Family Violence Death Review Committee

First Annual Report to the Minister of Health October 2008 to September 2009

Ngā mate aituā o tātou
Ka tangihia e tātou i tēnei wā
Haere, haere, haere.

The dead, the afflicted, both yours and ours
We lament for them at this time
Farewell, farewell, farewell.

Acknowledgements

At the time of writing, 41 people have died in New Zealand during 2009 as a result of family violence. We acknowledge each life and the heartbreak felt by their families, whānau and wider communities. As a committee, we make a commitment to learn the lessons from each tragedy, to develop and share solutions with local communities, and to work together to prevent and reduce family violence in Aotearoa New Zealand.

The Family Violence Death Review Committee is grateful to the following groups and individuals for assisting the Committee in its establishment phase and in the production of this report:

- the Mortality Review Secretariat within the Ministry of Health, in particular Aphra Green, Shelley Hanifan and Trina Tautau
- the Child and Youth Mortality Review Committee, in particular Nick Baker, Terry Sarten and Candy Cookson-Cox
- Committee advisors – Alana Ruakere (Māori Advisor, Ministry of Health), Craig Walker (Ministry of Justice), Ged Byers (New Zealand Police), Karen Vaughan (Office of the Chief Coroner), Kelly Anderson (Office of the Chief Social Worker, Child, Youth and Family), Mark Barrett (Ministry of Health), Nicola Johnston (Office of the Children's Commissioner)
- the New Zealand Police, in particular Win van der Velde, Gavin Knight and Obert Cinco
- the mortality review committees' Māori Caucus
- Jennifer Martin, Ministry of Social Development researcher.

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Chairperson's Introduction

So far in 2009 41 New Zealanders have been killed directly by members of their own family: 16 children, 13 women and 12 men. This toll does not include victims of ongoing abuse who have committed suicide as a result of the abuse, or non-family members killed when they bravely intervened to try to stop a family violence incident.

It is particularly shocking when a person is killed by a member of their own family. The life of the victim is ended by the very person from whom the victim expects love, support and protection.

Compared to other countries New Zealand has high rates of family violence generally, and family violence deaths in particular. Each year between one-third and one-half of all homicides in New Zealand are family violence deaths. Māori are disproportionately affected. Tragically, numbers of family violence deaths appear to be increasing rather than decreasing.

In many cases media reports state that the death came as a surprise to others and there had been no indication of problems within the family. On closer investigation the truth is usually otherwise: family violence deaths are almost never 'out of the blue'. In most cases there have been repeated prior incidents of violence and indicators of risk, as well as opportunities for agencies and individuals to intervene before the death. Family violence deaths are preventable.

The overarching goal of the Family Violence Death Review Committee is to contribute to the prevention of family violence and family violence deaths. Reviewing the specific circumstances of family violence deaths at both the local and national level will enable the Committee to identify specific measures, and develop strategic plans and workable systems, to prevent future deaths. There will be an emphasis on local and community initiatives as well as national initiatives.

Since 1990 family violence death review teams have been established in many states and communities in the United States, Canada and the United Kingdom, with a focus on preventing future deaths. Over time the number of family violence deaths in many of these areas has fallen, in some cases dramatically.

Under its ministerial Terms of Reference the Committee's task in its first year of operation has been to address establishment issues, and in particular to set up information-gathering and death-review structures and processes. At times our progress has been frustratingly slow because of other resourcing priorities within the Ministry of Health this year, but we are now poised to commence pilot reviews. By the end of 2010 the Committee aims to be able to: review every family violence death; formulate initial recommendations at the local and national level for system, policy and practice improvements to prevent future deaths; and begin the development of strategic plans to reduce the occurrence of family violence deaths.

The Family Violence Death Review Committee is a multidisciplinary committee whose members have many years of in-depth experience across a wide range of family violence prevention services. This Committee was established because many people who are committed to ending family violence have worked very hard over many years to put in place a family violence death review structure and process, with the intention that this would make a real difference. I would like to thank all the Committee members for their many hours of hard work, for freely contributing their exceptional knowledge and expertise, and for

their ongoing support to me as Chair. I acknowledge your deep personal and professional commitment to ending family violence and to making the difference.

I would also like to thank the Ministry of Health Mortality Review Committees' secretariat for their support, hard work and commitment.

Wendy Davis
Committee Chairperson

Executive Summary

Context

In reading this report the following contextual information surrounding family violence in Aotearoa New Zealand should be considered.

- Each year up to half of all murders in New Zealand are family violence related.
- On average, 14 women, six men and 10 children are killed as a result of family violence each year.
- In 2007 the New Zealand Police identified 63 culpable[1] deaths, of which 26 were family violence related. In 2008 there were 65 identified culpable deaths, of which 19 were family violence related.
- Police recorded more than 80,000 family violence events in 2008.
- It is estimated that only 18 percent of family violence cases are reported to police.
- In 1995 family violence in New Zealand had an estimated economic cost of between $1.2 and $5.8 billion per annum (Snively 1995)[2].
- The average cost of a homicide in New Zealand is $4 million (Roper and Thompson 2006). This would put the cost of family violence deaths in 2007/08 at an estimated $180 million.
- Māori women receive higher levels of medical treatment for abuse, and that abuse is of greater severity (Kruger et al 2004).
- Māori children are four times more likely to be hospitalised for injuries sustained as a result of deliberately inflicted physical harm (Kruger et al 2004).

Establishment of the Family Violence Death Review Committee

The Family Violence Death Review Committee was established in 2008 with support from community and family violence agencies following a recommendation by the Taskforce for Action on Violence within Families and support from the family violence sector. The Committee is located in the Ministry of Health and operates in close collaboration with the Ministries of Justice and Social Development, the New Zealand Police, and other key government and community agencies. The Committee is a ministerial committee set up under the New Zealand Public Health and Disability Act 2000 and is accountable to the Minister of Health.

