Family Violence Death Review Committee

He tao huata e taea te karo

Second Report: October 2009 to November 2011

Inaugural Report to the Health Quality & Safety Commission

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

The Family Violence Death Review Committee (FVDRC) is grateful to the following groups and individuals who have worked with the FVDRC during the two years this report covers:

- the mortality review committee secretariat, which is now housed within the Health Quality & Safety Commission (the Commission), in particular Jennifer Martin, Sue Dahl, Terry Sarten, Shelley Hanifan, Suzi Grindell, Kate Lawrence, and Marilyn Northcotte
- the advisors to the FVDRC, particularly:
  - Hingatu Thompson and Mark Barrett from the Ministry of Health
  - Craig Walker from the Ministry of Justice
  - Kelly Anderson and Nova Salomen from the Ministry of Social Development
  - Nic Johnstone, Marlene Welsh-Sauni, and Dr Nicola Atwool from the Office of the Children's Commissioner
  - Brigitte Nimmo, Ged Byers and others from the New Zealand Police
  - Julie Sach and Gill Aimer from the Department of Corrections
  - Karen Vaughan and Jackie Andrews from Coronial Services
- the mortality review committees' Māori Caucus
- the panel participants who contributed to the first pilot reviews
- Judy Paulin, who was contracted to provide research services to the FVDRC
- Rob Veale, who was an inaugural member of the FVDRC, and was later contracted to provide research services to the FVDRC
- Dr Patrick Kelly, who was an inaugural member of the FVDRC.

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Foreword

This year the FVDRC was welcomed to the Commission, alongside three other mortality review committees. The Commission recognises that the impact of family violence is substantial, widespread and affects the whole of society. Since we are committed to support the FVDRC in its work to reduce family violence deaths in New Zealand, it is essential to collaborate with the wider family violence sector.

This report describes the progress and development of a new form of mortality review in New Zealand. Mortality review brings together all agencies with a working knowledge of a deceased person, to develop a more comprehensive picture of that person's death. The review itself is an opportunity for organisations to improve their own systems – locally and more widely, in order to save lives. Information is also provided nationally for aggregated analysis, which can result in further positive change.

Family violence death review includes analysing the lives of living family members alongside those who have died and the perpetrator responsible for the death. This presents a new challenge for mortality review that the FVDRC must handle with sensitivity and caution. Additional effort must be focused on information security and on the integrity of processes and participants. The FVDRC welcomes this responsibility and remains focused on its end goal – preventing family violence deaths in New Zealand. The current members of the Committee (Wendy Davis (Chair), Ngaroma Grant (Deputy Chair), Dr Alison Towns, Brenda Hynes and Vaoga Mary Watts) are to be commended for their dedication and commitment. This report highlights the FVDRC's achievements and challenges.

The work of the FVDRC will be beneficial – not only in the field of family violence – but to inform mortality review practice. It is important to share the processes and systems that have been developed by the FVDRC with the other mortality review committees and to use them more widely.

Professor Alan Merry ONZM
Chair
Health Quality & Safety Commission
November 2011

Chair's Introduction

I am pleased to present the FVDRC's second report; the first to the Health Quality & Safety Commission. Our overarching goal is to contribute to the prevention of violence within families and family violence deaths. This report sets out the work we have done since September 2009 and our priorities for the next stage of our work.

Each year between one-third and one-half of all homicides in New Zealand are the result of violence within families. In 2010, 26 people in New Zealand were killed directly by members of their own family. The need for comprehensive and detailed reviews of family violence deaths, focussing on prevention of future deaths, was identified as a priority by a range of non-government and government agencies.

The FVDRC was established in 2008 as a ministerial committee under the New Zealand Public Health and Disability Act 2000 and first met in October 2008. In 2010 the Health Quality & Safety Commission assumed responsibility for mortality review under the New Zealand Public Health and Disability Amendment Act 2010, and the FVDRC is now hosted by the Commission.

The FVDRC is advised by representatives from the Chief Coroner's Office, New Zealand Police, the Children's Commissioner, and the Ministries of Social Development (Child Youth and Family), Justice, Health and Corrections.

A family violence death review is a systematic analysis of the lives of victims, perpetrators and their families, as well as events leading up to and factors surrounding family violence deaths, with the purpose of identifying changes and enhancements to systems, policies and services to prevent future deaths. Over the past three years the FVDRC has worked to develop robust review systems with a clear focus on prevention (rather than establishing liability, fault or cause of death, which are the focus of other processes - eg, coronial inquests and the criminal system).

In 2010 and early 2011 the FVDRC undertook three pilot reviews to assist in developing local review panels to carry out death reviews. The pilots have enabled us to:

- develop and refine systems to gather, manage, analyse and store confidential information for reviews
- select and train local panel members with a broad range of relevant expertise
- adopt processes to help identify what steps might have been taken to prevent each death.

Findings from local review panels will be used in the future by the FVDRC to make recommendations for changes and improvements at a national level, and to identify local prevention measures.

From here we intend to establish standing review panels in up to seven geographical areas, with each panel having capacity to review all of the family violence deaths occurring in their region, within 12 months of each death. More detail about our path forward is set out in this report.

Our second report includes data on family violence deaths in New Zealand from 2002–2008. This builds on the work done by Jennifer Martin and Rhonda Pritchard, published as *Learning from Tragedy* in April 2010. The two largest groups of family violence deaths are couple-related deaths and child deaths, and the next stage of our review work will address those deaths in particular.

The involvement of local and national family violence agencies is vital to the integrity of our work, as is the contribution of the mortality review committees' Māori Caucus and specialist expertise from many others working in the family violence area. On behalf of the FVDRC I would like to thank everyone who has contributed to the pilot stage of our review work for giving so generously of their time and expertise, and all those who have provided support to the FVDRC.

Wendy Davis
Committee Chair
November 2011

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Executive Summary

The FVDRC has continued the work discussed in our *First Annual Report to the Minister of Health*, published in February 2010. Considerable progress has been made since then towards establishing a robust family violence death review process.

A trial review process is currently underway. The trial started with paper reviews and has moved to piloting review processes with regional review panels. The work involved in the pilots includes review panel membership selection, training of review panels, and testing review methodology and approaches – from information collection and analysis, through to conclusions and recommendations. To date, each pilot review has been centrally managed and used as an opportunity for further development of methods and approaches.

Analysis of data also provides useful direction for the FVDRC when considering priorities for focus in reviews and for understanding the patterns of family violence deaths in New Zealand. An analysis of New Zealand family violence death data for the period 2002-2008 is provided in Chapter 3. Over this time, adult (ex-)partners, children under 15 years of age and Māori were over-represented in family violence deaths. The FVDRC intends to focus on these groups in its upcoming work.

While data taken from official records is useful for the development of an effective review system, it provides only a small part of the wider range of learning which can come from more in-depth review. Chapter 3 also focuses on the pilot reviews that have been completed to date. From those pilot reviews, the FVDRC has identified issues it wishes to explore further in the upcoming year. The issues include:

- recent release of convicted offenders
- care for infants
- family violence training for first responders, including Police.

The FVDRC has raised these issues and their concerns with the respective government agencies and requested information and updates on actions being completed to respond to the issues. The FVDRC will carefully monitor the findings of upcoming reviews for further information about these matters and associated preventative measures.

The FVDRC's main priority is to get the regional review process and a national data collection system fully developed, as both are integral to meeting its overall objectives. When these two systems are in place the FVDRC will be able to provide an overview of family violence mortality in New Zealand and make recommendations at the systemic and strategic level. More details of the FVDRC's priorities for immediate work are set out in Chapter 4 of this report.

Chapter 1: The FVDRC Review Process

The development and implementation of a death review system that reflects the complex array of factors contributing to family violence deaths requires commitment, expertise and time.

