REPORT OF THE DOMESTIC AND FAMILY VIOLENCE DEATH REVIEW PANEL

2010

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Executive Summary

The Domestic and Family Violence Death Review Panel was established by the Minister for Community Services and Housing and Minister for Women, the Honourable Karen Struthers MP, to provide expert advice to her and her colleagues, the Attorney-General and the Minister for Police on two major objectives:

1. Options for strengthening coronial processes and the Coroner's capacity to comment on domestic and family violence related issues; and

2. Options to identify systemic gaps and barriers to help prevent domestic and family violence-related deaths in the future, including models for an ongoing death review process.

The following panel members were appointed by Minister Struthers:

- Marg O'Donnell (independent Chair)
- Heather Nancarrow (Queensland Centre for Domestic and Family Violence Research, CQ University)
- Donna Justo (Gold Coast Domestic Violence Prevention Centre Inc)
- Ken Georgetown (Murri Watch)
- Katarina Carroll (Queensland Police Service)
- Cathy Taylor (Department of Communities)
- Terry Ryan (Department of Justice and Attorney-General)

In addition to the panel members listed above, Colleen Wall (Manager of the Aboriginal and Torres Strait Islander Women's Legal and Advocacy Service) was instrumental in providing expert knowledge and advice to panel member Ken Georgetown and the wider panel in terms of Aboriginal and Torres Strait Islander issues and concerns. Furthermore, Helen Warneke, Director of Child Safety, Youth and Family Policy and Performance, played a key role in managing the domestic and family violence death review panel, while Michelle Hayes carried out the research for the panel and wrote the final report. The panel consulted regularly with the State Coroner to develop recommendations to guide the establishment of an ongoing death review mechanism.

The implementation of the Death Review Panel was an initiative of the Queensland Government's Strategy to reduce domestic and family violence. The panel convened seven times over the course of its appointment to scope and plan its work, review progress, and make recommendations.

Methodology

The methodology adopted by the panel included:

- Liaising with the Office of the State Coroner about general operational arrangements

- Liaising with the Victorian State Coroner and Coroner's Prevention Unit regarding implementation of the Victorian Family Violence Death Review process

- Applying for, receiving access to, and reviewing de-identified documents from closed coronial files

- Consulting with other key stakeholders within the Queensland Government

regarding their interaction with the coronial process, including the Queensland Police Service (Queensland Police Service) and the Department of Justice and Attorney-General

- Consulting with service agency representatives regarding their feedback on processes and practices for an ongoing death review mechanism. Consultations were held with Aboriginal and Torres Strait Islander service workers, members of the Domestic Violence Death Review Action Group (DVDRAG), and staff from the Women's Legal Service

- Reviewing existing contemporary research on domestic and family violence related deaths, and death review boards within a national and international perspective

- Presentations from academic, non-government and government departments, including Griffith University; Domestic Violence Death Review Action Group (DVDRAG); the State Coroner, Queensland Police Service, and the Commission for Children and Young People and Child Guardian (CCYPCG).

The prevalence of domestic and family violence in Australia

The impact of domestic and family violence on individuals and communities is devastating. Australian research reports one in three women has experienced physical violence at some stage in their lives since the age of 15, with the majority of these cases perpetrated by men against women and their children (ABS, 2005). Women are mostly assaulted at their home, often repeatedly, by a man they know and with whom they are/were engaged in an intimate relationship (ABS, 2005). In particular, Aboriginal and Torres Strait Islander women and children experience domestic and family violence at much higher rates than non-Aboriginal and Torres Strait Islander women and children. In 2006-07, 13% of all Australian victims of homicide were Aboriginal and Torres Strait Islander, despite Aboriginal and Torres Strait Islander people comprising less than 3% of the total population (Dearden and Jones, 2008). Aboriginal and Torres Strait Islander women are more than 10 times more likely to be a victim of homicide than other Australian women (Mouzos, 1999), and most of these deaths (75%) are committed by an intimate partner (compared to 54% for non-Aboriginal and Torres Strait Islander women) (Mouzos and Makkai, 2004; Mouzos, 1999).

Dearden and Jones' (2008) analysis shows that of the 266 homicides in Australia during 2006-07, 65 (24.4%) were intimate partner homicides, and of these, 23 victims were male (35.3%) and 42 victims were female (64.6%). In addition, Dearden and Jones (2008) report two-thirds of male homicide victims were killed by someone outside the family (i.e., strangers and friends/acquaintances), while nearly three-quarters of female victims were killed by intimate partners or other family members. Women who kill their partners most often do so after a protracted history of severe and ongoing domestic violence previously perpetrated by the deceased partner (Mouzos and Rushforth, 2003). Another disturbing feature of domestic and family violence related homicide is the incidence of filicide: that is the killing of children by parents or custodians. On average, 25 children per year are the victims of homicide in Australia, with about a third of these occurring in circumstances of domestic violence and/or family breakdown. Once again, men are responsible for the majority of killings, with 63 percent of child killings committed by fathers, as opposed to 37 percent by mothers (Mouzos and Rushforth, 2003).

In 2008-09, the total cost of violence against women and their children was estimated

to have cost the Australian economy $13.6 billion per annum (KPMG Management Consulting, 2009). Using a population share estimate, it can be extrapolated that the cost to Queensland is approximately $2.7 to $3.2 billion per annum. If there is not a significant and successful change in the way we are addressing the problem, this figure would rise to approximately $15.6 billion in 2021- 22 (KPMG Management Consulting, 2009). To make sure the human and associated economic costs are reduced in communities, we need to work more strategically to change the situation in Queensland. This includes analysing domestic and family violence deaths to identify opportunities to intervene earlier and prevent deaths in the future.

Domestic and family violence death review mechanisms have been established in a number of states within Australia, and more extensively, within several countries internationally, including the United States, Canada (Ontario), the United Kingdom and New Zealand. The models vary, but share common features including: a legislative basis, membership comprising government and non-government representatives; strict confidentiality provisions; the view that domestic and family violence-related deaths are preventable; and a focus on prevention and intervention.

Positive outcomes that have been attributed to domestic and family violence death review mechanisms include:

- Greater knowledge about domestic and family violence;
- Improvements to services and systems;
- Enhanced public and professional education and training; and
- Generating inter-professional information sharing and discussions for change.

Annual reports released by international boards have consistently highlighted a reduction in domestic homicides and improved criminal and social justice responses to domestic violence within their communities (DVDRAG, 2008).

The need for a domestic and family violence death review process in Queensland

Domestic and family violence deaths are almost never without warning. In most cases, there have been repeated incidents of violence and indicators of risk, as well as opportunities for agencies and individuals to intervene before the death. When viewed as the escalation of a predictable pattern of behaviour, domestic or family homicides can be seen as largely preventable deaths. The lack of system and systematic analysis of domestic and family violence deaths has been noted in many of the jurisdictions that have subsequently introduced a review process. It is recognised that death reviews serve an important function to more fully consider particular types of deaths, such as child death reviews and mining fatalities.

While Queensland does have a mechanism for death reviews through the coronial system, there is no specific support for the investigation and review of domestic and family violence related deaths. In general terms, these deaths are investigated by the police and prosecuted by the criminal justice system as discrete homicides, not related or relevant to one another because they are factually and legally different. A united approach to addressing these deaths will enable valuable and broad systemic recommendations and changes to be made that can effectively reduce this devastating social issue.

For instance, the Sixth Annual Report of the Ontario Domestic Violence Death Review Committee (Office of the Chief Coroner, 2008) notes that since its inception in 2003, similar themes, issues and identifiable risk factors within the relationship between the victim and the perpetrator recur in many of the cases under review. Consequently, deaths in similar circumstances may be prevented by families, the public, law enforcement, judicial and social service agencies identifying these risk factors within relationships, and addressing them promptly before a tragedy occurs. The Ontario DVDRC reports that an analysis of all deaths reviewed since 2003 reveals that 86 per cent of the cases involved seven or more risk factors (Office of the Chief Coroner, 2008). The most common risk factors include actual or pending separation between the deceased and the perpetrator, a history of domestic violence, obsessive behaviour of the perpetrator and depression. The Ontario DVDRC report for 2006 notes that "the majority of domestic homicides may have been prevented if professional and/or the public were more aware of the dynamics of domestic violence and the risk for lethality" (p. 21).

Current coronial processes

Queensland has a coronial system that has the power to investigate and review domestic and family violence related deaths. However, having examined the processes and particularities of the coronial system, as well as a small cluster of de-identified domestic and family violence related death files, some issues have been identified which would enable a greater focus on these deaths. They include:

1. Resources and staff to provide the support required by the State Coroner for a death review mechanism which focuses on prevention of domestic and family violence related deaths.

2. Problems with information collection and sharing including:

   a. Limited capacity for the Form 1 to flag a death as domestic and family violence related. Form 1 is prepared by the police for the Coroner within 24 hours of a death occurring, and it is particularly important in terms of drawing the Coroner's attention to a death as being domestic and family violence related. Currently, the key question contained in Form 1 that is used to flag that the death might have been a result of domestic and family violence is:

      i. Was a domestic violence protection order (or application) registered in Queensland involving the deceased or parent/ caregiver of the deceased in place?

      The absence of a domestic violence protection order, or the application for a domestic violence protection order, is not an adequate indicator that domestic and family violence was not present.

   b. Problems with data sharing between key agencies (for example, the State Coroner's Office, Queensland Police Service, and the Department of Justice and Attorney-General)

   c. The need for access to expert advice, including the identification of the issues which require evidence from experts and evidence that provides a focus on systemic reform advice.

To provide the Coroner with a greater capacity to comment on domestic and family

violence related deaths, the panel has developed a proposed model that addresses the some of the limitations listed above and provides for an ongoing death review process. During this process, a number of different models – from both a national and international perspective - were considered by the panel. It should be noted that whilst comparisons between the operations of international models is useful, they are not easily comparable to Australia's system as the coronial structure and process in both Canada and the US are considerably different to that in Australia.

In particular, the panel looked closely at the domestic and family violence death review model proposed by DVDRAG and those established in Victoria and NSW. Importantly, the DVDRAG model recommended situating the domestic and family violence death review process within the Office of the State Coroner. A point of difference, however, with the recommendations made by DVDRAG is that the domestic and family violence death review model proposed in this report does not include a statutory basis. Based on the concerns of DVDRAG and the Queensland domestic and family violence sector, the panel's decision to not recommend a legislative basis for the death review mechanism is one that provoked much deliberation and discussion. In addition, it is recognised that a case has been made in the literature that a domestic and family violence death review mechanism should be legislated, with provisions articulating terms of reference, membership, powers, privacy, confidentiality, immunity of members and immunity of the body's deliberations from freedom of information applications. However, these issues are sufficiently addressed under the *Coroners Act 2003* and via the structure of the proposed Queensland model. The following reasons underpin the panel's decision to not seek legislative underpinnings for Queensland's domestic and family violence death review mechanism:

- Coroners already have a wide range of existing powers to carry out the investigative process and obtain all required information from both government and non-government organisations; the power to comment on any matter connected to the death; and, the power to make recommendations to any Minister, public statutory authority or entity.

- The independence of the State Coroner ensures an open and transparent review.

- All information obtained for the purpose of an investigation is subject to the confidentiality and privacy limitations imposed by the *Coroners Act 2003*. Unless and until an inquest is called with respect to the specific death, the confidentiality and privacy interests of the deceased, as well as those involved in the circumstances of the death, still prevail. Accordingly, all reports remain private and protected.

- The proposed expert advisory panel would be exempt from any concerns of personal liability in relation to the review of cases (for example, from prosecution or civil suit). The advisory panel would not be tasked with investigating individual or clustered cases and would be exposed only to de-identified information. In addition, the advisory panel would act as a consultative body for the State Coroner to augment the provision of providing expertise in the review of each case or clustered case. All findings and recommendations remain within the functions of the State Coroner.

Most importantly, a key recommendation in this report is that the Terms of Reference for the domestic and family violence death review mechanism be revisited after twelve month of operation for possible revision and amendment. Potential amendments might be a result of issues that arise during the first twelve months of operation.

Proposed domestic and family violence death review model

Following extensive research and discussions, the proposed model aims to not only improve the Coroner's capacity to comment on domestic and family violence issues, but most importantly, to provide the unique opportunity to identify systemic gaps and barriers that will contribute to preventing these types of deaths from occurring in the future.

In recognition of the devastating impact domestic and family violence related deaths have on individuals, families and communities, death review mechanisms have been established in various jurisdictions around the world, including several states in Australia. Emerging research shows that the investigation of these deaths as a connected group, rather than as individual incidents, is a particularly valuable process in identifying systemic changes that result in the reduction of these sorts of deaths (David, 2008). Furthermore, many domestic and family violence deaths have predictive elements to them. Research by the Australian Institute of Criminology reports that a history of domestic violence is common in intimate partner homicides and that in some cases, the homicide event is the end result of a culmination of numerous prior incidents of domestic and family violence (Davis and Mouzos, 2007). Domestic and family violence related deaths are not only tragic, but preventable, and thus the panel is recommending that a domestic and family violence death review mechanism be established in Queensland so that new approaches can be explored to investigate and prevent these deaths.

Using criteria based on political and administrative independence; extensive, relevant investigative powers; and the ability to strongly influence decision-makers, with an accountability process, the panel is recommending a death review mechanism be established in the Office of the State Coroner. The State Coroner has specific and broad legislative powers to investigate deaths under the *Coroners Act 2003.* Queensland's coronial system allows not only for an extensive investigation process, but also a systemic examination that allows recommendations to be made aimed at preventing deaths in similar circumstances and thereby triggering reform processes.

What is required to facilitate the establishment of such a mechanism is adequate resources and a review process specific to domestic and family violence deaths to carry out this level of investigation. Therefore, the panel is recommending the development and implementation of appropriate infrastructure to ensure its effectiveness, success and longevity. It is also recommending that a number of resources be made available to support the State Coroner to identify, investigate and review domestic and family violence related deaths, including:

1. A domestic and family violence homicide prevention unit within the Office of the State Coroner. The model requires research and investigative resources to support the State Coroner in the analysis of domestic and family violence related deaths.

2. An expert advisory panel to address the preventative process of a death review mechanism. The State Coroner, at his discretion, would consult with the panel in the development of recommendations and system and practice improvements based on an individual or cluster case-based analysis.

3. A register of experts to assist the State Coroner, when looking at individual cases, relevant to their area of expertise.

The model put forward for consideration is structured to ensure the death review

process is constituted for longevity and exerts maximum influence in addressing and improving systems to reduce the occurrence of these deaths. Its functions would include investigating the events prior to the death, the circumstances surrounding the death, and action that may be taken to prevent deaths occurring in similar circumstances in the future. Most importantly, the review process will only consider systemic and procedural weaknesses, not the actions of individuals. The review process is not an enquiry into how the victim died or who is culpable – they are matters for the Coroner and criminal courts.

The review process is to take culturally sensitive approaches across all of its operations, with a high priority placed on reducing harm in Aboriginal and Torres Strait Islander communities. The DFVHPU and advisory panel will engage with Aboriginal and Torres Strait Islander groups in as many ways possible to ensure it is operating in a culturally appropriate, sensitive and responsive manner. The expertise and knowledge of Aboriginal and Torres Strait Islander panel members, and Aboriginal and Torres Strait Islander experts on the register, 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 the future.

A number of important outcomes are expected following the establishment of a domestic and family violence death review process in Queensland. The key outcome is to reduce incidences of domestic or family violence homicides by improving system responses that better address domestic and family violence. Other significant outcomes include:

- Making recommendations aimed at continuous improvement and prevention strategies on a system-wide basis.
- Developing a broader perspective and knowledge about the culture and context of domestic and family violence related deaths;
- Creating a system that ensures compliance by government agencies in terms of responding to coronial findings and recommendations;
- Compiling specialised individual and aggregated death review reports, based on research by the DFVHPU, advice from the advisory panel, and findings from the State Coroner;
- Increasing recognition of the impact and circumstances surrounding this type of death, including greater community education and awareness;
- Providing comfort to the family and friends of the victim or victims of domestic and family violence by providing a process that recognises the devastating impact of these deaths and efforts provided to prevent future deaths.

It is important to highlight that the contribution made by a domestic and family violence death review mechanism cannot, and should not be measured based on whether or not there is a decline in the number of domestic and/or family violence related deaths alone. While this is clearly one important objective of such a mechanism, the factors that shape homicide rates are numerous. It is unlikely that the effects of a death review mechanism can be disentangled from other factors such as changes in law or legislation, policy, practices, and service provision related to domestic and family violence related deaths, or from the broader demographic, social, cultural and economic factors that shape homicide rates more generally.

Recommendations

The following recommendations are proposed for addressing the two key objectives of the panel.

1. Establishment of an ongoing death review process.

The model proposed in this report includes locating the review process within the already existing functions and powers held by the Office of the State Coroner, with the addition of a number of resources and areas of expertise:

- Domestic and Family Violence Homicide Prevention Unit
- Expert advisory panel
- Register of experts

This mechanism is recommended to prioritise the investigation of domestic and family violence related deaths as a connected group, not discrete homicides unrelated to one another, because they are factually or legally different. A holistic and robust review of these deaths will enable the identification of necessary systemic changes and make recommendations aimed at reducing this type of death occurring in the future.

The model recommended by the panel would be convened by the State Coroner, with membership comprising representatives from government and non-government agencies. Importantly, the purpose of the review process is not based on a shame and blame framework, but one focussed on prevention and the improvement of systems and intervention.

To date, whilst the Coroner has the powers to examine domestic and family violence related deaths, there are limitations to this process. The key limitation is the provision of available resources required to carry out systemic reviews of this group of homicides.

2. Implement the following procedures to improve the quality of information available to the State Coroner:

    a. Amendments to Form 1:

       To assist police and the State Coroner to identify and flag a death as domestic and family violence related, Form 1 requires additional questions. It is recommended that the Coroners Prevention Unit, in consultation with the Queensland Police Service, develop amendments to Form 1 to more clearly flag domestic and family violence related deaths. It is further recommended that the State Coroner consider and approve the amendments. This information will enable the State Coroner to more clearly identify the death as domestic and family violence related, which will subsequently enable a more thorough review of the death within this context.

    b. Amendment of guidelines to assist Coroners to identify domestic and family violence issues and seek expert evidence:

       One way of effecting change to ensure that domestic and family violence deaths are examined in such a way as to provide a means for

future systemic reforms is to amend the current guidelines for Coroners. The State Coroner is able to make guidelines which are relevant and desirable to ensure best practice for coronial processes. It is recommended that the State Coroner develop guidelines to improve the way in which domestic and family violence deaths are recognised, investigated and prevented.

c. Information and data sharing

Based on the high level of information required from Queensland Police Service, it is proposed that a Memorandum of Understanding (MOU) be established between the State Coroner's Office and the Queensland Police Service. The MOU would outline the process for the exchange of information, including the nomination of a key contact person/unit within Queensland Police Service to ensure this process operates efficiently and consistently. It would include establishing timeframes for information to be provided (albeit, this timeframe will depend on the type of death due to different processes required, i.e., homicide, murder-suicide) and improve the process of finding suitable Queensland Police Service staff to consult with on a state-wide basis for the purpose of gathering relevant information.

It is also recommended that, to improve data sharing between agencies, an information system be implemented that permits the exchange of information between Coroners, the Queensland Police Service and the Department of Justice and Attorney-General, with a view to the efficient identification of issues requiring attention. The information system must be able to assist Coroners to identify clusters of events which may be fruitful areas for prevention.

3. Education and awareness for key stakeholders

There are a number of levels at which education and awareness for key stakeholders will need to be carried out to understand domestic and family violence related deaths at each stage of the coronial process, as well as the role and functions of all elements of the death review mechanism. This includes providing education to: officers of the Queensland Police Service who participate in the investigation of the domestic and family violence related deaths; the officers of the Queensland Police Service entering the homicide data in the DV Index; staff of the DFVHPU; Coronial Support Team including those officers who enter data into the coronial case management system (CCMS); lawyers who provide support to the Coroners; and the Coroners themselves. At each stage of the process, different education content and strategies will be required.

It is recommended that all people involved in the investigation of domestic and family violence related deaths including Queensland Police Service officers and coronial staff, are made aware of changes to the amended Form 1. For example, this process will include local level meetings to ensure changes to the Operational Procedures Manual (OPM) when filling out Form 1 are understood by all relevant persons.

To ensure appropriate education processes are provided to staff, the panel also recommends that resources be established early on in the implementation phase of the death review mechanism. This will require establishing qualified human resource personnel to oversee this task to ensure appropriate staff receive the required training early in the establishment phase of the domestic and family violence death

review mechanism.

4. Consideration to be given to an internal review of the scope, functions, and Terms of Reference of the proposed model and all its components after 12 months, with a more detailed evaluation to be carried out after a three year period.

Chapter One: Introduction

> "Most homicides are preceded by multiple efforts by the victim to get help and multiple opportunities for the legal system and community to hold the abuser accountable for their violence. The actions and choices of both victims and abusers are substantially influenced by the institutional, social and cultural reality which surrounds them". (David, 2008).