In July 2008 the Committee was appointed by the Minister of Health and it met for the first time in October 2008. The Committee's overarching goal is to contribute to the prevention of family violence and family violence deaths. It will contribute to making communities safer by developing strategic plans to reduce family violence, and by reporting and making recommendations at a local and national level on systems, policy and practice improvements to reduce and prevent family violence deaths. The objectives for the first year involved setting up a local death review system and data collection protocols.

1 Murder, manslaughter or infanticide

2 This is the latest estimate available to the Committee

Key achievements for 2008/09

The ministerial Terms of Reference set out seven key objectives for the Committee to address in the first year. Below is a table of the key objectives and the Committee's achievements.

Table 1: The FVDRC's seven key objectives for 2008/09 and achievement against these

Objective	Achievements
Objective 1	
Develop mechanisms and protocols for family violence death reviews	The Committee has: • considered death review models and processes • consulted with, and received submissions from, key stakeholders on the family violence death review process • commenced pilot reviews • addressed legal, privacy and security issues with Health Legal, and received expert legal advice • decided on an interim process for local death reviews.
Objective 2	
Determine the availability, reliability and validity of existing data collection processes	The Committee has: • established a system for the Police to notify the Committee of family violence deaths • identified organisations that will provide information to the Family Violence Death Review database and the type of data collected • established a trial system for collecting information.
Objective 3	
Decide on definitions to be used for each piece of data during collection, analysing and reporting	The Committee has: • established a Data Working Group • developed a database prototype consistent with World Health Organization guidelines • researched definitions.
Objective 4	
Establish functional relationships with specified organisations	The Committee has established functional relationships with: • key organisations/stakeholders • relevant government departments • advisors (Ministry of Social Development, Ministry of Justice, Ministry of Health, New Zealand Police, Office of the Children's Commissioner, Chief Coroner's Office) • other mortality review committees.
Objective 5	
Establish processes to ensure secure storage of information	The Committee has: • developed and implemented protocols for securing information • developed information destruction procedures.

Objective 6	
Determine how the Committee will operate in a culturally appropriate, sensitive and responsive manner	The Committee has: • developed ongoing advice from Māori Committee members and Ministry of Health advisors • supported the mortality review committees' Māori Caucus • obtained ongoing cultural advice and input at all development stages.
Objective 7	
Establish processes to deal with stressful material	The Committee has: • received advice from a trauma specialist • discussed processes for monitoring the wellbeing of Committee members.

Goals for 2009/10

In 2009/10 the Family Violence Death Review Committee will:

- complete pilot reviews to ensure the integrity of the review process and the reliability of data collection
- further develop the family violence death review process
- refine processes for responsible agencies and local groups to 'take back the learnings' of the review process to their organisation and implement change at a local and/or national level
- appoint a lead co-ordinator to facilitate family violence death reviews
- establish a fully functioning data collection and resource information system to report on and analyse family violence deaths, while ensuring strict security protocols are in place
- engage with local communities in the family violence death review process
- engage with Māori at national and local levels to ensure that culturally appropriate and effective reviews occur and that Māori are involved in the family violence death review process
- establish relationships across sectors and communities so that any future work fits within the framework of whānau ora
- engage with appropriate cultural specialists in each death review case
- establish clear and safe protocols for the involvement of family and whānau
- establish protocols and tools to assist the Committee and its representatives in dealing with stressful materials
- continue to develop relationships with the family violence sector, government agencies/ organisations, key stakeholders and the community.

By the end of 2010 the Committee, subject to resourcing, expects to have a fully functioning database and to be able to review each family violence death within six months of the death occurring.

Recommendations

The Committee recommends that the Minister of Health:

Recommendation 1:	confirm his ongoing support for the Family Violence Death Review Committee and its work during the establishment phase
Recommendation 2:	request from his colleagues that they ensure all government organisations are supporting the Family Violence Death Review Committee and its processes by providing requested information as quickly as possible
Recommendation 3:	request that the Ministry of Health support the development of an information system that meets the needs of the Family Violence Death Review Committee
Recommendation 4:	continue to support the Family Violence Ministerial Group and the Taskforce for Action on Violence within Families.

Family Violence in New Zealand

Family violence is a global problem affecting all cultural, religious and economic groups and is caused by a multitude of complex factors (Māori Reference Group for the Taskforce for Action on Violence within Families 2009). The US, Canada, Australia and the UK already have family violence death review mechanisms.

New Zealand has unacceptably high rates of family violence and family violence deaths, including violence against women, child abuse and neglect, and elder abuse. Snively (1995) estimated that family violence affected one in seven New Zealanders, with an estimated total economic cost of $1.2 to $5.8 billion per annum.

Each year between one-third and one-half of cases investigated by the Police as homicide are perpetrated by a member of the victim's family or a person with some other close relationship. In the five-year period from 2000 to 2004 there were 121 family violence cases investigated by the Police as murder, of which 56 victims were women, 39 were children (under 17) and 26 were men (Taskforce for Action on Violence within Families 2006).

The New Zealand Police identified 65 culpable deaths in 2008, 63 in 2007 and 53 in 2006. Of these, 19, 26 and 25 were classified as family violence related, respectively. At the time of writing[3] the Committee had identified 41 family violence deaths for 2009.

Family violence deaths cause significant public concern and create significant costs in both personal and financial terms. It is estimated that, on average, each homicide costs New Zealand $4 million (Roper and Thompson 2006), putting the estimated cost of 2007/08 family violence deaths at $180 million.

Table 2: Family violence deaths, 2006–2009

	2006	2007	2008	2009
Culpable deaths	53	63	65	To be advised
Family violence deaths	25	26	19	41*

Note: The table shows culpable deaths and family violence deaths identified by the New Zealand Police.

* Preliminary count of family violence deaths identified by the Committee at the time of writing this report.

Contributing to the prevention of family violence deaths

Over the last decade family violence agencies have strongly advocated for the establishment of a family violence death review process in New Zealand to learn the lessons from these preventable deaths and to make recommendations to reduce and prevent family violence deaths in the future.