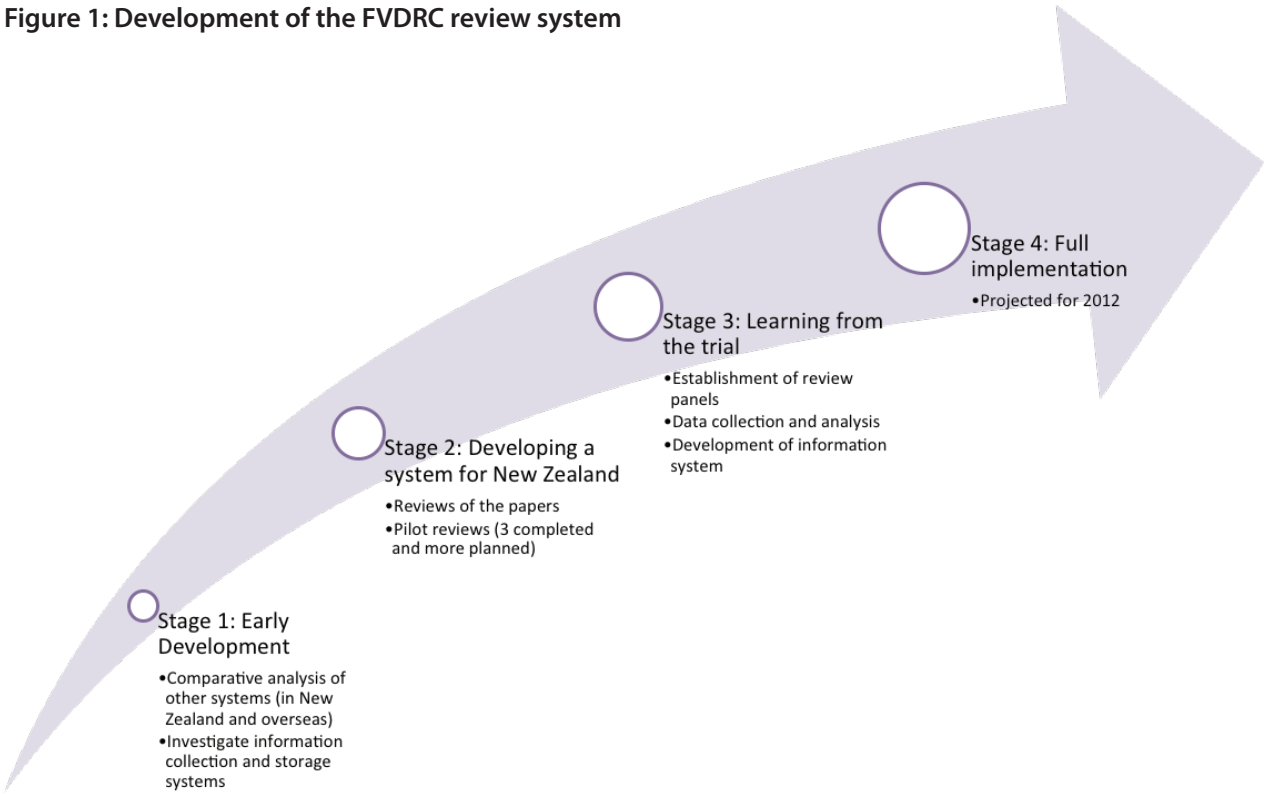
In its *First Annual Report to the Minister of Health* (2010), the FVDRC recommended that the Minister of Health:

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

The first, second, and fourth recommendations have been achieved. The third recommendation, related to the development of an information system for the FVDRC, is still in process, and will be discussed later in this report.

Considerable work has been undertaken since the establishment of the FVDRC in June 2008. Major progress has been made to meet one of the primary objectives of the FVDRC: to establish a sustainable and effective nationwide family violence death review system. The FVDRC has taken a carefully staged approach (Figure 1).

Figure 1: Development of the FVDRC review system



Developing a Family Violence Death Review System for New Zealand

A comparative analysis of domestic and international death review systems was conducted as part of the initial design phase prior to the establishment of the FVDRC. Further analysis occurred after the FVDRC was established to identify the essential elements of a sustainable and effective death review system.[1] In 2009, the FVDRC consulted with the family violence sector about the review process and received 40 submissions. This feedback from the sector has contributed to the development of processes appropriate to the New Zealand context.

The New Zealand Family Violence Death Review (FVDR) System is made up of two parallel, interconnected, work streams.

1. The first work stream seeks to collect a standard set of data on each family violence event that can be aggregated over time and reported annually.

2. The second work stream involves the establishment of a two-tiered review system to examine the unique details of family violence events in order to identify ways to prevent future deaths.

The two-tiered review system comprises regional review processes for in-depth review of death events[2], and a national committee (the FVDRC) to review and report on aggregated findings.

Once the basic framework of the FVDR system was agreed, the FVDRC undertook paper[3] reviews of three family violence events. Lessons from the paper reviews led to the FVDRC decision to conduct a series of pilot reviews as part of a trial, to further develop the FVDR processes, prior to rolling out a nationwide system.

The FVDR lead co-ordinator, appointed in 2010, led the pilots. The events selected covered a wide geographical spread and range of event types. To date, three pilot reviews have been completed and more will be undertaken. This development work provides a strong foundation for the establishment of effective and robust processes and a nationwide review network to undertake reviews and make recommendations aimed at preventing future deaths.

Each pilot review involved the following stages (see Figure 2):

- initial information sweep from relevant agencies and individuals
- preliminary analysis of information, followed by additional information sweeps as needed
- establishing a review panel and selection of Chair
- panel induction and training
- review meeting(s) and identifying learnings
- discussion of recommendations and any actions to follow
- data entry into the FVDRC database
- evaluation of the process and feedback for ongoing development.

1 While these elements were not explicitly identified in the FVDRC's First Annual Report to the Minister of Health, a number of them were alluded to in the FVDRC goals for 2009/10 (2010: 5). These goals related to objectives like: engaging with local communities, establishing and supporting relationships across sectors, engaging with appropriate cultural specialists, and so on.

2 A family violence event can comprise multiple victims or multiple perpetrators.

3 These reviews were paper-based and conducted by the FVDRC. Files and records were collected from a variety of agencies which had contact with the victim/s and perpetrator/s. No interviews were conducted.

Figure 2: The stages of a family violence death pilot review

Each pilot review was centrally-led and managed. Local participants were selected from relevant government and non-government agencies to join each local panel as 'agents' and participate in the death reviews. The information collection and review process was developed, updated and reviewed as each pilot review progressed. Panel members and any FVDRC observers present at the reviews provided feedback on the process. Each pilot consisted of three meetings; the last meeting was devoted to debriefing and evaluating the process.

Learning from the pilot reviews

On completion of each pilot review, the process was analysed and improvements made, including further development of the:

- process to establish and train regional review panel members, including provision of support during the review
- review methodology, ranging from initial collection of information to the framework for analysis and conclusions
- system for data collection and storage for the family violence death review database
- development of recommendations informed by review findings and aimed at preventing future deaths and improving interagency systems.

Panel membership

Learning from the pilot reviews has reinforced the importance of panel composition (ie, multi-disciplinary and interagency membership with gender and ethnic balance) and the personal and professional attributes of the panel members. Attributes such as sensitivity, collaboration, respect, and a 'no blame' approach (consistent with the FVDRC terms of reference) are critical to the success of the review.

The pilot reviews showed the importance of getting a balance between the knowledge and expertise required to conduct a family violence death review, the personal attributes appropriate for such a

review, and adequate support available to the panel member.

It is also important that the people who participate in reviews have standing or status within their own organisations and the community to be influential and able to respond to findings and recommendations resulting from the review.

Cultural considerations

It is essential to have a range of ethnicities on each panel and culturally safe processes while ensuring the safety of the individual. The FVDRC recognises the importance of cultural safety, particularly for Māori and Pasifika people and others of minority ethnicity engaging in family violence death review processes. The FVDRC starts each meeting with whakawhanaungatanga and ends with a poroporoaki.

There must be appropriate representation on the local and national committees to ensure the wellbeing of all concerned in what can be a very demanding process. Learnings from one pilot review in particular provide an exemplar for culturally safe processes.

Panel induction, training and coordination

A training package has been developed and updated in response to training needs, feedback from the panels and to incorporate best practice. Induction and training is currently undertaken by the lead co-ordinator to ensure consistent standards across the panels.

The role of the lead co-ordinator is critical to the success of the development of a nationwide review system.

Conducting the reviews

While there are similarities with other mortality review systems, a family violence death review system is new to New Zealand and to those developing the process and participating in the reviews. The review of family violence deaths differs from other mortality review because of the inclusion of both victim and perpetrator information, and the complexity and the sensitivity of the subject matter.

The pilot reviews conducted to date have highlighted the need for an analytical framework to enhance the FVDRC's ability to understand findings, identify key themes and make national and local recommendations. This is important to help achieve the FVDRC's overall objective, which is to prevent family violence deaths by improving systems, policies and services at the local and national level.

The details of most family violence events are very complex and can be difficult to analyse in a manner that leads to clearly prioritised recommendations. An analytical framework will enable reviewers to easily organise the information, sort through the complexity, consider the multiple socio-environmental factors that may have contributed to the event and then prioritise recommendations and actions.

The review process piloted to date is working well. The current framework model will be developed so that it can be replicated and the required volume of cases can be reviewed efficiently.

Developing the information system

Provisions relating to mortality review committee collection of information and its use are detailed in the NZ Public Health and Disability Act 2000 (the Act) Schedule 5, including strict confidentiality, and conditions for collection, storage and use of data. The Act:

- enables the FVDRC to appoint agents to collect information on its behalf (agents are subject to strict confidentiality requirements)
- enables a person to provide requested information to the FVDRC without breaching the Privacy Act 1993 or the Health Information Privacy Code 2004
- provides that information collected for the purpose of mortality review is not to be subject to the requirements of the Official Information Act 1982.

The University of Otago's Mortality Review Data Group is contracted to provide information collection, storage and some analysis services to the Child and Youth Mortality Review Committee (CYMRC) and the Perinatal and Maternal Mortality Review Committee (PMMRC). The FVDRC is not included in this contract, nor is the Perioperative Mortality Review Committee (POMRC).

