NSW Domestic Violence Committee Coalition

Black & Blue Campaign 2008

Understanding why women die: Domestic Violence Homicide Review.

Domestic violence-related homicide in Australia[1]

- During 2005–06, a total of 74 intimate partner homicides occurred, up from 66 in 2004–05.
- 80% of intimate partner homicides involved a male offender killing his female partner (n=59).
- 78% of intimate partner homicides occurred in residential premises (n=58).
- 65% of intimate partner homicides were associated with some form of domestic violence, indicated by the presence of legal intervention orders or a recorded history of domestic violence (n=48).
- Out of the 74 intimate partner homicides, 24% involved an Indigenous victim or offender (n=18), while 16% involved both an Indigenous victim and offender (n=12).
- 35 children under the age of 15 years were killed in 2005-06. 11 of these homicides involved the death of infants aged less than 12 months. 80% percent of the child homicides occurred in a residential location (n=28),
- The overwhelming majority (92%) of child homicides were committed by a family member, usually a parent (32 out of 34 recorded family relationships). [1]

> When domestic violence related deaths are seen as the escalation of a predictable pattern of behaviour with increasing risk factors, then domestic homicides can be viewed as essentially preventable deaths. [2]

There is now well established and documented evidence in Australia and internationally, that women are predominantly the victims of domestic violence and men are predominantly the perpetrators. The 2005–06 National Homicide Monitoring Program [1] reported that the majority of female victims (58%) were killed as a result of a domestic altercation, which includes arguments based on jealousy, separation or termination of a relationship, infidelity, children and custody issues, and other issues between intimate or past-intimate partners. Extensive research has observed that a history of domestic violence is common in intimate partner homicides, and that in some cases, the homicide incident is the end result of a culmination of numerous prior incidents of domestic violence. [1]

Current systems for responding to domestic violence-related fatalities and homicides in Australia

In Australia, there is growing state wide and whole of government strategies aimed at preventing and responding to domestic violence, together with strong calls and support to establish domestic homicide review teams.[2] Various different investigation systems into violent deaths exist in Australia, such as those conducted by the police, coroners, and the National Homicide Monitoring Program. However, none of these look specifically at domestic and family violence-related fatalities, or analyse a group of domestic homicides occurring within a particular period of time, searching for common patterns and issues that culminated in the fatality. [2] In a 2006 report, the NSW Ombudsman recommended the establishment of a domestic violence death review process. To date, no Australian state or territory government has established a domestic homicide review process, despite having well-established child-death review processes in most jurisdictions. [2]

Domestic Violence Homicide Review Teams

Since the early 1990s, Domestic Violence Fatality Review Teams (DVFRT) have developed and become widespread across the USA. DVFRT were established in the USA as a response to what was widely seen as a failure by agencies at the frontline of domestic violence service delivery, to adequately coordinate and provide care and protection to victims of domestic violence. Homicide review teams share the position that domestic violence homicides are preventable, given that the risk factors are usually present prior to the ultimate act of homicide. [3] [4]

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[1] Davies, M & Mouzos, J (2007), *Homicide in Australia: 2005-06 National Homicide Monitoring Program annual report,* Research and Public Policy Series, no 77, Australian Institute of Criminology, Canberra.

[2] David, N (2007), *Exploring the Use of Domestic Violence Fatality Review Teams,* Issues Paper no 15, Australian Domestic & Family Violence Clearinghouse, Sydney.

Domestic Violence Homicide Review Team – what is it?

The purpose of the homicide review team is to review domestic violence fatalities and collate data about them. It is a multi-agency taskforce seeking improvement in service delivery and a reduction in domestic violence fatalities. Its purpose is holistic and positive, focusing on systemic issues as opposed to individual performance and negligence. [2] The function of a homicide review team is different from a complaints and integrity commission, and separate in focus from an ombudsman. [2]

A common characteristic of homicide review teams is that they examine the events prior to the death, the circumstances surrounding the death, and action that may be taken to prevent domestic violence related deaths occurring in similar circumstances in the future.[3] Domestic homicide review teams are only focussed on systematic and procedural weakness, not the actions or negligence of individuals; it is the operating procedures, laws and systems in place at the time of the domestic violence related death that come under scrutiny of the investigation. [2]

In the USA, Fatality Review Teams have proven invaluable in identifying common weaknesses in systems and protocols responding to domestic violence, and represent important tools in the effort to evoke social change and make a positive difference in preventing domestic violence fatalities. [2] Fatality Review Teams typically establish strong interagency relationships, gather and collate accurate, detailed data and have become powerful, evidence-driven advocates, effecting positive change to systems and procedures responding to domestic violence. [2]

The most tangible benefit of homicide review teams is their ability to identify practices, protocols, behaviours and attitudes associated with service and criminal justice response systems that lead to domestic violence–related deaths. Fatality review teams can identify barriers to accessing services or agencies, and gaps and flaws in their response. It can then apply that information to all domestic homicides within a specific time, to establish whether the problem with the response is systematic, and make recommendations to improve interventions and service effectiveness. Homicide review teams can alter the way domestic homicides are viewed and responded to. [2,3]

Structure

In the USA, Domestic Violence Fatality Review Teams have a similar structure, and are set up like a government advisory board, with a 'lead agency' anchor of one organisation or government department charged with the responsibility and resources to administer and support the fatality review team. [2,3,4]

Generally, the agencies included in a homicide review team are drawn from government and non-government areas and consist of representatives from law enforcement, health and welfare government agencies, lawyers, the coroner's office and a range of non-government agencies, including victims advocates and women's services. [2,3] The chair of the review team is typically a senior public official, with well-resourced infrastructure support to facilitate the gathering of relevant information and dissemination for the purpose of the review. [3] Each homicide review team sets its own guidelines and methods of review, the form of which is dependent on the locality, rate of domestic homicide, political climate, current responses to domestic and family violence by stakeholders and the resources for effective intervention and prevention. [2,4]

In the USA, fatality review teams are generally supported by a legislative package which provides investigative powers and places restrictions around protecting confidential information on members of the review team. The legislative package provides the structure, the frame of reference and establishes the necessary framework for review teams to access confidential case information and records. This comprehensive legislative package needs to precede the establishment of homicide review teams to address concerns relating to privacy and confidentiality, terms of reference, powers, membership, agency responsibilities and reporting requirements, indemnity of members with immunity from liability or prosecution. [2,3]

The overall effectiveness of a homicide review team is dependent, ultimately, on political and community will.

Domestic violence-related homicide is preventable – this is the best reason to invest resources to better understand the complexities of domestic violence and the risks to victims preceding the fatalities so that more effective intervention and prevention strategies can be implemented in more coordinated and cooperative ways across agencies. [2]

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[3] Stewart, J (2005), *Literature review on the establishment of domestic violence fatality review teams,* Newsletter no 21, Australian Domestic & Family Violence Clearinghouse, Sydney.

[4] Thompson, R (2006), *Evoking Social Change: How Domestic Violence Fatality Team Recommendations Can Make a Difference,* Fatality Review Bulletin, National Domestic Violence Fatality Review Initiative, Texas.