Learning from Tragedy: Findings from the Queensland Domestic and Family Violence Death Review and Advisory Board

Associate Professor Kathleen Baird,
Griffith University &
Deputy Chair of the Queensland Domestic and Family Violence Death Review and Advisory Board

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Acknowledgment on behalf of the Queensland Death Review and Advisory Board

“We honour the voices of those who have lost their lives to domestic violence and family violence and extend our sympathies to those loved ones who are left behind, their lives forever changed by their loss. Our efforts remain with ensuring that domestic and family violence deaths do not go unnoticed, unexamined or forgotten.”
Established under section 91A of the Coroners Act 2003 to:

• Identify preventable measures to reduce the likelihood of domestic and family violence deaths in Queensland.

• Increase recognition of the impact of, and circumstances surrounding, domestic and family violence and gain a greater understanding of the context in which these types of deaths occur.

• Make recommendations to the Attorney-General for implementation by government and non-government entities to prevent or reduce the likelihood of domestic violence deaths.
Queensland statistical overview

• Since July 2006, there have been a total of 300 women, men and children killed by a family member or someone they were or had been, in an intimate partner relationship with. An additional 20 collateral homicides have also occurred in this period.

• Aboriginal and Torres Strait Islander people are over-represented making up one-fifth of all such deaths despite only about 4% of the population identifying as Aboriginal and Torres Strait Islander.

• Over one-fifth of all domestic and family homicides in Queensland involved a child being killed by their parent or caregiver, with the greatest risk occurring in the first year.

• Apparent suicides contribute the largest number of domestic violence deaths in Queensland each year, with 53 cases identified in 2018 – 2019 where there were clear links between domestic and family violence and the death.
Almost 80% of homicides involved a male killing his current or former female partner, and approximately 20% involved a female killing her current or former male partner.

The majority of females (60.7%) that killed a current or former male intimate partner were the primary domestic violence victim in the relationship.

- The vast majority of males who killed a female partner had been the primary domestic violence abuser against that female prior to the homicide.
- 36.4% killed a former female partner.
- Strangulation / suffocation was cause of death in 15.7% of cases.
- A DVO was in place in 24% of cases with the abusive male named as respondents.

Domestic and family homicides in Queensland

- Intimate partner
- Family
- Collateral

The chart shows the number of homicides from 2006-07 to 2017-18.*
Gender matters

<table>
<thead>
<tr>
<th>Category</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intimate partner</td>
<td>30</td>
<td>119</td>
</tr>
<tr>
<td>Family</td>
<td>61</td>
<td>55</td>
</tr>
<tr>
<td>Collateral</td>
<td>17</td>
<td>1</td>
</tr>
</tbody>
</table>
Aboriginal and Torres Strait Islander domestic and family violence homicides
Between 2006-07 and 2018-19 there have been 41 domestic and family homicides where the deceased identified as culturally and linguistically diverse, representing 13.1% of all domestic and family homicides in Queensland in that time.
Intimate partner homicide risk indicators

- 80.3% Prior history of domestic violence
- 57.4% Actual or pending separation
- 54.1% Sexual jealousy
- 50.8% Victim’s intuitive sense of fear of the perpetrator
- 45.9% History of violence outside of the family by perpetrator
- 45.9% Controlled most or all of victim’s daily activities
- 41.0% Prior attempts to isolate the victim
- 39.3% Prior threats to kill victim
- 39.3% Failure to comply with authority (i.e. breaches of an order)
- 24.4% Escalation of violence
Socially and/or geographically isolated

• Lower levels of reported contact with formal services.
• Informal support networks were more likely to be aware of the controlling and violent behaviour.
• When services were notified, usually at a point of crisis, responses were variable.
• Common themes included:
  • Prior threats and assaults with a weapon
  • Perpetrator was unemployed
  • Victim and perpetrator living in common-law
  • Excessive alcohol and/or drug use by perpetrator
  • Failure to comply with authority
  • Sexual jealousy.
**Older people**

- Between 2006 – 2019 22 of the 320 DFV homicides featured the deceased aged 65 years of age and older.
- Twelve older people homicides occurred within a intimate partner relationship and there nine family homicides and one collateral homicide.
- Three homicides were from CALD backgrounds and there were no Aboriginal and Torres Strait Islander homicides aged 65 years of age.
- Mental illness in the homicide offender was identified in 10 of the 12 cases, compared with just three of the deceased.
Child Deaths & Filicides

- Between 2006 – 2019 there were 74 homicides in a family relationship involving children aged 17 years and younger. Representing 23.1% of all domestic violence homicides.
- Seven of these deaths involved a child being killed by a family member external to the parent – child dynamic, for example a grandfather or sibling.
- Infants in the first year of life were at greatest risk of filicide, with more than one-third (34.3%) of all filicides occurring in this high risk period.
- In 2018 – 19 there were seven children who were allegedly killed by a parent or caregiver. Representing 35.0% of all domestic and family homicides for the year.
Disadvantage, trauma and heightened vulnerability

- Several of the cases reviewed by the Board in this and previous reporting periods involved victims, perpetrators and families exposed to entrenched disadvantage, trauma and heightened vulnerability, often across successive generations.