The FVDRC Data Working Group (a sub-group of the FVDRC) has conducted a thorough assessment of the data stored by other family violence death review committees, reviewed recent literature on family violence risk factors and developed a comprehensive list of data fields that might be collected from each review. The list of data fields is being used to develop a minimum data set for the FVDRC and to assist with the analysis of information collected by different agencies working with family violence in New Zealand.

The FVDRC has actively worked to build trust and good will with agencies and individuals working in the family violence sector. This has strengthened our understanding of the types and nature of information held by each respective agency, the format it can be provided in and any specific requirements the agency may have regarding transfer or use of the information.

Under its terms of reference, the FVDRC is required to provide protocols for the safe and secure collection and storage of information. As noted in its first report, the FVDRC has sought expert advice on secure information sharing (2010: 13) and has taken care to develop robust systems to assure agencies that the information they are providing to the FVDRC is safe and secure.

Agencies seem to prefer providing information to the FVDRC in differing ways, resulting in a number of methods used to store or access information. Procedures and protocols have been developed to ensure the safe collection, transfer, storage and use of information, regardless of the method by which it is obtained.

The FVDRC has developed and implemented procedures to manage the data received manually, in hard copy and electronically. The guidelines and protocols build on earlier work undertaken to establish contacts and build strong relationships with agencies which are key information sources for family violence review (eg, the New Zealand Police and Child Youth and Family (CYF)).

See Appendix 4 for more information on information security processes.

Chapter 2: Key Achievements for 2009/10

In our *First Annual Report to the Minister of Health* (2010), the FVDRC set out 12 goals. Table 1 provides an update on the FVDRC's progress in relation to those goals.

Table 1: Progress on the Family Violence Death Review Committee's goals for 2009/10 from its *First Annual Report to the Minister of Health*

Goal	Progress
Complete pilot reviews to ensure the integrity of the review process and the reliability of data collection.	Tools, processes and systems for local review were developed in the trial process. Three pilot reviews were completed as at 30 September 2011 and initial planning for more pilot reviews has also been completed.
Further develop the family violence death review process.	A 'continual improvement' model is being used to refine and improve review processes based on the evaluations of the trial 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.	'Local learnings' have occurred as part of the trial. The process for taking 'learning' from local review back to the organisations involved has been established as part of the overall tools, processes and systems. Further refinement will occur as the trial progresses and the review system is implemented.
Appoint a lead co-ordinator to facilitate family violence death reviews.	A lead co-ordinator was initially seconded from the Ministry of Social Development. The secondment period for the lead co-ordinator ended at 30 June 2011 and a new lead co-ordinator employed by the Commission began in August 2011.
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.	Currently there are two database systems: 1. a death notifications data storage system has been set up and is regularly updated. The notification system provides data to the FVDRC and secretariat to inform decision making and planning 2. an optimal model for reviewing data has been developed to inform a future system. In the interim, a temporary storage system is in use. The Commission aims to establish a comprehensive data storage and analysis system to be utilised by all of the mortality review committees over the next year.
Engage with local communities in the family violence death review process.	The FVDRC consulted with the family violence sector on the review process and received 40 submissions. The feedback was helpful for the further development of ideas and to ensure a direction appropriate to the New Zealand context. National contacts were used to identify and link with regional and local family violence sector representatives to take part in regional review panels.
Engage with Māori at national and local levels to ensure culturally appropriate and effective reviews occur and Māori are involved in the family violence death review process.	Contact has been made nationally and locally to ensure Māori involvement in reviews that have occurred to date. Further engagement is required to ensure appropriate involvement continues to take place.

Goal	Progress
Establish relationships across sectors and communities so any future work fits within the framework of whānau ora.	Additional engagement and relationship building is required nationally and regionally to ensure fit with the whānau ora framework.
Engage with appropriate cultural specialists in each death review case.	Engagement is occurring but further work is required to ensure cultural expertise (especially Pasifika) in reviews. A more systematic approach will be developed as part of the trial.
Establish clear and safe protocols for the involvement of family and whānau.	Sensitivity and privacy issues need to be carefully considered prior to involving family and whānau. The development of protocols is ongoing.
Establish protocols and tools to assist the FVDRC and its representatives in dealing with stressful materials.	Professional supervision is provided to staff and committee members dealing with stressful material, but additional work is required on tools and protocols. The FVDRC has developed guidelines that are being used in the pilot reviews (see Appendix 3). At national meetings, the FVDRC dedicates time at the start of the meeting to whakawhanaungatanga and at the end of the meeting for a poroporoaki.
Continue to develop relationships with the family violence sector, government agencies / organisations, key stakeholders and the community.	Relationships have been established with key government and non-government agencies. Ongoing relationship building is required to ensure cross sector linkages.

Chapter 3: Data Report and Analysis

The FVDRC's Terms of Reference define a family violence death 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.[6]*

Family violence deaths in New Zealand from 2009-2010

At the time of writing this report, the New Zealand Police have identified 88 culpable deaths in 2009 and 72 in 2010 (see NZ Police April 2010 and NZ Police April 2011, respectively). Of these, 42 were classified as family violence related for 2009 while preliminary data collection indicates 26 were family violence related for 2010. Additional analysis will be completed as more data is obtained.

Table 2: Family violence deaths, 2009-2010

	2009	2010
Culpable deaths / victims of homicide	88	72
Family violence deaths	42	26*

Note: The table shows culpable deaths / victims of homicide identified by the New Zealand Police. "A culpable death is one where the killer(s) is (are) liable for murder, manslaughter or infanticide" (April 2010: 3). This is live data, which means that the figures may change as additional information is collected on each case. Since investigations for suspicious deaths can take months, or even years, to complete, it can take a number of years for the data to be deemed complete.

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

Family violence deaths in New Zealand from 2002-2008

Before the FVDRC was established, researchers Jennifer Martin and Rhonda Pritchard, from the Ministry of Social Development (MSD), completed a study on all family violence deaths in New Zealand for the five-year period 2002 to 2006.[7] This study was commissioned to inform the development of the FVDRC. Because the Martin and Pritchard study was not published until 2010, its findings were not included in the FVDRC's *First Annual Report to the Minister of Health*.

Recently the FVDRC commissioned Judy Paulin to replicate Martin and Pritchard's research and analysis for the two-year period, from 2007 to 2008. Paulin replicated parts but not all of Martin and Pritchard's research because Paulin was unable to access all of the variables that were included in the original research (see Appendix 5 for more information). The data reported in this chapter is from the Martin and Pritchard study (2010) and the research completed by Judy Paulin.

Consistent with the Martin and Pritchard research, the FVDRC has chosen to present the data according to type of family violence death, in the belief that each type will be best understood from separate analysis. The three different types of family violence death that the FVDRC has chosen to analyse are:

1. couple-related deaths, where a suspected perpetrator[8] killed their current partner, ex-partner and/or the ex-partner's new partner
2. deaths of children and young people under 15 years of age

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, and foster-parent.

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

6 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; and accidental deaths related to family violence incidents, including bystanders. This definition of family violence death, which is from the FVDRC Terms of Reference, will be reviewed in 2012.

7 Martin and Pritchard use the term within-family homicides, but these are referred to as 'family violence deaths' in this report.

8 The terms 'suspected perpetrator' and 'perpetrator' are used interchangeably throughout this report. The research includes all perpetrators and suspected perpetrators, meaning those that are convicted perpetrators as well as those that have not been convicted in relation to the death but might be once the legal proceedings are complete.

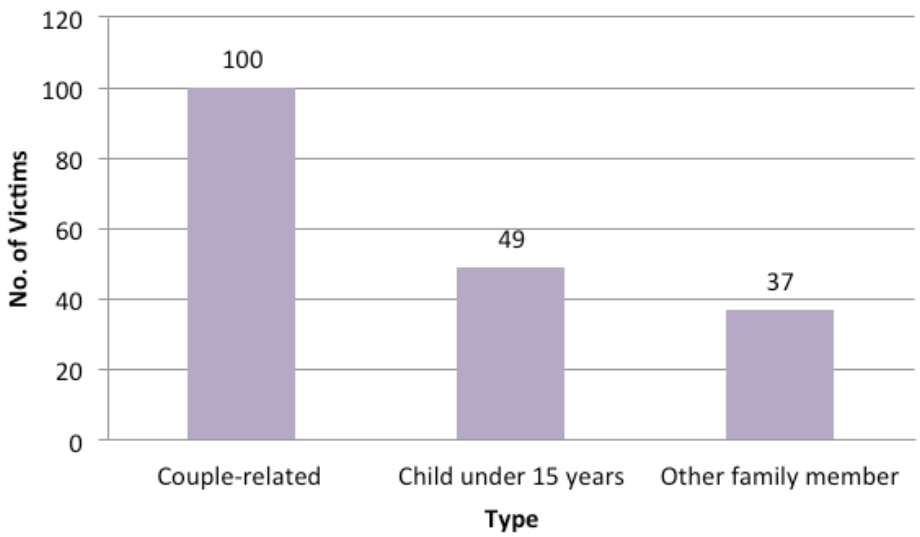
3. other family member deaths, where the adult victim was not in a couple-related relationship to the perpetrator but rather a sibling, cousin, child or young person over 15 years of age, parent, aunt, uncle, step-parent or in-law.

