Findings and Recommendations from the *Review of Domestic and Family Violence Deaths in the Australian Capital Territory*

Public Report

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EXECUTIVE SUMMARY

In 2014, the ACT Attorney-General requested that the Domestic Violence Prevention Council (DVPC / the Council) lead a review of deaths that occurred as a result of domestic or family violence. The review sought to provide a clearer picture of domestic and family violence in the ACT and provide advice to government to inform future decisions about violence prevention and detection mechanisms.

This report summarises the findings and recommendations of the *Review of Domestic and Family Violence Deaths in the Australian Capital Territory* that occurred between 2000 and 2012. This one off retrospective review, analysed deaths that were no longer before the courts or coroner when cases were identified in May 2015. A total of eleven cases involving external assault were reviewed, identifying common themes among the deaths. Twenty-eight recommendations for action were identified.

The findings from the review have been reported under the same priority areas as were identified in the DVPC report to the Attorney-General following an Extraordinary Meeting on domestic and family violence, including sexual assault, in April 2015.

In many of the cases reviewed, a person was killed in circumstances where there was no recorded history of physical violence prior to the death, but there were patterns of non physical family violence, including coercive and controlling behaviours by perpetrators against victims.

The review found there was a general lack of understanding of what constitutes domestic and family violence, especially the non-physical manifestations of family violence[1] – by victims themselves, family, friends, neighbours, services (including government services), doctors, counsellors, lawyers, co-workers and the general community. Greater awareness is needed in the community about what domestic and family violence looks like, and that an absence of physical violence in a relationship does not necessarily mean a lower risk of harm for the victim.

Many of the victims did not access help from police, domestic violence services or other frontline responders to violence. They did however, have contact with service providers unrelated to domestic violence (such as with healthcare and legal professionals). There is a need for better awareness about the risk factors from “first responders” because while such contact may not directly relate to domestic and family violence, they nonetheless provide an opportunity for early intervention. The review identified that there was a lack of awareness or consideration of risk factors such as pregnancy, separation and new relationships by first responders. The

[1] The term “family violence” is used throughout the report to refer to physical and non-physical forms of coercion and control that occur in families. At times the report differentiates between violence between intimate partners and violence between other family members.

health system should play a key role in screening for, and responding to, family violence.

The review identified a need to provide early interventions and supports to victims to ensure they remain safe, including assisting them to recognise what they are experiencing as domestic or family violence. In many of the cases, local services could only identify the police as an option for referral for the victims, even when the police were unable to act due to the lack of physical violence in the relationships.

The review highlights the importance of responses to family and domestic violence that are in addition to, and outside the scope of the criminal justice system, to respond to the risks of those who are subjected to subtle and explicit coercive control. In the cases reviewed police involvement prior to deaths rarely resulted in criminal charges, in part because the dynamics and risk factors at play were not physical acts of violence. Thus, the cases that were reviewed would not/did not come to the attention of the collaborative responses currently in place in the ACT.

The value of developing a screening, risk assessment and risk management framework across all ACT services, rather than a service by service approach, is an important finding in the review.

Timely access to and sharing of information is critical to ensuring the safety of people at risk of or experiencing family violence. The review found that information was often seen in isolation by service providers and information sharing was limited. Accessing information for the cases reviewed was challenging at times and further highlighted the problems associated with information sharing between agencies and services. In some of the cases reviewed, there were pieces of information available on the files of numerous service providers which, if viewed in isolation, did not indicate risk of future violence or lethality. However, when these various pieces of information were put together a different picture emerged, indicating a heightened risk of violence or lethality to victims.

Record management issues in this review also impacted on the ability of service providers to identify and respond to family violence; and on the quality of any risk assessment undertaken.

Despite police and service involvement (including corrections), none of the perpetrators received specific treatment or programs to address family violence behaviours. The review was unable to identify any existing programs in the ACT for youth or adult family violence offenders (there are however a number of programs that address spousal or intimate partner violence). The co-occurrence of family and domestic violence with risk factors such as drug and alcohol abuse, suicidality and mental health issues created additional issues and complexities and often resulted in lost opportunities to intervene in relation to the use of violence.

The report recommends that if the ACT is to successfully rehabilitate family violence offenders, their behaviour needs to be considered in its entirety. This requires co-occurring issues to be addressed, program participation to be maximised and for non-compliance to have consistent consequences. The need for family members' (usually the victims) input to risk assessments and compliance monitoring was identified – particularly for compliance to be confirmed by family members and not just the self-report of offenders. In all of the cases involving family members, limited or no support such as referrals or safety planning was provided, and this needs to be addressed.

Some vulnerable groups in the community were highlighted, especially older people, mental health carers, those experiencing social exclusion and those with issues such as poor English language proficiency. While family violence responses in the ACT are available for men experiencing family violence, there was a lack of awareness about this.

Children were identified as having particular unmet needs. In the cases reviewed, around 25 children witnessed family violence and at least 15 children experienced family violence. Despite this, children were largely invisible in the information contained in the cases reviewed. Children witnessing and experiencing family and domestic violence have special needs, in addition to the needs of the adults around them. The need for early intervention and ongoing support and assistance for the children who experience, witness and are exposed to family violence was identified by the review as a gap in services.

Opportunities for improvement in the criminal justice response to domestic and family violence were also identified. In particular the review highlighted the use of victim blaming language, the minimisation of the behaviour of perpetrators and responses that did not appropriately condemn the criminal behaviour of perpetrators. Minimising their behaviour is never rehabilitative and will not prevent future violence.

The Council recognises that work has already commenced in relation to some of the themes and issues identified in this report, however all of the findings are canvassed in order to provide a complete picture.

Sadly, in recent years there have been a number of deaths in the ACT which allegedly occurred in the context of family violence, both intimate partner and family relationships. These cases remain open either within the criminal justice system or the coronial system so were not included in this review. Setting up an ongoing death review process in the ACT will be an important action moving forward.

The Council wishes to acknowledge the families of those individuals whose cases were examined in this report, and hopes the recommendations presented in this report will result in work that will improve responses to domestic and family violence in the ACT and prevent future deaths.

Summary of Recommendations

The Council highlights (in bold) fifteen ***priority recommendations*** that can be achieved quickly and easily or should be actioned as soon as possible. The remaining recommendations may require longer term work and some may be dependent on achieving the priority recommendations.

Recommendation 1. The ACT Government commissions the development and implementation of a public education and communication strategy aimed at improving community understanding of the manifestations of and risk factors for family violence, including non-physical violence such as controlling and coercive behaviour. This should provide information for the general community, and bystanders such as family, friends, work colleagues and neighbours of victims and perpetrators, as well as specific groups identified as vulnerable in this report such as older people, male victims and culturally and linguistically diverse (CALD) communities.

In addition to general community awareness raising, specific targeted information should be developed for professionals who may be "first responders" and interact with victims and perpetrators including:

- legal professionals, lawyers and solicitors; and
- health professionals, psychologists and General Practitioners (GPs).

The strategy should draw on international research, and should aim to educate the community about the nature and dynamics of family violence, including:

- the times when victims are most at risk such as at the point of separation, the presence of new partners and during pregnancy;
- the similarities and differences between violence against family members and against intimate partners;
- the presence of risk factors such as stalking behaviour, coercive and controlling behaviour or suicidal threats, which may fall outside of the paradigm of traditional physical family violence; and
- why it is important to act.

The strategy should also provide practical advice about:

- how to respond to family violence;
- where assistance can be sought including family violence help lines, crisis services and the police; and

- how and when to contact police.

Note: This community awareness campaign about the signs and risk factors for domestic and family violence will align with but not replicate the soon to be launched national campaign to address the attitudes of young people to gender equality and respectful relationships (which the ACT Government has supported).

PRIORITY RECOMMENDATION
2. Given the prominence of the issue of family violence, the Chief Minister should, as a priority, relaunch the Whole of ACT Government Statement on Family Violence. This statement should be made easily accessible on all government websites in order to assure the community that family violence is an issue that is best addressed through a whole of government response.

3. The Attorney-General tasks and resources the DVPC to coordinate the development of a standard family violence training package for those in frontline service delivery.

PRIORITY RECOMMENDATION
4. The ACT Government fund an independent academic, supervised by the DVPC, to develop a Risk Framework for the ACT. In developing a framework, consideration must be given to:

- **who is screened for family violence (victims and perpetrators); who screens for family violence; when they screen for family violence; and a standardised set of screening questions;**
- **what risk is assessed (risk of further assault or lethality); and validated risk assessment tools for intimate partner violence as well as violence against children, siblings and parents;**
- **appropriate risk management for all levels of risk;**
- **ensuring the recognition of the vulnerable groups identified in this report; and**
- **developing an implementation strategy, including training and evaluation.**

PRIORITY RECOMMENDATION
5. The ACT Government to request the following key organisations to take specific actions to reduce and prevent family violence and the risks of related deaths.

- **All tertiary education providers in the ACT, especially the Canberra Institute of Technology, University of Canberra, Australian National University, University of NSW (Australian Defence Force Academy) and Australian Catholic University (Canberra Campus), should be requested**

to include family violence training in all law, education and health related programs.

- **The ACT Law Society and ACT Bar Association should be requested to make continuing professional development about family violence a priority, particularly for those practicing family and criminal law, and to host family violence information on their websites.**
- **The Australian Public Service (APS) Commissioner should be informed that a number of the homicide victims and perpetrators were current or former employees of the APS and the APS should consider addressing family violence in mandatory induction training.**
- **Government funded drug and alcohol and mental health services should be made aware of the findings of the death review and should train their staff on family violence; understand the need for screening clients; and address all co-occurring issues.**

6. ACT Health prioritises:

- Formulation of the ACT Health family violence policy; specifically acknowledging the propensity for overlap between family violence behaviours and mental health (including suicidality) and/or drug and/or alcohol issues.
- Development and implementation of operational guidelines for clinical and health staff to respond appropriately and make accurate records in relation to disclosures of family violence.
- Work with the ACT Primary Health Network to include family violence as a topic in the Capital Health Network's *Health Pathways* tool for GPs and health care teams.
- Consideration of the use of specialist family violence social workers in ACT hospitals who can receive referrals if violence is disclosed and who can be used as a resource to advise other staff on how to recognise or respond to family violence. These social workers should be linked in to other relevant service providers such as Domestic Violence Crisis Service (DVCS), Canberra Rape Crisis Centre (CRCC), Carers ACT and EveryMan Australia (formerly Canberra Men's Centre).
- Exploration by Mental Health, Justice Health, Alcohol and Drug Services (MHJHADS) about how family members can be provided with information about the illness that the person they care for experiences, and how to facilitate their participation in care planning. Where sharing information with carers violates privacy provisions in the *Health Records (Privacy and Access) Act 1997*, amendments should be considered to ensure carers who may be at risk of violence can be provided with information that enables them to make informed decisions about their safety.

- Development and implementation by MHJHADS of operational guidelines for dealing with family violence disclosures by clients and client's family members. These must address the safety of potential family violence victims.
- MHJHADS incorporate the views of family members in the application of Outcome Measure assessments. In addition, policies and procedures should cover assessing risk of violence at key points in the clinical pathway including triage, admission, after critical events, at discharge and when a patient does not comply with medication requirements (this could be enhanced by any future whole of government risk assessment and response frameworks and actions).
- The safety of family members is considered and addressed by MHJHADS when applying for and monitoring Psychiatric Treatment Orders (PTOs).