Background

The impact of domestic and family violence on individuals and communities is devastating. One in three women experience physical violence at some stage in their lives since the age of 15, with the majority of these cases perpetrated by men against women and their children (ABS, 2005). Women are mostly assaulted at their home, often repeatedly, by a man they know and with whom they are/were engaged in an intimate relationship (ABS, 2005). In particular, Aboriginal and Torres Strait Islander women and children experience domestic and family violence at much higher rates than non-Aboriginal and Torres Strait Islander women and children. For example, in 2006-07, 13 percent of all Australian victims of homicide were Aboriginal and Torres Strait Islander, despite comprising less than 3 percent of the total Aboriginal and Torres Strait Islander population (Dearden and Jones, 2008). y

Dearden and Jones' (2008) analysis shows that of 266 homicides in Australia in 2006-07, 65 (24.4%) were intimate partner homicides, and of these, 23 victims were male (35.3%) and 42 victims were female (64.6%). In addition, Dearden and Jones (2008) report two-thirds of male homicide victims were killed by someone outside the family (i.e., strangers and friends/acquaintances), while nearly three-quarters of female victims were killed by intimate partners or other family members. Women who kill their partners most often do so after a protracted history of severe and ongoing domestic violence previously perpetrated by the deceased partner (Mouzos and

Rushforth, 2003).

Men, however, are reportedly shown to kill for other reasons. The National Homicide Monitoring Program (NHMP) report from 2006-07 found that the biggest single category (44%) of female victims were killed as a result of 'a domestic altercation' (which includes arguments that arise based on jealousy, separation or termination of a relationship, and other domestic arguments that may relate to infidelity, children and custody issues, alcohol-fuelled domestic altercations and other issues between intimate or past-intimate partners). It is important to note that these numbers are only representative of those deaths covered under the term 'homicide' and do not include deaths covered under manslaughter or suicide which may also be related to domestic and family violence.

Another disturbing feature of domestic and family violence related homicide is the incidence of filicide, that is, the killing of children by parents or custodians. On average, 25 children per year are the victims of homicide in Australia, with about a third of these occurring in circumstances of domestic violence and/or family breakdown. Once again, men are responsible for the majority of killings, with 63 percent of child killings committed by fathers, as opposed to 37 percent by mothers (Mouzos and Rushforth, 2003). More recent research by Dearden and Jones (2008) report that 84 percent of the 27 child homicides in 2006-07 were committed by a parent; 7 by the child's mother (30.4%) and 15 (55.6%) by a male parent. In this context, the figures around domestic violence homicides are of serious concern. Edleson (1999) reports that in a large number of cases in which children are killed, there is a history of domestic and family violence.

In Queensland, child death reviews, as conducted by the Commission for Children and Young People and Child Guardian (CCYPCG), are examined through the lens of child protection, with scope to expand the context in which these cases are reviewed, including the existence of domestic violence perpetrated against their mothers or other adults. This is not an issue specific to Queensland, and as suggested by Websdale (1999), the link between adult domestic violence and the killing of children is not clearly established. Child death reviews focus on the nature and appropriateness of prior child protection interventions, thus the broader systems that respond to domestic and family violence are not taken into account, even when an adult or adults may die in the same incident.

High profile domestic death media reports could lead us to believe that the death came as a shock and surprise to others and that there had been no indication of problems in the family. However, often, on closer investigation, this is not the case. Domestic and family violence deaths are almost never without warning. In most cases there have been repeated incidents of violence and indicators of risk, as well as opportunities for agencies and individuals to intervene before the death. When viewed as the escalation of a predictable pattern of behaviour, domestic homicides can be seen as largely preventable deaths. For example, during 2007-08, there were 15 632 Domestic Violence Orders and 12 374 Temporary Protection Orders made in Queensland. During this same period, there were 8 283 breaches of Domestic Violence Orders (Queensland Police Service Annual Statistical Review). In 2008-09 Aboriginal and Torres Strait Islander people were around seven times more likely to have a domestic violence order made on their behalf than non-Aboriginal and Torres Strait Islander persons (22.7 per 1000 persons compared with 3.4 per 1000 persons). In addition, Aboriginal and Torres Strait Islander respondents were around 9 to 10 times more likely to have a domestic violence order imposed on them by the court than non-Aboriginal and Torres Strait Islander respondents (30.4 per 1000 compared with 3.3 per 1000 persons).

Since the establishment of the first women's refugee in Queensland over thirty-four years ago, a large variety of domestic and family violence interventions and

responses have been developed and implemented in Queensland. Policy and funding initiatives have seen the establishment of women's shelters, state-wide domestic violence specific telephone services for both men and women, a network of specialist domestic violence services, a state-wide research centre, as well as enhanced responses from government agencies including, but not limited to, police, court and health services. There have been subsequent changes in legislation, policy direction and interagency cooperation. Many of these responses grew largely from recommendations in the *Beyond These Walls* report by the Queensland Domestic Violence Task Force (1988). This report propelled the issue of domestic and family violence on to the public agenda in Queensland in a significant way, highlighting the "catastrophic" effects of physical, emotional and sexual abuse that results in pain, suffering, permanent injury, and in some cases, death.

The overall homicide data for the twenty year period since the *Beyond These Walls* report was launched indicates that, irrespective of changes in legislation, policy direction and interagency cooperation, intimate and family homicide rates have maintained a yearly average of 20 – 25 deaths in Queensland (based on unofficial Queensland Police Service statistics). Based on these figures, domestic and family violence related homicides would account for a significant proportion (approximately 40%) of homicides each year (Queensland Police Service Annual Statistical Report, 2008-09). In this context, the figures around domestic and family violence are of serious concern, and new approaches are required to investigate and prevent such deaths.

Currently, while Queensland does have a mechanism for death review through the coronial system, there is no specific support for the investigation and review of domestic and family violence related deaths. In general terms, these deaths are investigated by the police and prosecuted by the criminal justice system as discrete homicides, not related or relevant to one another because they are factually and legally different.

Why we need a domestic and family violence death review process

On 10 July 2009, the Honourable Karen Struthers, MP Minister for Community Services and Housing and Minister for Women launched *For our Sons and Daughters: a Queensland Government strategy to reduce domestic and family violence 2009-14* (the Strategy) and the *Program of Action 2009-2010* (the Program of Action). The Strategy aims to reduce the incidence and impact of domestic and family violence in Queensland and identifies five key areas for future reform: prevention; early identification and intervention; connected victim support services; perpetrator accountability; and system planning and coordination.

The Strategy was developed collaboratively across government following broad consultation with the community. The Program of Action was developed to support the implementation of the Strategy for the first twelve months and committed to the establishment of an expert Death Review Advisory Panel to oversee a review of coronial processes and practices, including a review of de-identified information from relevant closed coronial files and to make practical recommendations and consider options for future reviews with a view to preventing deaths in similar circumstances occurring in the future.

Calls have been made for the establishment of a domestic and family violence death review process in other jurisdictions in Australia and internationally. In April 2009, the report of the National Council to reduce violence against women and their children, *Time for Action*, included a recommendation to improve the uptake of relevant coronial

recommendations through the Standing Committee of Attorneys-General and to work with the States and Territories to develop national responses to establish or build on emerging domestic homicide/fatality review processes. The Council of Australian Governments is currently considering the development of a National Plan to reduce violence against women and their children in response to the *Time for Action* report.

At the time of writing this report, the Department of Communities was undertaking a review of the *Domestic and Family Violence Protection Act 1989* (the DFVPA), as part of a key initiative under the Queensland Government's Strategy. This comprehensive review of the legislation is timely given that more than 20 years has elapsed since its introduction. Research and consultation undertaken in the development of *For our Sons and Daughters: a Queensland Government strategy to reduce domestic and family violence 2009 – 2014* highlighted some legislative issues in need of review. It was noted that most other Australian States and Territories have reviewed their domestic and family violence legislation in recent years. An increasing focus on stronger criminal justice responses to domestic and family violence, with a contemporary system of civil protection orders, has emerged through these reforms.

The review is aimed at ensuring the legislation is effective and efficient in protecting victims of domestic and family violence – particularly the needs of women and children today - and holding perpetrators accountable for their actions. Part of this process includes the consideration of an ongoing death review mechanism in Queensland, and any legislative amendments that might be required to support a panel. The domestic and family violence legislative review and the proposed death review mechanism demonstrate the necessity of implementing new initiatives given the increase in reported incidences of domestic violence in Queensland (from 2957 applications for domestic violence orders in 1989-90 to 21 071 in 2008-09) and the high number of intimate partner homicides (70 to 80 each year nationally). Both processes aim to manage and prevent the potential for future violence to occur.

The scope of the legislative review will ensure legislation reflects contemporary understandings of domestic and family violence, and examines existing mechanisms (such as a death review process) to ensure it:

- protects those who experience domestic and family violence from further violence;
- provides for the safety and wellbeing of children and young people affected by domestic and family violence; and
- holds those who commit domestic and family violence accountable.

Some issues that will be discussed in this report feed into considerations and support for the DFVPA review. This includes the need for a more focused investigation of domestic and family violence systemic gaps and barriers that might contribute to preventing similar deaths from occurring in the future as well as domestic and family violence incidents. It is also anticipated that if an ongoing domestic and family violence death review mechanism is implemented in Queensland, its scope and functions may be impacted by changes made to the *Domestic and Family Violence Protection Act 1989*.

Domestic Violence Death Review Action Group

The establishment of a domestic and family violence death review mechanism has been at the forefront of work by non-government agencies in the domestic and family violence sector in Queensland. In 2004, a high profile case of domestic homicide

involving the murder of two children and the suicide of the father was used as the basis for a report on the ABC's Australian Story. This prompted the former Chair of the Queensland Domestic and Family Violence Council, Ms Betty Taylor, and other workers within the domestic violence sector to write to the then Minister for Communities and then Premier calling for a domestic and family violence death review mechanism to be established in Queensland. In particular, the commissioning of a domestic and family violence death review mechanism within Queensland has been the key objective of the Domestic Violence Death Review Action Group (DVDRAG). Established in 2004, DVDRAG has worked to forge relationships both nationally and internationally with groups that have either already developed a domestic violence death review process or are currently working towards such an establishment.

In 2008, DVDRAG compiled a discussion paper, *Dying to be Heard* (by Betty Taylor) to invoke further engagement by the government to implement a death review board. The paper argues that domestic and family violence deaths "are stylised killings that exhibit common patterns and antecedents. Although they share many of the characteristics of abuse cases that do not result in death, many of the cases that do end in death may be preventable" (p.14).

The paper outlines a number of key issues that need to be addressed in the development of a death review mechanism in Queensland, with specific reference to the following key factors:

- Reviews allow for a better understanding of the nature and pattern of lethal domestic violence and abuse;
- Recommendations from reviews can lead to social and systems reforms – and ultimately prevention; and
- Based on research into domestic and family violence review boards operating overseas, the paper outlines a proposed model to guide the development of a review mechanism in Queensland (see Appendix One for a summary of this model), coupled with a number of recommendations to progress its implementation.

Dying to be Heard (2008) was a particularly valuable resource for the panel during the consideration and development of the proposed domestic and family violence death review model. The information and recommendations contained within the discussion paper were benchmarked against each issue deliberated during the design of the review mechanism as recommended by the panel. These issues are discussed throughout this report.

Queensland's death review panel

Following the launch of the first Program of Action for the Queensland Government strategy to reduce domestic and family violence, an expert Domestic and Family Violence Death Review Panel (Panel One) was established. The role of the panel was to make practical recommendations and consider options to improve coronial practices in reviewing domestic and family violence related deaths as well as the establishment of an ongoing death review mechanism. Panel One members were appointed in mid 2009 to oversee stage one of the death review process. The panel comprised an independent chair, three senior government representatives and three members of the 2008-2009 Ministerial Advisory Council on Domestic and Family Violence with responsibility for, and/or expertise in, domestic and family violence policy and service delivery. The following members were appointed by Minister

Struthers:

- ✶ Marg O'Donnell (independent Chair)
- ✶ Heather Nancarrow (Queensland Centre for Domestic and Family Violence Research, CQ University)
- ✶ Donna Justo (Gold Coast Domestic Violence Prevention Centre Inc)
- ✶ Ken Georgetown (Murri Watch)
- ✶ Katarina Carroll (Queensland Police Service)
- ✶ Cathy Taylor (Department of Communities)
- ✶ Terry Ryan (Department of Justice and Attorney-General)

In addition to the panel members listed above, Colleen Wall (Manager of the Aboriginal and Torres Strait Islander Women's Legal and Advocacy Service) was instrumental in providing expert knowledge and advice to panel member Ken Georgetown and the wider panel in terms of Aboriginal and Torres Strait Islander issues and concerns. Furthermore, Helen Warneke, Director of Child Safety, Youth and Family Policy and Performance, played a key role in managing the domestic and family violence death review panel, while Michelle Hayes carried out the research for the panel and wrote the final report. The panel consulted regularly with the State Coroner to develop recommendations to guide the establishment of an ongoing death review mechanism. The panel convened seven times over the course of appointment.

The key objectives of the death review panel were to provide expert advice, based on research undertaken, to strengthen coronial processes and the Coroner's capacity to comment on domestic and family violence issues, and to identify systemic gaps and barriers to help prevent these types of deaths from occurring in the future (see Appendix Two for a complete list of the Terms of Reference for the panel). It is important to note the panel was not tasked to re-investigate cases, review coronial findings or recommendations or attribute fault or blame to any individual, agency or body involved in cases. In addition, no specific legislatively prescribed powers were allocated to this body (as considered not necessary).

Panel members were required to comply with all relevant confidentiality provisions and other conditions imposed under relevant legislation on information or documents received by them. This was not intended to limit members in briefing their departments on progress, issues and possible recommendations, as it was established early on that the recommendations contained within this report would be released publicly. It was important also throughout the course of stage one that information regarding the process and progress of the panel was shared amongst the sector, and that they were provided with the opportunity to provide input and advice relevant to the establishment of an ongoing death review mechanism. To enable this, two communiqués were disseminated to all relevant domestic and family violence agencies across Queensland during the course of Panel One, with the following information summarised:

- ✶ Progress to date
- ✶ Discussion topics from the meeting and accompanying key issues
- ✶ Issues for the next panel meeting
- ✶ Contact details to provide any comments and/or advice relevant to material provided in the communiqué.

The panel also met with a number of government and non-government agencies in

order to obtain a thorough understanding of the workings of other death review processes and relevant research at a national level, including:

- ✶ The Office of the State Coroner regarding general operational arrangements.
- ✶ The Victorian State Coroner and Coroner's Prevention Unit regarding implementation of the Victorian Family Violence Death Review process.
- ✶ Several key stakeholders within the Queensland Government regarding their interaction with the coronial process, including the Queensland Police Service (Queensland Police Service) and the Department of Justice and Attorney-General.
- ✶ Service agency representatives regarding their feedback on processes and practices for an ongoing domestic and family violence death review mechanism. Consultations were held with Aboriginal and Torres Strait Islander service workers, members of the Domestic Violence Death Review Action Group (DVDRAG), and staff from the Women's Legal Service.
- ✶ Presentations were provided to the panel from academic, non-government and government departments, including Griffith University, DVDRAG, the State Coroner, Queensland Police Service, and the Commission for Children and Young People and Child Guardian (CCYPCG).

Death review mechanisms in Queensland

As highlighted in the DVDRAG paper, Queensland domestic and family violence deaths are not currently examined as a connected group. The process of examining deaths as related events, rather than as separate, individual cases is a practice that has already been implemented in Queensland for certain types of deaths. For example, the Commission for Children and Young People and Child Guardian (CCYPCG) established a body to review, register, analyse and report on trends and patterns in child deaths, whilst the mining industry set up the Queensland Mining Death Review process. The former body was founded on the premise of not wanting young lives to end prematurely, and the desire to dignify those that do with a determined search for the contributing factors as a means of preventing further deaths in similar circumstances. It was established in the wake of historical service system failures highlighted by the Queensland Ombudsman's *Baby Kate Report* and the Crime and Misconduct Commission in its report *Protecting Children: An Inquiry Into Abuse of Children in Foster Care*. The latter death review mechanism was established to determine the root causes of mining incidents resulting in death, with the aim of preventing similar accidents from occurring in the future.

Child death reviews

The Queensland Child Death Review Case Committee (CDRCC) is particularly valuable because the processes carried out are in addition to the work traditionally performed by Commonwealth statistical bodies. The CDRCC probes beyond a compilation of death certificate data and routinely involves consideration of autopsies, coronial files, child protection and police information. The work continues to grow through the Commission's ongoing promotion of awareness about risk factors associated with child deaths. This information is also increasingly being accessed by relevant agencies and organisations to inform policy development and the formulation

of strategies and campaigns aimed at preventing child deaths (see Appendix Three for more information).

The panel explored the workings of child death review processes in Queensland, particularly in relation to how these functions might overlap with the proposed functions of a Queensland domestic and family violence death review mechanism. Death reviews conducted by the Child Death Review Team involving domestic or family violence are examined through the lens of child protection with little or no focus on the circumstances in which this violence occurred, including the existence of domestic violence perpetrated against their mothers or other adults. With a specific focus on the nature and appropriateness of prior child protection interventions, the broader systems that respond to domestic violence are not considered even when adults may die in the same incident.

The focus and functions of Queensland's child death review processes will in no way duplicate the workings of a domestic and family violence death review mechanism. However, there is scope to consider ways in which mutual cooperation between these review processes would work for the betterment of both adult victims and children.

Mining death reviews

The Queensland Mining Death Review model is particularly relevant to the domestic and family violence death review model proposed in this report. This body comprises a Mines Inspectorate, which operates as part of the Safety and Health Division of the Department of Natural Resources and Mines. Its objective is to achieve the goal of zero harm, and advances in safety have resulted from recommendations made by the Mining Wardens Court and the Coroners Court.

An arrangement between the Mines Inspectorate and the State Coroner requires the Chief Inspector to advise the State Coroner of the fatality as soon as is reasonable. The purpose is to inform relevant authorities so that independent investigations can commence. Once the police are satisfied there are no suspicious circumstances surrounding a death, the investigating officer will hand over the site and the investigation to the Mines Inspectorate. The Investigating Inspector will submit a preliminary report to the Chief Inspector regarding the initial details of the fatality. The aim of the preliminary report is to provide an initial view about nature and cause so that the Coroner, Chief Inspector, and the Industry are fully informed about the death. The Chief Inspector, upon reviewing the preliminary report, will forward it to the State Coroner.

The Inspectorate then undertakes the ongoing and far more detailed investigation, which looks at the nature and cause of the death and recommendations to avoid a reoccurrence. The Mines Inspectorate has a process that investigators must follow for such matters as complaints, serious accidents and fatalities. This is outlined in the Mine Inspectorate's Investigation Process Manual to ensure there is a systematic approach to investigating the event, and the various actions and omissions that led up to the event. The Mines Inspectorate has an obligation to be impartial. During the course of the investigation, the Inspector will discuss the investigation with relevant stakeholders which include the family, mine management and the mine's workforce.

In a mining inquest, the task of keeping the Coroner informed is usually undertaken by the Mines Inspectorate. However, any party granted leave to appear at the Inquest should understand that they should also keep the Coroner informed of developments.

It is a legislative requirement that both the mine and the Inspectorate must produce a report where there has been a fatal accident. The mine has to provide a report to the

Mines Inspectorate within one month. It is accepted practice that mine management will be invited to be present during the investigation undertaken by the Inspectorate.

The mine report submitted by the Senior Site Executive (SSE) becomes an annexure within the investigating inspector's final report to the Chief Inspector. The Chief Inspector, after reviewing the final report, will forward it to the Coroner, and provide copies to the Coroner for distribution to the parties granted leave to appear at the inquest.

It is important to note that the Mines Inspectorate and the Industry do not have to wait for the various legal proceedings to end (for example, processes of the criminal courts) before changes to promote safety can be made. See Appendix Four for a more detailed explanation of Queensland's mining death review process.

Death review mechanisms in other jurisdictions

In addition to examining child death review mechanisms and other specific, focused death review processes that currently operate in Queensland, the panel examined domestic and family violence death review panels that have been established nationally and internationally. The catalyst for the establishment of the first domestic and family violence death review was the death of Veena Charan in San Francisco in 1990. A landmark investigation into this murder/suicide was conducted, and significant gaps at a community and systems level were found. The report emphasised that a more cohesive agency response was required to deal appropriately with both victims and perpetrators of domestic violence. The recommendations from this report became a watershed which changed the way government and community responded to domestic violence. Following the release of the Charan Report, review mechanisms have been established across several states and communities within the US, some provinces in Canada as well as in the UK and New Zealand. Annual reports released by these boards have consistently highlighted a reduction in domestic homicides within their communities (DVDRAG, 2008).