In the period 2002-2008, 186 family violence deaths were identified by the FVDRC. This equates to approximately 27 per year on average.

There were 209 suspected perpetrators of family violence homicide. Sixteen of the family violence death events had more than one suspected perpetrator. Similarly some death events had multiple victims, with the 186 deaths being associated with 180 events.

Of the 186 family violence deaths, 100 were couple-related, 49 were children and 37 were another family member of the suspected perpetrator (Figure 3). Some of the child deaths were in the context of couple-related violence (Martin and Pritchard 2010: 36).

Figure 3: Family violence deaths in New Zealand by type, 2002-2008 (n=186)



Couple-related deaths

From 2002-2008, there were 103 perpetrators and 100 victims of couple-related family violence. Couple-related family violence in New Zealand is mostly committed by males against their female partners and, sometimes, males against their former partner's perceived new partner (Table 3).

Table 3: Sex of perpetrators and victims of couple-related deaths in New Zealand, 2002-2008

	Female victim (n=76)	Male victim (n=24)
Male perpetrators (n=85)	75	13*
Female perpetrators (n=8)	1	7∞
Perpetrators in combination‡ (n=9)	0	4

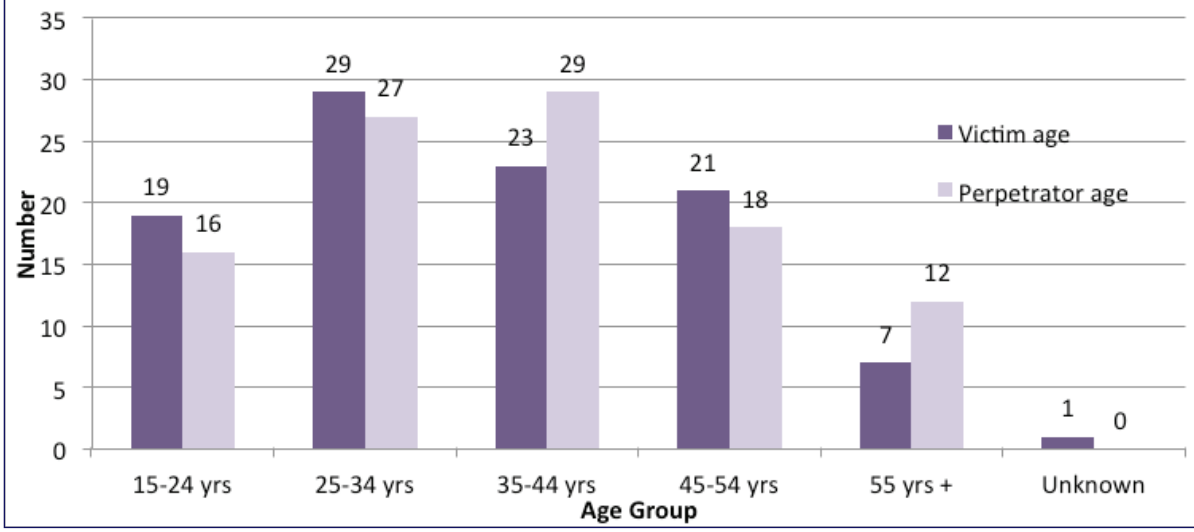
* These were all new male partners of the female victim.

∞ Two of these cases occurred between 2002 and 2006, while the other five occurred during 2007 and 2008. This highlights the importance of small number variation and the difficulties related to identifying trends in New Zealand.

‡ These events consisted of two or more perpetrators working in combination against one victim. Generally, these events involved male and female combinations although there was one event with two female perpetrators.

Figure 4 shows the distribution of couple-related victims and perpetrators by age group. Perpetrators of couple-related family violence deaths are generally older than the victims.

Figure 4: Age of victim and suspected perpetrator in couple-related deaths in New Zealand, 2002-2008 (n=100 victims, n=102 perpetrators)



According to Martin and Pritchard, one of the risk factors of lethal violence is if the woman's male partner is 10 years older or younger than she is (2010: 8). They found that almost a quarter of the relationships where a family violence death occurred had a 10-year age gap, often with the male perpetrator being 10 years (or more) older than the victim (29).

International intimate partner death review processes have shown that couple-related deaths frequently involve multiple associated factors, which in combination contribute to the perpetrator's lethal use of violence (eg, Office of the Chief Coroner for the province of Ontario 2009). Overall, the New Zealand findings from 2002-2008 suggest that the most common factors contributing to the events were:

- threatened, imminent or recent separation
- violence
- alcohol and/or drug abuse, particularly by the perpetrator
- jealousy.

At least a third of all perpetrators of couple-related family violence deaths in 2002-2008 were reported to have made specific threats or warnings to either the victim or other associate prior to the event.

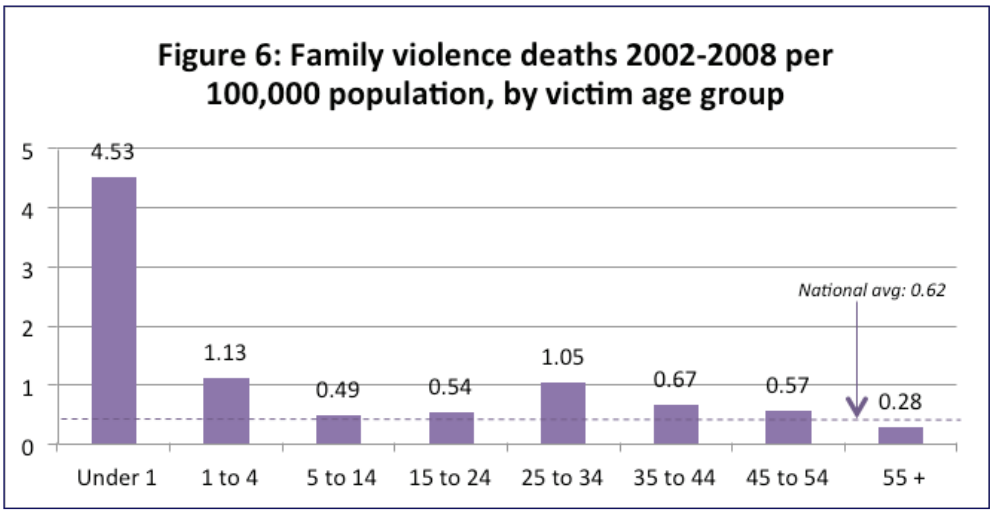
The most common methods used to kill were use of a knife or assault without a weapon.

Child deaths

From 2002-2008, there were 58 perpetrators of child family violence deaths and 49 victims (children under 15 years).

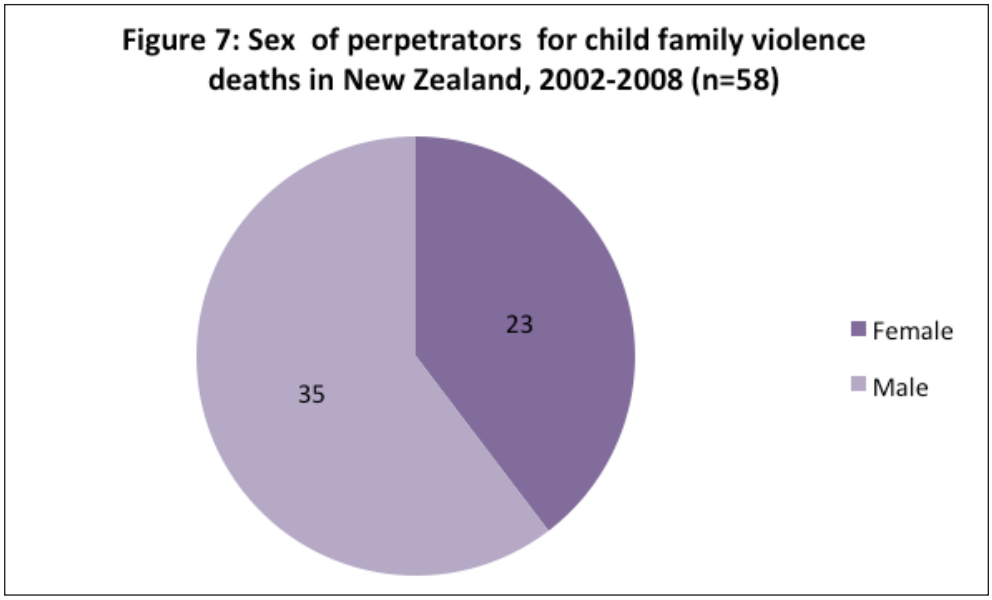
Of the victims, 19 were less than one year old, 19 were between 1-4 years, five were between 5-9 years, and six were between 10-14 years, as shown in Figure 5.