- There was evidence that challenging clients were excluded or closed to services despite an ongoing risk of harm.

- In a small number of cases, there was evidence of frequent and sustained contact with multiple services but an absence of collaboration of integration of services.
Service system contact: Homicides in a domestic and family relationship

- Police: 73.1% (Perpetrator), 86.5% (Victim)
- Magistrates Court issued DVO: 51.8% (Perpetrator), 51.9% (Victim)
- Other services: 11.5% (Perpetrator), 11.5% (Victim)
- Legal services (e.g. Family Court): 7.7% (Perpetrator), 9.6% (Victim)
- Specialist DV services: 9.6% (Perpetrator), 17.3% (Victim)
- Child safety services: 6.8% (Perpetrator), 21.2% (Victim), 28.8% (Victim)
- Relationship service: 7.7% (Perpetrator), 17.3% (Victim)
- Psychologist, counsellor: 9.6% (Perpetrator), 17.3% (Victim)
- GP: 15.4% (Perpetrator), 28.2% (Victim)
- Hospital (incl. ED): 13.5% (Perpetrator), 25.0% (Victim)
- Mental Health: 9.6% (Perpetrator), 19.2% (Victim)
- Corrective Services: 9.6% (Perpetrator), 21.2% (Victim)

Note: The percentages represent the proportion of perpetrators and victims who contacted each service.
Service system contact: Domestic and family violence related suicides

- Police: 84.6%
- Magistrates Court issued DVO: 73.8%
- Mental Health: 52.3%
- Mental Health: 52.3%
- Relationship service: 46.2%
- Specialist DV service: 4.6%
- Police: 12.3%
- Other: 1.5%
- Psychologist / counsellor: 18.5%
- Corrective Services: 23.1%
- GP: 38.5%
- Hospital / ED: 52.3%
Substance misuse

- There was limited, if any, evidence of effective intervention, counselling or support for substance dependency issues
- If support was provided there were high levels of non attendance or incompletion
- Community service and parole orders had limited success in mandating participation in community based treatment programs
- Options offered did not match the extreme level of addiction
Culturally informed approaches to care

- Barriers when clients were reluctant to engage or ‘fit’ in with a service approach.
- Lack of family focused approaches despite evidence of intergenerational trauma.
- Limited focus on strengths–based approaches.
- Finalisation of cases for low engagement or non-attendance which failed to recognise this might be indicative of further violence or a need to alter service approaches.
- Disproportionate focus on immediate, presenting issues with no commensurate attempts to address underlying issues.
Integrated service responses

• Several cases examined by the board demonstrated a fragmented approach to service provision suggesting there are still opportunities to bridge the gap between policy and implementation.

• Information sharing remained inconsistent and sporadic despite significant reforms to facilitate pathways for services to do so, particularly in cases of where a high risk of harm was identified.

• There was evidence, particularly in the Aboriginal and Torres Strait Islander youth suicide cases, of frequent and sustained contact with multiple agencies over time without any interaction or collaboration between agencies.
Strengthening our systems

• The majority presented to generalist services for support (with relatively minimal ongoing contact with specialist services for those who did).

• There continues to be opportunities to enhance screening and assessment process (for both victims and perpetrators); information sharing and collaboration; follow-up and continuity of care; and standards, training and accreditation for services working with both victims and perpetrators).

• There is also a need for earlier detection, and targeted intervention and support within the health service and other systems.
Key Messages from the 2018-19 report

• Females remain significantly over-represented as intimate partner deceased, with males the offender in 80% of all intimate partner relationships.

• The highest rates of domestic violence were observed in the Northern areas of Queensland.

• There were elevated number of homicides in geographically isolated areas of Queensland.

• Actual or pending separation was identified in almost one-half of intimate partner homicides.

• Filicides, represented over 20% of all domestic violence homicides

• Apparent suicides contribute the largest number of DFV deaths each year with 53 in 2018 – 2019.
2016 – 2019 Reports

2016-17


2016-17


2016-17

Acknowledgements

Queensland Domestic and Family Violence Death Review and Advisory Board.

Queensland Domestic and Family Violence Death Review Unit.

Contact Details:
k.baird@griffith.edu.au