PRIORITY RECOMMENDATION
7. The ACT Government's Human Services Blueprint in collaboration with service providers develop ways for service providers in the ACT to co-operate, co-ordinate and integrate their response to family violence outside the criminal justice system. This should include consideration of extending the current Strengthening Families program (using specialised, trauma informed services with flexible funding and lead workers) to families with complex needs and are at risk of, or experiencing, using or witnessing family violence.

It could also include families who are caring for adult children or partners with mental health issues who have a propensity for violence. For these reasons, the Human Services Blueprint needs to work with a broader range of service providers (in particular ACT Health) and work with families with adult children as appropriate.

PRIORITY RECOMMENDATION
8. A working group of suitable agencies (e.g. DVCS, Carers ACT, mental health and alcohol and drug services, ACT Policing) be formed to identify appropriate service responses, referral pathways and gaps in service provision to respond to family violence that is not intimate partner violence or non-physical family violence, as well as alternative housing/care arrangements for adults with mental illness who are presenting a risk to their parents.

PRIORITY RECOMMENDATION
9. The *Information Privacy Act 2014, Health Records (Privacy and Access) 1997* and the *Children and Young People Act 2008* and any other relevant legislation be reviewed to facilitate the sharing of information to protect family violence victims. Consideration must be given to inserting a specific section to address family violence. Any reform should be supported by policies,

guidelines and cultural changes within and outside government to support and promote information sharing.

10. ACT Government develop a policy and guidelines on family violence and information sharing to be implemented by Government Directorates and community sector organisations funded by government. Consideration should also be given to working with external organisations such as the ACT Law Society and the Capital Health Network to consider options for information sharing from “outside” the government and government funded system.

11. MHJHADS ensure that where multiple health providers (e.g. GPs, private psychiatrists, private psychologists and community organisations) are involved in a shared management plan there is an effective flow of appropriate information between them. Where the patient refuses consent for the exchange of information a senior clinician should take responsibility for deciding whether information will be exchanged to mitigate risk.

PRIORITY RECOMMENDATION
12. The Attorney General write to the ACT Auditor General to ask the Auditor General to consider conducting an audit of MHJHADS files to identify where improvements can be made especially in relation to the administration and implementation of ACT Health Outcome Measures, other risk assessment tools and the associated risk management approaches.

13. All ACT Government Directorates and ACT Government funded community sector service providers review their record keeping and record management policies with a view to update policies addressing critical points at which they should create records relating to family violence. Embedding a family violence “flag” or “tick a box” into databases would be particularly useful.

PRIORITY RECOMMENDATION
14. Consideration should be given to whether a whole of ACT Government policy on record keeping and record management in relation to family violence is required.

15. ACT Government develop appropriate programs to rehabilitate those who use violence against their family members, particularly for children, young people and young adults who use violence against their parents; and identify and provide resources for appropriate supports for parents whose children use violence in the home.

16. In order to achieve rehabilitation of family violence offenders ACT Corrective Services and Child and Youth Protection Services should:

- consider and respond to all co-occurring offender issues including mental health, drug and alcohol and family violence;

- implement all recommendations included in orders by judges and magistrates;
- hold offenders accountable for non-compliance through timely breaches;
- consider non-compliance as an indicator of future risk;
- not terminate supervision early for family violence matters, particularly where there has been non-compliance with conditions of court orders; and
- work more closely with a range of service providers including MHJHADS, alcohol and drug services, Victim Support ACT, Canberra Rape Crisis Centre, Service Assisting Male Survivors of Sexual Assault, the Domestic Violence Crisis Service and EveryMan Australia.

17. ACT Corrective Services develop guidelines to ensure that family violence victims have a voice and role in the management of family violence perpetrators. To ensure the safety of family violence victims, family violence perpetrators must be managed within the context of their family including current and ex-partners (who they remain in contact with); parents and family members. Supervision should not rely solely on self-reports but should be balanced by the voice of their victim/s.

PRIORITY RECOMMENDATION
18. The ACT Government resource the development and distribution of family violence education materials in languages, other than English, for display in public forums where CALD communities gather.

PRIORITY RECOMMENDATION
19. ACT Government service providers review their adherence to the ACT Government *2012-16 Australian Capital Territory Language Policy* with particular reference to section 4.4 'Interpreters and translators will be used depending on clients' particular circumstances and legal requirements' and the policy implementation requirements outlined in section 4.7.

PRIORITY RECOMMENDATION
20. The ACT Government continue advocating for the retention of Commonwealth funding of interpreter services for non-government organisations that come into contact with family violence victims and perpetrators.

21. The Attorney-General task the DVPC to work with appropriate organisations to raise the profile of elder abuse (in a family violence context) and to consider areas for collaboration in prevention and intervention activities.

PRIORITY RECOMMENDATION
22. The ACT Government ensure appropriate responses and services are available to assist children who experience or witness family violence, including:

- **services for children who are exposed to non-physical family violence**

- **services for children who are no longer living with the perpetrator; and**
- **early intervention responses aimed at preventing the intergenerational transmission of family violence.**

PRIORITY RECOMMENDATION
23. The Attorney-General continues to implement, as a matter of priority the Australian and NSW Law Reform Commission's recommendations relating to family violence in *Family Violence – A National Legal Response (2010)*; to ensure that non-physical manifestations of family violence are recognised and addressed in ACT legislation.

24. ACT Policing, ACT Corrective Services and Child and Youth Protection Services (formerly Youth Justice) develop guidelines for gathering, recording and presenting information for records and report writing to ensure that perpetrator's voices are balanced with victim's voices and that a more objective and complete picture is provided to courts and releasing authorities.

25. All survivors of family violence deaths, especially children, should be provided with ongoing counselling and support services appropriate to their specific trauma experience and age, in a timely manner and until they show good progress in their physical and mental health and educational progress. This should be a multi-agency coordinated response with a lead agency such as Victim Support ACT.

26. The Government reviews the *Victims of Crime Regulation 2000* to ensure Victim Support ACT has the capacity to respond to the long term needs of children who are victims and witnesses of family.

PRIORITY RECOMMENDATION
27. The ACT Government establish a family violence death review mechanism to review all family violence homicides. The Australian Domestic and Family Violence Death Review Network, which includes the ACT as an observer, has identified a number of "best practice principles" which government should consider when establishing a death review. These "best practice principles" are that reviews:

- **have government endorsement (including adequate funding, resources and agency engagement);**
- **are appropriately empowered to access information (including from interstate);**
- **are supported by expertise in domestic and family violence;**
- **have the capacity to make and monitor recommendations;**
- **are empowered to conduct quantitative and qualitative reviews;**
- **contribute to the Network;**

- **are supported by case identification procedures and mechanisms;**
- **are collaborative and consultative, but retain independence;**
- **operate with knowledge an awareness of national and state level policy including domestic violence response frameworks;**
- **are supported by confidentiality and privacy protections; and**
- **operate in accordance with the overarching philosophy of death review processes including conducting individual and systemic reviews.**

28. The ACT Government's family violence death review mechanism include the power to consider deaths such as suicides of both family violence victims and perpetrators and the accidental deaths of family violence victims.

INTRODUCTION

Domestic and family violence claims the lives of more than 100 people in Australia every year and causes enduring damage to individuals and to society as a whole. The personal, social and economic costs arising from these deaths are substantial.

In monetary terms, violence against women costs Australia $21.7 billion each year (PwC, 2015). This cost is spread across our society and economy, and includes health costs, pain and suffering, loss of productivity due to absences from work, and law enforcement and court system costs, to name but a few.

Accordingly, a strong and ongoing commitment to ending domestic and family violence is required, through whole of government and whole of community action.

Australia is a signatory to several important international instruments that relate to addressing the issue of violence against women, including domestic and family violence. The obligations outlined in these instruments have shaped Australia's responses to family violence, and have led to the development of the National Plan which informs approaches to domestic and family violence across Commonwealth, state and territory jurisdictions.

The ACT Government is party to the *National Plan to Reduce Violence Against Women and their Children 2010-2022* (the National Plan) which focuses attention on domestic violence homicide through Key Outcome 5 - Strategy 5.2. This strategy identifies the need to "drive continuous improvement through sharing outcomes of reviews into deaths and homicides related to domestic violence" and to monitor domestic violence homicides at a national level (Department of Social Services, 2011). The review therefore forms part of the ACT Government's commitment to the *National Plan to Reduce Violence Against Women and Their Children 2010-2022*.

In June 2014, the ACT Attorney-General requested that the Domestic Violence Prevention Council (DVPC / the Council) undertake a review of domestic and family violence related deaths in the ACT. The DVPC brings together senior representatives from key government and non-government service providers, specialist domestic and family violence sectors, and groups representing vulnerable groups in the ACT (see Attachment A).

The review aimed to provide a robust and independent picture of domestic and family violence in the ACT, inform government decisions about domestic and family violence mechanisms and assist in identifying issues that point to legislative, policy, practice and service changes across the government and community sectors. Thereby also contributing to the four primary objectives of the *ACT Prevention of Violence Against Women and Children Strategy 2011-17*.

This report summarises the key issues and themes identified from the analysis of the 11 case reviews (involving external assault) of the 14 deaths which occurred in a family violence context in the ACT between 1 June 2000 and 30 June 2012[2]. The report also provides 28 recommendations for action. These are reported under the same priority areas as were identified in the Report from the DVPC Extraordinary Meeting held in April 2015.

The Council has taken great care to maintain the privacy of individuals (both living and deceased) whose details were accessed in the cases reviewed. This public report has been developed within the ethical framework of the Justice Human Research Ethics Committee and seeks to ensure that no individual can be identified from information provided. The small number of cases that were available for review in the ACT means that few specific details about individual cases can be articulated.

Attachment B outlines the background and approach to the review including the terms of reference, scope of the review, information collection processes, methodology and limitations.

Attachment C outlines the methodology used for the review, which was based on that used by the NSW Domestic Violence Death Review Team. Attachment D describes the background to domestic and family violence death reviews in Australia.

[2] The review scope was limited to reviewing closed cases no longer before the courts. The deaths were identified using the National Coronial Information System which includes only cases from 2000.

TERMINOLOGY USED IN THIS REPORT

Domestic and family violence

Definitions of domestic and family violence differ across jurisdictions, as do the definitional terms that inform similar death reviews. There is a wide range of terminology associated with domestic and family violence in the community, within legislation, and in literature and research.

Domestic violence is an overall term used to describe a pattern of behaviour where a person intentionally and systematically uses violence and abuse to gain and maintain power over another person with whom they share (or have shared) an intimate or family relationship. The key element which defines this behaviour is the perpetrator's use of coercion and control to assert and maintain power and dominance over the victim.

For ease of understanding, consistency and to promote anonymity the term "family violence" has been used throughout this report. The term acknowledges that the impact of domestic violence occurring within a couple's relationship is often experienced by other family members, particularly children. It also acknowledges that extended family members can become involved with the violence that is occurring. Where there are noteworthy differences between violence between intimate partners and violence between family members, this is acknowledged.