Babies younger than 12 months were most vulnerable to child death from family violence, as shown in Figure 6.



Note: the national average figure (0.62) is the rate of family violence deaths per 100,000 population across all age ranges. Source for the population data is Census 2006 from Statistics NZ.

Thirty-five of the perpetrators of child homicide were male, while 23 were female (Figure 7).



Martin and Pritchard found that children in their first year of life were most likely to be killed by a natural parent, with mothers frequently suspected of killing a baby in the first four weeks of life and fathers frequently suspected of killing an older baby in the 1-12 month age group (2010: 49). Fathers and stepfathers were more often the perpetrator as the child grew older (Ibid).

The majority of suspected perpetrators of child family violence deaths are under 35 years of age (see Figure 8).

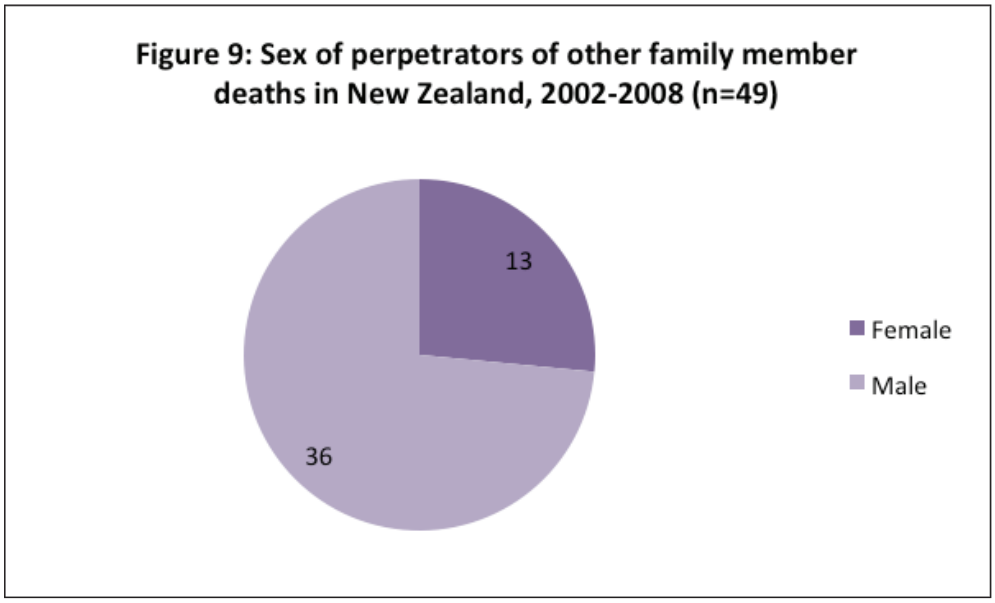
Overall the findings on child victim family violence deaths from 2002-2008 suggest:

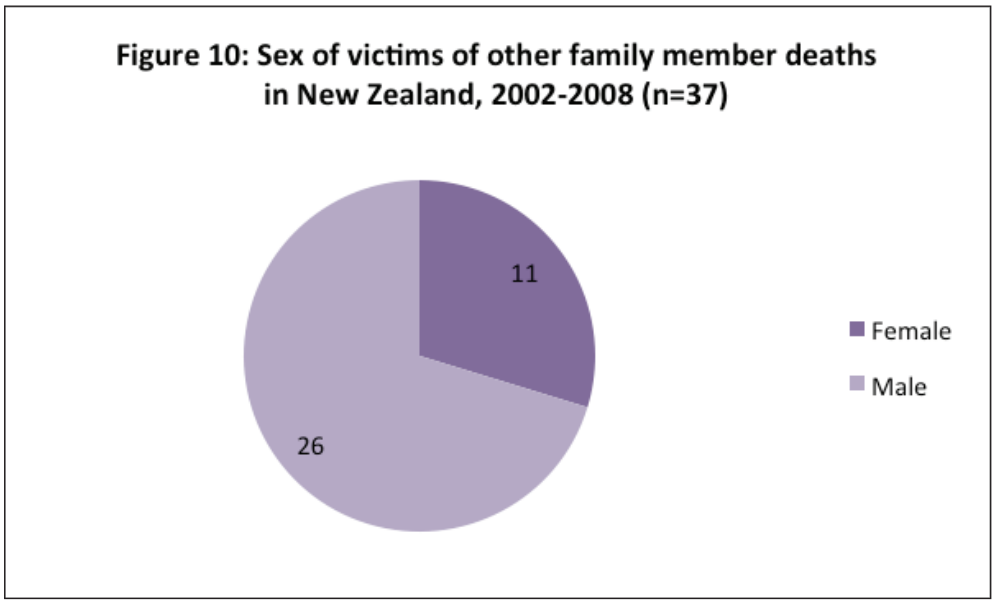
- the first year of life is the highest risk period for child death[9], followed by one year up to five years. More than three quarters of the child victims in the period studied had died within their first five years of life
- the majority of children died from injuries inflicted through assault
- associated factors include drug and alcohol use by the suspected perpetrators, physical punishment of the child and an extreme response to intimate partner separation.

9 This is also highlighted in the research by Duncanson, Smith and Davies (2009).

Other-family-member deaths[10]

Thirty-six of the suspected perpetrators of other-family-member deaths were male (Figure 9), and 26 of the victims were also male (Figure 10).





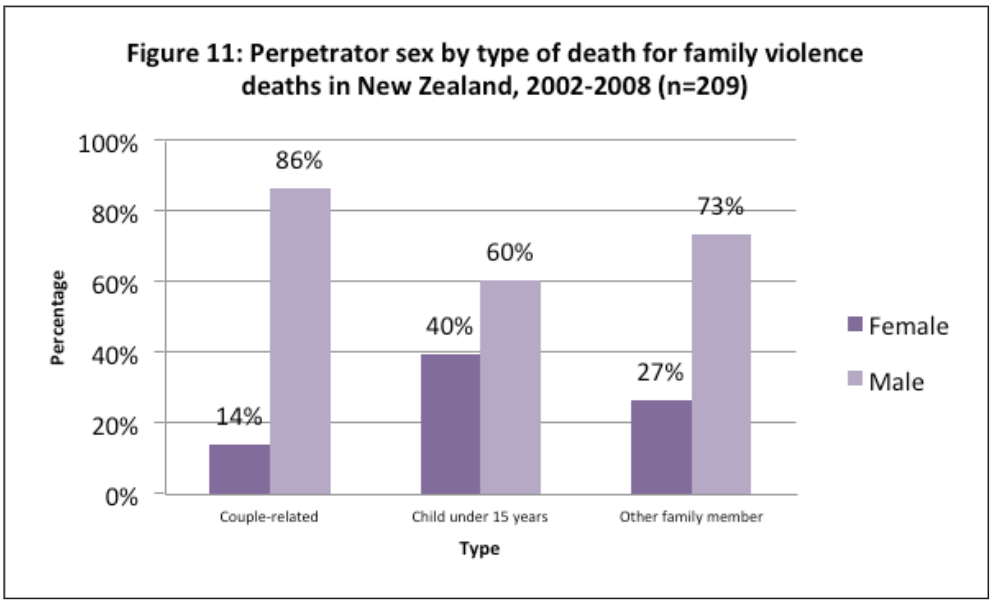
Drug and alcohol use was the most common factor in other-family-member deaths. Other common factors included prior threats or warnings and mental illness.

Perpetrator and victim demographics for all family violence deaths

The suspected perpetrators for all family violence deaths were predominantly males:

- couple-related (86 percent)
- children (60 percent)
- other-family-member (73 percent) (Figure 11).

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



Socio-economic factors

Martin and Pritchard's research suggests that while lethal violence by a family member occurs in all socio-economic groups, the rate of family violence mortality increases at each step of the deprivation scale (2010: 20).[11] The more deprived the neighbourhood, the greater the number of homicides within families. The mortality rate for Māori and New Zealand European increases at each step of neighbourhood deprivation, but the association is stronger for Māori than for New Zealand Europeans.

Other international studies find a similar association between socio-economic status and ethnicity. For instance, the Australian Bureau of Statistics writes: 'Family and domestic violence [FDV] occurs across all socio-economic and cultural groups. However, FDV may become a more complex problem in population groups where it compounds existing social disadvantage' (Pink 2009:1).

Future FVDRC reports will include socio-economic data to help understand differences across the sexes and ethnic groups to help identify protective factors that operate for some population groups but not for others.

Ethnicity

Tables 4 and 5 show the ethnicity of victims and perpetrators. While the highest numbers of deaths are New Zealand European, Māori are over-represented as both victims and perpetrators.