The Taskforce for Action on Violence within Families established in 2005 supported the death review process as a means of identifying systems, policy and practice improvements, and for developing strategic plans to reduce and prevent family violence deaths. The Taskforce gave the Ministry of Health responsibility for designing a process to review family violence-related deaths by 2007, consistent with a public health approach to preventing family violence.

3 16 December 2009.

The Ministry of Health established a cross-agency Family Violence Death Review Project and recommended that a multidisciplinary family violence death review system be established under the New Zealand Public Health and Disability Act 2000.

In July 2008 the Family Violence Death Review Committee was appointed by the Minister of Health, and the first meeting was held in October 2008. The Committee's ultimate goal is to make our communities safer by reducing family violence and preventing family violence deaths. The Committee's priorities in its first year have been to put systems in place to review local family violence death and data collection.

Definitions of family violence death and family violence death review

Family violence death is defined in the Terms of Reference as:

> The unnatural death of a person (adult or child) where the suspected perpetrator is a family or extended family member,[4] caregiver,[5] intimate partner, previous partner of the victim, or previous partner of the victim's current partner.

The following categories of deaths are initially excluded from this definition:

- suicides
- assisted suicide (based on pact)
- deaths from chronic illness resulting from sustained violence
- accidental deaths related to family violence incidents.

A family violence death review is a systematic analysis of the lives of victims, perpetrators and their families, and the events leading up to and the factors surrounding death(s), by a combination of agencies and disciplines in a confidential and culturally safe environment. The purpose of the review is to identify changes or enhancements to systems, policies and services that may contribute to the prevention of family violence deaths. All family violence deaths, both adult and child, will be reviewed by the Committee.

The family violence death review process is expected to start in early 2010, once a lead co-ordinator is engaged.

A formal review of the Committee's Terms of Reference, including the definitions, will be undertaken at the end of 2011. The Committee foresees widening the scope of the definition in the future to include other family violence-related deaths (eg, suicide as a result of family violence) and morbidity.

Focus, function and guiding principles

The Family Violence Death Review Committee (the Committee) is bound by the relevant sections in the New Zealand Public Health and Disability Act 2000 and by the Committee's Terms of Reference. These provide the Committee with broad powers to collect information on family violence deaths and impose commensurate strict confidentiality obligations on the Committee.

The Committee is directly responsible to the Minister of Health and is expected to give advice and report directly to the Minister independent of any government departments, professional bodies or other agencies.

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4 'Family or extended family member' is used in the broadest sense and includes whānau, hapū, mother, father, child, sibling, grandparent, aunt, uncle, step-parent, foster-parent etc.

5 'Caregiver' refers to a person living in a 'domestic' relationship with, and providing care for, the victim.

The overarching goal of the Committee is to reduce and prevent family violence deaths by:

- reviewing and reporting to the Minister on family violence deaths, with a view to reducing the numbers of family violence deaths, and to maintaining continuous quality improvement through the promotion of ongoing quality assurance programmes
- developing strategic plans and methods that are designed to reduce family violence morbidity and mortality, and that are relevant to the Committee's functions
- advising on any other matters related to family violence deaths the Minister specifies.

When undertaking its functions, the Committee will:

- be sensitive to, and respectful of, victims and their families, and minimise the revictimisation and trauma that death reviews may cause
- keep information and data secure, and protect confidentiality
- operate in a culturally appropriate, sensitive and responsive manner
- be objective and impartial, and have a systemic focus on learning in order to improve/enhance current and future systems, policy and practice
- develop, enhance and foster inter-agency collaboration, trust and networking in the family violence sector
- formulate clear, meaningful and practical recommendations, developed from a 'non-blaming' perspective
- support and protect individual and agency death review participants
- ensure that local family violence death review processes are undertaken in accordance with the values and principles set out in the Committee's terms of reference
- develop mechanisms for organisations and communities to 'take back lessons learnt'.

In order to fulfil its functions, the Committee will:

- report and make recommendations at a local and national level on system, policy and practice improvements to contribute to the reduction of family violence deaths
- monitor the number, categories and demographics of family violence deaths
- identify patterns and trends in family violence deaths over time
- make available to researchers data about family violence deaths within the privacy and confidentiality restrictions of the Committee
- liaise with any other mortality review committees appointed by the Minister to assist, on mutual agreement, with reviews of deaths that are within the scope of those other committees.

The Committee is supported and advised on process matters by a secretariat based in the Ministry of Health.

Membership of the Committee

The Committee met for the first time in October 2008.

Committee members have expertise and experience in:

- the causes and dynamics of family violence and risk assessment
- mortality review systems
- social science and health research
- social work and family violence case work
- service provision and operational policy in the enforcement and social sector
- child abuse and protection issues
- the health sector, including paediatrics, primary health provision and clinical psychology
- family violence law
- family violence issues from a service user/family perspective.

The Committee's membership includes:

- Māori members with knowledge of family violence issues, or experience working with Māori families affected by family violence
- other ethnic group members with knowledge of family violence issues, or experience in working with families affected by family violence.

The Committee is also supported by advisors from the Ministries of Health, Social Development and Justice; the New Zealand Police; the Office of the Children's Commissioner; and the Office of the Chief Coroner.

Key Achievements for 2008/09

The Committee's Terms of Reference specify key objectives for the Committee to address in its first year. The Committee achieved good progress on these objectives within the constraints of limited resourcing and will continue to build on its achievements in the 2009/10 year.

For several months the Committee did not have dedicated secretariat support, and this significantly slowed progress. There has been a lack of resourcing for the establishment of a database and the Committee has not had a lead co-ordinator to organise review meetings at a local level. Both of these factors significantly impeded the Committee's work and progress for the last six months of 2009. Fortunately, the expertise and dedication of Committee members has enabled key tasks to be achieved. The Ministry has now provided capable and dedicated secretariat support and progress has been good.

The objectives for 2008/09 are summarised below.