For the purpose of the review, family violence was defined in respect of the following behaviours and relationships:

Behaviours including:	Relationships including:
• Physical assault and abuse (including directly assaulting a person, their child, or a pet and includes the use of weapons and reckless behaviour); • Intentional property damage; • Sexual assault and abuse; • Psychological abuse; • Emotional abuse; • Verbal abuse (including the intent to humiliate, degrade, demean, threaten, coerce or intimidate and includes the use of derogatory language or continual "put-downs" to highlight a particular part of a person's being or their societal role); • Economic abuse (including the control of finances in a relationship or family and the deprivation of basic	• Intimate partner: spouse, separated spouse, de facto, ex-de facto, extramarital partner, former extramarital partner, boyfriend, ex-boyfriend, girlfriend and ex-girlfriend; and • Relative/kin: all familial relationships (including in-laws) and extended family where kinship systems are relevant to a person's culture.

necessities); • Social abuse (including social abuse and isolation to separate the victim from supportive friends, family and community agencies); • Harassment or stalking; and/or • Spiritual abuse.	

For the purposes of this review, a "domestic and family violence related death" was defined as a death that occurred:

- when the person who killed and the deceased were involved in an intimate or family relationship, either at the time of death or prior to the death, and domestic or family violence was the catalyst for the death; or
- when the death of a family member(s), friend(s), and community member(s) was motivated by domestic or family violence (e.g. the killing of a new partner); and/or
- the death resulted from legal intervention.

First responders

The term "first responders" is commonly used in emergency services and generally refers to police, paramedics, firefighters etc. In this report, however, the term is used to describe professionals without specialisation in family violence who are approached for assistance of some kind by victims of family violence. First responders do not traditionally have the specific knowledge or skills to identify and respond appropriately to family violence. Examples of first responders identified in this review included GPs, solicitors/family lawyers and private psychologists.

Bystanders

In this report, the term "bystander" is used to describe someone in a social relationship with a family violence victim or perpetrator who has in some way seen or been informed about the family violence. Examples of bystanders identified in this review included family members, friends, neighbours, or co- workers.

Other definitions

Other definitions were important in relation to the deaths, depending on the nature of a person's involvement and their experience of domestic and family violence.

For the purposes of this report the following definitions were used:

- Deceased – the person who died;
- The person who killed – the person who inflicted the injury that led to the death;
- Victim – the person against whom family violence was perpetrated;
- Perpetrator – the person who perpetrated family violence; and
- Legal intervention – this is a term used by the National Coronial Information System to mean the use of lethal force by police.

DEMOGRAPHICS

The following basic demographic information from the review has been de-identified to protect the identity of the individuals involved, as required by the ethics approval.

The demographics from the review revealed that:

- the deceased were either family violence victims, family violence perpetrators or both family violence victims and family violence perpetrators; and
- in all but one case, the persons who killed were either family violence perpetrators or both family violence victims and family violence perpetrators.

The review identified eleven family violence related cases overall which resulted in thirteen deaths during the period 2000-2012, plus the suicide of a person years after the original incident.

Family relationship was the most common relationship category (with five of the eleven deceased being relatives or family members) followed by the intimate partner relationship category (with four of the deceased being intimate partners). There were three suicides linked to the cases reviewed, including two murder-suicides.

A substantial proportion of the deaths were committed by relatives/family members and intimate partners, with four of the persons who killed being an intimate partner, and five being a relative or family member.

The results showed that both sexes were much more likely to experience death at the hands of men – a vast majority of the people who killed were men. Six of the deceased were female, and five were male. Another three males were deceased after suicide.

Eight of the deaths occurred in the home of the deceased (four were in the home shared by the person who killed and the deceased).

Three individuals in the review were both perpetrators and victims of family violence.

Family violence, mental illness, drug and alcohol use, and experiences of trauma were co-occurring issues in many of the cases.

Six of the perpetrators experienced or witnessed family violence in childhood

Prior to the lethal events, seven of the perpetrators had contact with mental health services (locally or interstate). After the lethal events another two perpetrators established on-going contact with mental health services.

Prior to the lethal events, five of the perpetrators were diagnosed with some form of mental health condition. After the lethal events another four perpetrators were diagnosed to have a mental health condition.

Seven perpetrators had suicidal behaviours and ideation.

Seven of the perpetrators had problematic drug and/or alcohol use, although only three had recorded contact with specialist drug and/or alcohol services.

FINDINGS AND RECOMMENDATIONS

Action Priority 1: Cultural change

This supports and aligns with National Priority One: Driving whole of community action to prevent violence from the Second Action Plan 2013-16 of the National Plan to Reduce Violence Against Women and their Children 2010-2022.

The DVPC report to the Attorney-General following the Extraordinary Meeting (the DVPC EM Report) in April 2015 identified a need to challenge and change the culture and attitudes towards domestic and family violence in the ACT. The following cases reviewed highlight specific areas to focus on in relation to community awareness.

Findings: cultural change

Within the cases reviewed the majority of bystanders and first responders did not identify non-physical behaviours, such as economic abuse, emotional abuse and coercion and control, as family violence. Other bystanders and first responders appeared to consider risk only in the context of existing physical violence. Equally, the cases reviewed highlighted a lack of awareness relating to factors that heighten risk such as separation, the presence of new partners or pregnancy.

Victims of family violence in the cases reviewed rarely identified their experience as domestic or family violence. A number were not afraid of the perpetrator.

This lack of recognition of family violence by victims, friends, family members and professionals resulted in missed opportunities to intervene or inappropriate responses to disclosures, the consequences of which were serious.

This emphasises the importance of educating the general community about family violence, risks and help-seeking options. Australian research notes that informal supports are important when victims of intimate partner violence seek help: “seeking informal help is often the first step in the help-seeking process and the outcome can shape victims’ subsequent help-seeking decisions” (Meyer, 2010). In order to prevent future deaths, community members need to be more aware of the dynamics of, and helpful responses to, family violence.

Recommendations: cultural change

1. The ACT Government commissions the development and implementation of a public education and communication strategy aimed at improving community understanding of the manifestations of and risk factors for family violence, including non-physical violence such as controlling and coercive behaviour. This should provide information for the general community, and bystanders such as family, friends, work colleagues and neighbours of victims and perpetrators, as well as

specific groups identified as vulnerable in this report such as older people, male victims and culturally and linguistically diverse communities (CALD).

In addition to general community awareness raising, specific targeted information should be developed for professionals who may be 'first responders' and interact with victims and perpetrators including:

- legal professionals, lawyers and solicitors; and
- health professionals, psychologists and GPs

The strategy should draw on international research, and should aim to educate the community about the nature and dynamics of family violence, including:

- the times when victims are most at risk such as at the point of separation, the presence of new partners and during pregnancy;
- the similarities and differences between violence against family members and against intimate partners;
- the presence of risk factors such as stalking behaviour, coercive and controlling behaviour or suicidal threats, which may fall outside of the paradigm of traditional physical family violence; and
- why it is important to act.

The strategy should also provide practical advice about:

- how to respond to family violence;
- where assistance can be sought including family violence help lines, crisis services and the police; and
- how and when to contact police.

Note: This community awareness campaign about the signs and risk factors for domestic and family violence will align with but not replicate the soon to be launched national campaign to address the attitudes of young people to gender equality and respectful relationships (which the ACT Government has supported).

2. Given the prominence of the issue of family violence, the Chief Minister should, as a priority, relaunch the Whole of ACT Government Statement on Family Violence. This statement should be made easily accessible on all government websites in order to assure the community that family violence is an issue that is best addressed through a whole of government response.

Action Priority 2: Reliable practical supports for victims from skilled service providers

This supports and aligns with National Priority Three: Supporting innovative services and integrated systems from the Second Action Plan 2013-16 of the National Plan to Reduce Violence against Women and their Children 2010-2022.

The DVPC Extraordinary Meeting Report identified that families experiencing domestic or family violence need to feel confident that they will receive appropriate support from professionals and service providers (both government and non-government). To build this confidence, frontline workers need to be trained to understand the dynamics and impacts of family violence and know how to respond appropriately. They also need to be able to determine when information sharing with other agencies is required to ensure the safety of potential victims.

Findings: Reliable practical supports for victims from skilled service providers

The findings from the cases reviewed are consistent with the issues identified in the EM Report and highlight:

- Limited evidence of frontline worker understanding and/or recognition of family violence indicating a need for the training of frontline staff. In particular, frontline staff should be resourced to identify when clients are perpetrating family violence and when this violence may need a response in addition to mental health or drug and alcohol treatment and to be able to refer appropriately.
- Risks of family violence were poorly understood or assessed; and were rarely responded to appropriately which indicated a need for the development of consistent family violence screening, risk assessment and risk management processes across human service providers and the criminal justice system.
- There are some important distinctions between violence among family members compared with intimate partner violence that needs consideration when developing risk assessments and risk management strategies.

Service provider screening of family violence

The cases reviewed highlighted that service providers identified family violence only where assaults and physical injury occurred. Specific responses by service providers when family violence *was* recognised were limited in scope, not recognising or responding to the actual risks to victims. It is particularly noteworthy that in several cases, service providers (often in mental health or drug and alcohol services) worked with perpetrators and were aware of their propensity for violence, including violence in the home environment. There appeared to be no admissions to either Canberra or Calvary Hospital that could be directly linked to family violence however, there were admissions to hospital by the perpetrators and victims that

represented missed opportunities for family violence screening. Indeed, across all the cases reviewed, victims and perpetrators of family violence had interactions with at least one formal health service, for example, a hospital, a GP or mental health. Health service delivery is a key opportunity to engage in screening for family violence.

In five of the cases reviewed, the victim and/or perpetrator resided in Housing ACT properties – so interactions with Housing ACT also represent a good opportunity to screen for family violence.[3]

Optimally, screening for family violence should be undertaken at multiple points across an individual's lifetime; by a range of service providers; facilitate disclosure by victims and perpetrators of family violence using of a range of questions to identify non-physical manifestations of family violence; and include appropriate follow-up and referrals. Some texts recommend the importance of screening (of possible victims) for intimate partner violence by mental health services and hospitals after a suicide attempt (Allen, 2013).

The World Health Organisation (2013) make a number of evidence-based recommendations about health service screening of, and responses to, intimate partner violence (but not family violence). These recommendations are focussed primarily on screening for victimisation, not perpetration of family violence. The cases reviewed instead point to a need to also screen for *perpetration* of violence as the suicide attempts identified in the review were by perpetrators of violence, not victims. The presence of children and their experiences in relation to any violence should also be included in any screening.[4]

Screening and risk assessment tools need to be selected carefully. Some screening tools rely on the victim identifying that they feel fearful at home as an indicator of family violence dynamics. In three of the cases reviewed, the victim was not afraid of the perpetrator, demonstrating that reliance on the victim's level of fear is not always adequate for identifying risk of family violence.

Frontline workers, and screening tools, need to be sensitive to recognising risk even where physical violence is not evident. In several of the cases, there was no history of physical violence, however, there were histories of property damage; threats of physical violence; emotional abuse, stalking and other non-physical forms of family violence. Frontline workers should be empowered and encouraged to seek

[3] The Council recognises that the publication of a ACT Government Housing and Community Services *Domestic and Family Violence Policy Manual* (2015) is an important tool that will contribute to more effective responses to domestic and family violence among housing clients.
[4] Children and family violence will be considered more extensively in the section on diverse needs of victims.

additional information from other record holders to improve screening and identification of family violence. The issue of information sharing will be discussed in greater detail in priority three.

