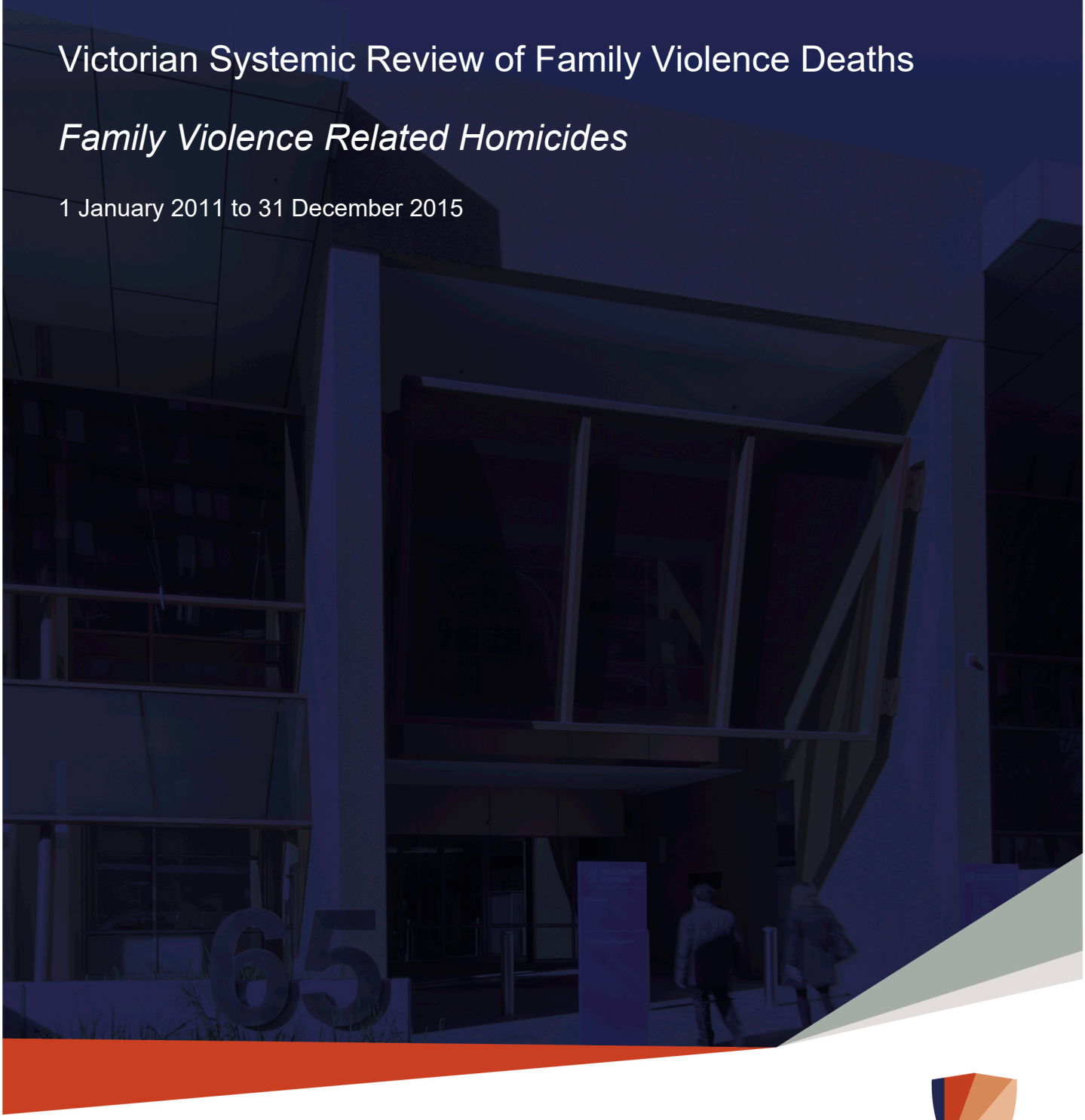
# Coroners Court of Victoria

## Victorian Systemic Review of Family Violence Deaths

## *Family Violence Related Homicides*

1 January 2011 to 31 December 2015



Coroners Court of Victoria

**Acknowledgement**

The Coroners Court of Victoria is situated on the land of the Traditional Owners, the Wurundjeri and Boon Wurrung people of the Kulin Nation. We acknowledge and pay respect to their history, culture and their Elders past, present and emerging.

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# Foreword

I am pleased to present the Victorian Systemic Review of Family Violence Deaths (VSRFVD) report on family violence homicides between 1 January 2011 and 31 December 2015.

Introduced in 2009, the VSRFVD was the first dedicated family violence death review to be established in Australia. The VSRFVD plays a pivotal role in improving the Victorian service system for those affected by family violence and highlighting the importance of early intervention in reducing and preventing fatalities from family violence.

Following a recommendation made by the Royal Commission into Family Violence (RCFV) in 2016, the Victorian Government formally acknowledged the unique perspective and role of the VSRFVD and amended the *Coroners Act 2008* (Vic) to provide a legislative basis for the VSRFVD. While expanding in scope and expertise since 2009, the VSRFVD continues to provide high quality advice to coroners in family violence related deaths.

The VSRFVD works with coroners to provide insight into the factors and circumstances in which family violence deaths occur in Victoria. The VSRFVD utilise their specialist knowledge to assist coroners in detecting challenges within the Victorian service system and identifying gaps in the provision of services to people experiencing family violence.

Researching trends in family violence related deaths is one element of the work that is undertaken by the VSRFVD. This report complements the VSRFVD report released in 2012 which examined similar data relating to family violence homicides from 1 January 2000 to 31 December 2010. It is hoped that the information contained within this report will provide the community and government sector with greater insight to assist them in undertaking their work towards ending family violence in Victoria.

I would also like to take this opportunity to acknowledge that the death of a person in the circumstances of family violence is especially tragic. Such a loss has far reaching ramifications, not only for surviving family members, but for everyone in their community and the wider Victorian community. I would like to extend my condolences, on behalf of the Coroners Court of Victoria, to the family members of those individuals who have lost their lives as a result of family violence. I would also like to thank these families for their patience, their support and their contribution to the work that is undertaken by the Coroners Court of Victoria. It is our intention that through the work of VSRFVD, the Coroners Court of Victoria can draw on the information gained from these tragic events to inform service improvements and delivery to prevent similar deaths from occurring in the future.

**Judge John Cain**
**State Coroner of Victoria**
**June 2020**

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## Terms

### Familial relationship

Refers to the type of relationship between a homicide offender and homicide victim. These relationship types are drawn from the *Family Violence Protection Act 2008* (Vic) (FVPA) and include:

- Intimate partner: Current or former intimate partners, including a current or former spouse or domestic partner.
- Parent-child: The relationship between a parent and their child. For the purposes of this report this indicates that a parent has been found responsible for killing their child. The child may be under or over the age of 18. The parent may be a biological parent or stepparent (including de facto stepparents).
- Child-parent: The relationship between a child and their parent. For the purposes of this report, this indicates a child has been found responsible for killing their parent. The child may be under or over the age of 18. The parent may be a biological parent or stepparent (including de facto stepparents).
- Other intimate or familial: This refers to familial relationships within immediate and extended family that are not intimate partner, parent-child, or child-parent. It also includes other relationships which may be deemed family-like. Further examples of such relationships are contained in the FVPA. This also refers to instances where there was a sexual relationship between the homicide offender and homicide victim, but they were not identified, or did not identify, as being in a relationship with one another. This category also includes family violence bystanders and kinship relationships as defined by the Victorian Indigenous Family Violence Taskforce (2003).
- Not intimate or familial: There was no identified intimate or familial relationship between the homicide offender and homicide victim.

### Family violence

The definition of 'family violence' used in this report reflects that contained in the FVPA. Family violence includes behaviour by a person towards a family member of that person if that behaviour is physically, sexually, emotionally, psychologically or economically abusive. It can also include behaviour that is threatening or coercive, and any other behaviour that controls or dominates a family member and causes that family member to feel fear for the safety or wellbeing of themselves or another person. Family violence also includes behaviour that causes a child or children to hear, witness or be exposed to family violence.

### Family violence bystander

Refers to an individual who was killed in a family violence related homicide but was not a family member (as defined by the FVPA) of the homicide offender. For example, a new partner or family member of a family violence victim who is killed by the family violence perpetrator.

### Family violence perpetrator

Refers to the primary perpetrator of family violence prior to the homicide incident. This may be different to the homicide offender, for example in circumstances where a family violence perpetrator is killed by a family violence victim.

### Family violence related homicide

Refers to homicide incidents that occurred in circumstances where there was a familial relationship (as defined by the FVPA) between the homicide offender and a homicide victim, regardless of whether there was an identified history of family violence prior to the homicide.

This term also refers to homicides where family violence featured within the circumstances of the homicide incident, but where there was no familial relationship between the homicide offender and the homicide victim. For example, this may include homicides where a person was killed while intervening in a family violence incident, or where a new partner or family member of a family violence victim was killed by the family violence perpetrator.

### Family violence victim

Refers to the primary victim of family violence prior to the homicide incident. This may be different to the homicide victim, for example in circumstances where a family violence victim kills a family violence perpetrator.

### Homicide

Refers to the unlawful killing of a person. For the purposes of this report, homicide includes cases where someone has been charged with murder, manslaughter, defensive homicide or infanticide, and may include cases where an offender was not apprehended or was found not guilty by reason of mental impairment.

This definition does not include lawful homicides, such as instances where a police member may cause a death in the course of their professional duties. For the purposes of this report, homicide also excludes missing persons' cases where a charge of murder or manslaughter has not been laid by police against an offender. Driving-related fatalities are also excluded in instances where a criminal event has not immediately preceded the fatality.

### Homicide deceased

Refers to a person who died as a result of a homicide incident. This term may be used interchangeably with the term homicide victim.

### Homicide victim

Refers to a person who died as a result of a homicide incident. This term may be used interchangeably with the term homicide deceased.

## Homicide incident

Refers to an incident of violence from which single or multiple deaths may have resulted. The date of the homicide incident may be different to the date of a death in circumstances where injuries were inflicted upon a person during a homicide incident, but the death occurred as a result of those injuries at a later date.

## Homicide offender

Refers to a person determined, following criminal justice or coronial proceedings, to be responsible for the death of the victim.

## Mechanism of death

Refers to the primary means by which a death was caused. These include:

- Blunt object: An object was used to inflict the fatal injury by striking and transfer of force.
- Bodily force: The fatal injury was inflicted without the use of a weapon, such as via an assault using hands and/or feet. This includes strangulation inflicted using the body (e.g. hands).
- Firearm: The fatal injury was inflicted through the discharge of a firearm. This does not include the firing of arrows, which are classified under 'sharp object'.
- Sharp object: The fatal injury was inflicted using a sharp object which caused a penetrating or cutting injury. This could include a range of implements such as knives, bottles, razors or the other pointed objects.
- Threat to breathing: The death was caused by a deliberate restriction to breathing using an object or implement. The cause of the restriction may be from a range of methods including ligature strangulation, suffocation using an object such as a pillow, drowning, or otherwise using an object to cause a restriction to breathing.
- Other: This classification is used where none of the other mechanisms of death apply, or where there were multiple mechanisms which contributed equally to the cause of death.

## Mental illness

Includes conditions categorised as a mental illness according to the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10).

# Abbreviations

| | |
|---|---|
| CCOV | Coroners Court of Victoria |
| FVPA | *Family Violence Protection Act 2008* (Vic) |
| FVIO | Family Violence Intervention Order |
| FVDR | Family Violence Death Review |
| RCFV | Royal Commission into Family Violence |
| VHR | Victorian Homicide Register |
| VSRFVD | Victorian Systemic Review of Family Violence Deaths |

# Executive summary

The Victorian Systemic Review of Family Violence Deaths (VSRFVD) at the Coroners Court of Victoria (CCOV) is led by the State Coroner and examines the context in which family violence-related deaths occur. Through coroners' findings, comments and recommendations, the VSRFVD contributes to strengthening the response to family violence in Victoria.