Positive outcomes include the identification of risk indicators and the implementation of appropriate legislation and practices to address them (see DVDRAG, 2008). For example, in the US Hennepin County, more than twenty-five improvements have been made to the justice system as a result of the domestic violence fatality review process. These improvements include greater support for victims and increased consequences for perpetrators (A Matter of Life and Death: The Domestic Fatality Review Team, 2004). Another example is the San Diego Domestic Violence Fatality Review Team (DVFRT) which identified access to firearms as one of the single greatest concerns arising from the first review, given the significant proportion of homicides committed with a firearm. The DVFRT made a number of strong recommendations to a Senator, and as a consequence, the Senator introduced a Bill which required domestic violence perpetrators to surrender firearms to police after a domestic violence incident (County of San Diego DVFRT, 2006). In the current review period, the number of homicides has dropped and the number committed using a firearm has dropped by 50 percent.

Considerable international research, particularly in the United States, has been undertaken into the factors that may be considered as indicative of risk when considering domestic and family violence homicides. There is general consensus that certain factors, including the following, may indicate a higher potential for a domestic homicide to occur (see Campbell, et al, 2003):

- Prior domestic and family violence;

* Partner used or threatened woman with a weapon;
* Partner threatened to kill woman;
* Partner tried to choke (strangle) woman;
* Estrangement; and
* Gun in the house.

One of the best known studies in this area, *Intimate Partner Homicide: Review and Implications of Research and Policy* (Campbell, Glass, Laughon and Bloom, 2007), provides compelling evidence of the strong correlation between these factors and domestic and family violence homicides. By considering risk factors in depth, both government and non-government agencies are better placed to detect risk and intervene before the risk escalates. For example, the Ontario committee has consistently found seven or more risk factors were present in more than two thirds of the cases that they have reviewed; they consider that the presence of seven or more risk factors indicates that the homicide was preventable. Actual or pending separation and a history of domestic and family violence were present in approximately three quarters of all cases (Office of the Chief Coroner, 2006).

Risk factors and risk assessment tools are not about predicting a domestic and family violence homicide per se; rather, this type of research is undertaken so that appropriate risk management interventions can be put in place. A domestic and family violence homicide review is more concerned with exploring issues such as: did service providers recognise high/escalating risk (implications for training); was this communicated clearly between agencies (implications for interagency work); and were all possible interventions put in place to manage the risk and increase the safety of women and children (service delivery, legislation implications) (Dutton and Kropp, 2000).

The lack of systemic and systematic analysis of domestic and family violence deaths has been noted in many of the jurisdictions within Australia, and consequently, we are now seeing a movement towards the establishment of death review mechanisms similar to those implemented overseas. Nationally, Victoria and New South Wales have established domestic and family violence death review processes and South Australia is at a similar stage to Queensland in the development of a death review process. Whilst there are various projects such as the National Homicide Monitoring Program (NHMP) which provides statistical analysis of domestic and family violence deaths, this is not a detailed case based analysis of the circumstances surrounding the death or deaths.

Victoria

The Victorian Systemic Review of Family Violence Deaths commenced in January 2009 and is undertaken by the Coroner's Prevention Unit (CPU), located in the State Coroner's Office. The Government decided to situate the review process inside the coronial system for several key reasons, including:

* Family violence related deaths fall within the ambit of compulsory reportable deaths under the *Coroners Act 2008*;
* Coroners are conducting daily investigations into reportable deaths, are

familiar with the range of expertise available to them, and are required to making findings surrounding a reportable death. In addition, if an inquest is conducted, information may become available which otherwise may not be elicited during the investigation;

- Coroners have a wide range of existing powers to support the investigative process, including powers of entry, inspection and production of documents and compulsion of witnesses;

- The Act provides Coroners with the power to comment or make recommendations on any matter connected with the death, including those about public health and safety, to endeavour to prevent future preventable deaths from occurring in the same or similar circumstances. This established process provides a sound mechanism for prevention objectives to be conveyed; and

- The *Coroners Act 2008* compels any statutory authority or entity that receives recommendations from the Coroner to respond in writing within three months specifying what action has, is or will be taken in regard to the recommendations made by the Coroner, and requires that the response be published on the internet.

All cases referred to the State Coroner's Office from 1 January 2009 are subject to review. The team reviews all of the initial summary reports from the police as they come into the Coroner's office and flag those that appear to have a family violence component. Flagged cases are then followed through when the police brief of evidence is provided to the Coroner. Once the police brief is delivered to the Coroner, a thorough analysis of the material commences in order to identify the presence of family violence risk factors and any opportunities for intervention in the lead up to a death. There is a focus on assessing the incident in the context of other family violence matters to ensure that commonalities are documented and reported. In turn, this provides the potential for prevention recommendations to be targeted at systemic issues as they emerge.

A Reference Group has been established, comprising approximately 40 representatives from government, non-government and the community, and their role is one of support and guidance for the State Coroner, with no decision-making capacity. Information gathered from the Reference Group is used by the CPU in conjunction with national and international research and literature and the particular facts in a case to inform their reports. The Reference Group maybe asked to provide information and advice to the review team or to provide a response and feedback on a particular issue. The review team may also consult with individual members of the Reference Group on particular issues in their area of expertise. This may include discussion on a range of issues such as understanding the history of a particular system, through to advice about what else has been tried, what is currently in place and what is being contemplated.

New South Wales

In November 2009, the NSW government announced the establishment of an ongoing Domestic Violence Death Review Team (the Team), consisting of government and non-government experts with administrative and research support. The Team will be convened by the State Coroner and will commence operation in 2010. At the time of writing this report, a bill to amend the *Coroner's Act 2009* with respect to the establishment and functions of the Team had been introduced into Parliament. The

objects of this bill are:

1. To amend the *Coroners Act 2009* to establish the Team and to provide for its membership and functions;

2. To exempt the Team from the operation of legislation relating to public access to government information;

3. To amend the *Commission for Children and Young People Act 1998* to enable the Child Death Review team to exercise functions relating to a child death that may also be the subject of review by the Team.

The Team will largely comprise representatives from government agencies, as well as two non-government service provider representatives, an Aboriginal person or a Torres Strait Islander representative, and two persons who, in the opinion of the Minister, have expertise appropriate to the functions of the Team. Government members are to be nominated by their appropriate Minister. The Team must consist of not less than 15 members (in addition to the Convenor) and not more than 19 members (in addition to the Convenor) at any one time.

It is particularly important to note that the Team that is required to carry out reviews of domestic and family violence deaths, so their role extends beyond providing advice to the State Coroner. The functions required of the Team include:

- To review closed cases of domestic and family violence deaths;

- To analyse data to identify patterns and trends relating to such deaths;

- To make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths;

- To establish and maintain a database (in accordance with the regulations) about such deaths; and

- To undertake, alone or with others, research that aims to help prevent or reduce the likelihood of such deaths.

In carrying out a review of domestic violence deaths occurring in NSW, the Team is to consider the following:

- The events leading up to the death;

- Any interaction with, and the effectiveness of, any support or other services provided for, or available to, victims and perpetrators of domestic violence;

- The general availability of such services;

- Any failures in systems or services that may have contributed to, or failed to prevent, the domestic violence deaths.

The Team is required to prepare an annual report on domestic violence deaths reviewed in the previous year for Parliament. The report is to include:

- Identification of system and procedural failures that may contribute to domestic violence deaths;

- Recommendations as to legislation, policies, practices and services for

implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths; and

- Details of the extent to which its previous recommendations have been accepted.

The State Coroners in both Victoria and NSW already have a wide range of statutory powers to investigate all domestic and family violence related deaths. Similarly, both Victoria and NSW define domestic and family violence according to the relationships contained within their Act (*Family Violence Protection Act 2008* and *Crimes (Domestic and Personal Violence) Act 2007*, respectively). The key feature that differentiates the Victorian family violence death review mechanism from the NSW domestic violence homicide review process is the former is situated within, and performed by, the State Coroner's office, whilst the latter is supported and convened, but not hosted, by the State Coroner.

Irrespective of the location, domestic and family violence death review mechanisms typically include the following elements:

- A non-blaming, non-shaming policy;
- A multidisciplinary expert group, including government and non-government representatives;
- Group members are bound by strict confidentiality provisions;
- A clear notification of case structure, which relies upon the police notifying the review mechanism, as well as other agencies such as the State Coroner;
- The power to make publically available recommendations that can be directed at both government and non-government agencies, as well as a means to ensure the implementation of recommendations (e.g., a reporting back system); and
- Have the view that domestic violence related deaths are preventable, and have, as a key focus, prevention and intervention.

Refer to Appendix Five for further discussion of these models.

Chapter Two: The Status of Domestic and Family Violence Homicide Review Processes in Queensland

"The identification of avoidable risks provides an opportunity for something positive to come from tragedy."
(State Coroner, Michael Barnes)

As indicated earlier, one of the key objectives of Panel One, as dictated by its Terms of Reference, was to explore options designed to strengthen coronial processes and the Coroner's capacity to comment on domestic and family violence issues. To address and report on this issue, a number of research strategies were undertaken. They included:

- Liaising with the Office of the State Coroner about general operational arrangements and the application for access to de-identified documents from closed coronial files, including:

- Examining current coronial processes utilised in investigating domestic and family violence homicides

- Data collection and record keeping and the extent to which domestic and family violence may be identified and recorded as a contributing factor in deaths

✶ Liaising with other stakeholders within the service system in regard to their interaction with coronial processes; for example, the Department of Justice and Attorney General and the Queensland Police Service.

In order to best understand the way in which the coronial system operates across the State, it is useful to examine the statistics outlining the number of coronial cases lodged and finalised in the 2008-09 financial year and the number of cases pending as at 30 June 2009 (Report on Government Services, 2009). In the 2008 – 09 financial year a total of 3,745 deaths were reported to Queensland Coroners and a total of 3,657 coronial cases were finalised. Of these 69 cases were inquests. As at June 2009, 2,242 coronial cases remained pending as investigations were ongoing. The State Coroner presided over 27 inquests and finalised 76 cases. In Brisbane, 9 inquests were held and 1,272 coronial cases were finalised, while 725 cases remain pending.

Currently in Queensland, the police investigate and collate information on each domestic and family violence related death that occurs. This information is not released to the public. The Coroner investigates these 'reportable deaths'. However, both the police and Coroner's investigations are done on a case by case basis. In particular, the police investigation is largely focused on whether a criminal offence has been committed and not on the response to the domestic and family violence issues leading up to the death. The Coroner, therefore, may not consider domestic and family violence issues unless they are specifically brought to his/her attention in relevant cases. Patterns in domestic and family violence related responses are less likely to be apparent to Coroners considering individual cases in isolation, which therefore limits the understanding of the nature and pattern of lethal domestic and family violence abuse and does not identify gaps in current service responses across government and non-government sectors. To identify system issues requires research, identification and coordination of domestic and family violence cases. To date, the coronial system has not had this focus.

In order to develop strategies that will strengthen coronial processes and the Coroner's capacity to comment on domestic and family violence issues, it is important to have an understanding of the way in which the current system operates. An examination of the system and the limitations regarding the way in which domestic and family violence related deaths are reviewed provide a means by which options for strengthening that system will be apparent. Based on the consortium of information provided by both the State Coroner's Office and the Queensland Police Service regarding the investigative practices accompanying a domestic and family violence related homicide, a number of key issues are identified, with recommendations provided.

Figure One: Flowchart of the coronial process

Coronial process

Criminal investigation intersection

Current processes and practices

Certain deaths must be reported to the Coroner, usually by police who will have attended the scene and obtained some information about the death from family members, friends and witnesses. The police will prepare an initial report (called a Form 1) notifying the Coroner of the death. Police assist the Coroner to investigate reportable deaths.

The Coroner is responsible for investigating reportable deaths which are defined in section 8(3) of the Act, as deaths where:

- The identity of the person is unknown;
- The death was violent or unnatural;
- The death happened in suspicious circumstances;
- A 'cause of death' certificate has not been issued and is not likely to be issued;
- The death was a health care related death;
- The death occurred in care;
- The death occurred in custody;
- The death occurred in the course of or as a result of police operations.

In practice, deaths are usually reported to the Coroner by police or medical practitioners. The police will prepare a Form 1 for the Coroner within 24 hours of the death occurring. This stage is particularly important in terms of the Coroner's ability to identify a death as being domestic and family violence related, however, this is not always obvious or immediately apparent. There is a recognised risk that relevant case are not always identified by police as being the consequence of domestic and family violence.

During the process of an investigation, while the investigative steps are being undertaken by the police officers or forensic experts, they are acting as agents of the Coroners and can be subject to the directions of Coroners. The Coroner might identify issues that are to be investigated and the means by which this should happen.

After considering the initial report of a death, the Coroner must consider whether an

autopsy is to be performed to help find out how and why the person died. At this early stage of the investigation, the Coroner may ask police to conduct further investigations which may include obtaining medical records and taking further statements from witnesses.

Once the autopsy report has been received, and the cause of death is known, the Coroner will consider what further investigation is required. The Coroner investigates the death with a view to making findings about the identity of the deceased person, when and where they died, how they died and the medical cause of death. The Coroner has wide powers for investigative purposes and can request additional reports, statements or information about the death. In addition, the Coroner may access specialised and expert information to inform the investigative process. Coroners will obtain reports from independent experts, for example, medical specialists, and relevant specialist investigators, for example, the Forensic Crash Unit of the Queensland Police Service. Sometimes the death is being investigated or reviewed concurrently by another agency, for example, the Health Quality and Complaints Commission, Workplace Health and Safety or the Child Death Case Review Committee. In these cases, the Coroner's investigation is also informed by the outcomes of these independent investigation or review processes.

Once the Coroner has completed all enquiries they will consider whether or not to hold an inquest. In some cases the Coroner may hold an inquest if it is in the public interest to do so. This decision is often based on considerations such as the prospect of the Coroner being able to make recommendations that would reduce the likelihood of similar deaths in the future or otherwise contribute to public health and safety or the administration of justice. If criminal proceedings have been laid against someone in relation to the death the Coroner must not commence or continue an inquest until the outcome of the criminal proceedings is known. In practice this means that the coronial investigation is postponed pending the outcome of the criminal proceedings.

The coronial investigation is finalised when the Coroner makes written findings (as far as is possible) about the identity of the deceased, when and where they died, how they died and the medical cause of death. The Coroner must make findings whether or not an inquest is held. If an inquest is held the Coroner can also make recommendations relating to public health or safety, the administration of justice or ways to prevent similar deaths in the future. A copy of the recommendations must be given to the government entity which deals with matters to which the recommendation relates.

In December 2006 the Queensland Ombudsman tabled the report 'The Coronial Recommendations Project: An investigation into the administrative practice of Queensland public sector agencies in assisting coronial inquiries and responding to coronial recommendations'. The Ombudsman stated that 'the effectiveness of the coronial system is reduced by the fact that public sector agencies to which coronial recommendations are directed are not required to respond to those recommendations'. As such, in 2007, new coronial reporting arrangements were established to require government departments to report their responses to coronial recommendations. The Government released a report entitled *The Queensland Government's Response to Coronial Recommendations – 2008* (the Report) which documents the Government's response to coronial recommendations and comments, directed to Queensland Government departments, handed down between 1 January 2008 and 31 December 2008. The Report contains implementation details for 170 recommendations directed to the Queensland Government drawn from 31 coronial inquests and two coronial investigations. A number of recommendations were directed to more than one department, as a consequence, the report contains 183 responses. Of the 183 recommendations 72 were 'completed', 21 were 'completed with ongoing implications', 63 were 'partially completed', 19 were 'under consideration'

and eight were designated 'not being implemented'. It is expected that a further report that will address the recommendations of the Coroners made during 2009 will be published in mid 2010.

Finally, the State Coroner must issue directions and guidelines about the investigation of deaths and other matters under the Act. The guidelines, without detracting from the purpose of the Act enhance, support and guide Coroners in their decision making. For example, the way in which the Office of the State Coroner deals with deaths in custody is exemplary of the way in which the guidelines support the Coroners. Section 7.2 of the guidelines then deals specifically with how deaths in custody should be investigated to ensure best practice. They outline the reasoning behind why deaths in custody warrant particular attention, including that experience demonstrates that some prison deaths that appear to be suicides may in fact be murders and they stipulate that all investigations be completed within 6 months from the date of death unless delays are unavoidable. The guidelines also explain the process for the way in which officers from the Queensland Police Service and the Department of Community Safety (DCS) should investigate the matter and the requirement for the overview of particular investigations by officers of the Crime and Misconduct Commission in order to ensure compliance with the Royal Commission into Aboriginal Deaths in Custody. The guidelines also instruct that investigations should extend beyond the immediate cause of death and whether it occurred as a result of criminal behaviour and outline a process by which this ought to be done to ensure that the broad focus will provide a Coroner with a sufficient evidentiary basis to discharge his/her obligation to devise preventative recommendations.

Preventative role of the Coroner

Halstead (Boronia Halstead, Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study, (Australian Institute of Criminology, 1995) has commented that:

> "*a potentially preventive role of a Coroner has been marginalised in some coronial practice through the emphasis on unpacking the facts of individual cases, rather than the systematic identification of patterns of death and injury. This emphasis reflects the over-riding modus operandi of the legal profession as a whole, which has concerned itself solely with dealing with events on a case by case basis, closing the file at the conclusion of each*".

The Queensland coronial system recognises the potential for a Coroner to have a role in preventing deaths in the future, rather than simply reporting on past ones. The object of the Act (as set out in section 3(d)) is to 'help to prevent deaths from similar causes happening in the future by allowing Coroners at inquests to comment on matters connected with deaths, including matters related to… public health or safety… or the administration of justice.' One of factors that the Coroner may consider in deciding whether to hold an inquest is the extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future.

As discussed previously, coronial findings and recommendations are published on the Queensland Courts website. A published annual report is consolidated on the basis of the response of each department to each relevant recommendation, by the Department of Justice and Attorney-General. This process aims to enhance the role of the coronial process in effecting systemic change within government agencies and to support the prevention role of the Coroner.

Agencies across government have established a number of internal mechanisms to ensure coronial recommendations are acted upon appropriately. For example, Queensland Health has established a Coronial Management position within the Patient Safety Unit and Quality Improvement Service to address and respond to all recommendations made by the Coroner to Queensland Health. The role ensures that Queensland Health is taking into account recommendations for systemic reform. Coronial recommendations have led to a number of systemic and practice improvements at Queensland Health. Of particular importance is the work that has been done around 'not for resuscitation' orders. The issue first arose during the inquest into the death of Margaret Bodell, 23 November 2007, which resulted in a recommendation being made by Magistrate Chris Clements, Deputy State Coroner, that state-wide protocols need to be developed to "clarify the decision making, documentation and communication of decisions involving the reduction, withdrawal or withholding of life sustaining treatment, in particular 'do not resuscitate orders' ". A second inquest (the hearing for which was almost concurrent with the delivery of findings of the Inquest into the death of Margaret Bodell) which related to the 'not for resuscitation' policy was held after the death of June Woo. The Coroner recommended that the policy governing the making of 'not for resuscitation orders' be reviewed to ensure compliance with the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*. In response, Queensland Health is currently developing a state-wide policy about withholding or withdrawing life-sustaining measures.

The Coroner may also hold an inquest into multiple deaths which appear to have happened at different times in similar circumstances. A recent example of a joint inquest which resulted in a number of recommendations relating to the standardisation of mental health documentation is the Inquest into the deaths of Baggott, Barlow and Lusk (15 December 2006). While the mental health system was already undergoing some reform, the recommendations of the Coroner expedited the reform process by illustrating the preventative nature of the deaths. The comments of the Coroner resulted in the development of the *Achieving Balance* project: http://www.health.qld.gov.au/mentalhealth/docs/deidentified_report.pdf.

Most recently, the Attorney-General and Minister for Industrial Relations, Hon. Mr Cameron Dick, announced on 3 March 2010, that a new code of practice has been developed to provide greater regulatory consistency and certainty for the industry in response to coronial recommendations following dive incidents. The State Coroner commented in the Findings of the Inquest into the death of Stephen James Broe 24/04/09, that Workplace Health and Safety Queensland consider reviewing the code of practice to examine a number of different factors. The State Coroner relied upon the expert evidence of a number of medical and diving experts to ascertain the evidentiary basis for the comments. The development of this code in response to coronial recommendations highlights the effectiveness of the preventative role of the Coroners and the reliance upon expert advice and evidence to form effective recommendations. See Appendix Six for further information regarding how the Queensland Health provides advice to coronial and criminal court processes.

Findings from an analysis of de-identified coronial files

In order to assess what improvements are required to enhance the Coroner's capacity to comment on domestic and family violence deaths, it was necessary to determine the current level of information obtained by a Coroner in the event of a domestic and family violence related death. The purpose of considering nine closed death cases was to assess current information and data sharing procedures, as well as to report back to the panel on aggregate-level trends, practices and procedures

that might contribute to a reduction in preventable homicides. The panel intended to provide a 'snap-shot' of what features are common to domestic violence homicides in Queensland and where, based on these limited cases, there is need for further research or improvement.