The cases reviewed also highlighted that specialised health services, such as mental health or drug and alcohol services may play a key role in preventing further family violence related deaths. It was clear from the cases reviewed that in mental health or drug and alcohol settings, violence is likely to be understood as a symptom or outcome of poor mental health and/or drug or alcohol use. This issue will be discussed further under Action Priority 4.

Service provider risk assessment

Where there was Mental Health, Justice Health and Alcohol and Drug Services[5] (MHJHADS), community based service or ACT Police involvement prior to family violence deaths, there was (sometimes extensive) awareness of risk factors that indicate risk of physical violence (for example, known threats, unstable mental health and a history of physical violence); as well as evidence of other family violence behaviours (e.g. psychological abuse, economic abuse, and verbal abuse).

Risk of violence was rarely assessed or measured. Any specific attention to violence in assessments was based on measuring client outcomes[6] rather than on measuring risk. The responses were focused on the needs of the client (frequently the perpetrator of violence) and physical violence was viewed as a consequence of drug and alcohol use and/or mental health issues. The ongoing safety of the victims was rarely given priority in case management or service responses. Where victims / potential victims sought assistance from MHJHADS or community based services, they were referred to the police. Police interventions are necessarily limited when an offence cannot be identified or is not disclosed by victims.

The cases indicate that specialised services such as mental health and drug and alcohol services should have the knowledge and skills to assess their clients for risk of perpetrating family violence. They should also have the skills and knowledge to

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[5] Mental Health, Justice Health and Alcohol & Drug Services is a division of ACT Health that includes: ACT wide mental health services, adult mental health services, alcohol & drug services, child & adolescent mental health services, and justice health services.

[6] The review was provided with ACT Health Outcome Measures for relevant cases. Mental health services within ACT Health (including Mental Health and Adult Mental Health Unit – formerly Psychiatric Services Unit) make use of four Outcome Measures. These are the Focus of Care (which determines the primary goal of care); the Behaviour and Symptom Identification Scale 32 (BASIS 32) (a self-report tool designed to measure the major symptoms and functional difficulties experienced by the client in the previous two weeks); the Health of the Nation Outcome Scales (HoNOS) (to measure the health and social functioning of people with mental illness); and the Life Skills Profile 16 (LSP 16) (to identify client living skills). In general, outcome measures are used to assess consumer progress, develop treatment plans, review mental health status (MHPOD, 2016).

make appropriate referrals for those at risk in addition to police.[7] Policies and procedures need to be in place that guide worker measurement of risk and responses to domestic and family violence victims and perpetrators.

Recognising the nuances of family violence and intimate partner violence

The review found that violence against family members, especially violence by children against parents, was not always treated seriously by service providers, and appeared to be interpreted as "lack of respect", acting out or resulting from the perpetrator's mental illness. The deaths of parents identified in the review show that violence between family members can be an ongoing dynamic, can result in death and must be taken seriously. Where the violence was directed at family members, there was interaction with the criminal justice system, a number of perpetrators were charged with at least property damage. There were also a higher proportion of mental health conditions for those who killed their family members compared to those who killed their intimate partners.

Despite police and service involvement (including ACT Corrective Services and mental health services), none of the perpetrators received specific treatment or programs to address family violence behaviours. The review was unable to identify any existing programs in the ACT youth or adult family violence offenders (there are however a number of programs that address spousal or intimate partner violence). In all of the family member cases, limited or no support such as referrals or safety planning was provided to the parents.

Unlike the family member cases, none of the intimate partner cases had family violence charges.

The difference between family member deaths and intimate partner deaths highlights some key points. Both family violence and intimate partner violence can be lethal and, therefore, must be recognised and taken seriously by those who are aware of the behaviours (family, friends, service providers etc), however, the risk factors and indicators for the two may not be the same. The broad term 'family violence' is increasingly framing policy and legislative reform, however, there needs to be more in-depth understanding of the differences between family violence and intimate partner violence, especially as these differences pertain to risk measurement, safety responses and treatment for perpetrators. The Council acknowledges that identifying and responding to non-intimate partner family violence is an underdeveloped field of research and practice currently in Australia.

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[7] The review acknowledges that working with risk in relation to family violence perpetrators outside the criminal justice system is an underdeveloped area. Furthermore, risk assessment tools require further development to improve accuracy of prediction (see for example, Eke et al, 2011).

Recommendations: Reliable practical supports for victims from skilled service providers

3. The Attorney-General tasks and resources the DVPC with coordinating the development of a standard family violence training package for those in frontline service delivery.

4. The ACT Government fund an independent academic, supervised by the DVPC, to develop a Risk Framework for the ACT. In developing a framework, consideration must be given to:

- who is screened for family violence (victims and perpetrators); who screens for family violence; when they screen for family violence; and a standardised set of screening questions;
- what risk is assessed (risk of further assault or lethality); and validated risk assessment tools for intimate partner violence as well as violence against children, siblings and parents;
- appropriate risk management for all levels of risk;
- ensuring the recognition of the vulnerable groups identified in this report; and
- an implementation strategy, including training and evaluation.

5. The ACT Government to request the following key organisations to take specific actions to reduce and prevent family violence and the risks of related deaths:

- All tertiary education providers in the ACT, especially the Canberra Institute of Technology, University of Canberra, Australian National University, UNSW (ADFA) and Australian Catholic University (Canberra Campus), should be requested to include family violence training in all law, education and training and health related programs.
- The ACT Law Society and ACT Bar Association should be requested to make continuing professional development (CPD) about family violence a priority, particularly for those practicing family and criminal law, and to host family violence information on their websites.
- The Australian Public Service (APS) Commissioner should be informed that a number of the homicide victims and perpetrators were current or former employees of the APS and the APS should consider addressing family violence in mandatory induction training.
- Government funded drug and alcohol and mental health services should be made aware of the findings of the death review and should train their staff on family violence, understand the need for screening clients; and address all co-occurring issues.

6. ACT Health prioritises:

- Formulation of the ACT Health family violence policy; specifically acknowledging the propensity for overlap between family violence behaviours and mental health (including suicidality) and/or drug and /or alcohol issues.
- Development and implementation of operational guidelines for clinical and health staff to respond appropriately and make accurate records in relation to disclosures of family violence.
- Work with the ACT Primary Health Network to include family violence as a topic in the Capital Health Network's *Health Pathways* tool for General Practitioners and health care teams.
- Consideration of the use of specialist family violence social workers in ACT hospitals who can receive referrals if violence is disclosed and who can be used as a resource to advise other staff on how to recognise or respond to family violence. These social workers should be linked in to other relevant service providers such as DVCS, CRCC, Carers ACT and Everyman Australia (formerly Canberra Men's Centre).
- Exploration by Mental Health, Justice Health, Alcohol and Drug Services (MHJHADS) about how family members can be provided with information about the illness that the person they care for experiences, and how to facilitate their participation in care planning. Where sharing information with carers violates privacy provisions in the *Health Records (Privacy and Access) Act 1997*, amendments should be considered to ensure carers who may be at risk of violence can be provided with information that enables them to make informed decisions about their safety.
- Development and implementation by MHJHADS of operational guidelines for dealing with family violence disclosures by clients and client's family members. These must address the safety of potential family violence victims.
- MHJHADS incorporate the views of family members in the application of outcome measure assessments. In addition, policies and procedures should cover assessing risk of violence at key points in the clinical pathway including triage, admission, after critical events, at discharge and when a patient does not comply with medication requirements (this could be enhanced by any future whole of government risk assessment and response frameworks and actions).
- The safety of family members is considered and addressed by MHJHADS when applying for and monitoring Psychiatric Treatment Orders (PTOs).

Action Priority 3: Integrated service delivery system as whole of government priority

This supports National Priority Three: Supporting innovative services and integrated systems from the Second Action Plan 2013-16 of the National Plan to Reduce Violence against Women and their Children 2010-2022.

There is a need for a properly integrated service delivery system in the ACT, with multiple Government Directorates and community organisations working together to deliver connected and well-targeted services and responses to family violence. Timely access to and sharing of information is critical to ensuring the safety of people at risk of or experiencing family violence.

The cases reviewed highlight further areas to focus on in relation to this priority area.

Findings: Integrated service delivery

The review found that where services were accessed by victims and/or perpetrators, the service providers tended to operate in silos dictated by a focus on their own mandates and service models. Information sharing between agencies, particularly in relation to managing risks of violence was limited. The cases reviewed also identified problems in record management by agencies. These findings confirm issues noted in the DVPC Extraordinary Meeting report relating to a lack of a whole of ACT approach to dealing with domestic and family violence.

Information sharing and collaboration

A substantial proportion of family violence victims and perpetrators in the cases reviewed accessed or were provided with support from services that focused on specific aspects of wellbeing, primarily mental health or drug and alcohol services; or statutory services such as police or child protection. The service responses they received appeared to attribute family violence to mental health and/or substance use. These services did not engage with other service providers in relation to the family violence.

Evidence of information sharing between and within service providers was very limited. In only one case were consent forms found on a file explicitly recording that the client consented to information sharing between the agencies involved. Despite this consent, information was shared only sporadically. In the cases where mental health services were delivered by MHJHADS, most of the information sharing was one way from MHJHADS to external providers. The information sharing did not appear to follow any particular format or protocol and external providers including psychiatrists, psychologists and GPs shared only very limited, if any, information with MHJHADS. Where there *was* information sharing identified, it was not in relation to family violence. In some cases reviewed, there were pieces of information available on the files of numerous service providers which, if viewed in isolation, did not

indicate risk of future violence or lethality. However, when these various pieces of information were put together in the review of cases, a different picture emerged, resulting in a risk profile that indicated heightened risk of violence or lethality.

Currently in the ACT, Family Violence Intervention Program (FVIP) case tracking and the Sexual Assault Wraparound Program provide a basis for agencies to share information and work collaboratively to support and protect victims of family violence and sexual assault in criminal justice matters. In the intimate partner violence cases reviewed, there was no police involvement prior to the lethal event. Thus, these intimate partner violence cases would not come to the attention of the collaborative responses in place in the ACT.

The findings in this section highlight a need for information sharing, collaboration and coordination between services in relation to domestic and family violence that does not come to the attention of the police or proceed to criminal charges. Services that do not specialise in family violence responses are often in a position to identify that family violence is occurring. They are also likely to have information that assists in the identification of existing or changing risk. As such, an expectation to share information and/or work collaboratively in responding to family violence should not be limited to specialist family violence services or the criminal justice system.

A particular challenge in reducing the likelihood of future family violence related deaths therefore lies in all service providers being able to piece together information that provides an informative picture of risk. Responding to risk is contingent on identifying risk. Collaborative responses involving information sharing may be particularly valuable to identify heightened risk where dynamics of coercion and control and other risk factors co-occur in the absence of physical violence.

Cooperation between agencies could be coordinated by a lead worker who is knowledgeable about family violence, suitably empowered to seek solutions across agencies, and who can support an integrated response to a range of issues including, but not limited to, family violence. Such an approach would need to be different and much broader than the existing FVIP case tracking and Sexual Assault Wraparound Program.