To assist the work of the VSRFVD, and coroners, the CCOV captures data relating to homicides in Victoria using the Victorian Homicide Register (VHR). The VHR records every homicide reported to the CCOV and captures a range of information pertaining to the homicide victim and offender. In cases identified as family violence related homicides, further information regarding the dynamics of the relationship between the homicide victim and offender, any family violence history and risk factors are captured.

The VSRFVD 'First Report' was published in 2012 and used data relating to homicides from 1 January 2000 to 31 December 2010 to explore the factors and circumstances in which family violence homicide deaths occur. This report builds on that initial dataset, presenting data in relation to family violence homicides which occurred between 1 January 2011 and 31 December 2015.

Of the 257 homicide related deaths reported during this time period, where the coronial investigation was closed, 97 deaths were identified as family violence related deaths where coding into the VHR had been completed. Those deaths arose from 82 separate homicide incidents perpetrated by 86 homicide offenders. Data from these deaths was examined for the purposes of this report.

Key findings from the data are included below.

## Of the 82 separate homicide incidents

- Over one tenth resulted in more than one homicide victim (14.6%, n=12)
- The majority occurred in private residences (81.4%, n=79)

## Of the 97 family violence related homicide victims

- 78 were adults
    - 38 of these were the intimate partner of the offender
    - 25 were in another type of intimate or familial relationship with the offender
    - 11 were parents killed by their adult child
    - one was a parent killed by their child under the age of 18
    - three were killed by their parent
- 19 were children

## Of the 78 adult family violence related homicide victims

- Over half were female (55.1%, n=43)
- Over three quarters (both male and female) were killed by another male (82.1%, n=64)
- The highest proportion were killed by a current or former intimate partner (48.7%, n=38)
    - Of these, 39.5% (n=15) had recently separated, had indicated an intention to separate or were in the process of separating
- Females were most commonly killed by a current or former intimate partner (55.8%, n=29) whereas males were most commonly killed by another family member (44.4%, n=20)
- Over one third were born overseas (37.2%, n=29), one quarter had a language other than English as their first language (24.4%, n=19) and one fifth spoke a language other than English as their main language (17.9%, n=14)
- Many (41.0%, n=32) had a diagnosed or suspected mental illness within the year prior to the homicide incident
- Approximately two thirds (66.7%, n=52) experienced family violence prior to the homicide incident. Of these:
    - the most common family violence they experienced was emotional or psychological abuse (75.6%, n=31) and physical abuse (63.4%, n=26)
    - over half exhibited fear of the perpetrator prior to the homicide incident (56.1%, n=23), many believed the perpetrator was capable of killing them (41.5%, n=17) and over one third experienced an escalation in the frequency or severity of family violence prior to the homicide incident (39.0%, n=16)

## Of the 19 child family violence related homicide victims

- Almost three quarters were aged five years or under (73.7%, n=14)
- Most were killed by a parent, stepparent or de facto partner of a parent (89.5%, n=17)
- Over one quarter had been subjected to family violence by the homicide offender prior to the homicide incident (26.3%, n=5)

## Of the 85 adult family violence related homicide offenders

- The majority were male (78.8%, n=67)
- Around two thirds (67.1%, n=57) had a diagnosed mental illness in the year preceding the homicide incident
- Around one third (34.9%, n=30) were under the effect of substances at the time of the homicide incident
- Over half (60.0%, n=51) had a history of criminal offending prior to the homicide incident

- Over half had perpetrated family violence against a homicide victim prior to the homicide incident (56.5%, n=48)
    - Of these almost one third had stalked the homicide victim prior to the homicide incident (29.2%, n=14)
- Around one in ten adult homicide offenders (14.1%, n=12) suicided following the homicide incident

Inquests were held in relation to 20 of the family violence related homicide deaths and resulted in 52 recommendations to improve the family violence service system. The majority of these recommendations were made prior to the Royal Commission into Family Violence (RCFV) and were subsequently adopted or addressed by the RCFV recommendations. However, findings made subsequent to the RCFV indicate that there are still improvements to be made to the family violence response system in Victoria.

The CCOV, through the VSRFVD, continues to draw lessons from the tragedies that are family violence related homicides. The CCOV aims to use this knowledge to contribute to the improvement of the family violence service sector, with the aim of preventing family violence related homicides from occurring in the future.

# 1. Introduction

## 1.1 Background and establishment of the VSRFVD

Family violence is recognised as a public health issue, with significant and far reaching personal, social and economic costs. The last few decades have seen a concerted effort from governments and academics to identify the circumstances in which family violence manifests, in attempts to prevent its prevalence and impacts. It was in this context that Family Violence Death Reviews (FVDRs) were established.[1] After first being established in the United States of America in the 1990s, FVDRs have since been instituted in most English-speaking countries.

The VSRFVD was established in 2009 and was the first family violence death review to be founded in Australia. Since that time, many states and territories in Australia have developed a mechanism for reviewing family violence related deaths.

Whilst the establishment and function of FVDRs varies greatly both nationally and internationally, the Domestic Violence Fatality Reviews National Summit held in 1998, identified two central purposes for conducting a FVDR:

- to prevent homicide and suicide
- to increase community awareness in relation to family violence.[2]

In Victoria, the VSRFVD is positioned within the CCOV and operates under the provisions of the *Coroners Act 2008 (Vic)*. The VSRFVD is headed by the State Coroner and consists of a team of specialist family violence staff who hold a variety of roles within the court including a manager, legal officer, project officer, registrar, family liaison officer and case investigators.

The VSRFVD adopts the definitions of 'family violence' and 'family member' as outlined in the FVPA and the *Victorian Indigenous Family Violence Taskforce Report* (2003), and primarily works to assist coroners in the investigation of deaths suspected to have resulted from family violence. In providing this assistance, the VSRFVD aims to:

- examine deaths suspected to have resulted from family violence
- identify risk and contributory factors associated with deaths resulting from family violence
- identify trends and patterns in deaths resulting from family violence
- identify trends and patterns in responses to family violence
- provide coroners with information obtained through the exercise of the above functions.

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[1] Neil Websdale, 'Increasingly, criminal justice professionals and other practitioners are using a tool that may help reduce the many deaths due to intimate partner homicide; It's a fatality review' (1997) 10(4) *Justice Professional* 183-198.

[2] Louis McHardy and Merry Hofford, 'Domestic violence fatality reviews: Recommendations from a national summit' (National Council of Juvenile and Family Court Judges, 1999).

# 2. Method

## 2.1 Data source

The family violence related data examined in this report was retrieved from the Victorian Homicide Register (VHR).

The VHR is a database maintained by the Coroners Prevention Unit (CPU) within the CCOV. The VHR includes over 230 variables which capture information related to the homicide incident, offender(s) and decedent(s).

Information contained within the VHR is populated using a variety of materials available to the CCOV, including coronial files, briefs of evidence, police reports of death, post-mortem reports (including autopsy and forensic toxicology reports), sentencing remarks, transcripts from criminal proceedings, case review reports, agency records and coronial findings.

The VHR record for a homicide incident includes a core dataset of variables and an enhanced dataset.

The core dataset of the VHR encompasses the basic information that is available to the CPU when a death is first reported to the CCOV. This data is drawn from a limited range of source documents and includes basic data in relation to the homicide offender(s) and victim(s) (if known), and the homicide incident itself. This information is coded into the VHR on a preliminary basis when a probable or possible homicide is first referred to the CCOV and is subsequently reviewed once the forensic medical cause of death is established, when any relevant criminal proceedings are completed, and when the coronial proceedings are closed to ensure accuracy and that the death is still consistent with a homicide.

This data is reported on annually in the CCOV Annual Report and made publicly available on the Family Violence Data Portal managed by the Crime Statistics Agency.[3]

The enhanced dataset encompasses a range of variables which include information such as:

- socio-demographic information relating to the homicide offender(s) and deceased(s)
- details of any physical or mental health conditions and treatment undertaken by the homicide offender(s) and deceased(s)
- details of services who had contact with the homicide offender(s) and/or deceased(s), including government and non-government services and legal contacts such as courts
- information relating to the mechanism of death
- information relating to criminal justice outcomes
- family violence risk factors and details of any history of family violence (where applicable).

This information is usually only available in a sufficiently reliable and detailed form after any relevant criminal proceedings are completed, the CCOV has received a coronial brief of evidence, any other medical records, witness statements, and/or other relevant material that the coroner has

[3] <https://www.crimestatistics.vic.gov.au/family-violence-data-portalfamily-violence-data-dashboard/coroners-court>

requested, and the coronial case has been closed. Such information may only become available several years after a death has initially been reported to the CCOV. Consequently, full coding of the enhanced dataset in relation to a death may not be completed for several years after a death occurs. The enhanced data presented in this report is from 2011 to 2015 for this reason.

## 2.2 Data extraction

The data examined in this report was extracted from the VHR on 7 February 2020.

## 2.3 Inclusion criteria

For the purposes of this report, data analysis was restricted to homicide related deaths where:

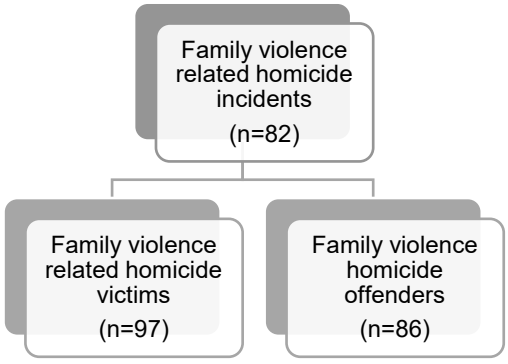
- the death(s) occurred between 1 January 2011 and 31 December 2015
- the Victorian Coroner had jurisdiction to investigate the death(s) under the *Coroners Act 1985* (Vic) or the *Coroners Act 2008* (Vic)
- the death(s) were confirmed as a homicide as determined by criminal proceedings or the coroner's investigative findings
- the coronial investigation was completed by 7 February 2020
- data from the death had been fully coded into the VHR by 7 February 2020.

Between 1 January 2011 and 31 December 2015, there were a total of 289 deaths resulting from homicide which were reported to the CCOV. At the time of data extraction, the coronial investigation had been completed in relation to 257 of these reported deaths. Of these, 97 were identified as family violence related homicide deaths where full coding into the VHR had been completed at the time of data extraction.

## 2.4 Counting units

The data examined for this report is broken into three separate counting units – family violence related homicide incidents, family violence related homicide victims and family violence related homicide offenders. This report examines 97 family violence related homicide deaths, arising from 82 separate incidents which were perpetrated by 86 separate offenders (Figure A).

**Figure A: Family violence related homicides by counting units**



## 2.5 Variables

The variables outlined in Table 1 were extracted for all included family violence related homicides.

**Table 1: Variables extracted**

| Factor | Variable |
|---|---|
| **Deceased Profile** | • Location of homicide incident<br>• Mechanism of death<br>• Nature of relationship between deceased and offender<br>• Sex<br>• Age<br>• Aboriginal and/or Torres Strait Islander identification<br>• Country of birth<br>• First language<br>• Main language<br>• Usual residence at time of death<br>• Employment status at time of death<br>• Mental illness<br>• History of substance abuse<br>• Substance use proximate to death<br>• Proximate service contact with health, justice or other services.<br>• Status of relationship between deceased and offender/s at time of death<br>• Presence of a family violence intervention order |
| **Offender Profile** | • Sex<br>• Age<br>• Aboriginal and/or Torres Strait Islander identification<br>• Country of birth<br>• First language<br>• Main language<br>• Usual residence at time of death<br>• Employment status at time of death<br>• Mental illness<br>• History of substance abuse<br>• Substance use proximate to offending<br>• Prior criminal offending<br>• Stalking of victim prior to homicide incident<br>• Choking of victim prior to homicide incident<br>• Presence of a family violence intervention order |
| **Incident profile** | • Number of resulting deaths from incident |
| **Investigations** | • Coroner's finding |
| **Family violence-specific variables** | • Presence of a history of family violence between the deceased and offender<br>• Role of deceased in historical family violence<br>• Role of offender in historical family violence<br>• Type of family violence experienced<br>• Family violence risk factors |

## 2.6 Limitations

The characteristics and circumstances surrounding homicides are complex and converting this information into a dataset presents significant challenges. As such, any statistics about the nature and/or frequency of homicide must be reported and interpreted with care.