However, it quickly became apparent during the analysis of the nine cases that this level of information was not provided in coronial death files. The information contained in the coronial files focus on the actual incident of the death, not on the events or history preceding the death. This is because police investigations are largely focused on whether a criminal offence has been committed and not on the response to domestic and family violence issues leading to the death. Consequently, historical and systems-based information required from the files was not available, making it difficult to piece together an understanding of the relationship between the deceased and perpetrator and the circumstances leading up to each death. In particular, the police criminal brief was missing from the files, with information generally limited to administrative documents such as the Coroner's autopsy and release orders, doctor's notice to the Coroner after an autopsy, etc. They do not provide the depth or consistency of information required to: a) identify and flag a death as domestic and family violence related, and b) investigate the circumstances, history, and system response leading up to the death.

Based on the analysis of the files, key findings include:

- Inconsistency of the sorts of information contained within each file and the identification of a domestic relationship.

- Domestic Violence Order (or application) is not necessarily a reliable measure to establish whether the death is domestic or family violence related or whether there had been a history of domestic or family violence in the relationship. For example, only two of the nine files indicated a history of domestic violence using QPRIME.

- Within the system there are differing ideas of what constitutes an "intimate personal" relationship which can affect whether a matter is identified as domestic violence related. For example, young people under the age of 18, not living together and who reportedly engaged in an on-off relationship over a period of months/years might convey a different understanding of an "intimate" relationship as opposed to a couple having lived together for a period of time.

- Unless reported by friends and/or family in witness statements, very little information was provided (if any at all) regarding the nature of the relationship between the deceased and the perpetrator.

- Some files provided very little information regarding the actual incident of the death.

- It was most often necessary to manually review each file to identify that the death is domestic and family violence related.

Refer to Appendix Seven for a summary of the findings of the nine closed death cases.

How the coronial system could be supported to review domestic and family violence related deaths

It is apparent from the depiction of the coronial system, and the particular features of the system, that Coroners in Queensland already have the legislative power to investigate and review domestic and family violence related deaths. However, having examined the processes and particularities of the coronial system, as well as a small cluster of de-identified domestic and family violence related death files, some limitations became apparent. They include:

1. Resources do not currently support a death review mechanism which focuses on prevention of domestic and family violence related deaths.

2. Limited capacity for the Form 1 to flag a death as domestic and family violence related.

3. Limitations around data collection and data sharing.

4. Limited accessibility to expertise upon which Coroners may rely during investigations and systemic reform advice in relation to possible domestic and family violence related deaths.

1. *Resources*

Currently, the State Coroner is supported by a Registrar. Under the Act, the State Coroner will delegate certain powers to the Registrar including consent to access an investigation document if the investigation to which the document relates is finished. The Registrar also manages the Office of the State Coroner, which includes a number of administrative and other support staff.

The Office of the State Coroner also provides administrative and legal support to the full time Coroners based in Brisbane, Cairns and Southport. The Office of the State Coroner also provides support to 16 regional registries responsible for coronial matters. In some jurisdictions additional investigative, research and support resources have been incorporated into the Office of the State Coroner to enhance the capacity of the preventative role of the coronial system. The Victorian model of the Coroners Prevention Unit within the Office of the State Coroner is an example of this (see Appendix Five).

The issues raised in relation to domestic and family violence deaths highlight the potential for in-depth investigation of particular relevant issues during the life of a deceased, as well as the circumstances of their death to inform real systemic reforms to prevent deaths in the future. This potential relates not only to domestic and family violence issues but could extend to broader systemic issues. Currently, the office is not resourced to undertake further specialised research to support the examination of domestic and family violence related deaths. Additional resources, including for investigative, research, legal and administrative resources would enhance the capacity of the coronial system to better inform systemic improvements within the existing legislative framework. This will allow consideration of further available information that could inform coronial investigations, findings and comments beyond the review of individual cases in isolation.

2. *Form 1*

Police prepare a Form 1 for the Coroner within 24 hours of the death occurring. This stage is particularly important in terms of the Coroner's ability to flag a death as domestic and family violence related, however, the limited questions pertaining to this

type of death currently included in the form do not elicit the depth of information that would assist in this regard. Currently, the most relied upon question contained within this form is:

History

Was a domestic violence order (or application) registered in Queensland involving the deceased or a parent/caregiver of the deceased in place?

Yes No Unknown

If yes, specify

If yes, what was the occurrence number?

Improvement of the information collected in this form concerning a domestic and family violence death would enable easier identification of cases that may be of interest to the domestic and family violence death review mechanism in a timely manner. Whether or not the deceased had a domestic violence order (or application) registered in Queensland is not necessarily a reliable indicator as the violence is not always reported or detected. In addition, a death that falls within the scope of domestic and family violence may have no previous recorded history of domestic and family violence at all.

Research into women's help seeking patterns suggests that only a small proportion of perpetrators had contact with police for any offence in the year preceding the homicide, as well as past incidents also involving the victim (ABS 2005 Personal Safety Survey). The BOCSAR report (2009) indicates that even fewer victims of domestic violence had reported the incident to police (10 percent). Research evidence based on victim surveys demonstrates that the majority of incidents of domestic violence are not reported to police. Many victims will first disclose to non-police sources, for example, health services or informal support such as family or friends. These results highlight the importance of looking beyond Queensland police data and seeking out other sources of information.

Currently, Form 1 has a sub-section dedicated to recording information relevant to a number of specific types of deaths, including:

- Infant/child death (suspected SUDI)
- Suspected drug/alcohol/poison-related death
- Hospital/health care-related death
- Drowning/water related-death
- Fire/burn related-death
- Child/infant death (other than suspected SUDI)
- Suspected suicide
- Transport related-death

* Death involving a weapon/firearm
* Work-related death
* Death in care

Given that not all domestic and family violence related deaths will have had previous involvement with police, it may be difficult to flag the death accurately, and recording the details relevant to domestic and family violence is lost in this crucial identifying process. However, where domestic or family violence is reported to the police, there is a wide range of information which the Queensland Police Service collect in relation to domestic violence incidents which may be useful in identifying deaths as domestic or family violence related, even where an order/application is not in place. Outlined below is a list of the current information collected:

* Type of relationship;
* Domestic violence incidents;
* Times called out to DV incident, regardless of whether it was later confirmed as a DV incident;
* DV orders registered in Queensland or interstate; and
* History of mental illness.

Some of the information which the Queensland Police Service currently collects should be incorporated into the Form 1 to provide a greater level of detail and background of the circumstances of the death which would lead to the flagging of the death as domestic or family violence related. Extra information such as relationship of the offender to the deceased and any prior exposure to domestic and family violence by the deceased could be added to the police form. This would need to be done in concert with additional training of police regarding the issues and importance of collecting this extra data, and needs to be considered in light of the already lengthy information police collect about the circumstances of a death.

3. *Data collection and data sharing*

In 2009, the Office of the State Coroner implemented the coronial case management system (CCMS). This information system is designed to improve the management of coronial files, to provide more detailed and accurate information about these files, and to interface with the National Coroners Information System (NCIS). There is currently no flag on CCMS for domestic and family violence – Form 1 is attached to the file and uploaded on CCMS as an electronic document. Therefore, the only way to link domestic and family violence to a death file is to do a word search for *domestic and family violence*.

In conjunction with CCMS, specific information on domestic and family violence dealt with by the police can be drawn from Queensland Police Service calls for service databases and QPRIME. All domestic violence calls that police attend must be entered onto QPRIME. Recording of domestic and family violence occurrences in QPRIME commenced in 2007, replacing the Queensland Police Service Domestic Violence Index. It records details of:

* domestic violence incidents;

* incidents initially coded as a domestic violence incident whether or not they are confirmed as such;

* domestic violence orders made under the *Domestic and Family Violence Protection Act 1989* by police and private applications; and

* interstate orders registered in Queensland (Queensland Police Service, 2003).

QPRIME links all information regarding one couple. That is, once a couple has been dealt with by police and entered into QPRIME, any subsequent attendance by police is added to the initial entry, thereby allowing a history of police attendance to be produced. Analysis of QPRIME allows examination of information such as the type of relationship, cultural background (victim and perpetrator), the day and time of incidents, and the action police took at the incident.

However, there are limitations within the Queensland Police Service systems concerning data collection and information recording in domestic and family homicide-related deaths. They include:

* The identification of the domestic homicide sample is not always straightforward and clear. Some incidents that come to be classified as a domestic related event, or as having a relevant relationship type, do not in fact have those characteristics coded. One reason for this is that when the deceased is found, the perpetrator is sometimes not known and these fields are left at their default settings until the offender is known. However, because there is no operational need to update these fields in the database, they are sometimes never updated.

* Police do not always identify victim-offender relationships as domestic (as defined in the legislation), particularly when the parties are not intimate partners or family members.

* Much less is known about homicides in which the offender also commits suicide. In cases where there is no inquest, Coroners are generally provided with limited information; police provide brief details compiled at or around the time that the death was discovered and this information is less than subsequently appears on the Queensland Police Service database.

* Information entered into the police database is not standardised, so the degree of detail varies, particularly regarding the history leading up to the event and associated issues such as the offender's mental health at the time of the offence. Supreme Court transcripts may assist the Coroner as a supplementary source of information for this purpose as some cases may take years to finalise or may not be publicly available.

All applications for domestic violence protection orders are dealt with by the Magistrates Courts of Queensland. The Department of Communities has general information relating to protection order applications from the initial implementation of domestic violence legislation in Queensland since 1989. These data provide a description of the number, type and outcome of protection order applications. However, the Department of Communities data is not available regarding applications by type of relationship, cultural identity or gender, so the value of the data is currently limited.

The sharing of domestic and family violence information between agencies is essential, particularly in relation to its demographic/personal nature in order to improve our understanding of how best to intervene early to minimise harm and avoid

homicide. Currently issues of confidentiality and protecting the privacy rights of persons contained within the files present unfettered information sharing between agencies. Attempts to obtain information on nine individual cases highlights the problems associated with data collection, identifying and flagging domestic and family violence incidents and deaths, and the sharing of information between agencies. For example, a report by BOCSAR (2009) found that up to 43 percent of matters had not been properly flagged as a domestic violence homicide in the Police COPS data system (they were subsequently identified and correctly re-classified by BOCSAR prior to data analysis). It was noted that of that 43 percent, 36 percent were intimate partners or intimate partner related.

Difficulties associated with the sharing of information are not unique to domestic violence homicides. However, this issue will only become more apparent over time and systems should be put in place to ensure a best practice model for the collection of data and sharing of relevant information is implemented so that information concerning victims or domestic violence is not lost.

A best practice model would do the following:

- Ensure that QPRIME has the ability to properly flag homicides as domestic violence homicides.
- Capture data concerning violence/incidents against previous partners.
- Allow a review mechanism to have access to all relevant data including, but not limited to, the QPRIME, NCIS, the Department of Communities database, and the court database (JAG).

It is recommended that an information system be implemented that permits the exchange of information between Coroners and interested parties (for example, the Queensland Police Service, Department of Justice and Attorney-General) with a view to the efficient identification of issues requiring attention. The information system must be able to assist Coroners to identify clusters of events which may be fruitful areas for prevention.

4. *Access to expert evidence*

Barriers regarding accessibility to expert evidence does not mean that there is no expert evidence available. On the contrary, the Queensland Police Service for example, works closely with the Office of the State Coroner in the event that a domestic or family violence related homicide occurs. Following this type of death, the Queensland Police Service can conduct an audit of the police response to ensure compliance with procedures. Current policy requires the State Queensland Police Service Domestic Violence Co-ordinator to "investigate and record the application of any domestic violence/policy/procedures/orders related to homicides with a view to identifying trends which could lead to procedural or policy changes or further training" (Queensland Police Service OPS).

There is also a requirement upon the Regional Crime Coordinator in cases of homicide resulting from an act of domestic violence, to assign a notification task to the Domestic Violence Unit in QPRIME. The message is to contain the name of the victim, offender and investigating officer and contact number and brief particulars of the incident.

At the time of writing this report the panel was awaiting findings from the research

project undertaken by the Queensland Police Service, in conjunction with the Australian Institute of Criminology (AIC), regarding a retrospective review of domestic and family violence related deaths with a view to informing operational decision making and policies surrounding this issue. The research includes a comprehensive review of literature in domestic violence risk assessment tools in Australia and abroad, and a study of a sample of domestic violence homicides and randomly selected domestic violence incidents tested against a range of risk factors. The information (risk factors and combinations) may be used as a guide in the future in the creation of a risk assessment tool.

In addition to the capacity of the Queensland Police Service, there are a vast array of experts, academics and service delivery providers who are able to provide evidence to the Coroners when requested. The limitation lies not only in the identification of the issues which require evidence from such experts but also evidence which provides a focus on systemic reform advice.

There have previously been coronial investigations focused on lives lost as a result of police pursuits, workplace health and safety issues, pool fencing, deaths in custody, and numbers of other laudable pieces of work. Given the number of the national population that die as a result of domestic and family violence each year, it is sobering to think that in Queensland there has been no systemic investigation of these deaths an analysis through a domestic and family violence lens up until now.

The following chapter outlines a model that has been developed by the panel to improve the investigation of, and system responses to, domestic and family violence related deaths. Through a systemic review and the wide range of powers available in the context of a coronial investigation, the ability to analyse whether such a death could have been prevented, and how future deaths could be prevented, can occur. The model proposed in this report is designed to strengthen the review of domestic and family violence related deaths, which in turn, will also assist in addressing the current limitations of the coronial system as discussed. In turn, this will better support the identification of improved prevention and intervention mechanisms within the domestic and family violence arena.

Chapter Three: Domestic and Family Violence Death Review Panel Model

"*We are convinced that this work saves members of our community from early and tragic death*" (Santa Clara County Domestic Violence Fatality Review, 2003)

The terms of reference of the panel include consideration of options for an ongoing domestic and family violence death review process, with a view to preventing deaths in domestic and family violence related circumstances occurring in the future. Based

on extensive research and discussions among the panel and external stakeholders, a model has been developed which aims to provide the unique opportunity to identify systemic gaps and barriers that will contribute to preventing these types of deaths from occurring in the future. Furthermore, it will address the key issues identified in the previous chapter regarding the Coroner's ability to identify and investigate domestic and family violence issues, which will improve capacity to comment and make recommendations regarding these deaths. During this process, a number of different models – from both a national and international perspective - were considered by the panel. It should be noted that whilst comparisons between the operations of international models is useful, they are not always easily comparable to Australia's system as the coronial structure and process in both Canada and the US are considerably different to that in Australia.

In particular, the panel looked closely at the domestic and family violence death review model proposed by DVDRAG and those established in Victoria and NSW. Importantly, the DVDRAG model recommended situating the domestic and family violence death review process within the Office of the State Coroner, and both Victoria and NSW have done likewise. A point of difference, however, with the recommendations made by DVDRAG and the NSW review mechanism is that the domestic and family violence death review model proposed in this report is not underpinned by legislation. Based on the concerns of DVDRAG and the Queensland domestic and family violence sector, the panel's decision to not recommend a legislative basis for the death review mechanism came after much deliberation and discussion. It is recognised that a case has been made in the literature that a domestic and family violence death review mechanism should be legislated, with provisions articulating terms of reference, membership, powers, privacy, confidentiality, immunity of members and immunity of the body's deliberations from freedom of information applications. However, the panel considers that these issues are sufficiently addressed under the *Coroners Act 2003* and via the design of the proposed model. The following reasons underpin the panel's decision to not legislate Queensland's domestic and family violence death review mechanism:

- Coroners already have a wide range of existing powers to: carry out the investigative process and obtain all required information from both government and non-government organisations; the power to comment on any matter connected to the death; and, the power to make recommendations to any Minister, public statutory authority or entity.

- The independence of the State Coroner ensures an open and transparent review.

- All information obtained for the purpose of an investigation is subject to the confidentiality and privacy limitations imposed by the *Coroners Act 2003*. Unless and until an inquest is called with respect to the specific death, the confidentiality and privacy interests of the deceased, as well as those involved in the circumstances of the death, still prevail. Accordingly, all reports remain private and protected.

- The proposed expert advisory panel would be exempt from any concerns of personal liability in relation to the review of cases (for example, from prosecution or civil suit). The advisory panel would be exposed only to de-identified information, and would act as a consultative body for the State Coroner to augment the provision of expertise in the review of each case or clustered cases. All findings and recommendations remain within the functions of the State Coroner.

Most importantly, a key recommendation in this report is that the Terms of Reference for the domestic and family violence death review mechanism be revisited after twelve

month of operation for possible revision and amendment. The need for legislative amendments will be considered as part of this review.

The panel focused on ensuring the proposed model would be independent, have extensive investigatory powers, and the capacity to strongly influence, through review-based recommendations for systemic changes aimed at preventing domestic and family violence related deaths.

Independence

Situating the death review function within the Office of the State Coroner enables the review process a degree of independence from government. The panel considered locating this body within other government departments, for example, the Department of Justice and Attorney-General, the Department of Communities, and the Ombudsman's Office. However, it was determined that the capacity and powers held by these departments were not suited to this purpose. Whilst the Office of the State Coroner is operationally part of the Department of Justice and Attorney-General, Coroners are independent judicial officers. Therefore, the independence of the State Coroner enables a more robust investigation of these deaths, including the legislative power to compel information from agencies/persons that is relevant to the investigation, and make recommendations that must be responded to by government departments.

The panel also considered the implementation of a newly created, independent committee to conduct domestic and family violence death reviews (i.e., outside the Office of the State Coroner). The model considered was for a committee – comprising a body of government and non-government representatives – to undertake the research and investigative process for all domestic and family violence related deaths, with the assistance of a secretariat unit. Based on these findings, the committee would make recommendations to parliament for systemic and/or practice improvements.

However, a number of limitations for the independent committee model were identified. First, this body would not have the power that the State Coroner already has, to compel the provision of all necessary information, documents and records (for example, police briefs, coronial files, and court records). To enable this process, would require the implementation of legislation recognising a newly created body, which brings with it significant policy implications and time delays. For example, the panel agree that a legislative base for the review mechanism is not essential to the successful operation of the model, it would unnecessarily delay its implementation process, and would not guarantee permanency.

Second, the panel raised the possibility of wider perceptions of duplication. Homicides are subject to several different systems of investigation including those conducted by the police, Coroner, and the National Homicide Monitoring Program. There was concern that an independent committee may duplicate existing work in light of the mechanisms already in place for investigation and review. Finally, the power to compel government and non-government agencies to respond to recommendations would unlikely carry the same influence and authority as that elicited by the State Coroner.

Influence

Together, the State Coroner, the advisory panel and the Domestic and Family

Violence Homicide Prevention Unit will provide a particularly unique and significant role in investigating domestic and family violence and deaths that result from domestic and family violence. Research shows that international domestic and family violence death review mechanisms have proved invaluable in identifying common weaknesses in systems and protocols responding to domestic violence that have contributed to a fatality. Teams have gone on to recommend potentially life-saving solutions as well as providing an excellent resource that constantly identifies potential improvements in service delivery David, 2007). Currently, there is no expert body within Queensland that has resources, mandate or capacity to review, investigate and make recommendations aimed at preventing domestic or family violence related deaths, and thus this level of influence is currently lacking. As a result, this death review mechanism would have the power to cause change in both government and non-government systems, as well as attitudes, knowledge and understandings surrounding the context of domestic and family violence related deaths.

Based on the findings and recommendations that emerge following investigations into domestic and family violence related deaths, it is anticipated that a number of reforms are likely to be advocated amongst government and non-government agencies, including:

- legislative and policy changes;
- government and non-government practices to responses to domestic and family violence to be improved;
- system services and guidelines modified; and
- compliance and reporting requirements following coronial recommendations to be significantly improved.

Power to make recommendations

In the event that a Coroner conducts an inquest into a death, recommendations relating to public health or safety, the administration of justice, or ways to prevent similar deaths in the future may be made. This is a particularly powerful function of the coronial process and one that the panel agreed would most effectively invoke systemic change to reduce domestic and family violence related deaths. A particularly important function of the domestic and family violence death review mechanism is the monitoring of all recommendations made by the State Coroner, and that each recommendation is given significant consideration and review by appropriate agencies. To ensure compliance, a response to each recommendation is to be made in writing within a particular time period (approximately six months).

Although the State Coroner's Office currently has the powers to examine domestic violence and family violence related deaths as a connected group, there are limitations to this process (as identified in the preceding section), particularly in relation to the availability of resources required to carry out this level of investigation. This section looks at each of the key issues that comprise the establishment of a domestic and family violence death review process. Consistent with the formation of national and international death review mechanisms, certain criteria and structure is provided to guide the scope and composition of a review model for Queensland. This includes defining the composition and role of the death review body, as well as the scope of deaths to be included for review.