Table 4: Family violence death victim ethnicity, New Zealand, 2002-2008 (n=186)

	Total n	NZ European n (%)	Māori n (%)	Asian n (%)	Pacific n (%)	Other n (%)	Unknown n (%)
Couple-related	100	35 (35)	32 (32)	16 (16)	10 (10)	0	7 (7)
Child under 15 years	49	17 (35)	23 (47)	3 (6)	5 (10)	0	1 (2)
Other-family-member	37	11 (30)	17 (46)	2 (5)	5 (14)	1 (3)	1 (3)
Total	**186**	**63 (34)**	**72 (39)**	**21 (11)**	**20 (11)**	**1 (1)**	**9 (5)**

Note: due to rounding, some rows do not total 100.

11 Martin and Pritchard (2010) used the New Zealand Index of Deprivation (NZDep) as a proxy for socio-economic status.

Table 5: Family violence death perpetrator ethnicity, New Zealand, 2002-2008 (n=209)

	Total n	NZ European n (%)	Māori n (%)	Asian n (%)	Pacific n (%)	Other n (%)	Unknown n (%)
Couple-related	102	34 (33)	25 (25)	11 (11)	12 (12)	1 (1)	19 (19)
Child under 15 years	58	19 (33)	23 (40)	6 (10)	2 (3)	2 (3)	6 (10)
Other-family-member	49	10 (20)	24 (49)	5 (10)	3 (6)	1 (2)	6 (12)
Total	**209**	**63 (30)**	**72 (34)**	**22 (11)**	**17 (8)**	**4 (2)**	**31 (15)**

Note: due to rounding, some rows do not total 100.

Preliminary issues identified from paper and pilot reviews

A key strength of the FVDRC is the information that is obtained through, and shared in, the local review processes. While different government and non-government agencies hold particular information about each family violence death, the FVDRC process is unique in that it brings all of this different information together to develop a broader picture than that available to any one agency.

As Chapter 1 discussed, the FVDRC is developing a nationwide network of local family violence death review panels. To date, the FVDRC has conducted a number of paper reviews and three pilot reviews. From these preliminary reviews, the FVDRC is beginning to identify issues and themes that are common across a number of family violence events, recognising the pilot nature of the process so far. Despite this, the issues that are emerging appear to resonate with a number of international studies and were not surprising to the experts who participated in the pilot review process.

The FVDRC is pleased to note that a number of the panel representatives from the New Zealand Police, Corrections and CYF have already taken learnings from the pilot reviews back to their respective institutions in order to improve their systems.

The recent release of convicted offenders

The Department of Corrections provides a key service in the risk management of offenders with histories of family violence. The department has an integral role to play in assessing risk to other family members, including (ex-)partners and children. These assessments of risk need to occur at the offender's initial engagement with Corrections and extend right through to their release from prison and then to the end of their supervisory period with community probation. The purpose of this risk assessment is to ensure there is a risk management plan in place for the offender that addresses risks to other family members, which can contribute to multi-agency family violence initiatives that focus on the safety of vulnerable (ex-)partners, children or other family members.

Information gathered from the pilot family violence death reviews indicates the importance of a systemic focus on victim safety to prevent further family violence in the period after offenders with a history of family violence are released. The FVDRC recognises that the Department of Corrections is aware of these risks and is currently undertaking a review of its policy, procedures and practice in this area, including the provision of domestic violence intervention programmes. The FVDRC looks forward to continued dialogue with Corrections.

Transitions of care

Infants are overrepresented in the children being killed by family members (Figure 6). It is important that information about infant and child risk is shared between service providers and agencies, particularly when infants and children are transitioning between care providers.

The transition from maternity care to the Well Child provider is an essential one. The CYMRC made recommendations in its *Fourth Report to the Minister of Health* (2008) and *Fifth Report to the Minister of Health* (2009) on the need for a holistic approach to the continuity of care for children and young people

transitioning between services. The FVDRC supports these recommendations.

In their *Fifth Annual Report* (2011: 6 & 54), the PMMRC made a recommendation that family violence screening should be a routine part of maternity care and screening should be documented in clinical notes. The FVDRC also supports this recommendation.

First responders

The FVDRC has also noted that first responders are often not able to fully assess the severity of family violence incidents. The data collected on family violence deaths often show that a number of agencies had visited the family prior to the death but the severity of the risk of lethal violence was not accurately identified.

While there is a growing interest in the use of domestic violence risk assessment tools and their validity, training in the use of these tools and understanding of the dynamics of family violence in general may be insufficient for many first responders. While there are many agencies that support people in the community, the Police are often the first responder to serious family violence incidents. The FVDRC would like to see the New Zealand Police continue to address the quality and amount of family violence training offered to new recruits and existing officers of all ranks.

The FVDRC acknowledges and supports the New Zealand Police in their work to identify and introduce a new intimate partner violence risk assessment tool, and their development of a child risk factor tool.

The FVDRC will continue to discuss the above three preliminary issues with the respective agencies and will monitor progress.

Further considerations

The above issues are not new[12] and reflect consistent patterns. However, while the patterns are familiar, our understanding of the nature and reasons for the uneven spread of family violence deaths across different populations is still limited. The findings from our work to date raise many questions for further consideration.

- Why do some groups of the population seem to have specific 'protective' factors that reduce the likelihood that they will be involved in family violence deaths?
- What are these factors, and how can we learn about them and ensure that they are better shared across the entire population?

While the FVDRC cannot yet answer these questions, it is hoped that as reviews are completed we will gain a stronger understanding of risk factors and protective factors, and use that understanding to improve systems to reduce family violence and family violence deaths in New Zealand.

12 See Duncanson, Smith and Davies (2009) and Campbell et al (2007).

Chapter 4: Looking Forward - Priorities for 2011/12

The FVDRC has spent considerable time and resources in developing and trialling a family violence death review system and a data collection system for New Zealand. This has been, and continues to be, a complex task.

While the FVDRC is acutely aware of the need to progress from the current trial to full implementation, we need to consolidate learning and build on it carefully.

During 2011/12, the FVDRC will seek to further progress goals set in 2009/10, particularly:

- establishing a fully functional data collection and information system
- ensuring effective and culturally appropriate reviews occur
- continuing to develop and build on relationships with the family violence sector, government agencies, key stakeholders and the community.

Local review panels

Based on experience to date and the volume of family violence related deaths, it is currently envisaged that up to seven panels will be established in Auckland, Wellington, Bay of Plenty, Waikato, South Island, Eastern North Island and Central North Island. The locality of panels relates to the volume of reviews required rather than the number of Police or District Health Board (DHB) districts, and may change over time.

It is envisaged that the panels established for the trial will transition into ongoing panels in their respective localities. At this stage, the FVDRC plans to set up the additional panels once the pilot reviews and their evaluations are complete.

Data systems

The FVDRC is working towards the development of an electronic information system to support its mortality review functions. Considerable work has been undertaken by the FVDRC Data Working Group to determine the information system needs of the FVDRC.

The Commission is scoping the information needs of all the mortality review committees, including the FVDRC. This work covers the collection, storage, retrieval and analysis tools required to support mortality review, and places an emphasis on how these functions can be provided across all of the committees. The Commission is giving consideration to the existing systems managed and administered by the New Zealand Mortality Review Data Group as well as current health and disability sector information systems, and is considering whether custom built systems are required and if services should be provided in-house or outsourced. As cost effectiveness and value for money implications are part of the Commission's scoping exercise, there is an expectation that all mortality review committees will utilise the same overall system, albeit with fields and facilities specific to their unique requirements.

The FVDRC has made considerable progress this year in the development of its privacy protocols and practices (see Appendix 4 on information security processes). These systems will be aligned with the Commission's system as it is developed in the future.

Memoranda of Understanding (MoU)

Good working relationships and networks currently underpin the availability of information for family violence mortality review. The FVDRC considers it is now timely to formalise arrangements with main information sources. This is especially important because FVDRC's recent move to the Commission, coupled with changes in the wider public sector, may result in personnel changes and potential loss of institutional knowledge.

MoUs will need to be agreed with key information providers and cover what information is required, how it will be transmitted, its usage for review purposes, and its ultimate storage, return or destruction.

MoUs will be developed in the context of recent government announcements concerning the sharing and re-use of information, including proposed legislation to provide a legal foundation for the sharing of information between government agencies.

The FVDRC considers the development and agreement of MoUs with Police, CYF, and Justice (Courts) to be priorities.

In the next stage of our work, the FVDRC will:

- focus effort on local/regional review in acknowledgement that local review is the core business of the FVDRC and it is important to get the local review system right prior to conducting national or cluster reviews
- consolidate learning from the pilot reviews and overall trial so that the FVDRC can move to full implementation
- do further work on an analytical framework to enable findings/themes, analysis and recommendations from local reviews to be captured and reported to national or cluster reviews
- establish regional review panels in regions such as Auckland, Wellington, Bay of Plenty, Waikato, South Island, Eastern North Island and Central North Island
- give priority to reviewing the most prevalent types of deaths in the short term (ie, couple-related and child deaths)
- work collaboratively with the Commission and other mortality review committees on the development of the information collection, storage and analysis system, which will meet our collective needs and objectives.