The VHR is a live database containing both open and closed criminal and coronial investigations. The data contained within the VHR is subject to re-classification and may be updated as further information becomes available. The data used in this report was extracted on 7 February 2020 and reflects the information available at that date. It is subject to change.

For the purposes of this report, the CCOV excluded all homicide incidents where the coronial investigation had not yet been finalised and the court did not have access to all available information about the case. This has been done in efforts to ensure that the data presented in this report is the most accurate and comprehensive available. As such the data contained in this report does not include every family violence related homicide that occurred in Victoria during the applicable time period.

It should also be noted that the data presented in this report is likely to differ from other reporting sources (such as the National Homicide Monitoring Program managed by the Australian Institute of Criminology). There are several reasons for this, including: distinctions in definitional terms used for the purpose of case identification, methodological variation regarding case inclusion and exclusion criteria, and differences in the materials used for classification.

In coding information into the VHR, the CCOV relies entirely on secondary sources, such as what other people know about the deceased, and what has been recorded in medical records and other documents. These secondary sources are an inadequate substitute for what people can tell us about who they are, their experiences of violence, and how they identify themselves. Specifically, measures of variables which require the self-identification of information by persons, such as gender, sexuality, cultural identity, Aboriginal and Torres Strait Islander status, and disability may reflect the assessment or knowledge of a person other than the deceased. It is also critical to highlight that the data presented in this report that relates to Aboriginal and Torres Strait Islander communities is small and, as such, caution should be taken with the interpretation of this data. Such data should not be interpreted in isolation and should be used in reference to relevant literature relating to the unique issues faced by members of these communities.

# 3. Results

## 3.1 Family violence related homicide characteristics

### Single and multiple fatality homicides

Around three quarters of the 82 separate family violence related homicide incidents resulted in a single fatality (85.4%, n=70), while 14.6% (n=12) of the incidents resulted in multiple fatalities.

### Location

Family violence related homicide victims were most likely to be killed within a private residence (81.4%, n=79). This includes their own residence (35.1%, n=34), the homicide offender's residence (13.4%, n=13), a shared residence (27.8%, n=27) or other residence (5.2%, n=5). It was less common for a family violence related homicide to take place in a public place (15.5%, n=15), workplace (2.1%, n=2), or other location (1.0%, n=1) (Table 2).

**Table 2: Location of family violence related homicides (by type)**

| Homicide location | Family violence related homicide victims | |
|---|---|---|
| | n | % |
| Deceased's residence | 34 | 35.1 |
| Shared residence | 27 | 27.8 |
| Offender residence | 13 | 13.4 |
| Other residence | 5 | 5.2 |
| Public place | 15 | 15.5 |
| Workplace | 2 | 2.1 |
| Other | 1 | 1.0 |
| **Total** | **97** | **100.0** |

### Mechanism of death

Family violence related homicide victims were most commonly killed using a sharp object (40.2%, n=39). This was the most common mechanism of death for both the 52 female victims (38.5%, n=20) and the 45 male victims (42.2%, n=19). Female victims were more likely to be killed using a blunt object (13.5%, n=7) or threat to breathing (13.5%, n=7) than male victims (6.7%, n=3) (Table 3).

**Table 3: Mechanism of death in family violence related homicides**

| Mechanism of death | Family violence related homicide victims | | | | | |
|---|---|---|---|---|---|---|
| | Female | | Male | | Total | |
| | n | % | n | % | n | % |
| Blunt object | 7 | 13.5 | 3 | 6.7 | 10 | 10.3 |
| Bodily force | 2 | 3.8 | 3 | 6.7 | 5 | 5.2 |
| Firearm | 7 | 13.5 | 7 | 15.6 | 14 | 14.4 |
| Sharp object | 20 | 38.5 | 19 | 42.2 | 39 | 40.2 |
| Threat to breathing | 7 | 13.5 | 3 | 6.7 | 10 | 10.3 |
| Other | 9 | 17.3 | 10 | 22.2 | 19 | 19.6 |
| **Total** | **52** | **100.0** | **45** | **100.0** | **97** | **100.0** |

## Family Violence Intervention Orders

In 15.9% (n=13) of the family violence related homicide incidents, there was an active family violence intervention order (FVIO) in relation to either the homicide offender or homicide victim in place at the time of the fatal incident.

In most of these incidents (53.8%, n=7) the FVIO was in place to protect the homicide victim from the homicide offender. In two incidents (15.4%, n=2), the FVIO was in place to protect the homicide offender from the homicide victim. It is noted, however, that in both of these incidents there was evidence that the homicide victim had also perpetrated family violence against the homicide offender prior to the homicide incident (Table 4).

In three cases (23.1%) a FVIO was in place which identified the homicide offender as the respondent (the person prohibited from perpetrating family violence) which did not identify the homicide victim as an Affected Family Member (AFM).[4] In all of these cases, the listed AFM was a current or former partner of the homicide offender, and the homicide offender killed the AFM's new intimate partner (Table 4).

There was one case (7.7%) where the homicide victim was listed as a Respondent to a FVIO at the time of their death, but this was unrelated to their relationship with the homicide offender (Table 4).

[4] In Victoria, 'Affected Family Member' refers to a person protected by a Family Violence Intervention Order.

**Table 4: Role of homicide offender in family violence intervention order in effect at time of homicide incident**

| Role of homicide offender in FVIO | Family violence related homicide incidents | |
|---|---|---|
| | n | % |
| Respondent, where homicide victim was AFM | 7 | 53.8 |
| Respondent, where homicide victim not included | 3 | 23.1 |
| AFM, where homicide victim was Respondent | 2 | 15.4 |
| Neither Respondent nor AFM | 1 | 7.7 |
| **Total** | **13** | **100.0** |

## 3.2 Adult family violence related homicide victims

### Sex

Out of the total 97 family violence related homicide victims, the majority were adults (aged 18 years or over) at the time of their death (80.4%, n=78).

Of these 55.1% (n=43) were female and 44.9% (n=35) were male. Both male and female adult victims were most commonly killed by another male, with 88.4% (n=38) of female victims, and 74.3% (n=26) of male victims killed by a male (Table 5).

**Table 5: Sex of adult family violence related homicide victims and corresponding offenders**

| Sex of homicide offender | Adult family violence related homicide victims | | | | | |
|---|---|---|---|---|---|---|
| | Female | | Male | | Total | |
| | n | % | n | % | n | % |
| Male | 38 | 88.4 | 26 | 74.3 | 64 | 82.1 |
| Female | 5 | 11.6 | 9 | 25.7 | 14 | 17.9 |
| **Total** | **43** | **100.0** | **35** | **100.0** | **78** | **100.0** |

### Age

The most common age group of adult family violence related homicide victims for both male and female combined was 50-59 years (24.4%, n=19). The highest proportion of female victims were in the 50-59 (30.2%, n=13) age group, whereas the highest proportion of male victims was in the 60 and over (28.6%, n=10) age group (Table 6).

**Table 6: Age of adult family violence related homicide victims**

| Age group | Adult family violence related homicide victims | | | | | |
|---|---|---|---|---|---|---|
| | Female | | Male | | Total | |
| | n | % | n | % | n | % |
| 18-29 | 9 | 20.9 | 4 | 11.4 | 13 | 16.7 |
| 30-39 | 6 | 14.0 | 8 | 22.9 | 14 | 17.9 |
| 40-49 | 9 | 20.9 | 7 | 20.0 | 16 | 20.5 |
| 50-59 | 13 | 30.2 | 6 | 17.1 | 19 | 24.4 |
| 60 and over | 6 | 14.0 | 10 | 28.6 | 16 | 20.5 |
| **Total** | **43** | **100.0** | **35** | **100.0** | **78** | **100.0** |

## Relationship between homicide offender and homicide victim

The most common familial relationship between the family violence related homicide victim and homicide offender, across both male and female victims, was that of a current or former intimate partner (39.2%, n=38) (Table 7).

Adult female victims were most commonly killed by a current or former intimate partner (55.8%, n=29). However, adult male victims were most commonly killed by someone with whom they had an intimate or familial relationship, who was not a current or former intimate partner, parent or child (44.4%, n=20) (Table 7).

In both parent-child and child-parent homicides, the homicide victims were equally male and female (Table 7). When looking at all family violence related homicide victims who were children killed by a parent, including the adult homicide victims in Table 7 and the child homicide victims in Table 21, the majority of homicide victims killed by a parent were under the age of 18 (85.0%, n=17).

**Table 7: Relationship between homicide offender and homicide victim in family violence related homicides**

| Relationship type | Adult family violence related homicide victims | | | | | |
|---|---|---|---|---|---|---|
| | Female | | Male | | Total | |
| | n | % | n | % | n | % |
| Intimate partner | 29 | 67.4 | 9 | 25.7 | 38 | 48.7 |
| Other intimate or familial | 7 | 16.3 | 18 | 51.4 | 25 | 32.1 |
| Parent-child | 1 | 2.3 | 2 | 5.7 | 3 | 3.8 |
| Child-parent | 6 | 14.0 | 6 | 17.1 | 12 | 15.4 |
| **Total** | **43** | **100.0** | **35** | **100.0** | **78** | **100.0** |

## History of family violence prior to the homicide incident

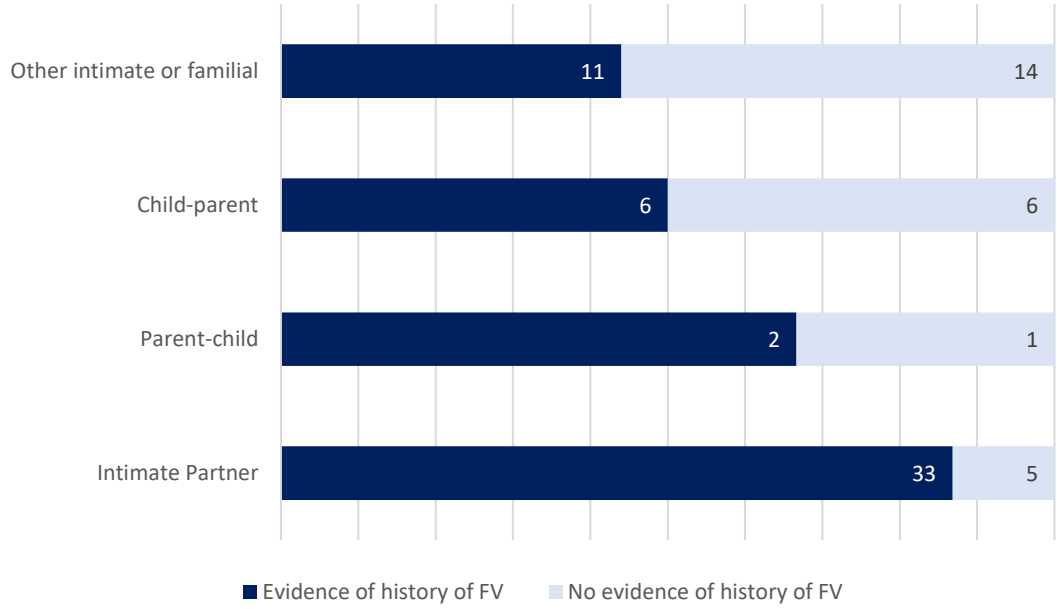
Evidence of a history of family violence between the homicide victim and homicide offender prior to a homicide was noted in relation to 66.7% (n=52) of the adult family violence related homicide deaths. It was more common for evidence of a history of family violence to be present in relation to female victims (74.4%, n=32) when compared to male victims (57.1%, n=20) (Table 8).