Composition

The implementation of a domestic and family violence death review process requires the development of appropriate infrastructure and adequate resourcing and staff to ensure its effectiveness and success. The panel is recommending the review mechanism be located within the Office of the State Coroner, with a number of resources established and made available to the State Coroner to more effectively identify, investigate and review domestic and family violence related deaths. They include:

- A Domestic and Family Violence Homicide Prevention Unit (DFVHPU) within the Office of the State Coroner. The model would require research and investigative resources to support the State Coroner in the analysis of domestic and family violence related deaths.
- An expert advisory panel to provide advice and address the preventative process of a death review mechanism. The State Coroner, at his discretion, would consult with the panel in the development of recommendations and system and practice improvements based on an individual or cluster case-based analysis.
- A Register of experts to assist the State Coroner, when looking at individual cases, relevant to their area of expertise.

The model being recommended is structured to ensure this process is constituted for longevity and exerts maximum influence in addressing and improving systems to reduce the concerning occurrence of these deaths. Ultimately, it is designed to channel the investigation of domestic and family violence related deaths into a specialist body that provides expert advice and recommendations (similar to the mining and aviation model). Most importantly, the model will work most effectively with the establishment and contribution of each tier in the review process, as each plays a crucial role in the death review process. Without these resources, the State Coroner would not have capacity to conduct analysis of this kind even if a specific mandate is given.

Domestic and Family Violence Homicide Prevention Unit

A Domestic and Family Violence Homicide Prevention Unit (DFVHPU) located within the Office of the State Coroner would comprise the first tier in the review process. The DFVHPU would be responsible for compiling all information relevant to the death of persons from domestic or family violence; investigating the circumstances preceding the death and gaps that might emerge within the system and/or its processes; and submitting a fully informed report to the State Coroner to assist in understanding the issues and events surrounding the death. Based on the findings, recommendations may be formulated to prevent future deaths.

Presently, the Coronial Support Unit (CSU) liaises with the Queensland Police Service in coordinating the management of coronial processes on a state-wide basis. The officers co-located with the Office of the State Coroner provide direct support to the State Coroner, Deputy State Coroner, Brisbane Coroner and other coroners on an as-needs basis. They are actively involved in various research projects and proactively review policies and procedures as part of a continuous improvement approach. However, a team that focuses specifically on domestic and family violence is required to comprehensively capture and investigate these deaths. In addition, the unit will assist the Coroners to more effectively achieve this prevention role by looking

at systemic issues relating to family violence deaths which would enable the State Coroner to develop recommendations aimed at reducing its incidence.

The central goals of the DFVHPU would be to:

- Improve the quality of coronial recommendations;
- Monitor the uptake and implementation rate of coronial recommendations;
- Contribute to the reduction of preventable deaths in Queensland;
- Liaise with government and non-government agencies regarding current system responses to domestic and family violence; and
- Establish and maintain a link with other national and international domestic and family violence death review teams.

Functions

The process of identifying and investigating the circumstances leading up to a domestic and family violence related death, as carried out by staff in the DFVHPU, would include the following:

1. Carry out several levels of review to identify cases requiring investigation:
    - Flag via police report to the Coroner (Form 1);
    - Review the media daily and highlight high profile cases;
    - Daily surveillance of all reportable deaths to the Coroner; and
    - Develop a relationship with the Queensland Police Service Homicide Unit, peak bodies in the sector (for example, domestic and family violence services, Women's Legal Services) and members of the advisory panel to receive notification of relevant deaths.
2. Upon receiving a death file, the researchers are to gather all documents available within the coronial file from the police.
3. Make requests to the Coroner for additional information (if necessary).
4. Focus on system responses prior, and leading up to, the death. This might include: protection orders, medical records, police domestic violence index history, and non-government organisation involvement (for example, counselling services, aid agencies, refuge housing, referrals, etc). Their role is not to analyse the death, or the circumstances of the death.
5. Prepare a report for the Coroner outlining a detailed history of the deceased and perpetrator. This might include the following (depending on the level of information and facts that can be substantiated from existing information): history of domestic violence and other related issues for the deceased person, referrals, services sought and provided, and pattern of abuse. This information is to be contextualised with knowledge from current literature, and may also include advice for additional avenues for investigation; for example, issues to pursue or requests for further information (see Appendix Eight for an

example of the headings and content that may be contained in a report).

6. Maintain a comprehensive literature base for all relevant research to assist inform reports to the State Coroner. For example, identify emerging domestic and family violence trends.

7. Create and maintain a comprehensive database about domestic and family violence deaths, their circumstances and trends.

8. Examine cluster cases where appropriate. For example, domestic and family violence deaths within remote Aboriginal and Torres Strait Islander communities.

9. Monitor the implementation of recommendations by the State Coroner to government and non-government agencies. For example, responses to recommendations made and the implementation of recommendations.

The information relied upon in a review of a domestic or family violence related death will be contained in official reports and brief of evidence. However, based on advice from the Victorian CPU, at times it will be necessary to conduct further enquiries into areas not covered by the brief, such as interviewing health professionals (for example, counsellors, medical practitioners) and domestic violence services (for example, staff at women's shelters and Legal Services) to compile additional information about the history of the relationship between the victim and offender. There may be areas of the relationship dynamic, or particular events preceding the fatality, that the initial investigation has not thoroughly explored and that require further examination subject to the approval of the State Coroner.

Additional duties and tasks required of the DFVPHU, in conjunction with the functions of investigating the history leading up to a death, might include:

- Liaising with domestic and family violence death review mechanisms in other jurisdictions regarding domestic and family violence death review processes and findings;

- Work with the National Coronial Information System (NCIS) in the sharing of Queensland-based domestic and family violence information and data. By increasing the amount and currency of Queensland data, there is great potential to improve the quality of research into death prevention and coronial recommendations, and also to improve NCIS data.

- Collection and analysis of data;

- Writing systemic and case reports for the State Coroner; and

- Evaluating the death review mechanism in terms of implementation, process, impact and outcomes (both short and long term).

A domestic and family violence homicide prevention unit, whilst having access to a range of reportable deaths, will concentrate on the means by which systemic reforms may be achieved, thereby supporting the preventative role of the Coroners. The implementation of the DFVHPU would also utilise existing expertise within the Office of the State Coroner as well as powers already vested in the Coroners to compile all reports.

Resources

Funding and staffing the DFVHPU within the Office of the State Coroner is required, and includes resources to collect, collate and review cases, and produce reports. Financial considerations need to be taken into account when examining the capacity of the Office of the State Coroner. Should an entity be set up within the office, it will require funding not only for financial and administrative support but also for accommodation. It is understood that there has been a 6.5% increase in the number of reportable deaths in 2009 without a concurrent rise in funding levels or additional staff. Given that resources are limited, the office requires capacity to fund a body of experts, as well as administrative support, to participate in all domestic and family violence matters before the Coroner.

It is recommended that the unit comprise the following staff:

- Management
- Research and evaluation staff
- Police investigatory officer/s
- Administration support
- Training staff

It is critical that all research and investigative staff are knowledgeable regarding what information is required to investigate a domestic and family violence-related death in order to compile a fully informed report for the State Coroner. The following key skills are proposed by the panel:

- Significant experience and advanced working knowledge of relevant research methods and techniques.
- An understanding of domestic and family violence issues and relevant legislation (for example, the *Queensland Domestic and Family Violence Protection Act 1989; Coroners Act 2003*).
- Excellent writing skills and networking capabilities and awareness of cultural diversity issues.
- Ability to diagnose trends, obstacles and opportunities in the internal and external environment.
- Forensic investigative experience.

DFVHPU staff will need to be sufficiently trained in all areas of reviewing, researching and investigating a domestic and family violence related death. It is recommended that this training would be sought from a number of avenues including:

- Experts working ‘on the ground’ in the domestic and family violence sector;
- Professional intelligence training courses;
- Training in common risk factors associated with domestic and family violence to ensure staff are aware of what ‘triggers’ of behaviour to look for; for example, mental health issues, alcohol and drug issues, patterns of abuse; and,

* Members of the advisory panel.

Finally, whilst domestic and family violence related deaths are tragic as they are preventable, there are a vast range of other circumstances of death which come to the attention of the Coroners. A prevention unit, whilst initially supporting investigations into domestic and family violence related deaths, may be expanded to provide a facility to the Coroners who would establish a basis for recommendations across a range of issues. A death review model which incorporates a DFVHPU will significantly strengthen the existing coronial process and draw upon existing knowledge and expertise, as well as provide the foundation for systemic improvements for the prevention of domestic and family violence in the community.

Expert Advisory Panel

It is recommended that the second tier in the review process comprise a multi-agency, multi-disciplinary expert advisory panel to provide advice to the State Coroner and DFVHPU on domestic and family violence issues. Given the placement of this model in the Coroner's jurisdiction, it is considered extremely important to have the expertise and experience of a body of professionals available to the State Coroner to assist with identifying systemic issues and gaps. The advisory panel would significantly bolster both the capacity of the State Coroner to incorporate the views of domestic and family violence experts, as well as provide a more robust preventative role. The advisory panel would sit external to the DFVHPU so would not cause delays in the coronial system and its commitment to provide timely and efficient advice and responses.

The key goals of the advisory panel would be to:

* Contribute to the prevention of domestic and family violence and domestic and family violence deaths;
* Assist the State Coroner in the review of deaths of persons that occur as a result of domestic and family violence;
* Identify the presence or absence of systemic issues, problems, gaps, or shortcomings of each case to assist facilitate strategic plans, workable systems and appropriate recommendations for prevention;
* Help identify trends, risk factors, and patterns from the cases reviewed to make recommendations for effective intervention strategies;
* Where appropriate, disseminate educational information; and
* Operate in a culturally sensitive, appropriate and responsive manner.

Functions

The role of the advisory panel would be one of support and guidance for the State Coroner, not decision-making in relation to individual or clustered deaths. It is anticipated the advisory panel would discuss key issues as identified by the State Coroner and the DFVHPU during the review of domestic and family violence related deaths, whilst providing information and advice on what strategies might have been implemented to prevent a death from occurring. It is not the panel's role to carry out case-related research or to coordinate activities associated with the inquiry process

as these functions are to be conducted within the Office of the State Coroner.

It is important that the terms of the functions for the advisory panel remain fairly flexible during its initial implementation phase to enable the State Coroner and members of the advisory panel to establish how this review body will most effectively operate. Following a twelve month establishment period, it is recommended that the State Coroner and the advisory panel compile a written protocol that more finely describes the role of the advisory panel, including its relationship with the State Coroner. Initially, however, some key areas of advice might include:

- Whether a case should proceed to inquest;
- Advice during an inquest;
- Common themes emerging from cases and whether they should be clustered together for the purpose of an inquest;
- Advice on closed cases that do not proceed to inquest.
- Additional avenues of investigation the State Coroner might pursue in reviewing the death;
- Systemic problems in the lead-up to a death that could be avoided in the future; and
- General policy discussions and recommendations.

The advisory panel would convene periodically (for example, quarterly), as well as at the discretion of the State Coroner if required. It is suggested the agenda for panel meetings and papers for discussion be prepared by the DFVHPU, and be designed to feed into the systemic and broad practice issues that emerge during the review process and/or that require expert advice. All de-identified case information provided to inform panel members at meetings is to be collected at the conclusion of each meeting and destroyed.

The maintenance of confidentiality of information is crucial to the functioning of the death review process. Due to the sensitive nature of information that may surround the domestic and family violence death review, the advisory panel would be required to sign confidentiality agreements. This not only protects the privacy of the family and friends of victims but also limits the exposure of agencies that may have had involvement with the victim. The confidentiality agreements would not be drafted with specific reference to the *Coroners Act 2003* or any other piece of legislation, but in terms of the general expectation of participation in the group.

Whilst the panel is recommending the establishment of an advisory panel to assist the State Coroner to review individual and clustered domestic and family violence related deaths, it is mindful that the powers vested in Coroners are broad. As such, the decisions, findings and comments that a Coroner makes must be exercised with judicial impartiality. The role of the advisory panel is not to be developed in any way that might undermine the function of the State Coroner in the coronial process by bringing into question his/her independence. The role of the advisory panel is to provide advice to the State Coroner, so the independence of the coronial system and processes for procedural fairness and natural justice will be maintained.

Membership

It is proposed that the State Coroner, in consultation with relevant government and non-government agencies, select individuals to sit on the advisory panel. Based on preliminary discussions between the State Coroner and the panel, it is recommended that the expert advisory panel would comprise between approximately eight to ten members from a consortium of government and non-government bodies. Members could be drawn from the some of the following agencies:

- Queensland Police Service
- Department of Communities
- Department of Justice and Attorney-General
- Domestic violence service workers
- Aboriginal and Torres Strait Islander representatives
- Mental health
- Victims of Crime

Membership is contingent upon experts who can provide advice to the State Coroner on many different aspects of domestic and family violence in such a way that will constructively contribute to the investigative and review work and the formulation of findings and comments of the Coroner. This would include people from different backgrounds and professions.

It is paramount that persons chosen to sit on the panel are selected based on their individual expertise and not simply due to the agency they represent. Members must have a commitment towards reducing domestic and family violence and domestic and family violence related deaths, and are expected to become familiar with the affairs of the advisory panel and the wider environment in which it operates (for example, the functions of the Office of the State Coroner).

Members will be appointed for up to two years, with the possibility of an extension so that members do not all leave the advisory panel at the same time. Unless a person sooner vacates their role on the advisory panel, every member shall continue in their role until their successor comes on board. Any member may, at any time, resign from the advisory panel by advising the State Coroner and the Minister for Community Services and Housing in writing. Furthermore, the State Coroner and the Minister may, by written notice, terminate the appointment of a member of the advisory panel. At the discretion of the State Coroner, new members may be appointed for the purpose of increasing membership or to supplement additional expertise.

Resources

Supporting a body of experts has implications for resourcing. Advisory panel members are entitled to be paid fees for attendance at meetings. Travel and accommodation expenses of the panel, while on panel business, should be met from the budget allocated to the death review mechanism. An executive support officer is

required to carry out administrative functions needed to ensure the advisory panel is managed effectively and efficiently.

Register of experts

It is recommended that a register comprising domestic and family violence experts and other relevant professionals (for example, medical practitioners) working within Queensland be established to provide the third tier of specialist advice to the State Coroner for the purpose of reviewing domestic and family violence related deaths. Based on the recommendation that a relatively small group of people comprise the expert advisory panel, it is not expected that this group would have the capacity required to address and make recommendations across each complex and encompassing social issue that might fall within the scope of domestic and family violence related homicides. For example, during the investigation of a death, it might become evident that specialist knowledge of general medical practitioner policies is required. Persons comprising the advisory panel will not necessarily know this policy in significant detail so to ensure the accuracy and integrity of the review process, it is imperative this information can be drawn from an expert body expeditiously and reliably.

To compile a register of experts, it is proposed the State Coroner disseminate a state-wide invitation to domestic and family violence agencies and other relevant bodies (for example, mental health experts), inviting persons to nominate themselves to be called on for specialist advice in the event that their expertise may be required. Interested individuals and/or agencies would be requested to submit an application outlining their expertise as relevant to domestic and family violence. Based on this information, and in conjunction with advice from the advisory panel, the State Coroner will select a sufficient body of experts to be included on the register. This register can be amended at any time - for example, in the event that a person wishes to be withdrawn from the register, or a new expert is added to the list. The task of maintaining an up-to-date register of experts would be assigned to the advisory panel, however, held within the Office of the State Coroner.

There would be no obligation for the State Coroner to make contact with any of the individual's listed on the register. The purpose of the register is to ensure a full and diverse body of expertise is available to the Coroner if required and at his/her discretion. Furthermore, the State Coroner may contact any persons/agencies beyond those belonging to the advisory panel and the register for specific expertise during the investigative process.

Similar to the confidentiality provisions required by the advisory panel, it is recommended that each time an individual from the register is requested by the State Coroner to provide expertise to a particular death investigation, a strict confidentiality agreement is to be signed.

Scope

Domestic violence review mechanisms in other jurisdictions vary considerably regarding the deaths that come within the scope of review. For instance, some jurisdictions only consider intimate partner deaths with a history of domestic and family violence, while others consider all family and household relationships. The panel agreed that the following eligible relationships guide the scope of Queensland's

death review mechanism.

Eligible relationships

It is proposed that definitions used to clarify the scope of the domestic and family violence death review mechanism are to align with existing relevant Queensland legislation and the definitions contained therein. Homicides involving persons in (or as having previously been in) an intimate relationship (currently or previously married, in a de facto relationship or otherwise 'intimate') will continue to follow the *Queensland Domestic and Family Violence Protection Act 1989*. Section 11A states that a domestic relationship is one that falls within the scope of the following definition: spousal, intimate personal, family and informal care.

> *Is/ was engaged to be married, including betrothal under cultural or religious tradition; have/ had dated and lives enmeshed; between relatives - a person who is connected to another by blood or marriage or where the concept of relative is wider, a person who is regarded by the other as a relative or regards him or herself as a relative of the other. Informal care relationship between two persons where one is or was dependent on the other to help in an activity of daily living due to disability, illness or impairment*.

In addition to the deaths that fall within the parameters of a domestic relationship, it is suggested that the following deaths also be examined by the Panel.

- Child deaths where there has been a history of domestic and family violence involving the child's parents/caregivers.

- Victims who are associates of victims of intimate partner violence, such as domestic and family violence workers (including police), friends, and extended family members.

A proportion of domestic violence related homicides involve the suicide of the perpetrator in what are commonly termed murder-suicides. It was agreed by the panel that the context of these deaths should be considered as part of the homicide review pertaining to their murder victim. This occurrence is usually marked by considerable media attention.

The panel also agreed that suicides of people who have been victims of domestic violence might also be included in the scope of the review because of the well documented association between women's experiences of domestic violence and severe mental health impacts. These impacts include increased rates of depression, anxiety, post-traumatic stress disorder and suicidality (Ellsberg, Jansen, Heise, Watts, and Garcia-Moneno, 2008; VicHealth, 2004; Golding, 1999; Stark, 1996). A Queensland study found statistically significant correlations between all forms of intimate partner abuse and depression and all forms of intimate partner abuse, except sexual abuse, and severe psychological symptoms (Nancarrow, Lockie and Sharma, 2009). It is well recognised that identifying women's suicides that occur in the context of domestic or family violence will present some challenges, however, the panel argued that omitting the possibility of reviewing these cases would fail to inform practice with these otherwise 'invisible' homicides associated with domestic violence. International research indicates that 42 percent of domestic violence homicide victims had been seen by health services in the year before the incident (Campbell, Glass, Laughon, and Bloom, 2007). This finding suggests that including suicides of women in the scope of the death review mechanism could yield important information leading to improvements in the identification and assistance offered to women suffering severe

impacts on their mental health.

Aboriginal and Torres Strait Islander people's understanding of domestic and family violence

Many studies report that Aboriginal and/or Torres Strait Islander communities often prefer the term 'family violence' as it encapsulates the broader issue of violence within extended families (see Stanley, Tomison and Pocock, 2003; Memmot, Stacey, Chambers and Keys, 2001). The usage of the term 'family violence' within Aboriginal and Torres Strait Islander communities continues to be diverse and localised, and may be difficult to define (Blagg, 2008). It is important to note that preference for the term 'family violence' does not represent a simple substitute of words. Rather, it is based on a culturally distinct definition of 'family' and an assumption that there is a need to address a range of forms of violence, in addition to spousal violence, simultaneously. However, typically family violence in Aboriginal and Torres Strait Islander households has the following characteristics:

- It may involve all types of relatives; the victim and the perpetrator often have a kinship relationship that is responsibility based;
- The victim and/or perpetrator of violence may be an individual or group;
- The term 'family' refers to an extended family which more technically means a kinship network of discrete intermarried descent groups, and in many such cases 'family' may constitute an entire community;
- The 'community' may be remote, rural or urban based; its residents may live in one location or be more dispersed, but nevertheless interact and behave as a social network;
- The acts of violence may constitute physical, psychological, emotional, social, economic and/or sexual abuse; and
- Some of the acts of violence are ongoing over a long period of time, one of the most prevalent examples being spousal (or domestic) violence.

What constitutes a domestic and family violence related death?

A domestic or family violence related death is the unnatural death of a person (adult or child), as the result of an act of domestic or family violence.

Behaviours that fall within the scope of domestic violence, as defined in s11 of the *Queensland Domestic and Family Violence Protection Act 1989*, in the context of a domestic relationship between two persons, include:

- Wilful injury
- Wilful damage to the other person's property
- Intimidation or harassment
- Indecent behaviour

* Threatening to commit such acts or procuring someone else to commit such acts

It is important to note that not all reportable deaths are a direct result of the domestic or family violence itself – cases may be examined where a death is indirectly linked with a history of domestic and family violence in the relationship. For example, the death of an abuser killed by their victim may be reviewed to enable recommendations about systemic change required to prevent ongoing abuse and thus the death of the abuser.

The death review process will need to align with the functions carried out by the Commission for Children and Young People and Child Guardian (CCYPCG). This department investigates all deaths of children and young people within Queensland, with no particular focus on domestic violence or system response. Some deaths of children may arise in the context of domestic or family violence and whilst Queensland has a Child Death Review Team in the CCYPCG, a domestic and family violence death review mechanism would need to be capable of operating in conjunction with the Child Death Review Team when necessary. As explained earlier in this report, the Child Death Review Team reviews the deaths of children and young people known to the child safety service system in the three years prior to their death. Whilst the Child Death Review Team picks those cases where children have died in the context of domestic or family violence, the review team investigates matters related to how child safety services managed the matter and whether that contributed to the death of the child. Therefore, the Commission is well placed to refer relevant matters to the domestic and family violence death review mechanism for review. See Appendix Three for information on this review process.