There is an existing opportunity to integrate a specific focus on responding to family violence risks through the ACT Human Services Blueprint Better Services Initiative.

Barriers to information sharing

Facilitating and improving information sharing related to family violence is complex due to the need to balance personal privacy with risk identification and risk management. However, information sharing is critical in supporting effective identification of risk and risk management; as well is in supporting integrated, effective responses to family violence.

The review identified multiple barriers to information sharing across agencies in the ACT that obstruct collaboration and management of family violence risk.

Information sharing is governed by multiple relevant laws, particularly the *Health Records (Privacy and Access) Act 1997*, and the *Children and Young People Act 2008*. In addition, health professionals are bound by codes of ethics that prescribe requirements around patient/consumer/client privacy and confidentiality. Health and other professionals struggle to understand when and how they can legally or ethically share information pertaining to a patient/consumer/client.

In general, in order to legally share information without patient/client consent, an information holder must be satisfied that their disclosure is “necessary to lessen or prevent a serious threat to the life, health or safety of an individual” (s19(1)(a)(ii) *Information Privacy Act 2014).* In the cases reviewed, it is unlikely that information holders had enough information in their own records to identify such a risk and allow information sharing.

The *Crimes (Sentencing) Act 2005* includes a provision (s136) for information sharing between criminal justice entities in the ACT where there is an offence or alleged offence. The cases reviewed highlighted that significant information may be held by agencies that are not criminal justice entities and that risk of serious or lethal family violence frequently exists without any intersections with the criminal justice system, particularly when non-physical forms of violence are being used by perpetrators.

The *Domestic Violence Agencies Act 1986* contains a provision (s18) that allows ACT Policing to disclose information to an approved crisis support organisation where they believe that the information may render assistance to the person. The Domestic Violence Crisis Service is the only approved organisation.

Cross border sharing needs to be supported by legislation, protocols and mechanisms.[8]

The Terms of Reference for the Government’s recently announced *Review into System Level Responses to Family Violence in the ACT* acknowledged that “the effective and integrated operation of a number of systems in the ACT are fundamental to ensuring the safety of women and children in the Territory” (ACT Government, 2016). Similar recognition of the importance of effective information sharing was flagged in the recommendations of the Coroner relating to Luke Batty’s

[8] The DVPC notes that ACT Government is working with the Commonwealth Government on implementing a National model Law for domestic violence orders to be supported by a technology solution that will allow access to cross-jurisdiction domestic violence orders. Cross border information sharing also needs to address child protection and other relevant service sectors.

death (Coroners Court of Victoria, 2015) and of the Victorian Royal Commission into Family Violence (2016).

Records management

Record management issues in this review impacted on the ability of service providers to identify and respond to family violence; and on the quality of any risk assessment undertaken. It also highlighted the importance of effective record keeping and conducting regular file reviews.

Issues identified in relation to records management also have an important impact on accurate information sharing in the context of collaborative responses to family violence. The review identified issues within the files of government service providers that included:

- relevant information being missing;
- the presence of illegible handwritten file notes;
- the presence of undated and unsigned file notes;
- poor recording of information;
- information within reports and correspondence which was inconsistent with information recorded elsewhere in the files;
- information that was relevant to family violence was not easily found within files;
- outside the criminal justice system family violence flags were not used;
- files were misplaced; and
- missing records (a record of an individual was unable to be found in electronic system despite a known contact).

There were also numerous disclosures of family violence across a number of the service providers' files which were recorded but either not recognised as family violence, not seen as their business/responsibility or not responded to appropriately.

Recommendations: Integrated service systems as a whole of government priority

7. The ACT Government's Human Services Blueprint in collaboration with service providers develop ways for service providers in the ACT to cooperate, coordinate and integrate their response to family violence outside the criminal justice system. This should include consideration of extending the current Strengthening Families program (using specialised, trauma informed services with flexible funding and lead workers) to families with complex needs and are at risk of or experiencing, using or witnessing family violence.

It could also include families who are caring for adult children or partners with mental health issues who have a propensity for violence. For these reasons, the Human

Services Blueprint needs to work with a broader range of service providers (in particular ACT Health) and work with families with adult children as appropriate.

8. A working group of suitable agencies (e.g. DVCS, Carers ACT, mental health and alcohol and drug services, ACT Policing) be formed to identify appropriate service responses, referral pathways and gaps in service provision to respond to family violence that is not intimate partner violence or non-physical family violence, as well as alternative housing/care arrangements for adults with mental illness who are presenting a risk to their parents.

9. The *Information Privacy Act 2014, Health Records (Privacy and Access) 1997* and other relevant legislation be reviewed to facilitate the sharing of information to protect family violence victims. Consideration must be given to inserting a specific section to address family violence. Any reform should be supported by policies, guidelines and cultural changes within and outside government to support and promote information sharing.

10. ACT Government develop a policy and guidelines on family violence and information sharing to be implemented by Government Directorates and community sector organisations funded by government. Consideration should also be given to working with external organisations such as the ACT Law Society and the Capital Health Network to consider options for information sharing from outside the government and government funded system.

11. MHJHADS ensure that where multiple health providers (e.g. GPs, private psychiatrists, private psychologists and community organisations) are involved in a shared management plan there is an effective flow of appropriate information between them. Where the patient refuses consent for the exchange of information a senior clinician should take responsibility for deciding whether information will be exchanged to mitigate risk.

12. The Attorney General write to the ACT Auditor General to ask the Auditor General to consider conducting an audit of MHJHADS files to identify where improvements can be made especially in relation to the administration and implementation of ACT Health Outcome Measures, other risk assessment tools and the associated risk management approaches.

13. All ACT Government Directorates and ACT Government funded community sector service providers review their record keeping and record management policies with a view to update policies addressing critical points at which they should create records relating to family violence. Embedding a family violence 'flag' or 'tick a box' into databases would be particularly useful.

14. Consideration should be given to whether a whole of ACT Government policy on record keeping and record management in relation to family violence is required.

Action Priority 4: Evidence-based perpetrator interventions

This supports National Priority Four: Improving perpetrator interventions from the Second Action Plan 2013-16 of the National Plan to Reduce Violence against Women and their Children 2010-2022.

The service system also needs to include adequate provision of services and responses for perpetrators of family violence, while holding perpetrators of violence to account for their conduct. The system should aim to put in place systems and programs aimed at behavioural change. Intervention programs should be mandated and evaluated to maximise behavioural change upon completion.

The cases reviewed highlighted specific issues in relation to this priority area.

Findings: Evidence-based perpetrator interventions

The DVPC EM report identified that greater attention needs to be given to preventing potential perpetrators from committing violence, or committing further acts of violence.

In the cases reviewed, where the person using violence did come to the attention of the police and courts, none were engaged in perpetrator programs or interventions. In addition, people who perpetrated violence against parents were rarely treated as perpetrators of family violence by non-criminal justice service providers. As suggested previously in this report, this highlighted that violent behaviour can be obscured where there are co-occurring issues such as drug and/or alcohol misuse and/or mental illness. There was also a disturbing tendency for victim blaming and/or minimisation of perpetrator responsibility after the deaths occurred.

Service responses, interventions and perpetrator accountability

In four of the cases, there were previous family violence charges based on violence against parents. Follow up by Child and Youth Protection Services (CYPS) /ACT Corrective Services and other statutory agencies did not focus on responding to the family violence (noting that formal programs are not currently available for family violence perpetrators as opposed to intimate partner violence perpetrators). These situations demonstrate missed opportunities to hold perpetrators of violence to account, as justice based supervision is one tool to reinforce accountability (Male Family Violence Prevention Association, 2013).

Service interactions are also opportunities to intervene with perpetrators to prevent violence or further violence. Mental health services were involved in service provision with five of the family and domestic violence perpetrators (two of whom were also victims). At least seven of the perpetrators (two of whom were also victims) were known to have either previously attempted suicide or to have

threatened suicide. At least three of the perpetrators had contact with ACT drug and alcohol services.

The cases highlight that mental health services were frequently aware that their clients were using violence and aggression at home. The violence was not recorded or conceptualised as family violence – instead, the records read as though the violent behaviour was viewed as a symptom of the mental health disorder. Outcomes measure assessments that were completed relating to people using violence often minimised the risk of physical violence and/or the other conflict/ concerns in those relationships. There were few specific responses to known acts of violence, rather it appears that symptom management through medication was the primary intervention. Finally, it appears that little consideration was given to the risk of violence experienced by family members (including) carers and to supporting these people to engage in safety planning. When carers specifically approached mental health services for assistance when feeling fearful of the perpetrator of violence, the most common advice given was to contact the police, who were unable to act due to a lack of evidence of criminal offences.

Suicide threats and attempts by the perpetrator are considered to be a key indicator of heightened risk of intimate partner violence in risk assessment instruments in New South Wales (NSW Government, 2015), Western Australia (Department for Child Protection and Family Support, 2015), South Australia (Office for Women, 2015) and Victoria (Department of Human Services, 2012). This link strengthens the case for mental health professionals being equipped with the skills and resources to assess and respond to risk of family violence when individuals with a history of perpetrating violence come to their attention in relation to suicidal ideation/behaviour. Such an approach would provide opportunities for perpetrator intervention and improve victim safety.

Perpetrator narratives

After the deaths, the legal responses tended to give more attention to the narrative of the perpetrator. Records contained victim blaming attitudes and explanations that minimised responsibility of the perpetrator. Many of these records were provided to the court in criminal trials.

In some cases, there were witnesses who knew about a history of family violence but who were not interviewed by police. Gender stereotypes and victim-blaming were common in the descriptions of deceased females. These women were portrayed as non-maternal or nagging mothers, as cheating wives, as unfeminine (“strong”, “dominant” or “wore the pants”), and/or were generally unlikeable. Some of the records gave the impression that witnesses or others thought the victim was deserving of the violence/death.

In two instances, pre-sentence reports prepared by ACT Corrective Services excluded the voice of family violence victims and minimised the perpetrator's history of, and responsibility for, the violence. In one, ACT Corrective Services suggested that the offender would benefit from counselling to address the trauma associated with killing someone and other childhood experiences, however there was no mention of the previous family violence perpetrated and no recommendation made for a behavioural change program or other accountability mechanism.

In another pre-sentence report, the abuse that the family violence perpetrator had suffered as a child was detailed and the author concluded that this had resulted in significant trauma, which explained their offending. The report revealed that the perpetrator minimised his history of violence in interviews with ACT Corrective Services. This case review found that ACT Corrective Services did not compare their statements with findings from the police investigation (especially that relating to his history of violence) or speak with others, including living victims, in preparing the pre-sentence report. At sentencing the Judge referred to their "lack of violent behaviour' as being "favourable", contributing to a lesser sentence. ACT Corrective Services made recommendations for the offender to receive counselling to address childhood trauma; but no recommendations in relation to violence or family violence behaviour change were made.

Pre-sentence reports "provide vital information [about offenders] to judges and magistrates" (Sentencing Advisory Council, 2015) and influence the conditions imposed by a sentence. Sentences that include a requirement for the offender to engage in a support program or behaviour change program are understood to be an effective way to hold family violence perpetrators accountable (Hawkins & Broughton, 2016). Indeed, s43 of the *Crimes (Sentencing) Act 2005* expressly provides for those who prepare pre-sentence reports with the power to ask the victim of the offence; or an approved crisis support organisation under the *Domestic Violence Agencies Act 1986 (*where an offender is to be sentenced for a domestic violence offence); or any other entity for information. This never occurred in the cases reviewed.