In more than eight out of every ten intimate partner homicides there was evidence of a history of family violence (86.8%, n=33). Homicides involving a parent killing an adult child (66.7% of such homicides, n=2), a child killing an adult parent (50.0% of such homicides, n=6) or homicides involving other intimate or familial relationships (44.4% of such homicides, n=11), were less likely to have evidence of a history of family violence prior to the homicide incident (Figure B).

**Table 8: History of family violence prior to adult family violence related homicide (by sex)**

| History of family violence prior to homicide | Adult family violence related homicide victims | | | | | |
|---|---|---|---|---|---|---|
| | Female | | Male | | Total | |
| | n | % | n | % | n | % |
| Yes | 32 | 74.4 | 20 | 57.1 | 52 | 66.7 |
| No | 11 | 25.6 | 15 | 42.9 | 26 | 33.3 |
| **Total** | **43** | **100.0** | **35** | **100.0** | **78** | **100.0** |

**Figure B: History of family violence prior to adult family violence related homicide (by relationship type)**




## Perpetration of historical family violence

Of the above 52 adult family violence related homicide deaths, where there was evidence of family violence occurring prior to the homicide incident between the homicide offender and homicide victim, it was most common for homicide victims to be identified as the primary victim of family violence prior to the homicide incident (63.5%, n=33) (Table 9).

Female victims were most likely to be identified as the primary victim of family violence prior to the homicide incident (84.4%, n=27). A smaller proportion of male victims were identified as the primary victim of family violence prior to the homicide incident (30.0%, n=6). It was more common for male victims to be identified as the primary perpetrator of family violence prior to the homicide incident (40.0%, n=8) when compared to female homicide victims who were identified as primary perpetrators of family violence (5.0%, n=1) (Table 9).

**Table 9: Role of the adult homicide victim in family violence prior to the homicide incident**

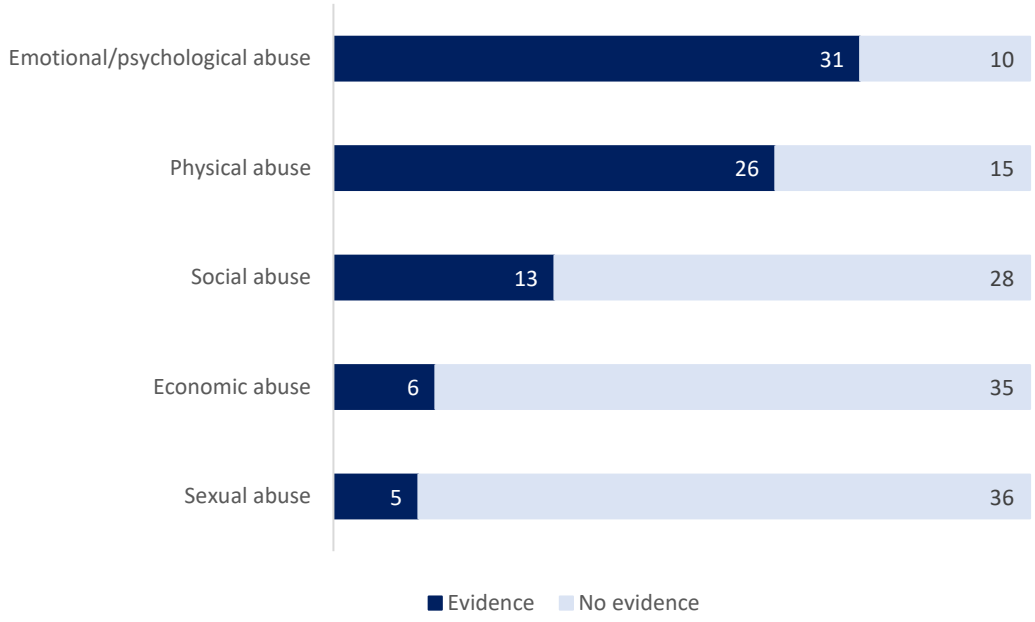
| Role of the homicide victim in historical family violence | Adult family violence related homicide victims with history of family violence | | | | | |
|---|---|---|---|---|---|---|
| | Female | | Male | | Total | |
| | n | % | n | % | n | % |
| Primary victim | 27 | 84.4 | 6 | 30.0 | 33 | 63.5 |
| Primary perpetrator | 2 | 6.3 | 8 | 40.0 | 10 | 19.2 |
| Victim and perpetrator | 3 | 9.4 | 5 | 25.0 | 8 | 15.4 |
| Neither victim nor perpetrator | 0 | 0.0 | 1 | 5.0 | 1 | 1.9 |
| **Total** | **32** | **100.0** | **20** | **100.0** | **52** | **100** |

## Type of family violence experienced

Over three quarters of the adult family violence related homicide victims (combined male and female) (78.9%, n=41) were identified as being victims of family violence at the hands of the family violence related homicide offender prior to the homicide incident. This number includes homicide victims who were identified as being both a victim and perpetrator of family violence prior to the homicide incident (Table 9).

Of the 41 homicide victims who experienced family violence prior to the homicide, the type of abuse they experienced was most commonly emotional or psychological abuse with 75.6% (n=31) of these victims experiencing this type of abuse. Physical abuse was experienced by 63.4% (n=26) of these victims, social abuse by 31.7% (n=13), economic abuse by 14.6% (n=6) and sexual abuse by 12.2% (n=5) (Figure C).

**Figure C: Types of family violence experienced by adult family violence victims**



## Recent or pending separation

There was a total of 38 adult family violence related homicide victims who were current or former intimate partners of the homicide offender. Of these victims, at the time of the homicide incident, 42.1% (n=16) were in a relationship with the homicide offender with no evidence that either of them was intending to separate. A similar number of victims had separated from the homicide offender, with nearly a quarter (23.7%, n=9) having separated within the three months immediately prior to the homicide incident. Six (15.8%) victims were intending to separate or separation was pending at the time of the incident (Table 10).

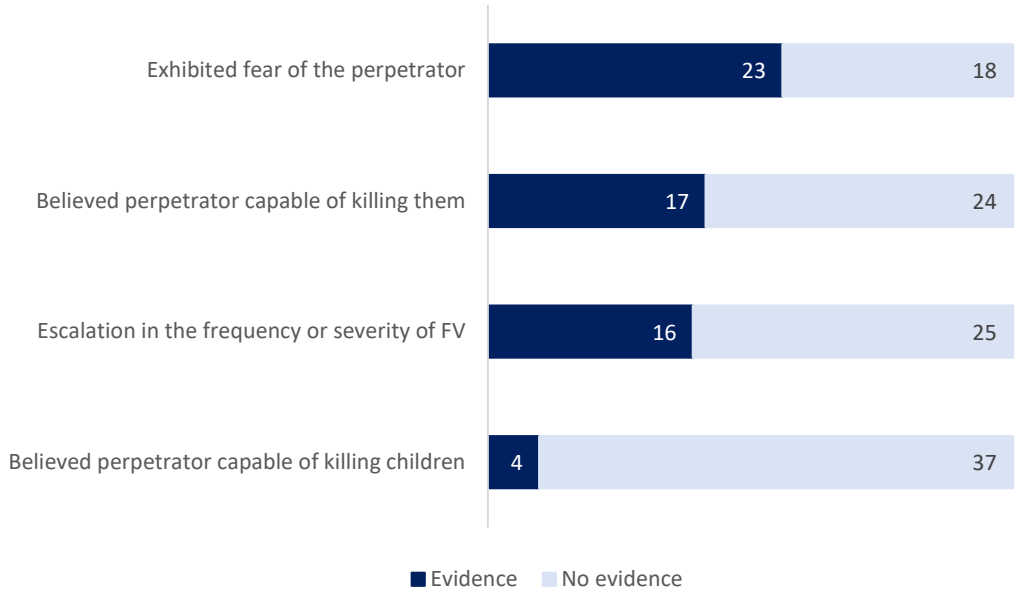
**Table 10: Recent or pending separation in adult family violence related intimate partner homicides**

| Relationship status | Adult family violence related intimate partner homicide victims | |
|---|---|---|
| | n | % |
| Not separated and no pending separation | 16 | 42.1 |
| Separated | 7 | 18.4 |
| Recent separation (<3 months) | 9 | 23.7 |
| Intention to separate or separation pending | 6 | 15.8 |
| **Total** | **38** | **100.0** |

## Other risk factors

There was evidence that over half of the 41 adult family violence victims exhibited fear of the perpetrator (56.1%, n=23), and many expressed a belief that the perpetrator was capable of killing them (41.5%, n=17) or experienced an escalation in the frequency or severity of family violence (39.0%, n=16) prior to the homicide incident (Figure D).

**Figure D: Other risk factors present for adult family violence victims**



## Aboriginal and/or Torres Strait Islander identification

The Aboriginal and/or Torres Strait Islander identification of a family violence related homicide victim is only coded into the VHR if adequate information from secondary sources is available to support this conclusion. As Aboriginal and/or Torres Strait Islander status is often self-identified, the coding in relation these communities may not be representative of the actual number of family violence related homicide victims who are of Aboriginal and/or Torres Strait Islander descent. This should be considered in any interpretation of the following data.

Most of the adult family violence related homicide victims were of neither Aboriginal nor Torres Strait Islander descent (85.9%, n=67). Four (5.1%) of the victims were of Aboriginal and/or Torres Strait Islander descent. Evidence as to whether the victim was of Aboriginal and/or Torres Strait Islander descent was unavailable in relation to seven of the victims (9.0%) (Table 11).

**Table 11: Aboriginal and/or Torres Strait Islander status of adult family violence related homicide victims**

| Aboriginal and/or Torres Strait Islander status | Adult family violence related homicide victims | |
|---|---|---|
| | n | % |
| Aboriginal and/or Torres Strait Islander | 4 | 5.1 |
| Neither | 67 | 85.9 |
| Unknown | 7 | 9.0 |
| **Total** | **78** | **100.0** |

## Cultural and linguistic diversity

Over one third of adult family violence related homicide victims were known to be born overseas (37.2%, n=29) (Table 12). One quarter were known to have a language other than English as their first language (24.4%, n=19) (Table 13), and one fifth were known to speak a language other than English as their main language (17.9%, n=14) (Table 14).

**Table 12: Adult family violence related homicide victims born overseas**

| Born overseas | Adult family violence related homicide victims | |
|---|---|---|
| | n | % |
| Yes | 29 | 37.2 |
| No | 46 | 59.0 |
| Unknown | 3 | 3.8 |
| **Total** | **78** | **100.0** |

**Table 13: Adult family violence related homicide victims first language**

| First language | Adult family violence related homicide victims | |
|---|---|---|
| | n | % |
| English | 45 | 57.7 |
| Language other than English | 19 | 24.4 |
| Unknown | 14 | 17.9 |
| **Total** | **78** | **100.0** |

**Table 14: Adult family violence related homicide victims main language spoken**

| Main language spoken | Adult family violence related homicide victims | |
|---|---|---|
| | n | % |
| English | 53 | 67.9 |
| Language other than English | 14 | 17.9 |
| Unknown | 11 | 14.1 |
| **Total** | **78** | **100.0** |

## Housing

Almost three quarters (74.4%, n=58) of adult family violence related homicide victims ordinarily resided in homes which they either owned or rented. This includes the 3.1% (n=3) of victims who were residing in public housing. A further 6.4% (n=5) of victims usually resided in other accommodation, which includes public places, temporary shelters, boarding houses, private hotels or other accommodation, and includes victims who were homeless. The usual residence of 19.2% (n=15) of the family violence related homicide victims was unknown (Table 15).