Range

It is proposed that all domestic and family violence deaths be referred to the State Coroner's Office and each death is to be identified and subject to review by the DFVHPU. This will include cases where the death occurred prior to this date but where the investigation and justice processes had not been completed.

The DFVHPU could consider both closed and open cases. Throughout the literature, arguments against the review of domestic and family violence deaths prior to completion of criminal proceedings are couched in terms that relate to the interests of the defence. Concerns include those circumstances where family members and other relevant people have been interviewed while the criminal investigation is still in progress. It is recognised that it is vitally important that confidentiality be maintained so that criminal proceedings are not compromised.

However, the challenges in reviewing cases where criminal proceedings have been completed suggest that the review must still be recent enough that the findings, usually from public records, inform and guide discussions about improving existing policies and procedures. The State Coroner would consult with the advisory panel during the investigative process of a domestic and family violence-related death as a means of obtaining expert opinions on systemic gaps and issues relevant to the death.

The proposed domestic and family violence death review process is not an enquiry into how the victim died or who is culpable. This is a matter for the Coroner and criminal courts. Rather, it seeks to investigate the events prior to the death, the circumstances surrounding the death, and action that may be taken to prevent deaths occurring in similar circumstances in the future. Most importantly, the review process will only be interested in systemic and procedural weaknesses, not the actions or negligence of individuals. Unlike criminal investigations, the individual is not the

responsible agent; it is the operating procedures, laws and systems in place at the time of the death that might come under scrutiny. For example, a community organiser sought refuge for a woman experiencing domestic and family violence, yet was unable to find the victim (who was later killed by her intimate partner) a bed. In this case, the death review would seek to understand if this circumstance was the result of a wider social issue (such as lack of available safe accommodation for victims of domestic and family violence in that area) or attributable to other causes.

Cultural sensitivities

The review process is to take culturally sensitive and appropriate approaches across all of its operations, with a high priority placed on reducing harm to Aboriginal and Torres Strait Islander communities. The DFVHPU and advisory panel will engage with Aboriginal and Torres Strait Islander groups in as many ways possible to ensure they are operating in a culturally sensitive and responsive manner. The expertise and knowledge of Aboriginal and Torres Strait Islander panel members, and Aboriginal and Torres Strait Islander experts on the register, will be a significant part of identifying the causes of family violence deaths and developing measures to be put into play to halt this trend and stop deaths in the future.

Important considerations regarding incidents of domestic and family violence and abuse in Aboriginal and Torres Strait Islander communities is that it is largely underreported for various reasons. For example, it has been reported that the extent of violence against women is underestimated because Aboriginal and Torres Strait Islander women do not access support services for fear of being ostracised by their community, or concern for the perpetrator, and so are more likely to use refuges as respite and then return to the violent partner. In addition, rural/remote geographical issues also mean that Aboriginal and Torres Strait Islander women may not have access to sufficient, if any, support services (Cunneen, 2010). These issues also have serious implications for the use of domestic and family violence protection orders as a legal mechanism to protect Aboriginal and Torres Strait Islander people against domestic and family violence. A key report that addresses this issue is the Aboriginal and Torres Strait Islander Women's Taskforce on Violence Report (ATSIWTV). Specifically, the ATSIWTV noted that:

> *In some cases they [domestic violence orders] may be ineffectual due to the way they have been constructed, implemented and enforced… Some Aboriginal and Torres Strait Islander women may only want 'time out' from the perpetrator with alcohol and substance abuse counselling and anger management programs enforced, rather than removal, containment or incarceration of their spouse* (ATSIWTV, 2000: 209).

Furthermore, under certain circumstances, applying for an order may be a culturally inappropriate response for Aboriginal and Torres Strait Islander people. Kinship rules of most Aboriginal and Torres Strait Islander people place great pressure on the victim and offender to stay together (Cunneen, 2010). It has been reported that Aboriginal and Torres Strait Islander women often refuse to take out domestic and family violence orders in fear that their children will be removed from them. Associated issues include culturally linked shame and fear and community attitudes towards violence (ATSIWTV, 2000). Applying for a domestic and family violence order may be a divisive factor in a community, particularly for those living in discrete communities and rural areas (Cunneen, 2010). The closed nature of many Aboriginal and Torres Strait Islander communities means that the application and granting of an order will likely become common knowledge within the community. Further, there may be no alternative living arrangement for either party to enable carrying out the conditions of the order. The tension between the requirements of a domestic and

family violence order and Aboriginal and Torres Strait Islander women's protection is a significant concern and one that is likely to arise during the course of the domestic and family violence death review mechanism.

It is recommended that the proposed model implements a specific and well resourced strategy to involve Aboriginal and Torres Strait Islander people in discussions on the way forward in respect to family violence death reviews. This may involve reviewing Aboriginal and Torres Strait Islander deaths as part of an overall review of domestic and family violence related deaths with Aboriginal and Torres Strait Islander representation on the panel, as well as the development of a specific inquiry into a cluster of Aboriginal and Torres Strait Islander deaths. For example, an Aboriginal and Torres Strait Islander worker/consultant working with an Aboriginal and Torres Strait Islander reference group could be employed to develop a process with which Aboriginal and Torres Strait Islander family violence deaths could be reviewed.

Following discussions with remote and rural domestic and family violence centres and safe house staff it is noted that in Aboriginal and Torres Strait Islander cultures there are issues around the death and 'sorry business' time. Three key issues were identified, they are:

1. That the use of the Aboriginal victim's name after death is restricted and is not to be used until the allocated time has passed. It is believed that the saying of the name calls the spirit back which causes much unrest in the family.

   In Torres Strait culture there is the time around the Tomb Stone Opening ceremony which is usually three years after the funeral and marks the end of the mourning period after the spirit has joined the ancestors.

2. In the event of seeking information from services such as domestic and family violence and legal services, there is to be a contact person who is local and known to the family of the deceased so they may negotiate contact with and permissions from the family.

3. That the 'extended family' tensions around 2 families of a possible murder/ suicide or suicide related to domestic violence be dealt with very sensitively as some communities still practice the 'payback' system of dealing with death and any move to be seen as working against the perpetrator may be viewed in a negative way.

Importantly, Aboriginal and Torres Strait Islander approaches to, and understanding of, death are distinctive. The customs and wishes of Aboriginal and Torres Strait Islander people are sometimes not fully appreciated by the official with whom they must deal with (Cunneen, 2010). Effective Aboriginal and Torres Strait Islander representation can assist identify issues of special concern, advise on lines of investigation, give a focus to the inquest, identify similar cases and suggest practical recommendations.

The DFVHPU and advisory panel is to be aware that the cultural needs of each domestic or family violence death will be different and these needs are to be addressed on a case-by-base basis. This will apply to all cultures, and cultural specialists and interpreters will be required in some cases.

Proposed outcomes of the domestic and family violence death review mechanism

A number of important outcomes are expected following the establishment of a domestic and family violence death review process in Queensland. The key outcome is to reduce incidences of domestic or family violence homicides by improving system responses that better address domestic and family violence. Other significant outcomes include:

- Making recommendations aimed at continuous improvement and prevention strategies on a system-wide basis;
- Developing a broader perspective and knowledge about the culture and context of domestic and family violence related deaths;
- Creating a system that ensures compliance by government agencies in terms of responding to coronial findings and recommendations;
- The compilation of specialised individual and aggregated death review reports, based on research by the DFVHPU, advice from the advisory panel, and findings from the State Coroner;
- Increased recognition of the impact and circumstances surrounding this type of death, including greater community education and awareness; and,
- Comfort to the family and friends of the victim or victims of domestic and family violence by providing a process that recognises the devastating impact of these deaths and efforts provided to prevent future deaths.

It is important to highlight that the contribution made by a domestic and family violence death review mechanism cannot, and should not be measured based on whether or not there is a decline in the number of domestic and/or family violence related deaths alone. While this is clearly one important objective of the mechanism proposed in this report, the factors that shape homicide rates are numerous. It is unlikely that the effects of a death review mechanism can be disentangled from other factors such as changes in law or legislation, policy, practices, and service provision related to domestic and family violence related deaths, or from the broader demographic, social, cultural and economic factors that shape homicide rates more generally.

Reporting of findings and recommendations

Monitoring of, and reporting on, the implementation of recommendations would be essential for a domestic and family violence death review mechanism. Currently the State Coroner compiles an annual report documenting findings and recommendations made across all deaths investigated by Queensland Coroners throughout the year. The panel discussed the possibility of an annual report specific to domestic and family violence deaths and the key findings and recommendations to emerge from the investigative and review process. However, because the decisions, findings and recommendations for all domestic and family violence deaths are to be made by the State Coroner, the panel decided it was not appropriate for the advisory panel to submit an annual report on behalf of the workings of the State Coroner. As a result, it was proposed the State Coroner include a sub-section in the Annual Report specific to the investigation of domestic and family violence deaths and dedicated to systemic findings and recommendations.

The DFVHPU would be responsible for following up the considerations and implementation of all recommendations (across both government and non-government agencies) made by the State Coroner following the investigation of a

domestic and family violence related death.

Chapter Four: Summary and Recommendations

Domestic and family violence is a profound social problem that impacts on a wide cross section of the community. The sad and sombre reality of the proposed domestic and family violence death review mechanism is that the worst possible outcome in this continuum has occurred. Domestic and family violence death review mechanisms have been operating in many international states for a number of years, and are emerging as an important process within Australia. The need for this review mechanism is paramount based on the devastating impact that domestic and family violence deaths have on families and the wider community, and the need to examine these deaths as a part of complex web of behaviours and interactions involving individuals, organisations and agencies. Findings from overseas jurisdictions demonstrate that the benefits of a domestic and family violence death review mechanism are very encouraging in reducing this tragic death, and highlight, in particular, one very critical aspect of its occurrence – with the right investigative processes in place, this type of death can be prevented.

In accordance with the *Queensland Government's Strategy to reduce domestic and family violence 2009-14*, and the *Program of Action 2009-12*, the establishment of an ongoing death review process would significantly feed into a number of key areas under reform, in particular: prevention; early identification; and system planning and coordination. Building on from Queensland's current death review process in the Office of the State Coroner, we are proposing additional support processes be established to aid in the investigation and review of domestic and family violence deaths. A number of procedures and practices underlying the establishment of this mechanism have been identified throughout this report, and below are the recommendations as compiled by the panel.

Recommendations

1. Establishment of an ongoing death review process.

The model proposed in this report includes locating the review process within the already existing functions and powers held by the State Coroner, with the addition of

the establishment of a number of resources and areas of expertise:

- ✶ Domestic and Family Violence Homicide Prevention Unit
- ✶ Advisory panel
- ✶ Register of experts

This mechanism is recommended to increase priority to the investigation of domestic and family violence related deaths as a connected group, not discrete homicides unrelated to one another because they are factually or legally different. A holistic and robust review of these deaths will enable the identification of necessary systemic changes and improve the quality of recommendations which aims to reduce incidences of this type of death in the future.

The model recommended by the panel would be convened by the State Coroner, with membership comprising representatives from government and non-government agencies. Importantly, the purpose of the review process is not based on a shame and blame framework, but one focussed on prevention and the improvement of systems and intervention.

To date, whilst the Coroner has the powers to examine domestic and family violence-related deaths, there are some limitations to this process. The key limitation is the provision of available resources required to carry out this function thoroughly.

2. Implement the following procedures to improve the quality of information provided to the State Coroner:

a. Amendments to Form 1:

To assist police and the State Coroner to identify and flag a death as domestic or family violence related, Form 1 requires additional questions to provide this opportunity. It is recommended that the Coroners Prevention Unit, in consultation with the Queensland Police Service, will develop amendments to Form 1 to improve flagging of all domestic and family violence related deaths. It is further recommended that the State Coroner consider and approve the amendments. This information will enable the State Coroner to more clearly identify the death as domestic or family violence related, which will subsequently enable a more thorough review of the death within this context.

b. Amendment of guidelines to assist Coroners to identify domestic and family violence issues and seek expert evidence.

One way of effecting change to ensure that domestic and family violence deaths are examined in such a way as to provide a means for future systemic reforms is to amend the current guidelines for Coroners. The State Coroner is able to make guidelines which are relevant and desirable to ensure best practice for coronial processes. It is recommended that the State Coroner develop guidelines to improve the way in which domestic and family violence deaths are recognised, investigated and addressed.

c. Information sharing

Based on the high level of information required from Queensland Police

Service, it is proposed that a MOU be established between the State Coroner's Office and the Queensland Police Service. The MOU would outline the process for the exchange of information, including the nomination of a key contact person/unit within Queensland Police Service to ensure this process operates efficiently and consistently, and relates only to domestic and family violence deaths. It would include establishing timeframes for information to be provided (albeit, this timeframe will depend on the type of death due to different processes required, i.e., homicide, murder-suicide) and revoke the process of trawling through lists of Queensland Police Service staff to consult with on a state-wide basis to gather relevant information.

It is also recommended that to improve data sharing between agencies, that an information system be implemented that permits the exchange of information between Coroners, the Queensland Police Service and the Department of Justice and Attorney-General, with a view to the efficient identification of issues requiring attention. The information system must be able to assist Coroners to identify clusters of events which may be fruitful areas for prevention.

3. Education and awareness for key stakeholders

There are a number of levels at which education and awareness for key stakeholders will need to be carried out to understand domestic and family violence related deaths at each stage of the coronial process, as well as the role and functions of all elements of the death review mechanism. This includes providing education to officers of the Queensland Police Service who participate in the investigation of domestic and family violence related deaths; the officers and staff of the Queensland Police Service entering the homicide data in the DV Index; staff of the DFVHPU; the Coronial Support Team including those officers who enter data into the CCMS; lawyers who provide support to the Coroners; and the Coroners themselves. At each stage of the process different education and training will be required.

It is recommended that all people involved in the investigation of domestic and family violence related-deaths including Queensland Police Service officers and coronial staff, are made aware of changes to the amended Form 1. For example, this process will include local level meetings to ensure changes to the Operational Procedures Manual (OPM) when filling out Form 1 are understood by all relevant persons.

To ensure education and training is provided to all necessary parties efficiently, the panel also recommends that resources be established early on in the implementation phase of the death review mechanism. This will require establishing qualified human resource personnel to oversee this task.

4. Consideration to be given to an internal review of the scope, functions, and Terms of Reference of the proposed model and all its components after 12 months, with a more detailed evaluation to be carried out after a three year period.

Conclusion

As indicated earlier in this report, the panel considered at length the research

concerning domestic and family violence death review mechanisms, with a focus on the models implemented in Victoria and NSW, and that proposed by DVDRAG in *Dying to be Heard* (2008). The panel reached consensus on a number of critical elements regarding the death review mechanism including: the scope of its functions; membership; range of deaths to be investigated and reviewed; and, an emphasis on culturally sensitive and appropriate approaches across all of its operations, with a high priority placed on reducing harm to Aboriginal and Torres Strait Islander communities.

The panel concluded that, should a mechanism be established in Queensland, the preferred model for a review process is one that is situated within the Office of the State Coroner and expands upon the already existing functions of the State Coroner. This model draws on the judicial independence of the State Coroner and his/her ability to influence change by building on existing expertise in death reviews and wider systemic reviews.

It was a concern for some panel members that the proposed domestic and family violence death review mechanism is not underpinned by legislation. However, this decision was based on the consensus that the *Coroners Act 2003* already provides a wide range of existing powers to investigate and make findings following the review of a domestic or family violence related death. They include the power to compel all necessary information from government and non-government agencies for the purpose of the investigative process, as well as the power to comment and make recommendations to ensure wider systemic change and prevent similar deaths from occurring in the future. Given that a similar coronial model has already been adopted in other jurisdictions, the State Coroner was also considered to be in the advantageous position of being able to utilise current and developing coronial networks across Australia and potentially internationally.

The panel acknowledges that if the recommendations are accepted regarding the proposed model, the Queensland government will explore options for implementation and resourcing requirements.

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Appendix One

DVDRAG Model

In the *Dying to be Heard* (Taylor, 2008) discussion paper, DFDRAG outline a proposed model to guide the implementation of a domestic and family violence death review mechanism.

Legislative Framework

DRDRAG recommends that the a legislative base is required to support the establishment and operation of a domestic and family violence review board, providing it with structure, terms of reference and the necessary legal framework for accessing confidential case information. A legislative framework is proposed irrespective of where the review mechanism might be 'housed'.

The powers to compel and request data, information and records from all relevant government and non-government agencies must be clearly articulated in legislation specifically drafted for the Death Review Board.

Location of the Review Process

A number of suggestions are provided regarding the location of the review board, including the State Coroner's Office, the State Ombudsman Office, or the development of a separate entity supported by legislation and funding. It is recommended that consideration by given to the need for the review mechanism to have the ability to remain independent and autonomous.

Membership

Suggestions regarding board membership include the State Coroner and the Police Commissioner, as well as representation from the Department of Justice and Attorney-General, Health, Aboriginal and Torres Strait Islander services, the domestic violence sector, and any other persons with pertinent expertise in domestic and family violence. It was recommended that an independent Chair be assigned to convene meetings, as well as support staff including research and administrative functions.

Functions

The primary role of the board would be to conduct a confidential review of each domestic and family violence homicide; maintain a database about the victims and perpetrators, and the circumstances leading up to the deaths; identify systemic gaps and risk factors that may have contributed to the death; and based on larger trends and patterns, provide recommendations to the Queensland Government via an annual report designed to implement the changes needed to stop domestic and family violence related deaths.

Scope

It was suggested that the scope of the reviews would fall under the relationships outlined in the *Queensland Domestic and Family Violence Protection Act 1989*, and

only closed cases would be investigated. In addition, DVDRAG suggest that the scope also include other groups of people whose deaths is considered to have occurred as a direct result of their relationship to someone who is or has been in a domestic violence relationship as defined by the Act. This could include new partners, friends and work colleagues.

Recommendations

Finally, to ensure any recommendations submitted by the panel are given serious consideration, it was proposed that the government be required to provide a response to the recommendations within six months.

Appendix Two

Terms of Reference of the Panel

The panel was guided by a set of Terms of Reference, including:

- ✶ To provide expert advice, based on the research undertaken, to the Minister for Community Services and Housing, the Attorney-General and the Minister for Police on two main objectives:
  - o Options for strengthening coronial processes and the Coroner's capacity to comment on domestic and family violence issues; and
  - o Options to identify systemic gaps and barriers to help prevent domestic and family violence-related deaths in the future, including models for an ongoing death review process.
- ✶ The panel is not a body tasked with re-investigating cases, reviewing coronial findings or recommendations or attributing fault or blame to any individual, agency or body involved in cases accessed to inform aggregate level information about domestic and family violence homicides.
- ✶ Promote an informed preventative approach to reduce the harms associated with domestic violence.
- ✶ The State Coroner, and the Office of the State Coroner, other government representatives, or any other government or external experts, such as academics, those with expertise on Aboriginal and Torres Strait Islander, culturally and linguistically diverse, same sex, rural and remote, disability issues or family law matters, can be consulted on an *ad hoc* basis to provide relevant information.
- ✶ Support for the panel to be provided by a principal research officer from the Strategy Implementation Team based in the Department of Communities.
- ✶ The proceedings and records of panel meetings will be confidential and

members will be required to sign a confidentiality agreement. The panel are required to comply with all relevant confidentiality provisions and other conditions imposed under relevant legislation on information or documents received by them.

- Where possible, decision making to be by consensus. The Chair can assist the members of the panel to resolve issues of concern. Where consensus is not possible, dissenting views may be noted in the final report to the Ministers.

- The Terms of Reference will be reviewed following the completion of Stage One to reflect the model for an ongoing death review process.

Appendix Three

Child Death Review Mechanisms in Queensland

Child death function of the CCYPCG

The Commission reviews, registers, analyses, and reports on trends and patterns in child deaths as part of key international, national and state obligations.

Focus

Under the *Commission for Children and Young People and Child Guardian Act 2000*, the Commission has a statutory obligation to maintain a register of all deaths of children and young people under the age of 18 that are registered in Queensland.

Accompanying the Commission's privileged access to information is a duty of confidentiality that is specified in legislation (see s. 153 (Confidentiality of Other Information) of the Commission for Children and Young People and Child Guardian Act).

Functions

The information in the register is required to be classified according to cause of death, demographic information and other relevant factors. The Commission is required to maintain the register from 1 January 2001. In this capacity, the Commission has responsibility for the centralised collection and coding of mortality information for both

coronial and non-coronial deaths.

The Commission analyses information in the Child Death Register to identify and report on patterns of child mortality and make recommendations about policies, practices and procedures aimed at reducing or preventing child deaths.