It is also important to consider that many family violence perpetrators who have a history of engaging in family violence may have no recorded criminal history. Indeed

> ...accurately identifying first-time family violence perpetrators is difficult because of the high under-reporting of family violence [and so] reliance on the use of police offence record information in isolation may lead to many 'false negatives' and a failure to identify recidivist offenders (Boxall et al 2015).

Reliance on a perpetrator's account of their history of behaviour for a pre-sentence report is unlikely to result in a genuine reflection of previous perpetration of violence. Their self-report should not, therefore, be solely relied upon when such accounts

may minimise the severity of a court sentence. Nor should their account be allowed to be substantiated only by witnesses and others (such as family members) who support the perpetrator.

The review identified that courts need to understand that the experience and narrative of victims in court proceedings are frequently limited, especially where the victim is deceased. The perpetrator's narrative as it pertains to mitigating factors should be regarded lightly and, where possible, tested against the word of others who know the perpetrator and victim but who are not necessarily aligned with the perpetrator.

Overall, if the ACT is to successfully rehabilitate family violence offenders their behaviour needs to be considered in its entirety and co-occurring issues must be addressed; program participation should be maximised and non-compliance must have consequences; and change should be confirmed by family members / intimate partners, not just the self report of offenders. This will also assist in achieving perpetrator accountability - which has been flagged as a priority in the *National Plan to Reduce Violence Against Women and their Children 2010-2022.*

Recommendations: Perpetrator interventions

15. ACT Government develop appropriate programs to rehabilitate those who use violence against their family members, particularly for children, young people and young adults who use violence against their parents; and identify and provide resources for appropriate supports for parents whose children use violence in the home.

16. In order to achieve rehabilitation of family violence offenders ACT Corrective Services and Child and Youth Protection Services should:

- consider and respond to all co-occurring offender issues including mental health, drug and alcohol and family violence;
- implement all recommendations included in orders by judges and magistrates;
- hold offenders accountable for non-compliance through timely breaches;
- consider non-compliance as an indicator of future risk;
- not terminate supervision early for family violence matters, particularly where there has been non-compliance with conditions of court orders; and
- work more closely with a range of service providers including MHJHADS, alcohol and drug services, Victim Support ACT, Canberra Rape Crisis Centre (CRCC), Service Assisting Male Survivors of Sexual Assault (SAMSSA), the Domestic Violence Crisis Service (DVCS) and EveryMan Australia (formerly Canberra Men's Centre).

17. ACT Corrective Services develop guidelines to ensure that family violence victims have a voice and role in the management of family violence perpetrators. To ensure the safety of family violence victims, family violence perpetrators must be

managed within the context of their family including current and ex-partners (who they remain in contact with); parents and family members. Supervision should not rely solely on self-reports but should be balanced by the voice of their victim/s.

Action Priority 5: Meeting the diverse needs of victims and their families

This supports National Priority Two: Understanding diverse experiences of violence from the Second Action Plan 2013-16 of the National Plan to Reduce Violence against Women and their Children 2010-22.

The DVPC EM Report stressed that victims' experiences of violence are diverse and as such there is no one size that fits all approach to meet their needs – there must be a range of intervention and support options for victims and perpetrators. It also identified that some people face additional barriers when accessing support in relation to family and domestic violence.

This review identified, in particular, CALD people, male victims, children and older people as having particular unmet needs.

Findings: Meeting the diverse needs of victims and their families

Culturally and linguistically diverse victims of family violence

Several of the deceased were born overseas. A few of the deceased from CALD backgrounds appeared to be socially isolated and/or disconnected from the service system. Service provider records, where available, did not appear to acknowledge the impact of cultural background on service engagement.

One case particularly demonstrated the importance of interpreter use in service interactions and the justice system. In this case it appears speaking some English was equated with understanding all English, including technical, legal, medical and bureaucratic terms, despite staff themselves having difficulty understanding the client. The "use of interpreters is required by ACT Government policy and legislation" (ACT Health, 2016) and it is crucial to use interpreters to ensure effective communication with people with limited English proficiency in mental health settings (Miletic et al, 2006). The right to an interpreter for an accused with partial or no English is now widely accepted in common law (Foley, 2015).

Male victims

It is widely accepted that women and girls are disproportionately affected by family violence, however, the Council recognises that men and boys are also affected, and their experiences and disclosures should be legitimised and assistance should be provided. Several males were killed in the cases reviewed. None of the male family violence victims appear to have been scared of the family violence perpetrator.

In two of the cases service providers were aware of the violence against male clients. In one case, the service provider did not address the family violence victim's safety and the perpetrator's behaviour was seen as related to mental illness. In the other case, friends, family, neighbours and service providers were aware of the violence but provided no support or referrals. Some service providers appear to have taken their cue from the victim who spoke about it as if it was a "joke", however, the disclosures were of serious physical violence and bruises were also cited.

Men and boys can experience violence from both females and males and the perpetrators can be intimate partners but also parents, children and siblings. Gender stereotypes associated with masculinity, especially strength, are barriers to disclosures and receiving help. The fact that males can be victims of family violence does not, however, change the fact that structural inequality and widespread community attitudes perpetuate violence against women, as well as rigid gendered roles that entrap women and men alike.

Family violence services are available for male victims in the ACT, however there is a lack of awareness about this issue and male victims in the study did not appear to seek help in general or from appropriate services.

Children

Children witnessing and experiencing family and domestic violence also have special needs, in addition to the needs of the adults around them. In the cases reviewed, around 25 children witnessed family violence and at least 15 children experienced family violence. Despite this, children were largely invisible in the information contained in case files. Only two of the children had been reported to CYPS. In one case where a report of sexual abuse was received, CYPS called the school who said the child was fine and no further action was taken. In the same case an opportunity to report to CYPS was missed when a family violence offence was charged.

In another case, CYPS had extensive involvement, and Housing ACT, MHJHADS and CYPS were aware that the parent was violent and a victim of violence, mentally ill and often the sole carer of the child in contravention of a Family Court Order. Communication between involved agencies relating to the safety of the child was sometimes inadequate.

The remainder of the children were not actively identified in service provider records. In one of these cases police recorded very serious allegations of child abuse and sexual abuse after the fatal event. No further investigation or action was recorded in relation to these allegations, nor did the victim access any counselling or support.

A number of family violence victims and perpetrators were subjected to or witnessed family violence as children. In not intervening in these children's lives at the time of their exposure to family violence, and not as adjuncts to the violence suffered by

their parents, opportunities to prevent the future transmission of family violence were missed. Services and programs should be available to children who have witnessed or experienced family violence. There currently appears to be limited services and programs for children as family violence victims and witnesses before crisis point.

The impact of family violence on children is well documented elsewhere. It can be severe and long-lasting. The cases reviewed gave glimpses of these impacts. For example, a surviving child's sexualised behaviour escalated following the fatal event. They spoke about the "bad" person who was "mean" and hurt their parent. They told their carers that they were glad the "bad" person was dead. A surviving nine year old began having behavioural problems at school after hearing about the family member's death. It is important that children receive the help they need to deal with their loss and the trauma associated with the circumstances of the death.

In addition to the 25 children who witnessed family violence, many more were affected, such as grandchildren, nieces and nephews. The propensity for this harm to cause disruption to these children's lives should be considered when formulating responses tailored to the needs of children impacted by family violence.

Older victims and elder abuse

A few of the deceased victims were over 65 years of age and by definition can be considered "older people".[9] There is increasing recognition in the community and by government of elder abuse – which can "take various forms such as physical, psychological or emotional, sexual or financial abuse" (Department of Social Services, 2016). Elder abuse can be committed by family members, so consideration should be given to how work in preventing and responding to family violence can complement work in preventing and responding to elder abuse (and vice versa).

Recommendations: Meeting the diverse needs of victims and their families

18. The ACT Government resource the development and distribution of family violence education materials in languages, other than English, for display in public forums where CALD communities gather.

19. ACT Government service providers review their adherence to the ACT Government *2012-16 Australian Capital Territory Language Policy* with particular reference to section 4.4 'Interpreters and translators will be used depending on clients' particular circumstances and legal requirements' and the policy implementation requirements outlined in section 4.7.

[9] The Australian Institute of Health and Welfare (2016) defines adults 65 and over as "older people".

20. The ACT Government continue advocating for the retention of Commonwealth funding of interpreter services for non-government organisations that come into contact with family violence victims and perpetrators.

21. The Attorney-General task the DVPC to work with appropriate authorities and organisations to raise the profile of elder abuse (in a family violence context) and to consider areas for collaboration in prevention and intervention activities.

22. The ACT Government ensure appropriate responses and services are available to assist children who experience or witness family violence, including:

- services for children who are exposed to non-physical family violence
- services for children who are no longer living with the perpetrator; and
- early intervention responses aimed at preventing the intergenerational transmission of family violence.

Action Priority 6: Improvements to the legal and justice system's responses to domestic, family and sexual violence

This supports the overarching outcome: Justice responses are effective of the National Plan to Reduce Violence Against Women and their Children 2010-2022.

The DVPC EM report acknowledged that the ACT has a solid foundation in terms of criminal justice responses to family violence, and recognised that government was working on a range of welcome law reforms in this area. The review identified that further improvements in the civil and criminal justice system can be made. Some cases highlighted issues that have already been remedied in law reform – these issues will not be addressed here.

Findings: Improvements to the legal and justice system's responses to domestic, family and sexual violence

Inappropriate referrals to police

Where disclosures occurred and family violence was recognised in the cases, service providers such as Housing ACT and MHJHADS mainly advised family violence victims to call the police or to get a protection order. Not everyone was willing to call the police. This was particularly the case for parents who wanted to protect their children's future and, therefore, the police were seen as a last resort response. It needs to be recognised, then, that referring concerned victims routinely to police is not a realistic or helpful referral in some instances. Additionally, police may be restricted in the actions they can take, as they are limited by the range of offences they can charge for: usually to physical violence or property damage.

Protection orders

In respect of civil protection orders, only one of the family violence victims had an order and it was ignored by both parties for at least its final three months, despite a number of service providers being aware of that order. It was a Personal Protection Order (PPO) (which can apply for up to12 months) but should have been a Domestic Violence Order (DVO) (which can apply for up to 24 months). It is important that assistance is provided to applicants for protection orders to ensure they are making application for an appropriate order.

Against the current definition of domestic violence (s13) in the *Domestic Violence and Protection Orders Act 2008,* it is unclear whether all of the family violence victims would have been eligible for a protection order. The current definition does not specifically acknowledge that emotional or psychological abuse constitutes domestic violence. Indeed, DVCS confirmed that some of their clients, who experience emotional and psychological abuse and not physical violence, were not eligible for DVOs or were not granted DVOs by the courts. The Australian and NSW Law Reform Commissions (2010) provide a useful guide for legislative definitions of family violence at recommendations 5-1 which could be implemented locally.

Recommendations: Improvements to the legal and justice system's responses to domestic, family and sexual violence

23. The Attorney-General continues to implement, as a matter of priority the Australian and NSW Law Reform Commission's recommendations relating to family violence in *Family Violence – A National Legal Response (2010)*; to ensure that non-physical manifestations of family violence are recognised and addressed in ACT legislation.