**Table 15: Usual residence of adult family violence related homicide victims**

| Usual residence | Adult family violence related homicide victims | |
|---|---|---|
| | n | % |
| Private residence (owned/private rental) | 55 | 70.5 |
| Private residence (public rental) | 3 | 3.8 |
| Other | 5 | 6.4 |
| Unknown | 15 | 19.2 |
| **Total** | **78** | **100.0** |

## Employment status

Many of the adult family violence related homicide victims were employed (43.6%, n=34) at the time of their death. A further 44.9% (n=35) were unemployed, on home duties, retired or unable to work (36.1%, n=35) at the time of the fatal incident (Table 16).

**Table 16: Employment status of adult family violence related homicide victims**

| Employment status | Adult family violence related homicide victims | |
|---|---|---|
| | n | % |
| Employed | 34 | 43.6 |
| Unemployed | 16 | 20.5 |
| Retired/pensioner | 8 | 10.3 |
| Student | 3 | 3.8 |
| Unable to work | 7 | 9.0 |
| Home duties | 4 | 5.1 |
| Unknown | 6 | 7.7 |
| **Total** | **78** | **100.0** |

## Mental illness

The presence of mental illness is coded into the VHR for a person if there is evidence that they had a diagnosed or suspected mental illness in the 12 months preceding the homicide incident. A diagnosed or suspected mental illness was identified in 41.0% of the adult family violence related homicide victims (n=32) (Table 17).

**Table 17: Presence of mental illness in adult family violence related homicide victims**

| Mental illness | Adult family violence related homicide victims | |
|---|---|---|
| | n | % |
| Diagnosed | 14 | 17.9 |
| Suspected | 18 | 23.1 |
| Neither | 46 | 59.0 |
| **Total** | **78** | **100.0** |

## History of substance abuse

For the purposes of coding into the VHR, a history of substance abuse is coded where there is evidence that a person had a serious problem with abuse of alcohol, illicit drugs, prescription drugs and/or inhalants. Of the 78 adult family violence related homicide victims, there was evidence that over a third (39.7%, n=31) had a history of substance abuse (Table 18).

**Table 18: History of substance abuse in adult family violence related homicide victims**

| History of substance abuse | Adult family violence related homicide victims | |
|---|---|---|
| | n | % |
| Yes | 31 | 39.7 |
| No | 33 | 42.3 |
| Unknown/no evidence | 14 | 17.9 |
| **Total** | **78** | **100.0** |

## Substance use by the homicide victim proximate to the homicide incident

There was evidence that nearly two thirds of the family violence related homicide victims (64.1%, n=50) had evidence of being affected by substances at the time of their death. The remaining 28 victims (35.9%) had no evidence of substance use at the time of the homicide incident. For the purposes of this variable, substances include alcohol, illicit drugs, prescription drugs and/or inhalants.

## 3.3 Child family violence related homicide victims

### Sex

Out of the total 97 family violence related homicide victims, around one fifth were children (aged 17 years or under) at the time of their death (19.6%, n=19). These deaths arose from 13 separate homicide incidents perpetrated by 13 homicide offenders.

### Age

Approximately three quarters of family violence related child homicide victims were aged between 0 and 5 years old (73.7%, n=14) (Table 19).

**Table 19: Age of family violence related child homicide victims**

| Age group | Family violence related child homicide victims | |
|---|---|---|
| | n | % |
| 0-2 | 5 | 26.3 |
| 2-5 | 9 | 47.4 |
| 5-9 | 1 | 5.3 |
| 10-17 | 4 | 21.1 |
| **Total** | **19** | **100.0** |

### History of family violence prior to homicide

There was evidence of a history of family violence perpetrated by the homicide offender prior to the homicide incident in relation to 36.8% (n=7) of these deaths (Table 20). The family violence was directly perpetrated against five of the child victims. In the remaining two deaths, the child was a family violence bystander.

**Table 20: History of family violence prior to family violence related child homicides**

| History of family violence prior to homicide | Family violence related child homicide victims | |
|---|---|---|
| | n | % |
| Yes – direct | 5 | 26.3 |
| Yes – indirect/bystander | 2 | 10.5 |
| No | 12 | 63.2 |
| **Total** | **19** | **100.0** |

## Relationship between homicide offender and homicide victim

Family violence related child homicide victims were most commonly killed by a parent (89.5%, n=17) (Table 21). Of the 17 child family violence related homicide victims killed by a parent, 10 (58.8%) were killed by a mother and 7 (41.2%) by a father or step-father.

Of the 13 family violence related homicide incidents, seven were perpetrated by females and six were perpetrated by males.

**Table 21: Relationship between homicide offender and homicide victim in family violence related child homicides**

| Relationship type | Family violence related child homicide victims | |
|---|---|---|
| | n | % |
| Parent-child | 17 | 89.5 |
| Other intimate or familial | 2 | 10.5 |
| **Total** | **19** | **100.0** |

## Aboriginal and/or Torres Strait Islander identification

The Aboriginal and/or Torres Strait Islander identification of a person is only coded into the VHR if adequate information from secondary sources is available to support this conclusion. As Aboriginal and/or Torres Strait Islander status is often self-identified, the coding in relation these communities may not be representative of the actual number of family violence related child homicide victims who are of Aboriginal and/or Torres Strait Islander descent. This should be considered in any interpretation of the following data.

None of the family violence related child homicide victims were identified as Aboriginal or Torres Strait Islander.

## Cultural and linguistic diversity

Only one family violence related child homicide victim was identified as having been born overseas (5.3%) (Table 22). Information about first and main languages of these victims was unknown in approximately half of cases, and where this information was known the main and first language were identified as English in all cases (Table 23, Table 24).

**Table 22: Family violence related child homicide victims born overseas**

| Born overseas | Family violence related child homicide victims | |
|---|---|---|
| | n | % |
| Yes | 1 | 5.3 |
| No | 18 | 94.7 |
| **Total** | **19** | **100.0** |

**Table 23: Family violence related child homicide victims first language**

| First language | Family violence related child homicide victims | |
|---|---|---|
| | n | % |
| English | 9 | 47.4 |
| Unknown | 10 | 52.6 |
| **Total** | **19** | **100.0** |

**Table 24: Family violence related child homicide victims main language spoken**

| Main language spoken | Family violence related child homicide victims | |
|---|---|---|
| | n | % |
| English | 10 | 52.6 |
| Unknown | 9 | 47.4 |
| **Total** | **19** | **100.0** |

## 3.4 Adult family violence related homicide offenders

### Sex

The adult family violence related homicide offenders were most commonly male. Out of the 85 adult homicide offenders, just over three quarters 78.8% (n=67) were male and 21.2% (n=18) were female.

### Age

The highest proportion of adult family violence related homicide offenders were aged between 30 and 49 years old (57.6%, n=49). Both male and female homicide offenders most commonly fell within this age group. The next most common age group for male homicide offenders was 50 to 59 years old (22.4%, n=15) whereas for female homicide offenders it was the 18 to 29 years old cohort (21.2%, n=4). There were significantly fewer female homicide offenders over the age of 50 compared to male offenders in this age group (Table 25).

**Table 25: Age of adult family violence related homicide offenders**

| Age group | Adult family violence related homicide offenders | | | | | |
|---|---|---|---|---|---|---|
| | Female | | Male | | Total | |
| | n | % | n | % | n | % |
| 18-29 | 4 | 22.2 | 11 | 16.4 | 15 | 17.6 |
| 30-39 | 6 | 33.3 | 20 | 29.9 | 26 | 30.6 |
| 40-49 | 7 | 38.9 | 16 | 23.9 | 23 | 27.1 |
| 50-59 | 0 | 0.0 | 15 | 22.4 | 15 | 17.6 |
| 60 and over | 1 | 5.6 | 5 | 7.5 | 6 | 7.1 |
| **Total** | **18** | **100.0** | **67** | **100.0** | **85** | **100.0** |

### Aboriginal and Torres Strait Islander identification

The Aboriginal and/or Torres Strait Islander identification of a person is only coded into the VHR if adequate information from secondary sources is available to support this conclusion. As Aboriginal and/or Torres Strait Islander status is often self-identified, the coding in relation these communities may not be representative of the actual number of family violence related homicide offenders who are of Aboriginal and/or Torres Strait Islander descent. This should be considered in any interpretation of the following data.

There were six (7.1%) adult family violence related homicide offenders who were known to be of Aboriginal or Torres Strait Islander descent. Most adult family violence related homicide offenders were of neither Aboriginal nor Torres Strait Islander descent (88.2%, n=75) (Table 26).

**Table 26: Aboriginal and/or Torres Strait Islander status of family violence related homicide offenders**

| Aboriginal and/or Torres Strait Islander status | Adult family violence related homicide offenders | |
|---|---|---|
| | n | % |
| Aboriginal and/or Torres Strait Islander | 6 | 7.1 |
| Neither | 75 | 88.2 |
| Unknown | 4 | 4.7 |
| **Total** | **85** | **100.0** |

## Cultural and linguistic diversity

Over one third of adult family violence related homicide offenders were known to be born overseas (38.8%, n=33) (Table 27), approximately one quarter (23.5%, n=20) were known to have a language other than English as their first language (Table 28), and 15.5% (n=13) were known to speak a language other than English as their main language (Table 29).

**Table 27: Adult family violence related homicide offenders born overseas**

| Born overseas | Adult family violence related homicide offenders | |
|---|---|---|
| | n | % |
| Yes | 33 | 38.8 |
| No | 46 | 54.1 |
| Unknown | 6 | 7.1 |
| **Total** | **85** | **100.0** |

**Table 28: Adult family violence related homicide offenders first language**

| First language | Adult family violence related homicide offenders | |
|---|---|---|
| | n | % |
| English | 41 | 48.2 |
| Language other than English | 20 | 23.5 |
| Unknown | 24 | 28.2 |
| **Total** | **85** | **100.0** |

**Table 29: Adult family violence related homicide offenders main language spoken**

| Main language spoken | Adult family violence related homicide offenders | |
|---|---|---|
| | n | % |
| English | 55 | 64.7 |
| Language other than English | 13 | 15.3 |
| Unknown | 17 | 20.0 |
| **Total** | **85** | **100.0** |

## Housing

Most of the adult family violence related homicide offenders ordinarily were known to reside in homes which they owned or rented at the time the homicide incident occurred (72.9%, n=62). This includes 10.6% (n=9) of the offenders who resided in public housing. The remaining 4.7% (n=4) of homicide offenders were known to usually reside in other accommodation, which includes public places, temporary shelters, boarding houses, private hotels or other accommodation, and includes homicide offenders who were homeless. The usual residence of 22.4% (n=19) of the offenders was unknown (Table 30).

**Table 30: Usual residence of adult family violence related homicide offenders**

| Usual residence | Adult family violence related homicide offenders | |
|---|---|---|
| | **n** | **%** |
| Private residence (owned/private rental) | 53 | 62.4 |
| Private residence (public rental) | 9 | 10.6 |
| Other | 4 | 4.7 |
| Unknown | 19 | 22.4 |
| **Total** | **85** | **100.0** |

## Employment

Just over half of the adult family violence related homicide offenders (52.9%, n=45) were known to be unemployed, on home duties, retired or unable to work at the time of the fatal incident. The remaining offenders were either employed (42.4%, n=36) or students (1.2%, n=1) or unknown (3.5%, n=3) (Table 31).