The Commission examines all child deaths, with a key focus on searching for the contributing factors as a means of preventing further deaths in similar circumstances. The review process includes an in-depth consideration of autopsies, coronial files, child protection and police information.

Information sharing agreements are in place with all relevant government agencies and additional agreements have been established to support research projects in three priority areas: youth suicide, rural deaths and fatal assault and neglect.

To support the establishment and maintenance of the register, the Registry of Births, Deaths and Marriages and the Office of the State Coroner both advise the Commission of a child's death and provide available relevant particulars. To the extent practicable, this information is provided within 30 days after the death is registered.

Data provided includes:

- The registration number
- The child's name and date and place of birth
- The child's usual place of residence
- The Child's age and sex
- The child's occupation (if any)
- Aboriginal and/or Torres Strait Islander status
- The duration of the last illness, if any, had by the child
- The data and place of death
- The cause of death
- The mode of dying

Recommendations

Review processes have led to the identification of the extent of under-reporting of youth suicide in Queensland (Child Deaths Annual Report 2005-06), highlighted the significance of pool fence compliance and supervision as risk factors in toddler drownings (2006-07) and enabled concerns about unsafe infant sleep practices to be actioned by Queensland Health through the provision of appropriate information and resources to new parents (2004 – 05).

The Commission works collaboratively with a body of experts focused on developing agreed priorities for work that can be undertaken to target modifiable risk factors in preventable deaths. A number of agencies and organisations access and utilise this information to inform contemporary evidence based policy development and the formulation of strategies and campaigns aimed at preventing child deaths.

Child Death Case Review Committee

The Child Death Case Review Committee (the Committee) constitutes the second tier in the Queensland child death case review jurisdiction. It is responsible for assessing the reviews conducted by the Department of Communities (Child Safety Services) (CSS) about its involvement with a child who has died and was known to the child safety service system in the three years prior to their death.

Focus

Under Chapter 7A of the *Child Protection Act 1999*, if a child has died and in the three years prior to the child's death, CSS has involvement with the child, CSS is required to conduct a review of its involvement with the child. CSS must provide its review report to the Committee within six months of becoming aware of the subject child's death.

The CDCRC is comprised of a panel of experts drawn from the fields of paediatrics, mental health, investigations and child protection. It acts independently when performing its functions and is not under the control or direction of any other entity.

Under Part 4A of the Commission for Children and Young People and Child Guardian Act 2000, once the Committee has received the original review report, the Committee must review it and provide a report back to CSS within three months.

The legislative tasks of the Committee include:

- Reviewing the original reviews conducted by Child Safety Services under Chapter 7A of the *Child Protection Act 1999*.
- Making appropriate recommendations to the Chief Executive of CSS, and monitor the implementation of those recommendations.
- Provide information to the Minister about reviews if requested.
- By 31 October each year, give to the Minister a report about the performance of the Committee's functions during the previous financial year.

Functions

Operationally, the original review (including all relevant documents) is received by the Secretariat. The Secretariat will review the original review and all relevant documents and prepare a review brief for Committee members. The review brief will be provided to Committee members a week prior to the Committee meeting, and be discussed at the meeting.

There must be a quorum for each meeting, which equals half of the members holding office at that time (or the next higher whole number). If the matter involves an Aboriginal child, the Committee's Aboriginal representative must be in attendance for there to be a quorum. If the matter involves a Torres Strait Islander child, the Committee's Torres Strait Islander representative must be in attendance.

After the meeting, the Secretariat will then incorporate the feedback of Committee members and prepare a draft report. This is then provided to Committee members for their feedback. Once all feedback has been received, a final report is prepared

and provided to CSS within the legislated three month time frame.

The Committee utilises a set of criteria when working with the original review. It focuses the quality of the reviews conducted by the CSS and adds value by identifying whole of government service system issues and making recommendations or referrals where appropriate.

In reviewing the original reviews, the Committee identifies the following issues:

- Cause of death
- Aboriginal and/or Torres Strait Islander status
- General child protection risk factors associated with the child and his/her family
- Risk factors that were relevant to the child's death
- Service system issues present in the case (distinguished between those that resulted in an adverse outcome for the child while he/her was alive)
- Recurring risk factors
- Recurring service system issues
- Any issues regarding the quality of the original review

In addition to complying with the review criteria, the identification of this information enables the Committee to identify issues which may shape recommendations, referrals and also be reported on in its annual report. For example, in its 2008-09 annual report the Committee considered family and child issues present in each of the twelve children and young people who suicided. This information assists the Committee gain an understanding of the needs of such young people which may then influence recommendations or referrals in the future.

Recommendations

Under the legislation the Committee can make recommendations to CSS. While the Committee does not have the capacity to make recommendations to other agencies, if necessary, it will refer issues to other agencies for their consideration and appropriate action. In addition, the Committee may refer concerns to the Commission for Children and Young People and Child Guardian for assessment and appropriate action (for example, where concerns may be held about the safety of siblings of the subject child).

Appendix Four

Queensland Mining Death Review Process

The purpose of inquiries is to find out the nature and cause of the accident and to recommend actions to prevent recurrence of a similar accident.

Why

Since 1907 there have been 958 mining fatalities in Queensland, as well as countless injuries as a result of mining accidents. Fatalities, particularly multiple fatalities, have had a major impact upon public perception of the mining industry. Mines have been forced to close. Parliamentary action has provoked significant changes to mining

practices and applicable occupational health and safety legislation.

Objective

To achieve the goal of zero harm.

The question the Queensland mining industry has to address is not just how to manage a fatality and subsequent public perception. The real issue is what does the industry expect government to do when the fatality was potentially caused by a failure to discharge a relevant safety and health obligation. What is the appropriate response? How should the industry view such a situation? What penalties should be imposed, if any?

Legislation

The statutory framework that governs mining in Queensland is principally to be found in the *Mining and Quarrying Safety and Health Act 1999* (MQSHA 1999) and the *Coal Mining Safety and Health Act 1999* (CMSHA 1999), together with their accompanying Regulations. These are the *Mining and Quarrying Safety and Health Regulation 2001* (MQSHR 2001) and the *Coal Mining Safety and Health Regulation Act 2001* (CMSHR 2001). There are also various other statutory instruments, including the guidelines (metalliferous) and recognised standards (coal) issued by the Minister.

Investigatory body

Reviews and investigations are undertaken by the mines inspectorate, which operates as a part of the Safety and Health Division of the Department of Natural Resources & Mines. The Chief Inspector of Mines and the inspectors and inspection officers reporting to the chief inspector, while having decision-making responsibilities under the legislation, for administrative purposes report through the Executive Director, Safety and Health Division and the Deputy Director-General, Mines to the Director-General and the Minister.

Regional Inspectors of Mines/District Managers Safety & Health are responsible for Inspectorate operations in the South-East, Central-West and Northern regions of the state. Regional and district offices of the Inspectorate are physically located within regional offices of the Department of Natural Resources and Mines, and administratively the inspectorate operations in the regions come under the control of the relevant Departmental Regional Service Directors.

Figure 2: Organisational structure and reporting arrangements of the Mines Inspectorate

Roles, responsibilities and functions

The legislated roles and functions of the Mines Inspectorate are set out in MQSHA 1999 (section 135), CMSHA 1999 (section 128) and associated regulations, recognised standards and guidelines.

An Inspector must, under the mining legislation, investigate all accidents causing death at a mine to determine the nature and cause of the fatality and report the

findings of the investigation to the Chief Inspector.

The functions of the inspectors and inspection officers are very broad. They include:

- enforcing the Act (above);
- monitoring safety and health performance at mines;
- inspecting and auditing mines to assess whether risk is at an acceptable level; and
- helping persons to achieve the purposes of this Act by providing advice and information on how the purposes are to be achieved.

Additional powers of inspectors include advising the chief inspector on safety and health at mines, and making recommendations to the chief inspector about prosecutions under these Acts.

Qualification requirements

The recruitment into the Inspectorate leads typically to the appointment of individuals with skills, formal qualifications and training in the areas of engineering (mining, mechanical, electrical, and chemical). The possession of a First-Class Mine Managers Certificate has been a prerequisite demonstration of competence and experience necessary for appointment as an Inspector of Mines. Inspection officers are generally appointed on the basis of substantial demonstrated practical experience and competence in mining operations usually at a supervisory level.

Under CMSHA 1999 (section 128) the chief executive may appoint a person

- as an inspector who has
  - a professional engineering qualification relevant to coal mining operations from an Australian university or an equivalent qualification; and
  - appropriate competencies, and adequate experience, at senior level in mining operations, to effectively perform an inspector's functions.
- as an inspection officer who has
  - appropriate competencies, or other adequate experience, to effectively perform an inspection officer's functions.

Resourcing

Since 1997, the use of contracts of employment under section 70 of the Public Service Act 1996 has provided a degree of flexibility to allow salary and conditions of service to be offered outside the constraints of normal public service guidelines. The operations of the Inspectorate are funded through budgetary allocations administered as part of the general Departmental (general appropriations) funding process. As such, the operations of the Inspectorate are subject to similar funding conditions and constraints as apply in many other areas of public service.

Death review process

Figure 3: Queensland Mining Death Review Process

Initial response

Under the *Coroners Act 2003*, a person who becomes aware of a mining fatality (or other notifiable death) has a statutory duty to report the death to a police officer or a Coroner. The Site Senior Executive (SSE) must also notify an Inspector and a District Workers' Representative (DWR) or an Industry Safety and Health Representative (IS&HR) about the incident either orally, or by notice in writing. If the SSE makes an oral report, it must be confirmed in writing within 24 hours.

An arrangement between the Mines Inspectorate and the State Coroner requires the Chief Inspector to advise the State Coroner of the fatality as soon as is reasonable. The purpose is to inform relevant authorities so that independent investigations can commence.

Investigation process

The Mines Inspectorate undertakes the role of providing the Coroner with a detailed report about the nature and cause of mining deaths. In circumstances where the police consider there are no suspicious circumstances surrounding the death, the investigating police officer will hand over the site and the investigation to the Mines Inspectorate. The Inspectorate then undertakes the ongoing and detailed investigation, which looks at the nature and cause of the death and recommendations to avoid a reoccurrence. An Inspector investigates all accidents causing death at a mine to determine the nature and cause of the fatality and reports the findings of the

investigation to the Chief Inspector. The primary purpose of the investigation is to determine the root causes of the incident, with the aim of preventing similar accidents from occurring in the future. The Inspectors, however, have another role; where there is evidence to indicate that a person, or company, has failed to discharge a relevant safety and health obligation, the investigating inspector must provide a report to the Chief Inspector, which may include a recommendation about a prosecution or other compliance action under MQSHA 1999 and CMSHA 1999.

The Mines Inspectorate has a process that investigators must follow for such matters as complaints, serious accidents and fatalities. This is outlined in the Mine Inspectorate's Investigation Process Manual to ensure there is a systematic approach to investigating the event, and the various actions and omissions that led up to the event. The Mines Inspectorate has an obligation to be impartial. During the course of the investigation, the Inspector will discuss the investigation with relevant stakeholders which include the family, mine management and the mine's workforce.

A Site Senior Executive (SSE) has a statutory obligation to assist the inspectorate in the performance of their duties. The Coroner provides the independent oversight of the process of investigation and the subsequent court process

Inspectorate investigation

On initially becoming aware of an incident leading to a fatality, the notified Inspector will liaise with the SSE, or a delegate, to ascertain:

- The number of fatalities and whether other people are in danger;
- What action is to be taken immediately (including emergency response);
- When the Mines Inspectorate will arrive on site;
- That the site is to remain undisturbed and secured;
- What personnel/resources are required to be made available; and
- Police response.

On site the Mines Inspectorate's investigation team, headed up by the lead investigator will, initially, be briefed by mine staff. Following this, a site inspection will occur, where relevant evidence will be gathered. This process will involve collecting photographic evidence, taking measurements and seizure of vital components. The investigating inspector will also call for documentation on procedures and risk assessments pertinent to the work that related to the fatality; training records; maintenance records; manufacturer manuals for equipment; and other documents relevant to understanding the nature and cause of the incident.

The investigating inspector will also interview personnel involved in the incident, which may include the operator, SSE, supervisors, operational workers, and service personnel. Statements will be taken during the interview to understand the nature and cause of the fatality and develop an accurate picture of the facts and events that led to the fatality.

Findings

During the investigation it is probable that the investigating inspector will discuss the preliminary findings with management and issue directives, or other corrective measures, to control hazards and risks identified during the investigation. These actions are not punitive in nature, but rather to improve safety by learning from tragedy. The Mines Inspectorate, where applicable, will also issue Safety Alerts and Safety Bulletins to the mining industry to highlight deficiencies that might be generic to the industry. Occasionally, the inspectorate has held workshops involving a range of expertise within the mining industry to find practical solutions for managing hazards.

The investigation model employed by the inspectorate investigation team aims at establishing both the contributing and non-contributing factors which related to the incident. In doing so, the investigating inspector attempts to identify what did not cause the accident as much as what did cause the accident. Ultimately, in the Report to the Chief Inspector the investigating inspector will make findings of fact, and draw technical conclusions, about what caused the incident.

The next step is to benchmark the identified causes against the mining legislation, and the safety and health management system developed by the mine, in order to identify possible failures, or unnoticed deficits, in the safety and health management system.

When investigating a fatality, the primary focus is on the following issues:

- Does the mine have a process for performing the task (procedures; risk assessments)?
- Was the person adequately trained and assessed as having the knowledge, understanding and skill to carry out the required processes (training and competency)?
- Was the process adequately supervised (supervision)?
- Was there adequate time and resources to perform the work (resources)?
- Was the workplace safe? For example, equipment / electrical / hazardous substances and dangerous goods / ground conditions / vehicle interaction (fit for purpose)?
- Was the mine adequately prepared with resources and facilities for reasonably foreseeable emergencies (emergency response)?

Preservation of evidence at the incident site is vital, and under the mining legislation the site of a serious accident, or high potential incident, must not be interfered with without the permission of an inspector. In a fatality, this rule is critical for mine management to avoid censure from police and the inspectorate. Action taken to save life or prevent further injury, however, is not considered interference with a place.

In reaching its conclusions on nature and cause, the Mines Inspectorate uses the Incident Cause Analysis Method to analyse information collected to determine the causes of the accident. The investigation would also consider additional recommendations, over and above the corrective measures issued at the mine site, to assist in preventing re-occurrence within the industry.

Investigation reports

The Investigating Inspector will submit a preliminary report to the Chief Inspector regarding the initial details of the fatality. The aim of the preliminary report is to provide an initial view about nature and cause so that the Coroner, Chief Inspector, and the Industry are fully informed about the death. The Chief Inspector, upon reviewing the

preliminary report, will forward it to the State Coroner.

It is a legislative requirement that both the mine and the Inspectorate must produce a report where there has been a fatal accident. The mine has to provide a report to the Mines Inspectorate within one month. It is accepted practice that mine management will be invited to be present during the investigation undertaken by the Inspectorate. Exceptions to this rule would be where there is a reasonable cause to believe that there are suspicious circumstances and thus deference must be paid to police investigation procedures.

The mine report submitted by the SSE becomes an annexure within the investigating inspector's final report to the Chief Inspector. The Chief Inspector, after reviewing the final report, will forward it to the Coroner, and provide copies to the Coroner for distribution to the parties granted leave to appear at the inquest.

At the Inquest, the investigating inspector will give a presentation, normally using power point which may include video simulations of the incident, to clarify the complexities of the investigation and to present the investigation and findings in a way that non-miners can understand.

The relationship between a mining investigation and the coronial system

A distinguishing feature of the mining industry is the high level of commitment given to the coronial process. For example, the Mines Inspectorate prepares a comprehensive report which is tendered as an exhibit in the coronial Inquest.

It is important to note that the Mines Inspectorate and the Industry do not have to wait for the various legal proceedings to end (for example, processes of the criminal courts) before changes to promote safety can be made. Change to promote safety in the future and to learn from the tragedy will not be criticised by a Coroner.

In a mining fatality it is usual for the Coroner to request a mine site visit for all the parties granted leave to appear in the Inquest. The purpose of a mine site visit, or "coronial view" as it is technically known, is to assist the court and the parties gain a practical understanding of the mine environment, the mining processes used at the particular mine, the geography and points of significance at the accident scene, as well as seeing any relevant machinery that may have been involved in the incident. A further advantage of a coronial view is that it tends to reduce the total hearing time in court, because the mine site visit has provided the court and the legal representatives with an opportunity to gain a shared understanding about many of the relevant facts that need to be discussed in court, before the taking of oral evidence when the Inquest commences.

At the commencement of the hearing of the Inquest, if not done before at the Directions Hearing, Counsel assisting the Coroner and other legal representatives will tender various documents as exhibits, such as the death certificate, autopsy report and a report setting out the facts and circumstances of the fatality from the police and the final report of the Mines Inspectorate, together with witness statements and other mine documents. The Inquest then proceeds to hear oral evidence from the witnesses who have been subpoenaed. For instance, police give oral evidence if required. The investigating inspector also gives oral evidence about the investigation and explains the final report provided to the Coroner by the Chief Inspector of Mines. Eye witnesses are called to give oral evidence. The SSE, by convention, is always the last witness to give evidence.

The coronial investigation and court process (i.e., an inquest) has the goal of identifying whether any procedural, or systemic, issues need to be addressed to avoid a further death in similar circumstances. Following an inquest, the parties will often assist the court in the formulation of the recommendations. This is a tradition in

the mining industry, since the days of the Mining Wardens Court. It is for the industry, the Inspectorate, the unions, and other interested parties to provide the Coroner with advice and submissions about safety, and how to improve safety.

Once the Coroner makes recommendations the relevant Chief Inspector takes steps to consider and implement the recommendations. The Coroner must give a written copy of the findings and recommendations to the family, the parties in the Inquest, the Minister for Mines and the Director General of the Department of Mines.

It is important that the Coroner be kept informed about how the recommendations are being implemented. In a mining inquest, the task of keeping the Coroner informed is usually undertaken by the Mines Inspectorate. However, any party granted leave to appear at the Inquest should understand that they should also keep the Coroner informed of relevant developments.

Outcomes

Advances in safety have resulted from recommendations made by the Mining Wardens Court and the Coroners Court, including welder safety switches; changes to articulation lockouts on underground loaders; training of maintenance personnel; changes to management of tyre handling; and trialling safer compressed air filters.

Appendix Five

Death Review Mechanisms in other Jurisdictions

Australian domestic and family violence death review processes

A Domestic and Family Violence Death Review mechanism has been established in both Victoria and NSW. Debates concerning the most appropriate model for a review of domestic violence related deaths in these jurisdictions canvassed a number of issues that were discussed by the advisory panel when nominating a model that best fits Queensland. Both models operate within a legislative framework, although the powers bestowed upon each committee differs.

Victoria

In December 2008, the Victorian government announced that a Family Violence Death Review would be undertaken through the Coroner's Prevention Unit (CPU) supported by a multi-disciplinary advisory body. It made the following recommendation in its Review of Family Violence Laws Report:

> *In consultation with the State Coroner, the State-wide Steering Committee to Reduce Family Violence should investigate and make recommendations to the government regarding the creation of a family violence death review committee in Victoria* (Recommendation 153).

Focus

The review commenced in January 2009. All cases referred to the State Coroner's Office from 1 January are subject to review, which also includes a number of cases where the death occurred prior to 1 January 2009 but where the investigation and justice processes had not been completed. As at October 2009, nine cases had been reviewed by CPU.

The CPU also established a database which captures data from 1 July 2006 to 20 June 2009 (to align with Victoria's statewide family violence reform timeframe) on homicides/suicides, and suicides linked to family violence or may have links to family violence. The process attempts to identify cases of domestic and family violence deaths as well as identify gaps in family violence service system in responding to victims. It does this by determining domestic and family violence risk factors that may

have been present in the lead up to the death and opportunities where intervention may have been possible. The specialist prevention unit provides information that will assist Coroners to make better informed recommendations and assesses whether coronial recommendations relating to family violence deaths are being implemented.

Legislation

The coronial system is regulated by the *Coroners Act 2008*. The Act was amended in 2008 to extend a Coroner's ability to make recommendations to any body. The new Act includes:

- The incorporation of safety and prevention in the objects of the Act, strengthens the coronial system's ability to contribute to prevention and safety issues; and

- Clarifies important issues of jurisdiction and procedure as well as the establishment of an overarching governance arrangement.

Family violence related deaths fall within the ambit of compulsory reportable deaths under the *Coroner's Act 2008*, whilst the working definition of family violence for the purposes of the review is that contained in the *Family Violence Protection Act 2008.*

> *Family Violence Protection Act 2008*, S*5*: Physical, sexual, emotional, psychological, economic abuse; threatening; coercive; controls or dominates the family member and causes fear for safety or wellbeing of that family member or another person; or behaviour that causes a child to hear or witness, or otherwise be exposed to the effects of those behaviours.
>
> *Eligible relationships S8*: is/has been, a spouse or domestic partner; has or had, intimate personal relationship; any person regarded as being a family member including social and emotional ties; live together or relate together in home environment; reputation and cultural recognition of the relationship as family in community; duration of the relationship and frequency of contact; financial or other dependence or inter-dependence; responsibility or care, whether paid or unpaid; provision of sustenance or support.