Table 3: The FVDRC's key objectives for 2008/09

Objective 1
Develop mechanisms, policies and protocols for family violence death reviews at local and national levels.
Objective 2
Determine the availability, reliability and validity of existing data collection processes within other organisations.
Objective 3
Decide on definitions to be used for each piece of data during collection, analysing and reporting.
Objective 4
Establish and maintain functional relationships with: • the National Health Epidemiology and Quality Assurance Advisory Committee • the Child and Youth Mortality Review Committee and the Perinatal and Maternal Mortality Review Committee • new and existing local non-statutory mortality review groups • other agencies who conduct family violence mortality reviews • other key stakeholders in the family violence sector.
Objective 5
Establish processes to ensure security of 'information', as that term is defined in clause 3 of Schedule 5 of the New Zealand Public Health and Disability Act 2000.
Objective 6
Determine how the Committee will operate in a culturally appropriate, sensitive and responsive manner.
Objective 7
Establish processes to ensure Committee members will be well supported, such as offering opportunities for confidential counselling, due to the potentially distressing nature of some of the material to be considered by the Committee.

Objective 1:
Develop mechanisms and protocols for family violence death reviews

Consultation

In July 2009 the Committee sent out a consultation document on the proposed family violence death review process to key stakeholders. The Committee wished to hold consultation meetings but was not resourced by the Ministry of Health to do so. The consultation document aimed to engage and facilitate feedback from the family violence sector indicating the high level of interest and support for the Committee's work.

The Committee received over 40 submissions, which were detailed, thoughtful and appropriately challenging, and were obviously the result of in-depth consideration by the agencies concerned. An initial analysis of the feedback was presented at the September meeting, and a comprehensive analysis of the large amount of feedback was carried out in early October. The findings will be taken into account in developing a review process.

The consultation process identified support for the involvement of family/whānau in the review process. The Committee realises it will need to carefully consider how this is achieved. The Committee agrees involvement will need to be done in a careful manner so that the families/whānau are not revictimised at any stage and they are made aware that the purpose of the death review is a 'no blame' process.

In order for the Committee to involve families/whānau in the death review process, the Committee feels the need for the family/whānau to be provided with enough support after a family violence death occurs. This will require the collaboration of all agencies/organisations that have been involved with the family/whānau before and after the death. The Committee will carefully consider the ongoing care and support provided to children affected by family violence deaths.

Pilot reviews

In October 2009 the Committee did its first pilot review 'on the papers'. Organisations targeted in the initial information-gathering process included the Police, Child, Youth and Family, District Health Boards, Family and District Courts, Women's Refuge, Education, Plunket, and the Ministry of Health's Information Directorate. There were gaps and unexplained delays in the provision of information, which limited the scope of the pilot reviews. It is a priority for the Committee to develop guidelines when requesting information from organisations to inform them of their obligations under the New Zealand Public Health and Disability Act 2000 and other relevant legislation (eg, the Privacy Act) and to develop memoranda of understanding with agreed time limits for providing information.

The death review process relies on obtaining comprehensive, reliable and accurate information from the agencies that hold that information. It is necessary to identify all key organisations involved in the lives of the families surrounding the death. The pilot review identified that the gathering of information will take longer than first indicated, involving several 'rounds' of requests for information. It is estimated that it may take at least three months to gather the information required for a review to take place. The Committee will carry out further pilot reviews in 2009 and 2010 as part of the development of the death review process.

Collaboration with the Child and Youth Mortality Review Committee

The Committee has engaged with the Child and Youth Mortality Review Committee (CYMRC) and their review process. This has included a review of the CYMRC's database and attendance at a local CYMRC review group meeting for child and youth family violence death cases.

The chair of the CYMRC, and the lead co-ordinator and chair of a local CYMRC group, have attended Committee meetings to share information on systems and processes. This has been invaluable in assisting the Committee to develop robust systems for reviewing family violence deaths. The Committees will continue to collaborate while acknowledging that family violence death reviews require an in-depth, multidisciplinary approach, as well as a health focus.

Information-sharing protocols

Extensive work has been done to inform the Committee of its responsibilities with regard to privacy and confidentiality. John Edwards, Barrister and Solicitor, provided the Committee with a privacy impact assessment, which gave the following recommendations.

- Any software, database or transmission mechanism should be designed according to industry best practice, and should be compliant with all health information security standards and protocols.
- The Committee should develop security and reporting guidelines to ensure sensitive material is adequately safeguarded.
- The Ministry should provide the Committee with assistance in the form of the relevant health information network security standards and the like, together with examples of how these have been translated into policy and procedures.

Strict protocols have been put in place to ensure the confidentiality and security of information gathered. Individuals representing the Committee in the death review process will be required to sign a confidentiality agreement, and representatives will be advised of their legal obligations under the New Zealand Public Health and Disability Act 2000.

Mortality review committees have focused on gathering information about those who have died, but this Committee's prevention focus requires relevant detailed background information on the lives of perpetrators and other family members and whānau. This is a new challenge for mortality review committees. The Committee has sought expert legal advice in this area, which will help to inform its policies and the advice it gives to organisations when collecting information for review.

Transitional family violence death review process

The review process will involve:

- a lead co-ordinator
- standard family violence death review group members in 12 districts
- additional family violence death review group members for each review, with relevant expertise
- seeking information from agencies and individuals through the provision of papers or an invitation to make a presentation at review group meetings
- informal learnings and recommendations to be taken back to relevant local agencies
- learnings and recommendations to be reported to the Committee
- the Committee making national and local recommendations that inform strategic planning and promote ongoing quality assurance.

The Committee will appoint a lead co-ordinator to co-ordinate and manage all death reviews on behalf of the Committee. Standard family violence death review group members will be identified in the 12 police districts and called on as required. This group is made up of police, a cultural advisor and a family violence specialist. Additional family violence death review group members will be co-opted on a case-by-case basis to ensure relevant expertise and local knowledge are included.

The cultural aspects of each death will be different, and the lead co-ordinator will ensure appropriate cultural expertise is obtained for each review.

Agencies and individuals will provide the information to the local review group in paper format and may also be requested to attend the meeting to present information to the members and discuss further details as necessary.

The local review group members will take back learnings to their respective agencies to improve practice. The review groups will report the learnings and recommendations to the Committee to support the development of national recommendations.