**Table 31: Employment status of adult family violence related homicide offenders**

| Employment status | Adult family violence related homicide offenders | |
|---|---|---|
| | n | % |
| Employed | 36 | 42.4 |
| Unemployed | 24 | 28.2 |
| Retired/pensioner | 5 | 5.9 |
| Student | 1 | 1.2 |
| Unable to work | 14 | 16.5 |
| Home duties | 2 | 2.4 |
| Unknown | 3 | 3.5 |
| **Total** | **85** | **100.0** |

## Mental illness

The presence of mental illness is coded into the VHR for a person if there is evidence that they had a diagnosed or suspected mental illness in the 12 months preceding the homicide incident.

Just over two thirds of the adult family violence related homicide offenders (67.1%, n=57) were known to have a diagnosed mental illness in the year preceding the homicide incident. A further 16.5% (n=14) of the offenders were known to have a suspected mental illness. There was no evidence of a diagnosed or suspected mental illness for 16.5% (n=14) of the offenders (Table 32).

**Table 32: Presence of mental illness in adult family violence related homicide offenders**

| Mental illness | Adult family violence related homicide offenders | |
|---|---|---|
| | n | % |
| Diagnosed | 57 | 67.1 |
| Suspected | 14 | 16.5 |
| Neither | 14 | 16.5 |
| **Total** | **85** | **100.0** |

## History of substance abuse

For the purposes of coding into the VHR, a history of substance abuse is coded where there is evidence that a person had a serious problem with abuse of alcohol, illicit drugs, prescription drugs and/or inhalants.

Just under a quarter of the adult family violence related homicide offenders (22.4%, n=19) had a known history of substance abuse (Table 33).

**Table 33: History of substance abuse in adult family violence related homicide offenders**

| History of substance abuse | Adult family violence related homicide offenders | |
|---|---|---|
| | n | % |
| Yes | 19 | 22.4 |
| No | 46 | 54.1 |
| Unknown | 20 | 23.5 |
| **Total** | **85** | **100.0** |

## Substance use by the homicide offender during the homicide incident

There was evidence that just over one third of family violence related homicide offenders (35.3%, n=30) had used substances at the time of the fatal incident. The remaining 55 offenders (64.7%) had no evidence of substance use at the time of the fatal incident. For the purposes of this variable, substances include alcohol, illicit drugs, prescription drugs and/or inhalants.

## Prior criminal offending

Over half of the adult family violence related homicide offenders (60.0%, n=51) had a known history of criminal offending prior to the homicide incident. Such prior offending includes any offences leading to criminal charges and is not isolated to family violence related offences (Table 34).

**Table 34: Prior criminal offending by adult family violence related homicide offenders**

| History of criminal offending prior to homicide incident | Adult family violence related homicide offenders | |
|---|---|---|
| | n | % |
| Yes | 51 | 60.0 |
| No | 29 | 34.1 |
| Unknown | 5 | 5.9 |
| **Total** | **85** | **100.0** |

## Stalking and attempted strangulation

Of the 85 adult family violence related homicide offenders, over half (56.5%, n= 48) perpetrated family violence against a homicide victim prior to the homicide incident. Almost one third of this cohort (29.2%, n=14) engaged in stalking of the homicide victim prior to the homicide incident (Table 35). Six (12.5%) of this cohort had attempted to strangle a homicide victim on at least one other occasion prior to the homicide incident (Table 36).

**Table 35: Presence of stalking prior to adult family violence related homicides**

| Stalking of homicide victim prior to homicide incident | Adult family violence related homicide offenders who perpetrated FV prior to the homicide incident | |
|---|---|---|
| | n | % |
| Yes | 14 | 29.2 |
| No | 34 | 70.8 |
| **Total** | **48** | **100.0** |

**Table 36: Attempted strangulation prior to adult family violence related homicides**

| Attempted strangulation of homicide victim prior to homicide incident | Adult family violence related homicide offenders who perpetrated FV prior to the homicide incident | |
|---|---|---|
| | n | % |
| Yes | 6 | 12.5 |
| No | 42 | 87.5 |
| **Total** | **48** | **100.0** |

### Subsequent suicide of the adult homicide offender

Of the 85 family violence related homicide offenders, 14.1% (n=12) suicided during or after the homicide incident.

## 3.5 Child family violence related homicide offenders

Only one family violence related homicide offender was under the age of 18 at the time of the homicide incident. For privacy and confidentiality reasons, specific data in relation to that offender has not been examined in further detail in this report.

## 3.6 Coronial findings and recommendations

### Closure method

Inquests were held in relation to around one fifth (20.6%, n=20) of the 97 family violence related homicide deaths examined in this report (Table 37).

Of the remaining investigations, 45.4% (n=44) were closed via a determination that an inquest would not be held or discontinued (Table 37). A coroner may decide to close a matter in this way if the circumstances of the death have been substantially investigated in another jurisdiction and to investigate the matter further would duplicate this process.

Approximately one third of the deaths investigated (34.0%, n=33) resulted in a finding into the death without inquest (Table 37). In these circumstances, the investigating coroner closed the matter with no inquest but may have conducted further investigations without an inquest and provided circumstances relating to the death in the finding. Recommendations may also be made in these cases.

**Table 37: Closure method of family violence related homicide death coronial investigations**

| Closure method | Family violence related homicide deaths | |
|---|---|---|
| | n | % |
| Finding into death following inquest (Form 37) | 20 | 20.6 |
| Finding into death without inquest (Form 38) | 33 | 34.0 |
| Determination that an inquest will not be held or will be discontinued (Form 41) | 44 | 45.4 |
| **Total** | **97** | **100.0** |

### Coronial recommendations

Coronial recommendations were made in relation to 11 of the family violence related homicide deaths, amounting to 51 coronial recommendations in total. These cases and recommendations are summarized in Appendix A.

Coronial recommendations were most commonly directed to the Victorian Government (26.4%, n=14), followed by Victoria Police (20.8%, n=11) and the Department of Health and Human Services (18.9%, n=10) (Table 38).

The VSRFVD conducted a review of the intersection between family violence related coronial recommendations and the recommendations of the Royal Commission into Family Violence (RCFV). This review identified that most of the recommendations made in relation to family violence related homicide deaths prior to 2016 were subsequently adopted or addressed by the RCFV recommendations and have been, or are being, implemented through that process.

These include recommendations for improvements to family violence training, for both family violence and non-family violence specific services, improved processes and procedures for dealing with family violence, better risk assessment and management of family violence risk, and improved information sharing between services.

Findings made subsequent to the RCFV, however, indicate that there are still improvements to be made to the family violence response system in Victoria. Recommendations made in these cases have been directed towards ensuring ongoing review and improvement of the response to family violence by Victoria Police, resourcing of family violence support services by the Victorian Government and improvements to mental health service responses to family violence.

**Table 38: Agencies and services recommendations directed to in family violence related homicide deaths**

| Recommendation directed to | Coronial recommendations | |
|---|---|---|
| | n | % |
| State of Victoria | 14 | 26.4 |
| Victoria Police | 11 | 20.8 |
| Department of Health and Human Services | 10 | 18.9 |
| Courts | 7 | 13.2 |
| Other | 6 | 11.3 |
| Non-government services | 5 | 9.4 |
| **Total** | **53**[5] | **100.0** |

[5] This number is higher than the total number of recommendations due to some recommendations being directed towards more than one service.

# 4. Conclusion

The impacts of family violence are widespread and multidimensional. Deaths attributed to family violence represent the extreme end of the consequences that family violence can have. This report examines the circumstances and characteristics of family violence homicides, the individuals who commit these offences and those who lost their lives to family violence.

As highlighted in this report, and consistent with national data, family violence homicides were most commonly perpetrated by men, and women in Victoria were most likely to be killed by their current or former male intimate partner.

There was a history of family violence prior to many of the examined homicide incidents, which indicates that there are opportunities to identify and assess risk to prevent family violence related homicides in the future.

Whilst significant work has been undertaken to improve the service response to family violence in Victoria, there is still significant work to be undertaken to reduce the prevalence and effects of family violence in our society.

The CCOV hopes that the publication of this report will strengthen understandings of the dynamics and risks of family violence and inform work being undertaken to reduce the occurrence of family violence within our community.

# Appendix A

## Coronial recommendations in family violence related deaths

| **Coroners court reference numbers** | **20110098; 20110099; 20110100** |
|---|---|
| **Coroner** | State Coroner Judge Ian Gray |
| **Date of finding** | 06/03/2014 |

**Summary of circumstances**

Parent-child homicide of three children by their biological mother, who then suicided, during a prolonged psychotic episode. The offender had a history of mental illness and diagnosed schizophrenia, with a history of involuntary admissions into mental health facilities. There was service contact with the then Department of Human Services – child protection, community mental health services and health services (general practice).

**Recommendation**

1. To improve the access to programs specific to improving mental health literacy for children, teenagers and young adults of parents with a mental illness, the Department of Health, Mental Health, Drugs and Regions review the scope of the FaPMI strategy roll out across all public mental health services and regions in Victoria, including:

    a. access by public mental health service families to peer support programs such as CHAMPS and PATS, regardless of where they live in Victoria
    b. access by families from other services that come into contact with families where a parent has a mental illness or significant mental health issue such as alcohol and drug services, family support services, child and youth services, community health, Child Protection, and schools.

**Responses**

North Western Mental Health (NWMH)

NWMH noted their support for the recommendation and advised that they would welcome the Department of Health extending the *Families of Parents with a Mental Illness* (FaPMI) strategy more broadly across Victoria.

Department of Health

The Department advised that:

a. they had developed policies and resources such as the FaPMI Strategy and the *Families and mental health – A parenting resource kit* to better support families and the services that work with them

b. they would provide ongoing funds for regional FaPMI coordinator positions in mental health services to implement the strategy and build capacity for family inclusive practice in mental health services and partner agencies and sectors.

The Department of Health also noted their provision of ongoing funds to the Bouverie Centre to deliver training in family inclusive practice to build capacity in the mental health workforce to support practice change and to embed family focused practice within organisations.

| Coroners court reference number | 2011 3947 |
|---|---|
| **Coroner** | State Coroner Judge Sara Hinchey |
| **Date of finding** | 31/07/2018 |

**Summary of circumstances**

Intimate partner homicide of an adult female by her male former partner. There was a history of family violence perpetrated against the deceased by the offender. This included physical, sexual, emotional and psychological abuse. Victoria Police had been involved in relation to the historical family violence. There was an active Family Violence Intervention Order in place to protect the deceased from the offender at the time of the homicide.

**Recommendations**

1. That Victoria Police conduct systemic reviews of family violence-related deaths where there was a known history of family violence between the deceased person and the perpetrator of family violence.

2. That the Victorian Government annually review the adequacy of resources and funding provided to family violence support services to ensure that the demand for services in Victoria is met.

**Responses**

Victoria Police

Victoria Police advised that they would implement the first recommendation and that they were committed to establishing a review process referred to as *Family Violence-related Death Assessment (FDA).* It was noted that this review would identify whether there were systemic compliance, process or legislative issues relevant to the police response to family violence incidents that occurred prior to a family violence homicide.

Victorian Government

The Victorian Premier advised that the Victorian Government was working to end family violence. They had established Australia's first Royal Commission into Family Violence (RCFV) and were committed to implementing each of the RCFV's 227 recommendations. Recommendation 223 of the RCFV recommended that the Victorian government develop a demand-modelling tool or set of indicators to be used for planning how government as a whole and relevant departments and agencies themselves (including those providing or funding universal services) respond to family violence.

The Victorian Government had developed a Family Violence Demand model, which would allow for demand modelling to occur for support services including the new Orange Door services and provide a better understanding of demand across family violence services.

| Coroners court reference number | 2012 0131 |
|---|---|
| **Coroner** | State Coroner Judge Ian Gray |
| **Date of finding** | 27/11/2015 |

**Summary of circumstances**

Intimate partner homicide of an adult female by her male husband. There was a long history of family violence perpetrated against the deceased by the offender. This included physical abuse. The deceased and offender were from culturally and linguistically diverse backgrounds. Prior to the fatal incident the deceased had engaged with Victoria Police, courts and CityLife Community Care in relation to her experience of family violence.