Membership

A reference group has been established with approximately 40 representatives from government, non-government, and the community. The reference group meetings are chaired by the State Coroner and are held a minimum of three times per year. The reference group is required to respond to, and provide feedback on, particular issues and acts as an advisory mechanism to the State Coroner in relation to the formation of prevention recommendations. The role of the reference group is clearly one of support and guidance, not decision making. They have no access to case specific, identifying information – all material presented during meetings is fictional, although based on an amalgamation of de-identified cases that the Coroner has considered. Discussion focuses on identifying issues in each 'case', practice and policy links for members, current systemic reforms in those areas, gaps and future responses. In addition, the reference group does not comment on coronial recommendations or have any access to draft recommendations – this remains the judicial function of the Coroner.

Resources

The team within the Coroner's Prevention Unit specific to the review of domestic and family violence related deaths includes the following staff members:

- Team Leader
- Investigator
- Research officers (x2)

Governance and recommendations

The power to make comments and recommendations is central to the review of domestic violence related deaths. A Coroner may make recommendations to any Minister or public statutory authority on any matter concerned with the investigation. The Victorian *Coroner's Act 2008* compels any statutory authority or entity that received recommendations from the Coroner to respond in writing within three months specifying what action has, is or will be taken in regard to the recommendations and requires that their response be published on the Internet.

New South Wales

The implementation of a permanent expert Domestic Homicide Advisory Panel was approved by the Premier in November 2009. At the time this report was written, no decision had been made regarding exactly what role the State Coroner will play in the review process – for example, whether the State Coroner will both host and facilitate the death review mechanism, or rather act as the convenor which would mean that the Coroner is but one of a panel of people who can make collaborative decisions and share information. Consequently, there has been no decision made regarding the role and responsibilities of the panel in relation to their advisory and review function.

Focus

The death review initially commenced as a one-off retrospective review of all domestic violence related deaths that occurred between January 2003 and June 2008 (BOCSAR, 2009). Findings showed that many deaths had been wrongly recorded by police and had therefore never been counted as domestic violence related. The number of deaths to be reviewed jumped from 108 to 215 during the course of the inquiry. A key finding, in view of the advisory panel, was that 43 percent of relevant cases were not flagged as domestic violence related on the COPS (police data) system. This finding was key to informing the government of the necessity for a death review mechanism.

Legislative

In accordance with the *Coroners Act 2009*, a Coroner has a wide range of powers to

investigate a death. During the investigative processes a Coroner can subpoena documents and, during an inquest, subpoena people to give evidence including family members and friends, police, court staff and professional staff who provided services or advice to the victim. The Coroner can also provide immunity from prosecution to people giving evidence.

It has been proposed that the Coroner's powers could be expanded so that the Coroner, when reviewing domestic homicides, could impose a duty on both government and nongovernment agencies to provide full and unrestricted access to records that are under the agency's control. In addition, legislative provisions are needed to provide for a reporting back mechanism following recommendations made by the Coroner. The following legislation will guide the content of the review process:

> *Crimes (Domestic and Personal Violence) Act 2007* S4: Personal violence offence is defined to include domestic violence offence, and includes an offence under a provision of the Crimes Act 1900 (NSW) specified in s 4(a) of the NSW Act. A wide range of offences against the person is specified, including murder, manslaughter, infliction of grievous bodily harm, assault, sexual assault and sexual abuse of a child.
>
> *Eligible relationships S5*: is or has been married; is or has had defacto relationship; intimate personal relationship; is living/has lived in same household; living in same residential facility; dependent care; is/has been relative including through a defacto relationship. ATSO – is/has extended family or kin.

Membership

The panel is to be chaired by the State Coroner, and will include both government and non-government representatives.

Resources

At the time this report was written, the NSW Domestic Homicide Advisory Panel was still in the process of implementation so the resources available to the review mechanism are not known.

Governance and recommendations

As a member of the judiciary, the State Coroner is not directly responsible to the Government or Parliament, except where specified by the relevant legislation. Rather, he or she can make recommendations where he or she sees fit to do.

The Coroner and panel are required to make their findings public by way of an annual report which is to be tabled in Parliament.

Presently, a Coroner may make recommendations to any government department, public statutory authority or non-government entity on any matter concerned with an investigation. Having considered all the evidence prepared for each matter by the support unit, the Coroner would make findings in relation to the victim's or victims' background experience of violence and access to services and safety, including

police intervention and the making and enforcement of protection orders.

International domestic and family violence death review processes

Mechanisms dedicated to reviewing domestic or family violence related deaths have been established, in various forms, in international jurisdictions including Canada, UK the US and New Zealand. A number of these jurisdictions have reported improvements in domestic violence service delivery, and a reduced number of homicides over time.

While models vary in relation to the scope, mode of operating and resourcing, mechanisms for review commonly include the following protocols:

- A non-blaming, non-shaming policy;
- A legislative basis;
- A multidisciplinary expert panel, including government and non-government representatives;
- Panel members are bound by strict confidentiality provisions; and
- Have the view that domestic violence related deaths are preventable, and have, as a key focus, prevention and intervention.

Currently, most international domestic and family violence death review committees examine only closed cases. A case is considered 'closed' after the criminal and coronial proceedings are complete. This ensures all death reviews are not seen as potentially prejudicial to criminal and coronial investigations. However, more recently, there has been a move to conduct open case reviews internationally, with both New Zealand and the UK seeking to permit open case reviews.

It should be noted that whilst comparisons between the operations of international models is useful, they are often not easily comparable to Australia's system as the coronial structure and process in other countries are considerably different from that in Australia.

United States

Following the occurrence of a particularly publicised domestic violence homicide-suicide case in San Francisco, the first domestic violence death review team was established in 1991 (David, 2007). Its implementation was a result of a key recommendation included in the Charan Report. Since then, at least 82 domestic violence death review teams have been developed in 35 states across the United States (Wilson and Websdale, 2006)

The death review teams vary in terms of size, membership, staffing, logistics, number of cases reviewed annually, and reporting. However, they have a similar structure that is parallel to a governmental advisory board; one organisation or government department with the responsibility, resources and interest in the area will administer and support domestic violence death review teams (David, 2007).

The approach uniquely taken by the United States is that the lead agency is removed

from frontline work in the field so that it is able to direct reviews of the procedures of all agencies involved in that work, without prejudice. The Attorney-General's department in each state is often a first choice for the role of the lead agency, as it is assumed to have no direct stakeholder status in the area of domestic violence (David, 2007).

Further characteristics common to the death review teams include that the death review teams:

- are established by legislation;
- have diverse membership, including representatives from government and non-government agencies who are knowledgeable, experienced, committed, and most involved with the victim, perpetrator, family, culture, and/or services provided;
- mostly have annual reporting requirements;
- review violence homicides for indications of system improvements and better agency and interagency response; and
- conduct an analysis of statistics, trends, and broader facts surrounding domestic violence.

During their investigation, the death review teams will be able to identify specific issues such as the context surrounding incidents; points of intervention; points of appropriate risk assessment; risk factors; action taken by agencies or organisations; effectiveness of these actions; means of improving interventions; policies and protocols that might strengthen responses; law reform required; and further prevention strategies (BOCSAR, 2009).

Ontario, Canada

As of February 2010, Ontario is the only Canadian province with a domestic violence death review mechanism. The Domestic Violence Death Review Committee was established in 2003 in response to recommendations made from two major inquests into the deaths occurred in 1998 and 2002, respectively (Office of the Chief Coroner, 2007). The purpose of the Domestic Violence Death Review Committee is to assist the Office of the Chief Coroner with the investigation and review of deaths occurred as a result of domestic violence, and to make recommendations to help prevent such deaths in similar circumstances and reduce domestic violence in general (Office of the Chief Coroner, 2007)

The death review committee consists of representatives with expertise in domestic violence from law enforcement, criminal justice, healthcare sector, social services and other public safety agencies and organisations and is chaired by the Regional Supervising Coroner (BOCSAR, 2009).

Specifically, the objectives of the death review committee that are specified in its terms of reference include:

- Providing a confidential multi-disciplinary review of all homicides that involve the death of a person, and/or his/her child committed by the person's partner or ex-partner from an intimate relationship;

- Offering expert opinion to the Chief Coroner regarding the circumstances of the event leading to the death in the individual cases reviewed;

- Creating and maintaining a comprehensive database about the victims and perpetrators of domestic violence fatalities and their circumstances;

- Identifying the presence or absence of systemic issues, problems, gaps, or shortcomings of each case to facilitate appropriate recommendations for prevention;

- Identifying trends, risk factors, and patterns from the cases reviewed to make recommendations for effective intervention and prevention strategies;

- Conducting and promoting research where appropriate.

- Stimulating educational activities through the recognition of systemic issues or problems and/or;

- referral to appropriate agencies for action;

- where appropriate, assist in the development of protocols with a view to prevention;

- where appropriate, disseminate educational information.

- Reporting annually to the Chief Coroner the trends, risk factors, and patterns identified and appropriate recommendations for preventing deaths in similar circumstances, based on the aggregate data collected from the Domestic Violence Death Reviews. Offering expert opinion to the Chief.

Since its commencement in 2003 till 2007, the death review committee has reviewed 62 cases that involved a total of 100 deaths (Lucas, Jaffee, and Campbell, 2008). Major themes and trends that the committee has identified include:

- The need for education and awareness for the general public and professionals: recommendations have been targeted to frontline workers, healthcare providers, lawyers, judges, child protection services, educators and the general public; and

- Assessment and interventions with focus on healthcare/social service interventions, police intervention, risk assessment tools, access/control of firearms, high risk case management, safety planning/shelters, crown/court interventions and workplace interventions.

The purpose of the death review committee is to understand and recommend change to prevent deaths involving domestic violence. The committee does not have power to implement or ensure implementation of their recommendations so are consequently repeating recommendations, as pointed out in its 2007 report. The committee highlighted the need of leadership from the Ministry of the Attorney General to create an inter-ministerial committee that will review all community agency and government responses to recommendations made by the committee.

United Kingdom

The United Kingdom is in the process of establishing a domestic violence death review mechanism on a statutory basis. The Home Office released a consultation paper in 2006, which set out proposals for the layout that domestic homicide reviews should follow. The details of the consultation paper are as follows (Home Office, 2006).

As part of their statutory duty under the *Domestic Violence, Crime and Victims Act 2004,* local bodies, such as chief police officers in England and Wales, councils, local probation boards, health authorities and primary care trusts will be required to conduct domestic violence reviews. Additionally, the Secretary of State may in a particular case direct a specified person or body to establish, or participate in, a review.

Under the Act a domestic homicide review is defined as

> "a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by: (a) a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship; or (b) a member of the same household as himself/herself, held with a view to identifying the lessons to be learnt from the death" (Home Office, 2006).

The proposed statutory purpose of a review is to learn lessons from the death; specifically,

- Identifying the lessons to be learnt, particularly about how local professionals and agencies work together to safeguard victims;
- Identifying how those lessons will be acted upon and what is expected to change as a consequence; and
- Improving inter-agency working and improving protection for domestic violence victims.

The consultation paper proposed that domestic homicide reviews complement the existing serious case reviews that take place when a child dies or is seriously injured and abuse or neglect is known or suspected to have played a part in the death or serious injury. It is therefore proposed that a similar standardised format for domestic homicide reviews be also adopted.

The ownership of the review, such as which body would take the lead responsibility for instigating the review, is yet to be defined. The consultation paper also proposed that the review body produce a concluding report that brings together and analyses the findings of the various review reports from agencies and others and makes recommendations for future action. The review body is to translate recommendations into an action plan which should be endorsed and adopted at a senior level by each of the agencies involved. The plan should describe who will do what, by when, and with what intended outcome. The plan should also set out how improvements in practice and systems will be monitored and reviewed.

New Zealand

In April 2008, the New Zealand Government announced funding of NZ$1.33 for the establishment of a Family Violence Death Review Committee (FVDRC). The FVDRC was established in June 2008 and reports to the Minister on family violence deaths.

The Chief Coroner is represented on the FVDRC.

New Zealand's review mechanism is situated with the Ministry of Health and comprises eight non-government members, each selected for their expertise in one of the following areas: mortality review systems, social science research, family violence law, child abuse and protection issues, and service provision in the social sector. The committee is chaired by a representative of the Ministry of Health and assisted by six government advisors. Members are appointed for up to three years.

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

The New Zealand Committee recently released the "Family Violence Death Review Committee – First Annual Report to the Minister of Health, October 2008 to September 2009". It outlines the key objectives involved in setting up the local death review system and data collection protocols. A formal review and evaluation of the Committee and its Terms of Reference will be undertaken by the Ministry of Health three years from the date of establishment.

Appendix Six

Clinical Forensic Medicine Unit - Delivering Advice to

Coronial and Criminal Court Processes

The Clinical Forensic Medicine Unit operates under the auspice of Queensland Health. The unit's role is to find, interpret and deliver medical advice to coronial and criminal court processes. The unit does not have a legislative basis requiring Coroners to consult with them or to take their evidence or advice into consideration. They operate within Coroners' wide investigative powers and prepare reports that contain expert opinion about facts in evidence before a Coroner. It consists of a team of officers, two of which provide full time assistance to Queensland Coroners. These officers, on a day to day basis, assist Coroners to make decisions under the Act. For example, a medical professional may seek advice from a Coroner on whether a death is reportable. An elderly woman may have undergone surgery and soon after passed away. It may not be immediately apparent to the medical professional whether the elderly person died as a result of the procedure or from pneumonia which is a common affliction for elderly people. As such, the responsible health care professional would seek the advice of the Coroner as to whether the death was a health care related death under the Act which would require further investigation. In such circumstances, the Coroner may seek the advice of the Clinical Forensic Medicine Unit, which is able to draw upon the knowledge and understanding of medical specialists to determine whether the procedure caused or contributed to the death and was an unexpected outcome of the procedure, in which case it would be a reportable death.

As such, the Clinical Forensic Medicine Unit provide reports to the Coroners because the medical issues to be considered by Coroners are often complex and beyond general knowledge or understanding. The experts within the Clinical Forensic Medicine Unit who prepare the reports have particular expertise, qualifications and experience in a relevant area, and are qualified to express an expert opinion or analysis of the facts in issue in the coronial process. How the Coroner takes their opinion into consideration, and the weight the Coroner places on their opinion, is a matter of judicial discretion, based on all of the information before the Coroner in each particular case.

Appendix Seven

Analysis of nine closed domestic and family violence-related homicide case files.

Table 2: Analysis of Ten Closed Domestic and Family Violence Related Homicide Case Files

Date	*Type of death*	*Relationship to perpetrator*	*No. of deaths*	*DV Order ticked (Form 1)*	*DV history*	*Sex*
2000	Murder-suicide Death by gun shot wounds	Ex-boyfriend By-stander	3	N/A (pre 2003)	- Some history of DV in the relationship provided by the police report (witness statements from friends and family). - The victim called police on the day of the incident to report that she was worried her ex-boyfriend would turn up at her work place that night and cause trouble. She said he told her that he had a gun and wanted to kill himself and she was worried about her safety. Police advised her to call them if he turned up at her work.	2 x F 1 x M
2001	Murder Death by stab wounds	Ex-boyfriend	1	N A (pre 2003)	- Relationship to the deceased explained in the police reports (statements from family and friends). - The term DV not mentioned in file.	1 x F

2004	Murder Death by stab wounds	Ex-boyfriend	1	No	- Labelled 'domestic homicide' in police report. States: *As the parties in this incident were involved in a relationship, a Domestic Violence Homicide Audit must be completed covering 15 points in relation to any previous incidents and police action at these incidents. Could you please research any Queensland Police Service statistics relating to domestic violence between these two persons as covered in the attached audit and report these to the Commissioned Officer in Line Command.* [This was the only file that mentioned this audit and search for history]. - An audit of DV procedures was carried out, no records found involving the deceased. - Recommended that the matter by forwarded to the State Domestic Violence Co-ordinator for their information and consideration.	1 x F
2005	Manslaughter Multiple head injuries	Boyfriend	1	Yes	- Lists incidents of DV from System Index (includes date of incident, location address and action taken). - Btw 12/11/03 and 19/10/04, 8 incidents: 1 x detention 4 x breach 3 x no DV	1 x F

2005	Murder Serious traumatic head injuries	Boyfriend	1	No	- Relationship identified as *domestic* in police report. - Child safety informed of death (victim aged 16 at time of death). Had a history with the Child Safety Department based on her relationship with a 27 year old. - The department had contact with victim prior to her death via assessment of child protection order.	1 x F
2005	Murder-suicide Gun shot wound	Estranged husband	2	Yes	DV Protection Order was issued to husband on the 11/07/05 for a period of two years. Does not provide any background information or statements from friends/family.	1 x F 1 x M
2006	Murder Stab wounds	Boyfriend	1	No	- Relationship identified as *intimate* in police report.	
2007	Manslaughter (charges later dropped) Assault occasioning bodily harm whilst armed	Wife	1	No	- history of DV in the relationship identified in police report (witness statements from family and friends). - history of a DV order breach in 2001.	1 x M
2006	Murder-suicide Gun shot wounds and smoke inhalation	Ex-boyfriend	2	No	- history of *previous intimate relationship* identified in police report (witness statements from family and friends. - Statements from friends/family provided little insight into the history of the relationship.	1 x F 1 x M

Appendix Eight

Example of a case review report for the State Coroner

1. Background

1.1 *Reason for referral*

Ms C's homicide in January 2008 and the subsequent suicide of her ex-partner Mr B (who was the only suspect identified by police in her death) fit within the scope of the Domestic and Family Violence Death Review Mechanism. As such, State Coroner Michael Barnes referred these two cases to the Domestic Homicide Prevention Unit and requested an evaluation of the circumstances surrounding them. In particular, the DHPU examined whether there were any missed opportunities for health, policing, counselling and other services to intervene before the deaths; and whether any lessons can be learnt for preventing future such deaths.

1.2 *Sources of information*

Information contained in this report has been obtained from the following sources:

- Inquest brief
- Additionally, the following external people were consulted:

1.3 *Case information*

1.3.1 Details

Victim/deceased

Name	SURNAME, Name
Date of birth	Day Month Year
Date of death	Day Month Year
Age (at death)	Years
Gender	Male/Female
Relationship status	
Cultural background	
Disability status	
Housing status	

Perpetrator

Name	SURNAME, Name
Date of birth	Day Month Year
Date of death	Day Month Year
Age (at death) (*If applicable*)	Years
Gender	Male/Female
Relationship status	
Cultural background	
Disability status	
Housing status	

1.3.2 Incident summary

2. Case review

Across the five year period that Ms C was in a relationship with Mr B, she has regular contact with the health care system as well as episodic contact with Queensland Police, housing services and counselling services. A number of these contacts were in the context of Mr B assaulting her. During the same period, Mr B also had contact with a number of services, pertaining mostly to his mental health issues; and after Ms C's death he sought specialist mental health assistance before suiciding.

The present case review will focus on these service contacts, examining what happened, what (if anything) should have happened, whether there were any reasonable prevention opportunities that might have been missed, and any potential recommendations for prevention initiatives that could reduce the incidence of further such deaths.

2.1. *DVO orders*

2.1.2. Comments concerning numerous breaches of DVOs

2.2. *NGO Outreach Program*

2.2.1. Comments concerning level of follow-up

2.3. *Primary care physician Dr A.*

2.3.1. Risk factors

2.3.2. Relationship discord and intimate partner violence

2.3.3. Treating Ms C and Mr B together

2.3.4. Treatment for Mr B's co-morbid drug use and mental health issues

2.3.5. Health care professionals who treated Mr B

2.4. *The Brisbane Hospital Psychiatry Department*

2.4.1. History of care and treatment received by Mr B

2.4.2. The Brisbane Hospital CAT Team

2.5. *The Queensland Police Investigation*

3. Conclusion

3.1. Intervention opportunities

3.1.1. Primary care physician Dr A.

3.1.2. Dr C Brisbane Hospital Psychiatry Department

3.1.3. Dr D Brisbane Hospital CAT Team

3.1.4. Medicare

3.2. *Other considerations*

4. Proposed action

That you note the contents of this report, and consider whether further information and statements outlines in Section 3.1. or the Conclusion are required from:

Dr A

Dr C

The Brisbane Hospital CAT Team

Medicare

Appendices

Appendix 1: Chronology of significant dates

Appendix 2: List of contacts between Ms C and Mr B.

Appendix 3: List of all notes in Ms C's medical records concerning her relationship with Mr B.

Appendix 4: List of all notes in Mr B's medical records concerning his relationship with

Ms A.

Appendix 5: List of all notes in Mr B’s medical records concerning homicidal and/or suicidal ideation.

Appendix 6: List of all notes in Mr B’s medical records concerning mental health issues.

Appendix 7: List of all notes in Mr B’s medical records concerning his substance abuse.