Draft flow of information in the family violence death review process

The data collection process will involve the following steps.

1. The New Zealand Police notify the Committee of a family violence death.
2. The lead co-ordinator identifies all relevant agencies/organisations that may hold information on the death and requests information.
3. Committee member is identified to attend each local review.
4. Agencies/organisations forward information to the lead co-ordinator.
5. A standard local review group identifies additional members for the local review group.
6. The lead co-ordinator invites local agencies and individuals to make a presentation to the review group.
7. The lead co-ordinator facilitates family violence death review meetings at the local level.
8. Local findings and recommendations are fed back to the Committee by the lead co-ordinator.
9. The Committee makes recommendations for system, policy and practice improvements to reduce and prevent family violence deaths.

Objective 2:
Determine the availability, reliability and validity of existing data collection processes

The Committee is investigating the availability, reliability and validity of data that other organisations hold (eg, the Ministries of Health, Justice and Social Development, and the New Zealand Police). The information collected will inform the planning of systems to support data collection and collation. The Committee will build and formalise relationships with these organisations through formal memoranda of understanding.

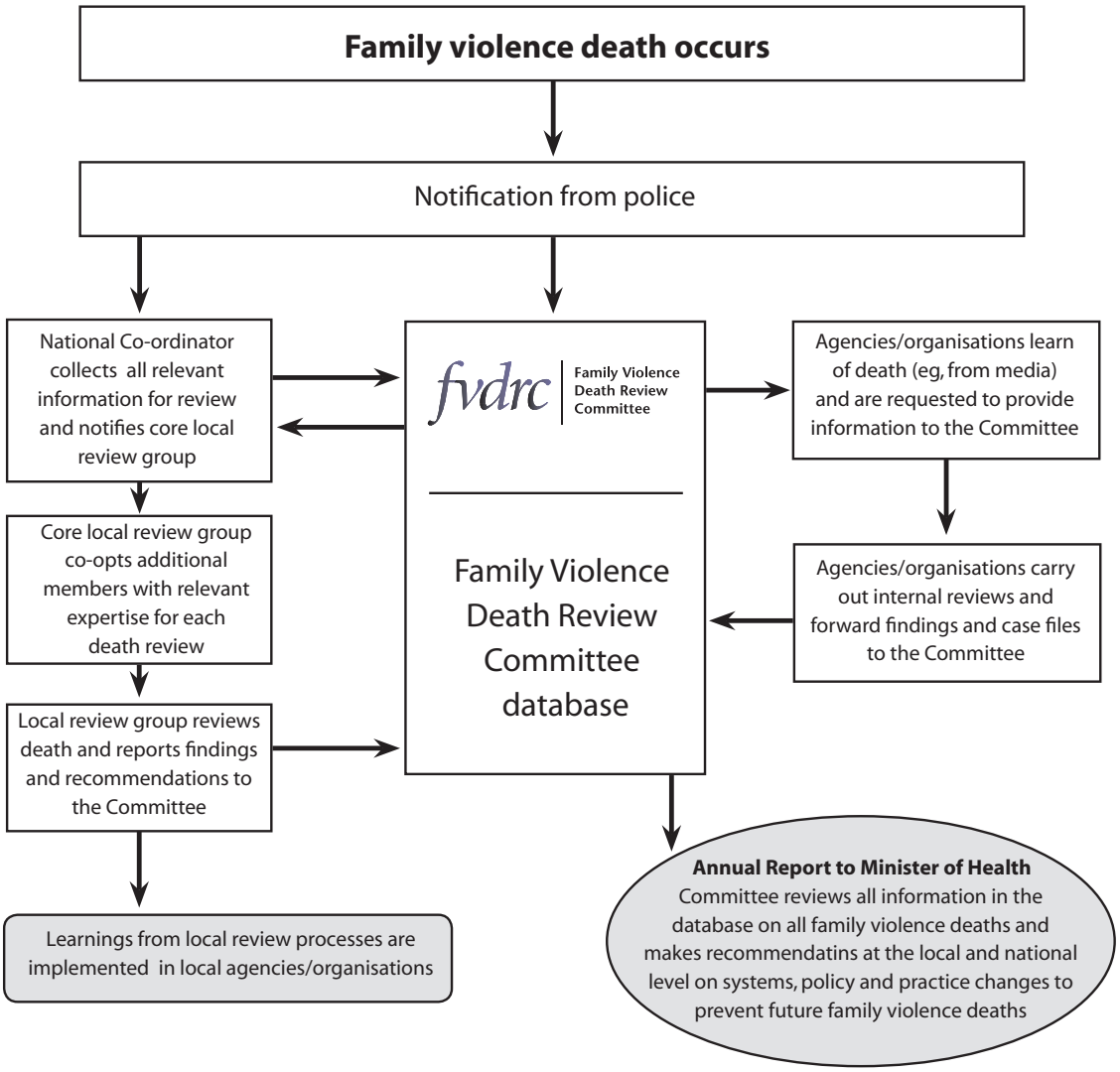
Objective 3:
Decide on definitions to be used for each piece of data during collection, analysing and reporting

The Committee set up the Data Working Group in August 2009 to identify the data needed for reviews and to develop definitions for a database for family violence deaths. It is currently building an interim database, including the necessary fields and definitions required for data collection.

The Committee is building relationships with organisations that will be providing information to populate the database. Most family violence death notifications will come from the New Zealand Police. However, the definition of family violence death used by the Police differs from the Committee's definition, and so the Committee is investigating options to identify family violence deaths that are not notified by the Police.

A set of Māori indicators will be included in the database, which will enable measurement and/or discussion of Māori conceptual domains; examples are whakamu (shame, embarrassment), whakamau (vindictiveness), waiora (health, soundness) and whatumanawa (seat of emotions, heart, mind). The Committee will work with the assistance of the Māori Caucus (formed from the Māori members of the mortality review committees) to develop the indicators.