**Recommendations**

That CityLife Community Care:

1. Ensure that the organisation's couple's counselling intake form prompts screening questions to be asked which give effect to the requirement of the organisation's Intake Procedure to "establish a risk or history of family violence", and further ensure that potential participants have the opportunity to provide that information in a safe and confidential environment.

2. Ensure that the organisation has clear and established referral policies and pathways to allow referral to culturally appropriate men's behaviour change, or similar programs.

3. Ensure that the organisation has clear and established referral pathways which allow for disclosures or identified risks of family violence to be referred to appropriately qualified agencies.

4. Develop and publish a clear policy on whether or not couple's counselling can be provided where there is a history or risk of family violence, and to the extent that the organisation determines that couple's counselling may proceed in those circumstances, the additional safeguards and safety planning that are required.

5. Ensure that the organisation's counsellors understand that, irrespective of the screening processes employed at intake and the characterisation of the presenting issue, family violence screening and risk assessment is their ongoing responsibility, and further ensure that their counsellors have the professional training and tools to be able to competently and consistently undertake this task and respond appropriately to any disclosures.

**Response**

<u>City Life Community Care</u>

City Life Community Care advised the coroner that they had hired an external consultant to work with them in reviewing and implementing changes to their structure, general policies and intake processes and procedures. They also noted that they would be providing further training for staff and volunteer workers in relation to family violence.

| Coroners court reference number | 2012 1474 |
|---|---|
| **Coroner** | State Coroner Judge Ian Gray |
| **Date of finding** | 16/03/2016 |

**Summary of circumstances**

Parent-child homicide of an infant by their biological mother, who was suffering from post-natal depression. The offender and deceased had attended a Maternal and Child Health service, a general practitioner and hospital appointments proximate to the homicide incident.

**Recommendation**

1. That relevant government departments (including the Department of Education and Training and the Department of Health and Human Services), in collaboration with the Municipal Association of Victoria and other stakeholders involved in delivering Maternal and Child Health services, examine the feasibility of the creation of a shared data base, being in effect a single health record, of the monitoring and treatment of infants and children passing through the Maternal and Child Health system in Victoria. The purpose of the database would be to enable those monitoring and treating the infant/child to inform themselves, in real time, of progress and/or changes in the health or development of that infant/child by accessing the full medical record to that point in time.

**Response**

<u>The Department of Education and Training, and the Department of Health and Human Services</u>

The Department of Education and Training (DET) and the Department of Health and Human Services (DHHS) provided a joint response to the coroner. They advised that they were working together to implement the coroner's recommendation and were exploring policy and legislative enhancements to create opportunities for service providers to accurately and reliably access, reference and share information about the welfare of a child.

It was advised that this work would be undertaken in combination with related recommendations made in the final report of the Royal Commission into Family Violence. In their response, the Departments also listed several other government initiatives relating to improved information sharing that were relevant to the implementation of the coroner's recommendation.

| Coroners court reference number | 2012 3465 |
|---|---|
| **Coroner** | State Coroner Judge Sara Hinchey |
| **Date of finding** | 5/04/2017 |

**Summary of circumstances**

Intimate partner homicide of an adult female by her male ex-partner. The offender had a history of substance abuse and mental illness. The offender had contact with health services and mental health services, including Orygen Youth Health (OYH).

**Recommendations**

1. That the State of Victoria through the Department of Health and Human Services give consideration to the removal of the requirement that a *"serious risk of harm"* be also one which is *"imminent",* this by amendment to the *Health Records Act 2001* (Vic), HPP 2.2 (h).

2. That the existing Code of Ethics and relevant Guidelines, together with the current training protocols provided to psychologists in this State, be reviewed by the Psychology Board of Australia in collaboration with the Australian Psychological Accreditation Council with a view to providing greater clarity as to:

    a. the need to enter into clearly understood arrangements with patients, which arrangements define the importance of patient confidentiality while setting out the circumstances in which confidentiality may be breached under HPP 2.2(h)
    b. when it should be reasonably concluded that the psychologist's obligation to disclose confidential Health record information under HPP 2.2(h) arises
    c. whom notification under b) above should be made and with what if any recommendation offered, this with a view to best manage the threatened behaviour under consideration;
    d. the need or other for a psychologist to seek to obtain collateral or third party information concerning the progress being made by a patient suffering from mental illness, when undertaking a risk analysis in respect of that patient
    e. That the Australian Psychological Society develop a separate online eLearning course specific to risk of harm to include assessment and management similar to the existing suicide prevention professional development training, but focussed on prevention of harm to others.

**Responses**

Department of Health and Human services (DHHS)

DHHS advised that the coroner's recommendation had been implemented. The *Family Violence Protection Amendment (Information Sharing) Act 2017* (the Amended Act) was introduced in the Victorian Parliament by the Attorney-General in the context of addressing family violence, but section 19 makes the specific amendments to the *Health Records Act 2001* (Health Records Act) that were recommended by the coroner and will operate to strengthen information sharing in high-risk situations in all contexts.

Psychology Board of Australia (PBA)

The PBA advised the coroner that it had approved the Australian Psychological Society (APS) Code of Ethics (the Code) under section 39 of the Health Practitioner Regulation National Law to provide guidance to the health practitioners it regulates. They advised that the APS had established a Code of Ethics Review Committee which was conducting a review of the Code and its guidelines. A nominated member

from the Board sat as a representative on that committee at the invitation of APS. PBA further advised that 'once the review of the Code [was] completed, the Board will determine if any changes are required to align any of its related standards, guidelines or policies. This will include reviewing the National Psychology Examination curriculum, which requires provisional psychologists to have detailed familiarity with relevant legislation (including applicable privacy legislation), the Code, and Board standards, guidelines and policies.'

Australian Psychological Society (APS)

The APS indicated that they had commenced the periodical review of their Code of Ethics (the Code) and that it planned to lodge the new Code for consideration of APS members at the 2019 Annual General Meeting (AGM). APS advised the coroner that any changes to the Code must be voted on by the membership at an APS AGM as required by the APS Constitution.

In regards to the Ethical Guidelines, the APS advised that the APS Ethical Guidelines Committee (EGC) oversees the development and review of the Guidelines in consultation with internal and external key stakeholders and that any revision to the Ethical Guidelines would be influenced by the review of the Code.

In response to recommendation three the ASP stated; 'we advise that the APS Institute, (the respected training arm of the APS responsible for the development and delivery of training and professional development for psychologists), has held a preliminary planning meeting with the APS College of Forensic Psychology about the development of Continuing Professional Development (CPD) on risk of harm to others. The next step is to implement an Expert Advisory Group to oversee the development of online training. The training will occur in the short term and it will be recommended that it make specific reference to Coronial findings relating to risk of harm for the benefit of course registrants, whilst the review of the Code is underway.'

| Coroners court reference number | 2012 4184 |
|---|---|
| **Coroner** | State Coroner Judge Ian Gray |
| **Date of finding** | 30/10/2015 |

**Summary of circumstances**

Intimate partner homicide of an adult female by her recently separated male husband, who subsequently suicided. There was a history of family violence perpetrated by the offender against the deceased. The deceased and offender were from culturally and linguistically diverse backgrounds. Prior to the fatal incident, the deceased had contact with Victoria Police, the courts and specialist family violence services.

**Recommendations**

Victoria Police

1. In line with my recommendations in the Luke Batty finding relating to the use of the L17, I recommend that the Chief Commissioner of Police amend the Victoria Police Manual and other relevant operating instructions and, if appropriate, the Code of Practice for the Investigation of Family Violence, to require police officers completing an L17 to review previous L17s relating to the same offender and, where possible, to contact the authors of previous L17s to ensure information regarding risk is shared and considered.

Victorian Government

2. In line with my recommendation in the Luke Batty finding, I recommend that the State of Victoria give consideration to the creation and resourcing of a Family Violence Advocate service to provide advocacy services for woman and families modelled on the UK Domestic Advocate position.

3. I recommend that the State of Victoria, working in conjunction with the family violence sector, give consideration to the development of education programs for CALD men who are perpetrators of family violence and who currently have limited or no access to such programs.

Department of Immigration and Border Protection (DIBP)

4. I recommend that when the Department of Immigration and Border Protection has completed the development of policy in response to proposed recommendations 8 and 10 put forward by the joint CLCs [Joint Community Legal Centres], those policies be provided to the Coroners Court of Victoria and made public.

**Responses**

Victoria Police

Victoria Police advised that recommendation one was under consideration and that the *Code of Practice for the Investigation of Family Violence* (Code of Practice) may be amended to make explicit the need for police to review previous L17s and other risk factors.

Victoria Police advised that it was not feasible for police members to contact authors of previous L17s and that doing so would impact police response time and capacity. Victoria Police alternatively recommended that quality improvements could be made to the information recorded by police officers in L17s.

Victorian Government

In response to recommendation two the Premier advised that the Victorian Government 'currently funds an alternative form of advocacy services for women and families as part of its outreach and case management services' and that they had recently increased funding to this service. The Victorian Government further advised that further changes may be made following the findings of the Royal Commission into Family Violence.

In response to recommendation three the Premier advised that the Victorian Government would also be cognisant on recommendations made to the Royal Commission into Family Violence and noted the importance of developing a specialised prevention strategy and culturally appropriate and accessible responses to perpetrators in the CALD community. The Victorian Government advised that they would be examining the "Challenge Family Violence" crime prevention project and would work with stakeholders and the community to review existing services and codesign programs to implement the recommendation.

Department of Immigration and Border Protection (DIBP)

DIBP advised that they offered a referral service to all applicants and visa holders who claimed to be victims of family violence and that these individuals were also referred to the police. The DIBP also advised that they would provide Common Risk Assessment Framework (CRAF) training to members of the Family Violence Unit team in line with the coroner's recommendation.

| Coroners court reference number | 2013 0122 |
|---|---|
| **Coroner** | State Coroner Judge Ian Gray |
| **Date of finding** | 16/11/2015 |

**Summary of circumstances**

Intimate partner homicide of an adult female by her male husband, who subsequently suicided. There was a history of family violence perpetrated by the offender against the deceased. This included physical, social and emotional abuse. Both parties lived in a rural town. Both parties had ongoing health and mental health issues, and each were classified as the other's carer. The family violence was witnessed by family and friends, however there was no service contact with respect to family violence.

**Recommendation**

1. I recommend that Victoria Police members should be advised that where a person contacts a police station out of hours to express concern for the safety or welfare of another, and that call is diverted to a second, open station, Victoria Police should:

    a. assess the call in the ordinary manner, including by obtaining information from the reporting person about the nature, reason and background for the report or request

    b. determine whether police attendance is warranted, including for the purpose of conducting a welfare check

    c. if it is assessed that police attendance is warranted, ensure that a job is created and allocated accordingly, without requiring the caller to phone around or phone back to coordinate a response.

**Response**

Victoria Police

Victoria Police advised that they had conducted a review of current practices, including the assessment and determination of the need for a welfare check to be undertaken at any time. Additionally, Professional Standards Command were developing a Customer Service Charter with the aim of improving customer service to the community.

| Coroners court reference number | 2014 0824 |
|---|---|
| **Coroner** | State Coroner Judge Ian Gray |
| **Date of finding** | 31/04/2016 |

**Summary of circumstances**

Intimate partner homicide of a female by her estranged partner, who then suicided. There was a history of family violence perpetrated by the offender, which included physical violence, and the homicide incident occurred proximate to police and court contact. At the time of the fatal incident, there was a FVIO in place to protect the victim, which had been reportedly breached on two prior occasions by the offender.