24. ACT Policing, ACT Corrective Services and Child and Youth Protection Services (CYPS) (formerly Youth Justice) develop guidelines for gathering, recording and presenting information for records and report writing to ensure that perpetrator's voices are balanced with victim's voices and that a more objective and complete picture is provided to courts and releasing authorities.

Action Priority 7: The provision of long-term supports

The DVPC EM report identified the need for investing in the provision of long-term, post-crisis supports for people who have left violent relationships.

The section on diverse needs of victims identified that children who have witnessed or experienced family violence, or lost a loved one in the context of family violence, need access to ongoing support.

Recommendations: Provision of long-term supports

25. All survivors of family violence deaths, especially children, should be provided with ongoing counselling and support services appropriate to their specific trauma experience and age, in a timely manner and until they show good progress in their physical and mental health and educational progress. This should be a multi-agency coordinated response with a lead agency such as Victim Support ACT.

26. The Government reviews the *Victims of Crime Regulation 2000* to ensure Victim Support ACT has the capacity to respond to the long term needs of children who are victims and witnesses of family.

Other findings: Continuing to build the evidence base

This supports National Priority Five: Continuing to build the evidence base from the Second Action Plan 2013-16 of the National Plan to Reduce Violence Against Women and their Children 2010-2022.

The development of an ongoing domestic and family violence death review mechanism will be important for the ACT to continue to build an understanding of how to better prevent future deaths in the context of family violence.

Sadly, over recent years there have been a number of deaths in the ACT which allegedly occurred in the context of family violence, both intimate partner and family. These cases remain open either within the criminal justice system or the coronial system so were not included in this review. Setting up an ongoing family violence death review in the ACT would be one way to monitor the implementation of recommendations contained within this report and one small way to respond to future deaths.

This is important because the recommendations from this review are similar to recommendations coming from reviews elsewhere in Australia and overseas, including New Zealand, United Kingdom, Canada and the United States of America. It is should also be noted that the recommendations and observations made in this report are similar to those formed in more general family violence reviews including the Victorian Royal Commission into Family Violence and Queensland's Special Taskforce on Domestic and Family Violence in Queensland.

Domestic Violence Crisis Service cases

Research could also be expanded to include a review of deaths identified as occurring in the context of family violence such as accidental overdoses, suicides and early deaths such as those cases identified by the Domestic Violence Crisis Service (DVCS) and referred to the review.

On 20 March 2015, DVCS provided the review with the names of 71 women, men and children who were current or previous DVCS clients at the time of their death. These deaths are remembered at DVCS' annual candle lighting ceremony. This review was unable to review these deaths for a range of reasons. Only 26 of the names had records identifiable in the National Coronial Information System (see Attachment B for more information). Of the remaining 45 deaths, 18 occurred before the existence of National Coronial Information System (NCIS) in 2000 and 27 were not identified because the ACT death review team only had access to deaths that had occurred within the ACT and/or the coronial process for them had been completed.

Of the 26 deaths identified by DVCS that had NCIS records, only two were included in this review because they satisfied the terms of reference. Of the remaining 24:

- Eleven died due to unintentional external causes. These cases were mostly accidental overdoses of prescription or non-prescription drugs..
- Five died due to intentional external causes i.e. suicide.
- Six died due to natural causes (including chronic alcohol use).

The 24 DVCS files were reviewed and show that these deaths differ significantly from the other deaths considered by the review in that:

- Victims reported physical violence to ACT Policing and the criminal justice system was subsequently involved.
- Victims had high levels of contact with DVCS, most had more than 10 contacts and almost half had more than 50 contacts.
- Victims had high levels of contact with numerous government and community sector agencies including ACT Health, drug and alcohol services, Housing ACT, CYPS, Family Court, Legal Aid and refuges to name a few. Nearly all were involved with five or more agencies and most were involved with at least ten agencies.

No further information was reviewed in relation to the 24 deaths because the review lacked power to compel information from the relevant agencies. Even if the police or coronial investigative files had been accessed it is unlikely that relevant information would have been found. Police and coronial investigations are concerned with determining the cause of death and excluding suspicious circumstances rather than documenting any history of family violence and relevant service contacts.

The information contained in the DVCS files suggests that family violence contributed in various ways to these deaths. This is unsurprising given that victims of family violence experience high rates of depression, anxiety, suicidal thoughts, suicide attempts, harmful alcohol and drug use and post-traumatic stress disorder. Intimate partner violence was found to be "responsible for more preventable ill-health

and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking" (Garcia-Moreno et al 2005; Krug et al 2002; VicHealth 2004).

A number of the deaths recorded by DVCS would make important case studies to examine the impediments to service providers working together to support victims of family violence. These deaths also support recommendations made by the review including in relation to screening, risk assessments and risk management, integrated service responses and perpetrator interventions.

Recommendations: continuing to build the evidence base

27. The ACT Government establish a family violence death review mechanism to review all family violence homicides. The Australian Domestic and Family Violence Death Review Network, which includes the ACT as an observer, has identified a number of "best practice principles" which government should consider when establishing a death review. These "best practice principles" are that reviews:

- have government endorsement (including adequate funding, resources and agency engagement);
- are appropriately empowered to access information including from interstate;
- are supported by expertise in domestic and family violence;
- have the capacity to make and monitor recommendations;
- are empowered to conduct quantitative and qualitative reviews;
- contribute to the Network;
- are supported by case identification procedures and mechanisms;
- are collaborative and consultative, but retain independence;
- operate with knowledge and awareness of national and state level policy including domestic violence response frameworks;
- are supported by confidentiality and privacy protections; and
- operate in accordance with the overarching philosophy of death review processes including conducting individual and systemic reviews.

28. The ACT Government's family violence death review mechanism include the power to consider deaths such as suicides of both family violence victims and perpetrators and the accidental deaths of family violence victims.

CONCLUSION

The Council recognises that there are a number of pieces of work already being undertaken in the ACT that aim to respond to issues relating to family violence, including sexual violence and that some of those will go some way to addressing the issues raised in this report.

Acknowledgements

The Council wishes to recognise the extensive work done by the ACT Domestic and Family Violence Death Review Principal Researcher, Emma Henderson. Her patience, hard work and expertise were invaluable to the Council. The review process was somewhat delayed due to the challenges associated with accessing information, causing the project to extend well beyond the initial budget. The Council acknowledges that the office of the Victims of Crime Commissioner / Domestic Violence Project Coordinator absorbed the additional costs associated with this delay and provided additional administrative support to finalise this report.

The Council is also grateful for the assistance and support provided by the NSW Domestic Violence Death Review Team, who assisted the ACT to set up this review and whose methodology helped inform the methodology for this review.

The Australian Domestic and Family Violence Death Review Network also provided support to the ACT throughout the review. The ACT participated in monthly telephone meetings of the Australian Domestic and Family Violence Death Review Network as well as the two day face-to-face meeting hosted by Victoria on 10 and 11 September 2015. As a result of its participation in the Network, the review has resulted in the collection of minimum data for the ACT deaths which have been entered into a specially developed database, based on the one used by NSW. This will allow ACT to participate in future national data reporting for family violence deaths.

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Attachment A: Domestic Violence Prevention Council Membership

Current members	Position	Organisation
Mr Greg Aldridge	Community member	Executive Director, Everyman Australia (formerly) Canberra Men's Centre
Ms Sue Salthouse	Community member	Convenor, Women with Disabilities ACT
Ms Chrystina Stanford	Community member	CEO, Canberra Rape Crisis Centre
Dr Sue Packer	Community member	Paediatrician
Ms Marcia Williams	Community member and Chairperson	Executive Director, Women's Centre for Health Matters
Ms Maryam Khazaeli	Culturally & Linguistically Diverse member (Community member)	Policy Officer, ACT Office for Women
Ms Mirjana Wilson	Domestic Violence Crisis Centre member (Community member)	Executive Director, Domestic Violence Crisis Service
Ms Robyn Martin	Aboriginal & Torres Strait Islander member (Community member)	Manager, Beryl Women Inc
Ms Andrea Quinn (DCPO)	Police officer member	Deputy Chief Police Officer, ACT Policing
Mr Geoffrey Rutledge	Public servant member	Executive Director, Strategic Policy and Cabinet, Chief Minister, Treasury & Economic Development Directorate
Mr Victor Martin	Public servant member	Director, Criminal Law Group, Justice & Community Safety Directorate
Ms Deborah Colliver	Public servant member	Unit Manager, Child at Risk Health Unit, ACT Health Directorate
Mr John Hinchey	Domestic Violence Project Coordinator	Victims of Crime Commissioner

(As at December 2015)

Attachment B: Terms of Reference, Scope and Process

Terms of Reference

The Terms of Reference defined the scope of the review, and outlined the context of the review and the methodology that would be used to ensure that all stakeholders had a clear and common understanding and expectations of the review. The final intent of the review was a report written by the DVPC to the Attorney-General about the findings and recommendations for the in scope domestic and family violence deaths in the ACT.

The review was coordinated by the DVPC and conducted primarily by a Principal Researcher[10] who was based in the office of the Victims of Crime Commissioner and supervised by the Commissioner in his capacity as the ACT Domestic Violence Project Coordinator. The Council acted as a multi-disciplinary reference group for the review, and was responsible for the final report to the Attorney General.

The Council and the Principal Researcher worked closely together in relation to project planning, timeframes, data availability and proposed outcomes.

The Principle Researcher role included:

- coordinating, gathering, collating and analysing case information and data;
- documenting information in relation to the deaths reviewed and preparing reports for consideration and review by the Council;
- researching relevant case files and reports to develop a thorough understanding in relation to the circumstances of a domestic and family violence related death;
- liaising with external agencies where necessary, and providing advice to and contributing to Council meetings; and
- contributing to the preparation of the Council's final report to the ACT Attorney-General.

Through the process, the Principal Researcher familiarised themselves with other death reviews. Publicly available information on domestic and family violence death reviews in Australia, Canada, New Zealand, United Kingdom and United States of America was reviewed. The Principal Researcher also met with the Senior Research and Review Officer of the ACT Children and Young People Death and the NSW Domestic Violence Death Review Team about processes and methodologies. The NSW team generously provided support and advice to the Council and Principal Researcher throughout the review.

[10] A merit selection process was conducted by the DVPC to select a qualified researcher for the project.

In addition, the Principal Researcher familiarised themselves with the ACT domestic and family violence sector by reviewing publicly available information, attending DVPC and Family Violence Intervention Program (FVIP) Coordinating Committee meetings and observing the Family Violence List at the Magistrates Court. The Principal Researcher also met with 43 government and community sector stakeholders. A summary of these meetings was provided to the DVPC Chairperson and helped inform the DVPC's Extraordinary Meeting Report to the Attorney-General (2015).

Once access to the National Coronial Information System (NCIS) was granted the review was then undertaken in two stages. The first stage of data-gathering and analysis was conducted by the Principal Researcher. The information and data gathered by the Principle Researcher was confidential and a strict privacy framework and practices guided this work. This included publicly-available data as well as data and information from coroners (through the NCIS), ACT Government Directorates agencies, and non-government organisations.