Figure 1: Family violence death data collection process



Objective 4:
Establish functional relationships

Advisors

The Committee is assisted by six government advisors from the Office of the Chief Coroner, Ministry of Health, Ministry of Social Development, Ministry of Justice, New Zealand Police and Office of the Children's Commissioner. These departments' information, expertise and advice is available to the Committee to ensure the Committee's discussions and debates are fully informed. The advisors are accountable to their department and are not members of the Committee. Each of these departments holds information that will be vital to the review and data collection of family violence deaths.

Other organisations/stakeholders

The Committee has established relationships with as many stakeholders and organisations as possible to inform them of the Committee's existence, to gather feedback on the consultation document and to request information for the pilot reviews. The Committee has experienced keen interest, input and support from non-government organisations. Ongoing work will be undertaken to make the Committee more visible in the family violence sector and community.

Mortality review committees

The Committee chair attends the mortality review chairs' meetings held quarterly. These allow the chairs to share information and establish processes to enable the committees to work collaboratively to ensure resources are well utilised.

A Māori Caucus has been developed, which includes all Māori members of mortality review committees. The Māori Caucus was created to provide Māori Committee members with support and as an avenue for the committees to gain the knowledge and information they need to be culturally appropriate, sensitive and relevant in their work.

A high number of adult and child victims of family violence deaths are Māori and a high number are perpetrators. Accuracy of information for reviews, accurate analysis of dynamics, and proper targeting of recommendations is dependent on the involvement of Māori in all aspects and at all stages and levels of reviews.

Objective 5:
Establish processes to ensure secure storage of information

The Committee has secure systems for storing information, and tight destruction protocols are in place. A policy is being developed for the privacy and security of information in conjunction with the design and completion of the review process and database.

All Committee members and agents are required to sign a confidentiality agreement that advises them of the confidentiality requirements under section 18 and Schedule 5 of the New Zealand Public Health and Disability Act 2000. Any person who discloses information contrary to Schedule 5 commits an offence and is liable to a fine not exceeding $10,000.

All information provided to inform members at the Committee meetings (and in future review meetings) is collected at the conclusion of each meeting and destroyed.

Objective 6:
Determine how the Committee will operate in a culturally appropriate, sensitive and responsive manner

Māori

The over-representation this year of Māori as victims and perpetrators of family violence deaths signals an impact on the fabric of Māori society. Preliminary data indicates that three-quarters of family violence deaths involve Māori. While Māori have been involved in a large number of the identified cases this year, the issues are not for Māori alone to address.

The Committee will work with the community as a whole, but will also engage with Māori in as many ways possible to ensure it is operating in a culturally appropriate, sensitive and responsive manner.

The expertise and knowledge of the Committee's Māori members will be a significant part of identifying the causes of family violence deaths and developing measures to be put in place to halt this trend and stop deaths in future. At present one of these positions is vacant, but nominations have been received and the Minister will appoint a new member in the near future. When appointing a lead co-ordinator the Committee's key requirements will include cultural competence and general understanding of tikanga.

Support and advice to both the Committee and the Māori members is provided by the mortality review Māori Caucus. Further support is also being given from the Māori Population Health Group within the Ministry of Health.

Other cultural groups

The Committee is aware that the cultural needs of each family violence death will be different and will address cultural needs on a case-by-case basis. This will apply to all cultures, and cultural specialists and interpreters will be required in some cases.

Objective 7:
Deal with stressful material

The Committee has obtained advice from a professional psychologist on ways of working with distressing material and how the Committee can support its members. The information learned from the review process will be distressing, so the Committee has agreed this will be an ongoing project that will need to be revisited often to ensure proper care is taken of those dealing with the materials. Tools and mechanisms will provide members and representatives of the Committee with appropriate support to cope with stress.

In some instances members of review groups and of the Committee may need to seek counselling to deal with the traumatic stress that being part of the review process may cause. The Ministry of Health provides employment assistance programmes to all Ministry of Health employees, which provide off-site individual assistance should personal problems occur, including stress, anxiety and depression. The Committee will investigate the availability of similar support for its members and representatives.

Appendix A:
The FVDRC Membership and Meetings 2008/09

Membership

Wendy Davis (Chairperson)

Ngaroma Grant (Deputy Chairperson)

Brenda Hynes

Patrick Kelly

Alison Towns

Rob Veale

Vaoga Mary Watts

Past members

George Ririnui

Meetings

The FVDRC met five times from October 2008 to September 2009. Meetings were held on:

- 2 October 2008 in Wellington
- 17 February 2009 in Wellington
- 29 and 30 April 2009 in Auckland
- 11 June 2009 in Wellington
- 9 and 10 September 2009 in Wellington.

Advisors

Kelly Anderson, Office of the Chief Social Worker, Child Youth and Family

Mark Barrett, Ministry of Health

Inspector Ged Byers, New Zealand Police

Nicola Johnstone, Office of the Children's Commissioner

Karen Vaughan, Office of the Chief Coroner

Craig Walker, Ministry of Justice

Appendix B:
Terms of Reference

The role of the Committee

1. The Family Violence Death Review Committee (the Committee) is a ministerial committee established under sections 11 and 18 of the New Zealand Public Health and Disability Act 2000 (the NZPHD Act).
2. The Committee is appointed by, and accountable to, the Minister of Health (the Minister).

The functions of the Committee

3. The Committee's functions are to:
   - 3.1 review and report to the Minister on family violence deaths, with a view to reducing the numbers of family violence deaths, and to continuous quality improvement through the promotion of ongoing quality assurance programmes
   - 3.2 develop strategic plans and methodologies that are designed to reduce family violence morbidity and mortality, and are relevant to the Committee's functions
   - 3.3 advise on any other matters related to family violence deaths that the Minister specifies.[7]
4. In order to fulfil its functions the Committee will:
   - 4.1 report and make recommendations at a local and national level on system, policy and practice improvements to contribute to the reduction of family violence deaths
   - 4.2 monitor the number, categories and demographics of family violence deaths
   - 4.3 identify patterns and trends in family violence deaths over time
   - 4.4 make available to researchers data about family violence deaths within the privacy and confidentiality restrictions on the Committee
   - 4.5 liaise with any other mortality review committees appointed by the Minister to assist, on mutual agreement, with reviews of deaths that are within the scope of those other committees.
5. In order to perform its functions, the Committee will:
   - 5.1 collect data and information from relevant sources on circumstances leading up to and surrounding family violence deaths
   - 5.2 review the circumstances surrounding family violence deaths, including system and agency practice interventions/processes
   - 5.3 conduct specific reviews/investigations into clusters/subgroups of family violence deaths
   - 5.4 undertake and/or support local family violence death reviews.