Appendix 1: Family Violence Death Review Committee Members

Membership[13]

Wendy Davis (Chair)

Ngaroma Grant (Deputy Chair)

Brenda Hynes

Dr Alison Towns

Vaoga Mary Watts

Past members

Patrick Kelly

George Ririnui

Rob Veale

Advisors

The FVDRC is also supported by advisors from Coronial Services, Department of Corrections, Ministry of Health, Ministry of Justice, Ministry of Social Development, New Zealand Police and the Office of the Children's Commissioner.

13 A new Family Violence Death Review Committee is scheduled to commence on 1 December 2011. Bios for the new committee members will be posted on the FVDRC website.

Appendix 2: Family Violence Death Review Committee Terms of Reference

The Role of the Committee

1. The Family Violence Death Review Committee ("the Committee") is a Mortality Review Committee, appointed under section 59E of the New Zealand Public Health and Disability Amendment Act 2010 ("the Act") by the Health Quality & Safety Commission ('the Commission').

The Functions of the Committee

2. The Committee's functions are to:

    2.1. review and report to the Commission on family violence deaths, with a view to reducing the numbers of family violence deaths, and to encourage continuous quality improvement through the promotion of ongoing quality assurance programmes

    2.2. develop strategic plans and methodologies that are designed to reduce family violence morbidity and mortality, and are relevant to the Committee's functions

    2.3. advise on any other matters related to family violence deaths that the Commission specifies.[14]

3. In order to fulfil its functions, the Committee will:

    3.1. 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

    3.2. monitor the number, categories and demographics of family violence deaths

    3.3. identify patterns and trends in family violence deaths over time

    3.4. make available to researchers data about family violence deaths within the privacy and confidentiality restrictions on the Committee

    3.5. liaise with any other mortality review committees appointed by the Commission to assist, on mutual agreement, with reviews of deaths that are within the scope of those other committees.

4. In order to perform its functions, the Committee will:

    4.1. collect data and information from relevant sources on circumstances leading up to and surrounding family violence deaths

    4.2. review the circumstances surrounding family violence deaths, including system and agency practice interventions/processes

    4.3. conduct specific reviews/investigations into clusters/subgroups of family violence deaths

    4.4. undertake and/or support local family violence death reviews.

Guiding Principles

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

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

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

14 Paragraphs 3 – 3.3 of 'The Functions of the Committee' are derived from section 59E of the NZPHD Act.

6.2. keep information and data secure, and protect confidentiality

6.3. operate in a culturally appropriate, sensitive, and responsive manner

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

6.5. develop, enhance and foster interagency collaboration, trust and networking in the family violence sector

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

6.7. support and protect individual and agency death review participants

6.8. 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

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

7.1. The unnatural death of a person (adult or child) where the suspected perpetrator is a family or extended family member[15], caregiver[16], intimate partner, previous partner of the victim, or previous partner of the victim's current partner.

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

8.1. suicides

8.2. assisted suicide (based on pact)

8.3. deaths from chronic illness resulting from sustained violence

8.4. accidental deaths related to family violence incidents.

Definition of Family Violence Death Review

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

9.1. 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.

10. 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.

Composition of the Committee

11. The Committee will have a maximum of eight members appointed by the Commission.

12. All members will have knowledge of, or expertise in, family violence issues.

13. The Committee's membership may include:

13.1. members with expertise in mortality review systems

13.2. members with expertise in social science and/or health research

13.3. members with experience as a social worker or a family violence case worker

15 '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.

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

13.4. members with knowledge of, or experience in, service provision or operational policy in the social sector

13.5. members who are experts in the field of child abuse and protection issues

13.6. members who are registered health practitioners or registered clinical psychologists

13.7. members who are lawyers with expertise in family violence law

13.8. members with knowledge of family violence issues from a service user/family perspective

13.9. Māori members with knowledge of family violence issues, or experience in working with Māori families affected by family violence

13.10. Members of other ethnic groups with knowledge of family violence issues, or experience in working with families affected by family violence.

14. 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:

    14.1. the Chief Coroner's Office

    14.2. the Ministry of Health

    14.3. the Ministry of Social Development

    14.4. the Ministry of Justice

    14.5. the New Zealand Police

    14.6. the Office of the Children's Commissioner.

15. The Committee may appoint sub-groups or establish working parties relevant to its agreed work plan and it may co-opt expertise as necessary to assist any sub-groups, within its budget.

16. 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

17. Members of the Committee are appointed by the Commission 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.

18. Unless exceptional circumstances are identified and these agreed upon by the Committee and by the Commission, 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.

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

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

21. The Commission may, by written notice, terminate the appointment of a member or Chair of the Committee.

22. The Commission 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.

Chair and Deputy Chair

23. The Commission will appoint a member of the Committee to be its Chair. The Chair will preside at every meeting of the Committee at which they are present.

24. The Committee may appoint one of its members to be Deputy Chair.

Duties and Responsibilities of a Member

25. The following sections set out the Commission'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.

26. 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

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

28. 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.

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

30. 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

31. 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.

32. 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

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

34. Members must note the statutory requirements in section 59E of the Act, which prevents disclosure of "information" as it is defined in clause 3 of schedule 5 of the New Zealand Public Health and Disability Act 2000. Under that clause, information means any information:

34.1. that is personal information within the meaning of section 2(1) of the Privacy Act 1993; and

34.2. 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.

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

Meetings of the Committee

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

37. 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.

38. 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 Chair's own vote, the Chair may choose to exercise a casting vote.

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

Performance Measures

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

41. The Committee must:

41.1. agree in advance to a work programme with the Commission

41.2. achieve its agreed work programme

41.3. stay within its allocated budget.

Reporting Requirements

42. The Committee is required to:

42.1. 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

42.2. provide the Commission with a report, on an annual basis or as otherwise required by the Commission, 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 Commission. The report will be tabled by the Commission in the House of Representatives pursuant to section 18 (4) of the NZPHD Act.

Servicing of the Committee

43. The Commission 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

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

45. The Chair 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 Chair is entitled to an allowance of two extra days per month to cover additional work undertaken by the Chair.

46. 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).

47. 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).

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

Establishment Issues

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

    49.1. developing mechanisms and protocols for family violence death reviews

    49.2. determining the availability, reliability and validity of existing data collection processes

    49.3. 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

    49.4. decide on definitions to be used for each piece of data during collection, analysing and reporting

    49.5. establishing functional relationships with:

        49.5.1. the Child and Youth Mortality Review Committee and the Perinatal and Maternal Mortality Review Committee

        49.5.2. new and existing local non-statutory mortality review committees

        49.5.3. other agencies who conduct family violence mortality reviews

        49.5.4. the Family Violence Interagency Response System

        49.5.5. key stakeholders in the family violence sector

    49.6. establishing processes to ensure security of "information" as that term is defined in clause 3 of Schedule 5 of the NZPHD Act

    49.7. determining how the Committee will operate in a culturally appropriate, sensitive and responsive manner

    49.8. 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 counselling.

Review of the Committee

50. A formal review and evaluation of the Committee and these Terms of Reference will be undertaken by the Commission, starting in 2012. 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.

Appendix 3: Taking Care of Those Working on Family Violence Death Reviews

Contributed by Dr Alison Towns

When dealing with deaths through family violence you will be working with some very disturbing material about the deaths of children, women or men at the hands of other family members. These deaths are deeply saddening to all those who are involved, particularly to family members but also to those who worked with them who may feel, in some part, responsible for their deaths.

The family violence death review has been set up as a 'no blame' process in order to assist all those involved with the victim and the perpetrator to make sense of their agency responses to the victim and the perpetrator. The intention is to find ways to assist agencies and government to improve their practices and their policies associated with family violence. As such it is not concerned with blaming individuals or agencies.

Family members and friends of victims and perpetrators have special support needs of which all agencies need to be aware. Ensuring that family members and friends receive the support they need following a death of a loved one should be a first consideration for any agency involved closely with the death of a family member. The FVDRC's focus is on improving agency systems and responses.

The FVDRC wants to ensure systems are in place for all those associated with these reviews who are exposed to the disturbing material and its contents. It is also important they receive the support they need to ensure they are protected from any adverse outcomes. The following groups will be exposed to this material:

- agencies involved with the victim or perpetrator
- agencies involved with investigating the deaths for accountability purposes
- local family violence death review groups
- agency guests of the local family violence death review groups
- the FVDRC
- the FVDRC secretariat.

The following is addressed to those agencies and the individuals who are working on a family violence death review.

Agency and individual action

When you know you are going to be exposed to traumatic material in the future there are some things you can do to help prevent any adverse outcomes and there are some things your agency can do to help with prevention. Feeling like you are in control of your situation will help protect you from trauma symptoms.