The second stage involved a broader high level analysis and multi-sectoral overview, which was undertaken by the Council. Council members did not have access to documents containing any identifying information or to reports or files from the first stage of the review, but was provided with de-identified reports prepared by the Principal Researcher as the initial steps of the review were completed, or at certain key points.

At the completion of the review the Principal Researcher assisted the Council to prepare the report on trends, risk factors, and patterns and suggested recommendations for preventing deaths in similar circumstances.

Scope of the Review

The review was considered one-off and was retrospective in nature. The timeframe for the review included closed cases of deaths from 2000 onwards that had occurred within the context of domestic and family violence. For the purposes of this review, a case was considered to be closed after the criminal and coronial proceedings were complete.

For the purposes of the initial data-gathering exercise, a broad and inclusive definition of domestic and family violence related deaths was applied. Accordingly, cases for consideration included:

- all known external assault cases involving the death of partners and family members;
- cases involving the death of others known to either or both the victim and perpetrator (for example, new partners, friends or work colleagues);

- cases in which the death was of a person unknown to either the victim or perpetrator, but where this person's death is as a direct result of a domestic and family violence incident (for example, police officers or bystanders);
- suicide of perpetrators of domestic and family violence either in a homicide/suicide situation.

The review included an examination of events prior to the death as well as the circumstances of the death, and included information about the deceased and the killer and details of any services that were accessed and provided.

Information collection process

The Death Review sought Level 1 access to NCIS as a basis for identifying potential domestic violence related deaths in the ACT. NCIS is an internet based data storage and retrieval system for all Australian and New Zealand coronial cases. NCIS contains case information about deaths reported to a coroner across Australia from July 2000, and most death review teams use NCIS for identification of relevant deaths for their review process.

The review also liaised with the Domestic Violence Crisis Centre (DVCS) which had compiled fatality statistics from their files over the 26-year period between 1988 and 2012. These statistics included "lives [that] have been cut prematurely short, either taken by an act of domestic violence or taken by the impact of having lived with domestic violence (including impacts such as drug overdoses and suicides and seemingly otherwise unexplained accidents)". The statistics from DVCS covered the deaths of clients where the organisation had been made aware of the death, either through media reports, death notices, another service provider, a family member of the deceased person or police.[11]

In addition, the review investigated a summary of findings from domestic and family violence death reviews undertaken by other Australian jurisdictions in order to provide a preliminary understanding of systemic issues and learnings that could also be considered in the ACT cases.

Limitations

A condition of the ethics approval for access to NCIS was that absolute care was taken by the review to maintain the anonymity of the individuals involved in the deaths.

The review process and the contents of the final report were constrained by the requirements of the ethics approval, and meant that even Council members did not have access to documents containing any identifying information, or to reports or files from the review - only de-identified reports were provided to members.

[11] Note: the DVCS statistics are not official ACT statistics.

While the Council needed to prepare a report on findings from the Death Review and any appropriate recommendations for preventing deaths in similar circumstances, any personal details or individual elements of the cases could not be identified.

This was particularly challenging, especially given the size of the ACT and the small number of cases. No identifying information has been included in this report, but as a result, specific examples that support particular themes and recommendations were not able to be included or were heavily edited.

Attachment C: Methodology

The final agreed methodology used was based on the methodology used by the NSW Domestic Violence Death Review Team, who assisted the ACT to set up this review.

The NSW Team are members of the Australian Domestic and Family Violence Death Review Network (the Network) which has developed a preliminary data collection protocol for use by Network members. The goal of this data collection is to develop a staged standardised National dataset concerning family violence homicides. All members of the Network have agreed to the common use of core national information about the deaths that they identify and investigate as family violence related, to ensure a common national framework for reviews. So the information collected and recorded for the ACT's review included the core national information as a minimum.

Step 1: Case Identification

The review used a three stage approach for the identification of cases that were in scope for the review, using the agreed Terms of Reference definitions for cases which were to be included.

NCIS was used to identify in scope cases. NCIS is an Internet based data storage and retrieval system for Australian and New Zealand coronial cases, which contains details of all closed cases of death since 2000. For every reportable death, NCIS records extensive detail, including: the deceased's name, age, sex, date of birth, place of usual residence, country of birth, employment status, usual occupation and Indigenous status. NCIS also records information about the nature of the death and provides links to electronic copies of full text reports, including: the police narrative of circumstances of death, the autopsy report, and the coroner's findings.

NCIS also records three key determinations made by coroners in relation to cause of death:

- whether the death is due to natural, external or unknown causes;
- cause of death from the autopsy report; and
- for deaths due to external causes only, the (presumed) intent is recorded including unintentional injury, suicide, assault, legal intervention, operations of war, complications of medical or surgical care, other, undetermined, still enquiring and unlikely to be known.

At 7 May 2015, the review identified 32 closed cases of death due to external assault in the ACT in NCIS, which had occurred between 2001 and 2012.

Step 2: Case Classification – Relationship

Once the deaths were identified and the details of the cases examined, the death was categorised by the Principal Researcher to determine the relationship between the perpetrator and the deceased:

- Intimate Partner: spouse, separated spouse, de facto, ex-de facto, extramarital partner, former extramarital partner, boyfriend, ex-boyfriend, girlfriend, ex-girlfriend;
- Relative/Kin: familial relationships (including in-laws) and extended family or kin where kinship systems are relevant to a person's culture;
- No relationship: non-intimate friends, acquaintances, flat-mates and strangers; or
- Unknown – the relationship is unknown.

From the original 32 closed cases of death by external assault:

- 4 were identified as a death of an Intimate Partner;
- 8 were identified as a death of a relative/kin;
- Eighteen deaths indicated there was no relationship; and
- 2 were unknown.

Step 3: Case Classification – Family Violence Context

Whether the deaths occurred in a context of family violence was determined by reviewing all available information for any reference to a relevant history of family violence between the deceased, the person who killed and other relevant parties. A death that occurred following a recent relationship breakdown/separation was considered to have occurred in a context of family violence regardless of whether a history of family violence between the parties.

For the 32 closed cases of death due to external assault:

- Intimate partner: 4 of 4 had a context of family violence (including two linked suicides);
- Relative/kin: 5 of the 8 had a context of family violence;
- No Relationship: 2 of the eighteen had a context of family violence (including one linked suicide);
- Unknown: none of the 2 had a context of family violence.

Therefore, a total of 14 deaths from the 32 closed cases of external assault clearly occurred within a family violence context and were considered relevant to the review.

Step 4: Case Reviews

After reviewing available information about the deceased, the person who killed and relevant third parties from service providers, the Principal Researcher prepared eleven de-identified case reviews for the DVPC. The case reviews summarised thousands of pages of information into between 5 and twenty pages for each case.

They included information about the deceased, the person who killed and relevant third parties; relationship details and history; events preceding the fatal event, including recorded service contact; details of the death; and subsequent events.

The case reviews were not considered a complete record of what happened before, during and after the deaths as the review did not have the legislative power to access all available information. Examples of information unavailable to the Principal Research included information from general practitioners and educational providers. The case reviews were also limited to the witnesses who were interviewed for police statements, the questions asked by police and the information which was recorded by service providers.

The Principal Researcher provided two briefings about the interim findings at DVPC meetings held on 1 July and 2 September 2015 and provided a detailed paper on recommendations from other reviews which was discussed at the DVPC meeting held on 14 October 2015, in order to gain a preliminary understanding of systemic issues and learnings that could also be considered.

Step 5: Recommendations

The Principal Researcher analysed the case reviews using thematic analysis and Miles and Huberman (1994) style grids. The case reviews were then discussed by the DVPC at its 11 November 2015 meeting. The Council reviewed the case studies and also considered the findings and recommendations from death reviews in other jurisdictions for relevance. During this meeting, the Council identified the themes within and across case reviews and broad areas for recommendations.

The Death Review findings and recommendations were drafted by the Principal Researcher in consultation with the DVPC between November 2015 and April 2016. Feedback on the initial draft was sought from ACT Government Directorates in December 2015.

Access to Information

The review collected information about the characteristics of the deceased, the person who killed and relevant third parties and their relationships; the events leading up to the death; circumstances of the death; and details of any services that were accessed. The review utilised a number of legislative provisions to request information for the review:

- s136 of the *Crimes (Sentencing) Act 2005*, which enables a criminal justice entity to exchange information relating to an offence, or an alleged offence, with other criminal justice entities. On 9 February 2015, the Domestic Violence Project Coordinator was designated as a criminal justice entity to facilitate this information exchange.
- Chapter 22 of the *Children and Young People Act 2008* which enables the Director-General of the Community Services Directorate (CSD) to give protected

information about a child or young person to a researcher for an approved research project. On 10 March 2015, the review was designated as an approved research project.

- Privacy Principle 10.3 of the *Health Records (Privacy and Access) Act 1997* which enables a record keeper to disclose health information about a consumer for public interest research purposes. On 10 April 2015, the Director General of the Health Directorate directed health personnel to support the review and provide access to information in line with Privacy Principle 10.3.

Information about the deceased, the person who killed and relevant third parties was requested from and provided by ACT Corrective Services; ACT Health; Housing ACT; ACT Policing; the Australasian Legal Information Institute (AustLII); Canberra Men's Centre (now Everyman Australia); Canberra Rape Crisis Centre (CRCC); Child and Youth Protection Services (CYPS); Coroner's Court; Domestic Violence Crisis Service (DVCS); National Coronial Information System (NCIS); newspaper articles; Office for the Director of Public Prosecutions (DPP); Supreme Court; and Victim Support ACT.

Attachment D: Background to Family Violence Death Reviews in Australia

In recognition of the impact that 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.

Research shows that the investigation of these deaths as a connected group, rather than as individual incidents, is a particularly valuable process and valuable information can be gathered, and systemic changes identified, to improve systems and processes that may in turn assist in preventing future deaths (David, 2007). This is because the reviews are able to look at the behaviours and interactions of each of the individuals, organisations and agencies involved.

In June 2014, the ACT Attorney-General requested that the Domestic Violence Prevention Council (DVPC) undertake a review of domestic and family violence related deaths in the ACT. The review forms part of the ACT Government's commitment to the *National Plan to Reduce Violence Against Women and Their Children 2010-2022*.

All states and territories except Tasmania and the Northern Territory have implemented or initiated death reviews through varying models of practice. Although these jurisdictions have differing operating models, they have all been implemented with a view to identifying gaps and opportunities for improving the service system response to domestic and family violence, and contributing to possible prevention strategies to reduce the incidence and impact of domestic and family violence. To achieve this, all review teams quantify the nature and frequency of domestic violence homicides through data collection, data analysis, and the undertaking of in depth case reviews.

There is an Australian Domestic and Family Violence Death Review Network which is a collaboration of all the operational domestic violence death review teams in Australia, and which was established with a view to facilitating the collection of data and knowledge at a national level, in order to share information and outcomes from the states and territories to inform prevention responses.

The Network comprises representatives of review teams from New South Wales, Queensland, South Australia, Western Australia and Victoria, and New Zealand. ACT has special observer status. Meetings are convened monthly to provide an opportunity for discussion and collaboration on common areas of interest among members, and to progress work on joint projects. In addition, the Network liaises with regional stakeholders to promote the development of a broader knowledge base around the function and contribution of review teams in general.