7 Paragraph 3.1–3.3 of 'The functions of the Committee' are derived from section 18 of the NZPHD Act.

Guiding principles

6. The overarching goal of the Committee is to contribute to the prevention of family violence and family violence deaths.

7. In addition, when undertaking its functions, the Committee will:

   7.1 be sensitive to, and respectful of, victims and their families, and minimise the revictimisation and trauma that death reviews may cause

   7.2 keep information and data secure, and protect confidentiality

   7.3 operate in a culturally appropriate, sensitive and responsive manner

   7.4 be objective, impartial and have a systemic focus on learning in order to improve/enhance current and future systems, policy and practice

   7.5 develop, enhance and foster inter-agency collaboration, trust and networking in the family violence sector

   7.6 formulate clear, meaningful and practical recommendations, developed from a 'non-blaming' perspective

   7.7 support and protect individual and agency death review participants

   7.8 ensure that local family violence death review processes are undertaken in accordance with the values and principles set out in these Terms of Reference.

Definition of family violence death

8. For the purposes of these Terms of Reference, a family violence death is:

   8.1 the unnatural death of a person (adult or child) where the suspected perpetrator is a family or extended family member,[8] caregiver,[9] intimate partner, previous partner of the victim, or previous partner of the victim's current partner.

9. The following categories of deaths are initially excluded from this definition:

   9.1 suicides

   9.2 assisted suicide (based on pact)

   9.3 deaths from chronic illness resulting from sustained violence

   9.4 accidental deaths related to family violence incidents.

Definition of family violence death review

10. For the purposes of these Terms of Reference, a family violence death review is:

    10.1 a systematic analysis of the lives of victims, perpetrators and their families, and events leading up to and factors surrounding death(s), by a combination of agencies and disciplines in a confidential and culturally safe environment.

11. The purpose of the review is to identify changes or enhancements to systems, policy and services that may contribute to the prevention of family violence deaths.

8 'Family or extended family member' is used in the broadest sense and includes whānau, hapū, mother, father, child, sibling, grandparent, aunt, uncle, step-parent, foster-parent etc.

9 'Caregiver' refers to a person living in a 'domestic' relationship with, and providing care for, the victim.

Composition of the Committee

12. The Committee will have a maximum of eight members appointed by the Minister.
13. All members will have knowledge of, or expertise in, family violence issues.
14. The Committee's membership may include:
    - members with expertise in mortality review systems
    - members with expertise in social science and/or health research
    - members with experience as a social worker or a family violence case worker
    - members with knowledge of, or experience in, service provision or operational policy in the social sector
    - members who are experts in the field of child abuse and protection issues
    - members who are registered health practitioners or registered clinical psychologists
    - members who are lawyers with expertise in family violence law
    - members with knowledge of family violence issues from a service user/family perspective
    - Māori members with knowledge of family violence issues, or experience in working with Māori families affected by family violence
    - members of other ethnic groups with knowledge of family violence issues, or experience in working with families affected by family violence.
15. The Committee will be assisted by six government advisors. This will enable those departments' information, expertise and advice to be available to the Committee, so that the Committee's discussions and debates are fully informed. The advisors are accountable to their department and are not members of the Committee. The advisors will be nominated by the chief executive, or their equivalent, from the following agencies:
    - the Chief Coroner's Office
    - the Ministry of Health
    - the Ministry of Social Development
    - the Ministry of Justice
    - the New Zealand Police
    - the Office of the Children's Commissioner.
16. The Committee may appoint subgroups or establish working parties relevant to its agreed workplan, and it may co-opt expertise as necessary to assist any subgroups, within its budget.
17. The Committee may appoint 'agents' to assist it to collect information relevant to the performance of any of the Committee's functions.

Terms and conditions of appointment

18. Members of the Committee are appointed by the Minister for a term of office of up to three years. The terms of office of members of the Committee will be staggered to ensure continuity of membership. Members may be reappointed from time to time.
19. Unless exceptional circumstances are identified, and these are agreed upon by the Committee and by the Minister, no member may hold office for more than six consecutive years. Such circumstances include an exceptional need for continuity of knowledge and skills; for example, if three of more members are leaving the Committee at the same time. In such circumstances, a member's term may be extended for up to one year.

20. Unless a person sooner vacates their office, every appointed member of the Committee shall continue in office until their successor comes into office.

21. Any member of the Committee may at any time resign as a member by advising the Minister in writing.

22. The Minister may, by written notice, terminate the appointment of a member or chairperson of the Committee.

23. The Minister may from time to time alter or reconstitute the Committee, or discharge any member of the Committee, or appoint new members to the Committee for the purpose of decreasing or increasing the membership or filling any vacancies.

Chairperson and deputy chairperson

24. The Minister will appoint a member of the Committee to be its chairperson. The chairperson will preside at every meeting of the Committee at which they are present.

25. The chairperson of the Committee is likely to be appointed as a member of the National Health Epidemiology and Quality Assurance Advisory Committee. The chairperson, therefore, should be aware that an approximate six days of meetings in Wellington would be required as part of that commitment.

26. The Committee may appoint one of its members to be deputy chairperson.

Duties and responsibilities of a member

27. The following sections set out the Minister's expectations regarding the duties and responsibilities of a person appointed as a member of the Committee. This is intended to aid members of the Committee by providing them with a common set of principles for appropriate conduct and behaviour and serves to protect the Committee and its members.

28. As an independent statutory body, the Committee has an obligation to conduct its activities in an open, ethical, and responsible manner within the parameters of its functions as set out in these Terms of Reference.