Actions agencies can take

In addition to legislated workplace safe practices, agencies can ensure that:

- their workplace has been audited for safe practices by participating in a violence-free workplace programme
- the management actively supports the work of the team involved in the violence sector
- there is a supportive team around individuals working in the violence or abuse sector, and that support systems are in place in order to make sure that:

- accessing debriefing and supervision is routine
- expertise is available when there is a critical incident
- well-being is monitored by an independent clinical expert in trauma effects at least bi-annually for those in the work long-term. This expert in trauma should work with managers to ensure the well-being of staff

- staff confidentiality is respected so that individuals who are experiencing trauma symptoms know that their confidentiality will be respected and feel safe to disclose to someone who can help
- no one individual works alone
- there are clear policies around the management of crises or critical incidents that involve consultation with others so that no one person is attempting to manage an immediate critical incident alone
- access to administrative support services is seamless and a primary role of support staff is to ensure those working in this area have ready access to these services without question
- individuals working in this area are protected from management issues that create uncertainty and over which they have no control, as much as possible
- where staff need to be involved in management decisions that affect them, their participation provides them with a sense of their own control over their situation
- the strategies put in place to support staff are developed with the staff involved, and trauma experts and staff management plans are maintained through any organisational changes
- these safe practices are reviewed and audited and that new staff members are orientated around these practices
- teams or groups involved in this work are conscious of the impact of the work and support each other.

Actions professionals or workers in the area can take

There are a number of useful things to do when working in the violence and abuse area that can help:

- keep clear boundaries - limit the work to fixed hours, stick to them and avoid bringing work home
- rigorously respect confidentiality as this avoids stressful situations later
- avoid invitations to break boundaries
- learn strategies that help you switch-off from work
- build in self-care strategies when you know the work is going to be hard – ie, exercise, good nutrition, relaxation and pleasure
- know the limits of your knowledge and seek expertise when needed, remembering that the violence and abuse sector is a complex one
- prioritise regular supervision and attend it
- prioritise debriefing after the hard work. Set informal time together as routine after meetings to process material. Share the difficult stuff with your team or a trusted other, such as a supervisor, as soon as possible after the event.

Warning signs for self-monitoring

Following exposure to traumatic events or material it is not uncommon for individuals to experience:

- interruptions in usual sleep patterns
- re-experiences of the traumatic material through, for example:
  - dreams or nightmares
  - intrusions into one's thoughts
  - ruminations of the event
  - flashbacks to the traumatic material or to similar events in one's life
- heightened levels of arousal, for example:
  - difficulties with relaxing
  - some startle responses
  - heightened vigilance
  - irritability
- avoidance, for example:
  - wanting to avoid any association with the material
  - wanting to avoid going to places associated with exposure to the material
  - avoidance of anything that might remind one of the exposure, for example, watching TV programmes which might expose one to similar events
- a sense of helplessness or that one has no control over the circumstances surrounding the event or that one cannot bring about any change.

These experiences should fade or dissipate over the days following the exposure to this traumatic material especially when the support systems are in place to ensure that opportunities are there to process the information.

If these experiences do not fade or go away and are still being experienced a month later, then experienced trauma support should be sought. Useful questions to ask yourself are:

- as a result of this exposure am I restricting my life or avoiding doing things that I would normally do? Am I doing at least three of the following:
  - avoiding supervision or debriefing sessions
  - avoiding doing the work that involves exposure to the material
  - avoiding places associated with the work
  - engaging in excessive activities (apparently healthy) such as excessive exercise or hours playing games that are really avoidance
  - constricting my life (eg, not going to family events or delaying phone calls)
  - drinking more
- do I feel generally okay except when I know I have to go to work?
- do I find myself working well in other areas and avoiding doing the work that will expose me to this traumatic material?

- am I sleeping well? Am I having bad dreams, nightmares or intrusive thoughts that have as their recurring content the trauma material that I have experienced?
- am I having difficulties with concentration?
- am I unusually forgetful?
- am I feeling excessively tired?
- am I becoming irritable, angry or tearful when I am not normally?
- do I feel like I am in control of my work and home situation or does it feel like I am not coping and this exposure is too stressful for me in my current situation?
- has this traumatic material reminded me of bad experiences that I have had in my own life that distress me and that I find hard to talk about? Do I get recurring thoughts about these past experiences while I am trying to do my work?
- am I emotionally in a good place to be able to deal with this material at the moment or is there too much going on for me emotionally to handle this difficult material?
- do I have a strong sense that there is nothing I can do to bring about change?

If there are indications that this work is affecting you or that you are not in a good place to do this work at the moment, moving away from the work for a period of time or permanently will probably prevent you from experiencing more lasting symptoms of trauma. Talk this possibility through with your supervisor and/or someone knowledgeable about trauma and its effects. Develop a plan or strategy that will allow you recovery time and prevent any ongoing trauma symptoms. Work these decisions and your responses through with your supervisor or a trauma specialist counsellor.

Sometimes post-traumatic symptoms do not appear until months after the exposure. You should seek help from a trauma specialist if this occurs to you as there may be some simple strategies that can be put in place to assist you.

If you experience trauma symptoms you should be aware that these responses are natural and normal responses to exceptional material. They are the ways that your body tells you to get away from this exposure and to protect yourself and recover, or that your body tries to assist you to process the material. It is important to listen to these responses and to act in your own best interest.

Appendix 4: Information Security Processes

The NZ Public Health and Disability Act 2000 (the Act) provides the statutory basis for all of the operational procedures and mechanisms that the FVDRC puts in place to ensure the security and confidentiality of information. References to the Act are included in all formal requests for information, along with information about how the FVDRC will keep the material confidential and protect the privacy of the individual and the agency from which the information is requested.

Both the Commission and the FVDRC websites include material for the public on the relevant sections of legislation, the personal and other information mortality committees can gather, and questions and answers relating to the mortality review functions.

The procedures and protocols developed for safe collection, transfer, storage and use of information are being developed and improved as necessary.

Local review information

The lead co-ordinator prepares material for review panels prior to review. All preparation occurs in the secretariat office. Information for the review panel is printed, copied and bound in packs. All packs are numbered, entered into a confidential document log (audit trail) and provided to panel members on the review day. Packs are collected up at the end of the day and checked against the confidentiality log.

Panel members selected by agencies may bring additional information related to their agency on the day. In these instances, the panel member is accountable for the safe transportation of their information. Publicly available information (eg, media summaries and judicial decisions) is not collected up at the end of the meeting.

Prior to the review meeting, all panel members have been made 'agents' of the FVDRC. This is a formal appointment, which involves a signed agreement that the agent has read and understood the statutory provisions of the Act and an attached information sheet defining the role of the agent, the meaning of information, how it is obtained and the penalty for disclosing information. Agent status allows review participants to comply with the legislative framework for safe use of mortality data.

Appendix 5: Data Collection Methodology and Limitations

Prior to the establishment of the FVDRC, the Ministry of Social Development completed an important piece of research for family violence in New Zealand. The study, *Learning From Tragedy: Homicide Within Families in New Zealand 2002-2006* (2010) by Jennifer Martin and Rhonda Pritchard, considered all family violence deaths in New Zealand for the five-year period 2002-2006. The Martin and Pritchard research was used to inform the development of the initial policy framework for the FVDRC, and has influenced much of the work since.

The FVDRC met for the first time in October 2008, and started collecting information on family violence deaths from the start of the 2009 year. The FVDRC wanted to ensure the Martin and Pritchard study was built on, and a record of all deaths could be maintained following on from that study. A decision was made to 'back-capture' information on family violence deaths for the 2007 and 2008 years to fill the gap in data from the end of the Martin and Pritchard study in 2006 to the start of the FVDRC collection in 2009.

A researcher was commissioned to complete the 'FVDRC Back-capture Project, 2007 and 2008'. This data is referenced throughout this report as 'the Paulin study' or by reference to the researcher, Judy Paulin.

The aim of the Paulin study was to capture data on family violence deaths for 2007 and 2008 so the FVDRC could report on family violence deaths from 2002 to 2008. The project had two specific goals:

- to replicate the methodology used by Martin and Pritchard
- to create a full dataset for reporting all family violence deaths from 2002 to 2008.

Both goals have only been partially achieved to date, due to a range of issues beyond the control of the researcher or the FVDRC.

The methodology used in the Martin and Pritchard study could not be replicated in full due to changes in record keeping within government organisations, and in particular within the New Zealand Police. Whereas the Martin and Pritchard study extracted data on factors associated with deaths mostly from the New Zealand Police National Homicide database, the Paulin study extracted data on associated factors mainly from judicial decisions. It is the FVDRC's understanding that the New Zealand Police National Homicide Database was not maintained through 2007 and 2008.

This change in data sources had a significant impact on the findings of the second study. While Chapter 3 reports the total number of family violence deaths from 2002 to 2008 (using the combined data from the two studies), it provides no additional information on the factors associated with each type of death because of the change in data sources. More data gathered across a longer period will be required before any understanding of trends, significant differences, or associated factors can be considered.

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Family Violence Death
Review Committee

He tao huata e taea te karo