individual's cultural group. This includes: a child, stepchild, parent, step-parent, sibling, grandparent, aunt, nephew, cousin, half-brother, or mother-in-law.
Relevant relationship	As defined by section 13 of the *Domestic and Family Violence Protection Act 2012*, includes an intimate partner relationship, family relationship or informal care relationship.
Reproductive Coercion	This refers to behaviours that interfere with women's reproductive autonomy, typically involving attempts to control when and under what circumstances they become pregnant, as well as controlling pregnancy outcomes.[65]
Respondent	A person against whom a domestic violence protection order, or a police protection notice, is in force or may be made under the *Domestic and Family Violence Protection Act 2012*.
Risk assessment	A comprehensive evaluation that seeks to gather information to determine the level of risk and the likelihood and severity of future violence. Levels of risk should be continually reviewed through a process of ongoing monitoring and assessment.
Risk management	An approach to respond to and reduce the risk of violence. Risk management strategies should include safety planning, ongoing risk assessment, plans to address the needs of victims through relevant services (for example, legal, counselling) and liaison between services utilising appropriate information sharing processes.

[65] Boxall, H., & Morgan, A. (2021). Intimate partner violence during the COVID-19 pandemic: A survey of women in Australia (11; Special Report). ANROWS. https://www.aic.gov.au/publications/special/special-11

Term	Description
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 DFV including health and mental health services, child protective services, police, corrections, court services, housing services and DFV services.
Sexual jealousy	Is a type of jealousy evoked in response to an actual or perceived threat of sexual infidelity.
Special Taskforce on Domestic and Family Violence in Queensland (the Special Taskforce)	Established on 10 September 2014 to define the DFV landscape in Queensland and make recommendations to inform the development of a long-term vision and strategy to stop domestic and family violence, the Special Taskforce's Final Report, *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland* (2015), made 140 recommendations that have now been implemented.
Specialist domestic and family violence services	Services designed to provide frontline support and resources to individuals affected by DFV (for example, victim services, women's refuges, PUV intervention programs).
Victim	The person who was the primary victim of DFV in the relationship and the person most in need of protection.
Women's Safety and Justice Taskforce (the Taskforce)	Was established as an independent, consultative taskforce by the Queensland Government to examine coercive control and review the need for a specific offence of domestic violence and the experience of women across the criminal justice system. The Taskforce has reported twice—in 2021 and 2022.

Appendix D: Queensland Government Response to the Domestic and Family Violence Death Review and Advisory Board 2022–23 Annual Report

The Domestic and Family Violence Death Review and Advisory Board 2022–23 Annual Report contained no recommendations.

The Queensland Government response to the Board's 2022–23 Annual Report was received on 22 July 2024. The Attorney-General and Minister for Justice and Minister for the Prevention of Domestic and Family Violence wrote to the Deputy Sate Coroner and Board Chair Stephanie Gallagher acknowledging the Board's 2022–23 Annual Report and the role of the Board in contributing to and shaping the ongoing reform in Queensland.[66]

[66] See: https://www.coronerscourt.qld.gov.au/dfvdrab/annual-reports-and-government-responses

Queensland Government