General

29. The Committee members should have a commitment to work towards reducing family violence and family violence deaths.

30. Members are expected to make every effort to attend all Committee meetings and devote sufficient time to become familiar with the affairs of the Committee and the wider environment within which it operates.

31. Members have a duty to act responsibly with regard to the effective and efficient administration of the Committee and the use of Committee funds.

32. Members attend meetings and undertake Committee activities as independent persons responsible to the Committee as a whole. Members are not appointed as representatives of professional organisations and/or particular community bodies. The Committee should not, therefore, assume that a particular group's interests have been taken into account because a member is associated with that group.

Conflicts of interest

33. Members must perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest. Proper observation of these principles will protect the Committee and its members and will ensure that it retains public confidence.

34. When members believe they have a conflict of interest on a subject that will prevent them from reaching an impartial decision or undertaking an activity consistent with the Committee's functions, they must declare that conflict of interest and withdraw themselves from the discussion and/or activity.

Confidentiality

35. The maintenance of confidentiality is crucial to the functioning of the Committee.

36. Members must note the statutory requirements in section 18(7) of the NZPHD Act, which prevents disclosure of 'information' as it is defined in clause 3 of schedule 5 of the NZPHD Act. Under that clause, information means any information:

    - that is personal information within the meaning of section 2(1) of the Privacy Act 1993; and
    - that became known to any member or executive officer or agent of a mortality review committee only because of the committee's functions being carried out (for example, because it is contained in a document created, and made available to the member or executive officer or agent, only because of those functions being carried out), whether or not the carrying out of those functions is completed.

37. The Committee is not subject to the Official Information Act 1982.

Meetings of the Committee

38. Meetings will be held at such times and places as the Committee or the chairperson of the Committee decides.

39. When the Committee has eight members, at least five members must be present to constitute a majority. When the number of appointed members is less than eight, a quorum is the number of members constituting a majority.

40. Every question before any meeting will generally be determined by consensus decision-making. Where a consensus cannot be reached, a majority vote will apply. In the case of equality of votes on an issue, including the chairperson's own vote, the chairperson may choose to exercise a casting vote.

41. Subject to the provisions set out above, the Committee may regulate its own procedures.

Performance measures

42. The Committee will be performing effectively when it provides relevant and timely advice to the Minister based on research, analysis and consultation with appropriate groups and organisations.

43. The Committee must:

    - agree in advance to a work programme with the Minister
    - achieve its agreed work programme
    - stay within its allocated budget.

Reporting requirements

44. The Committee is required to:

    - keep minutes, within the privacy and confidentiality restrictions on the Committee, of all Committee meetings, which outline the issues discussed and include a clear record of any decisions or recommendations made
    - provide the Minister with a report, on an annual basis or as otherwise required by the Minister, on its progress in carrying out its functions. The report will set out the Committee's activities, compare its performance to its agreed work programme, and summarise any advice it has given to the Minister. The report will be tabled by the Minister in the House of Representatives pursuant to section 18(4) of the NZPHD Act.

Servicing of the Committee

45. The Ministry of Health will employ staff to service the Committee, sufficient to meet the Committee's statutory requirements, out of the Committee's allocated budget.

Fees and allowances

46. Members of the Committee are entitled to be paid fees for attendance at meetings. The level of attendance fees is set in accordance with the State Services Commission's framework for fees for statutory bodies (2006) and the Cabinet Office Circular CO (06) 08.

47. The chairperson will receive payment consistent with Group 4, Level 2, of the Cabinet Office Circular CO (06) 08: $450 (GST exclusive) per day working for the Committee (plus half a day's preparation fee for any Committee meetings). The chairperson is entitled to an allowance of two extra days per month to cover additional work undertaken by the chairperson.

48. The attendance fee for members is consistent with Group 4, Level 2, of the Cabinet Office Circular CO (06) 08: $320 (GST exclusive) per day working for the Committee (plus half a day's preparation fee for each meeting).

49. The attendance fee for full Committee teleconferences and sub-committee meetings is calculated on a pro rata basis (the hourly rate will be calculated at one seventh the daily rate).

50. Actual and reasonable travel and accommodation expenses of the Committee, while on Committee business, will be met from the Committee's budget.

Establishment issues

51. During its first year of operation the Committee must address establishment issues, including:

    - developing mechanisms and protocols for family violence death reviews
    - determining the availability, reliability and validity of existing data collection processes
    - determining what, if any, additional data could reasonably be collected from whom, and for what purposes, in order that the Committee can undertake its functions
    - decide on definitions to be used for each piece of data during collection, analysing and reporting
    - establishing functional relationships with:
        - the National Health Epidemiology and Quality Assurance Advisory Committee
        - the Child and Youth Mortality Review Committee and the Perinatal and Maternal Mortality Review Committee
        - new and existing local non-statutory mortality review committees

  - other agencies that conduct family violence mortality reviews
  - the Family Violence Interagency Response System
  - key stakeholders in the family violence sector
- establishing processes to ensure security of 'information' as that term is defined in clause 3 of Schedule 5 of the NZPHD Act
- determining how the Committee will operate in a culturally appropriate, sensitive and responsive manner
- due to the potentially distressing nature of some of the material to be considered by the Committee, establish processes to ensure Committee members will be well supported, such as offering opportunities for confidential counseling.

Review of the Committee

52. A formal review and evaluation of the Committee and these Terms of Reference will be undertaken by the Ministry of Health three years from the date of establishment. The aim of the evaluation will be to ensure alignment between principles, purpose and processes of the Committee and to identify potential improvements. In particular, the definition of 'family violence death' should be reassessed, with a view to broadening the definition to include those deaths currently excluded under section 9 of these Terms of Reference.

Approved by Hon David Cunliffe, Minister of Health.
April 2008

Appendix C:
Contact Details

The FVDRC can be contacted at:

Family Violence Death Review Committee
c/o Ministry of Health
PO Box 5013
WELLINGTON

Email: fvdrc@moh.govt.nz

Website: http://www.fvdrc.health.govt.nz

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