**Recommendations**

1. I recommend that the Victorian Government, in implementing the recommendations of the Royal Commission across the family violence sector, adopt the practice that front line workers provide each and every risk assessment to the applicant, the applicants legal representatives, the local community family violence services, the magistrate during an FVIO hearing, and to Victoria Police.

2. I recommend that Victoria Police implement, if necessary by changes to the Victoria Police Manual and/or the Code of Practice for family violence, a practice that requires police officers who attend property collections where an FVIO is in place, to:

    a. review available information in relation to the parties before attending, including past L17 assessments, LEAP notes, the FVIO application and whether there have been previous property exchanges
    b. actively utilise the property exchange as an opportunity for risk assessment and risk management, if indicated by the circumstances
    c. give consideration to whether completion of a Form L17 is required and complete the Form L17 if so required
    d. record the fact of their attendance and their observations of the parties on LEAP.

    It may be appropriate to allow some flexibility in situations where members are attending property collections at very short notice and are not able to fulfil all of these requirements.

3. I recommend that Victoria Police and the Magistrates' Court of Victoria develop an information exchange system that will enable the details of the information contained in the intervention order applications made by self-represented, or privately represented parties, to be uploaded to LEAP in the same way as the information is uploaded in cases were police are making the intervention order application.

4. I recommend that Victoria Police examine the feasibility of developing a system for recording a telephone call to a police station by a party to a family violence incident, creating a record that is visible to members who subsequently check the parties on LEAP.

5. I recommend that the AFMs[6] be informed by police if the perpetrator is not charged with breach of the FVIO. I will not prescribe a precise time for that but I agree that seven days is reasonable.

6. I recommend that AFMs be educated/advised by Victoria Police and other family violence agencies to call 000 to report breaches of an FVIO.

[6] Affected Family Members

**Responses**

Victorian Government

The Premier of Victoria responded advising that the first coronial recommendation would be considered as part of the Victorian Governments response to, and implementation of the recommendations of, the Royal Commission into Family Violence.

Victoria Police

In response to recommendation two, Victoria Police advised it would be implemented through the implementation of recommendations of the Royal Commission into Family Violence.

In response to recommendation three, Victoria Police advised that they would work with the Magistrates' Court of Victoria to implement this recommendation, and acknowledged that police officers did not have access to important and relevant narrative information contained in self represented intervention order applications through the LEAP system. It was noted that this recommendation would be implemented via the implementation of recommendations from the Royal Commission into Family Violence regarding the need for better information sharing arrangements in cases involving family violence.

In response to recommendation four, Victoria Police advised that they had examined the feasibility of implementing the recommendation and were investigating options to improve processes for recording this information on LEAP. They advised that although the technology to implement this recommendation was available, technical and resource issues needed to be assessed.

Victoria Police advised that they would amend the Code of Practice for the Investigation of Family Violence to enable them to implement the fifth coronial recommendation, and would incorporate the recommendation within amendments put forward for consideration as part of the response to the Royal Commission into Family Violence.

Victoria Police advised that recommendation six would be implemented through Victoria Police's Media and Corporate Communication Department who would 'work with Family Violence Command and other Family Violence agencies to develop and implement a campaign to inform affected members of the community of the need to contact 000 in the case of any breach of an [FVIO] as well as Police Officers, and those working in Family Violence.'

Magistrates Court of Victoria

The Magistrates' Court of Victoria advised that in 'March 2014, the Court and Victoria Police set up an electronic exchange of information about family violence intervention orders.' The Court also highlighted their support for providing police with relevant information contained in applications for FVIOs made by individuals and identified their commitment to overcoming barriers to information sharing.

| Coroners court reference number | 2014 0855 |
|---|---|
| **Coroner** | State Coroner Judge Ian Gray |
| **Date of finding** | 20/09/2015 |

**Summary of circumstances**

Parent-child homicide of a young male by his father. There was a history of family violence perpetrated by the offender against his ex-wife and son. The homicide incident occurred in the context of proximate service contact with Victoria Police, courts and Child Protection.

**Recommendations**

Victorian Government

1. The State of Victoria undertake empirical validation of the Common Risk Assessment Framework (CRAF), including consideration of other family violence risk assessment measures in other jurisdictions, and the risk assessment tools based upon it, such as the L17, to determine the extent to which they accurately identify a:

    a. person's (including a child's) risk of being the victim of family violence
    b. perpetrator's risk of repeat and/or escalating family violence.

    As part of this validation process, consideration should be given to whether:

    a. greater weight ought be given to the victim's own level of fear in assessing the risk posed to her and any children
    b. there should be a rating and/or weighting of risk factors to assist the person undertaking the risk assessment to identify the risk of family violence to women and/or children as low, medium or high. Any tool or system which rates or weighs risk factors should be standardised across agencies dealing with family violence, taking into account the unique mandate of each agency.

2. The State of Victoria ensure *all* agencies, including the Magistrates' Court of Victoria, operating within the integrated family violence system:

    a. use the CRAF (once validated), including risk assessments aligned to the CRAF. This includes ensuring that those agencies that use external service providers (e.g. the DHHS) incorporate in service agreements with service providers, a requirement that the CRAF be used when dealing with family violence related matters
    b. undertake risk assessments that are reduced to writing, shared with, and accessible to all elements within the integrated family violence system dealing with a particular family, for the purposes of
        i. ensuring risk assessments are dynamic, collaborative, comprehensive and up-to date. That is, once commenced, a risk assessment considers all the information available to all relevant agencies, is updated and maintained for a family where family violence has been indicated or reported
        ii. ensuring risk assessments are accessible by police officers when
            - making an application for a family violence intervention order
            - bringing charges against a perpetrator for family violence related offences
            - responding to a bail application for a person charged with family violence related offences
            - informing presiding magistrates of the outcome of relevant risk assessments

iii. coordinating the response directed at perpetrators
iv. coordinating the support given and safety planning provided to victims of family violence
v. identifying common risk management strategies.

3. The State of Victoria, and where appropriate, in conjunction with the Office of the Victorian Privacy Commissioner, ensure *all* agencies operating within the integrated family violence system:

    a. have clear rules and education about their respective capacity and obligation to lawfully share information between agencies and/or to members of the public
    b. implement clear policies with respect to the *Privacy and Data Protection Act 2014* to inform respective staff members of the circumstances within which they may provide information to members of the public and other government agencies. Such policies must include circumstances where a police officer may inform a parent of any criminal charges laid against another parent (biological or other) or FVIOs, of the same child which indicate a risk to that child
    c. adequate training with respect to these policies.

    As part of this process consideration should be given to whether the criteria and/or thresholds for sharing personal and/or health information are appropriately calibrated to allow for dynamic, up to date risk assessment in a family violence context.

4. The State of Victoria identify legislative, or policy impediments to the sharing of relevant information, and remove such impediments, so that all agencies, including the Magistrates' Court of Victoria, operating within the integrated family violence system, are able to share relevant information in relation to a person at risk of family violence.

5. The State of Victoria ensure *all* agencies operating within the integrated family violence system are:

    a. clearly identified and their respective roles and responsibilities for responding to family violence are contained in legislation and/or documented in publicly available policies
    b. provided operational advice and assistance to develop clear policies, procedures and risk assessment tools aligned to the CRAF, to identify and manage a person's
        i. risk of being the victim of family violence, and
        ii. risk of perpetrating family violence.

6. The State of Victoria expand access to the Family Violence Court Division (FVCD) of the Magistrates' Court of Victoria across the State. I note the operation of the Family Violence Court Division at Ballarat and Heidelberg Magistrates' Courts. I recommend also that the Court Integrated Services Program (CISP) be made available at those court locations at which the FVCD is applied. This would provide equitable, coordinated and integrated responses to families affected by family violence when dealing with the multiple jurisdictions with which they are engaged including family violence, crime, family law, child protection and VOCAT. Most importantly criminal and family violence cases involving the same parties can be dealt with at the same time. I accept that there will always be a need to tailor or modify program availability at certain court locations, depending on the case volume and case mix at that court. However, the point is that Magistrates' Courts deal with an extremely high volume of family violence cases. Many of thousands of intervention orders are made annually. They are made to protect applicants. They are far more likely to be ultimately successful if Magistrates are in a position to make orders which combine protective elements, and then engage applicants and respondents with services (including the compulsory attendance by perpetrators men's behaviour change program) and, if necessary, with mental health treatment providers. The elements in the system should therefore include:

    a. specialist family violence case management for all matters, involving families at high risk of family violence
    b. a Senior Specialist Family Violence Registrar to coordinate the listing of all matters for the one family and manage the family violence team of registrars

c. registrars interviewing and initiating/processing in person applications have core competencies in family violence including risk assessment
d. family violence Applicant and Respondent support workers and family violence trained CISP case managers at all courts
e. the capacity to mandate perpetrators' timely access to and participation in Men's Behaviour Change Programs
f. dedicated police prosecutors and civil advocates, family violence outreach workers and access to legal representation (for both applicants and respondents)
g. resourcing of the system to meet the requirement for legal representation (free legal aid) depending on demand at court locations.

7. The State of Victoria, ensure *all* agencies operating within the integrated family violence system are sufficiently supported to provide their respective staff training and professional development to undertake CRAF based family violence risk assessments. Such training and professional development should include, but not be limited to, recognising, understanding; and responding to family violence. Each agency's staff, at all levels, should be educated in the dynamics of family violence, with specialist training provided to those employees whose primary role is to have contact with victims and perpetrators of family violence.

8. The State of Victoria, implement Risk Assessment and Management Panels (RAMPs) in all police regions as soon as possible.

9. I recommend that the State of Victoria, ensure there is a process that triggers a compulsory referral to a RAMP when a family violence agency and/or the Magistrates' Court of Victoria, assesses a person's risk for family violence as 'high'. Such a process should include, but not be limited to

    a. an initial case management conference during which the panel members use the CRAF to undertake a multi-agency case review and risk assessment of the affected person (and where relevant their children) using all information and all past risk assessments undertaken by the individual agencies:
        i. immediate safety action plans
        ii. longer term case management, including risk management strategies, for the affected persons, and establishment of ongoing case management of the care of the affected persons
        iii. providing the referring family violence agency and/or the Magistrates' Court of Victoria with details of the outcome in writing.

10. The State of Victoria give consideration to the creation and resourcing of a Family Violence Advocate service to provide advocacy services for women and families modelled on the UK Domestic Advocate position.

<u>The Attorney General of Victoria</u>

11. I recommend that the Attorney General review the *Bail Act 1977* and give consideration to the following legislative amendments:

    a. re-enact the former section 4(2)(c) of the *Bail Act* (as it appeared prior to the 2004 amendments to the *Bail Act)* to require bail to be refused where an accused person is in custody for failing to answer bail unless the accused person satisfies the court that the failure was due to causes beyond his or her control
    b. require bail to be refused where an accused person is in custody for failing to answer bail in relation to family violence related offences unless the accused person satisfies the Court that the failure was due to causes beyond his or her control
    c. ensure that bail conditions continue to operate until a warrant for arrest is executed. The new legislation should close the loop hole which presently results in persons who fail to attend Court to answer charges and a warrant is issued is subject to no bail conditions after their bail has been cancelled by virtue of the issuing of the warrant.

Family Law Council

12. I recommend that the Family Law Council consider the merits of amending section 68R of the *Family Law Act 1975* to provide that where a parenting order is suspended, revoked or varied pursuant to section 90 of the *Family Violence Protection Act,* that such suspension, revocation or variation operates until further order of a Court, and is not time-limited.

Victoria Police

13. The Chief Commissioner of Police amend the Victoria Police Manual and other relevant operating instructions and if appropriate, the Code of Practice for the Investigation of Family Violence to require police officers:

    a. to provide all completed L17s relevant to an affected person to all relevant agencies operating in the family violence system
    b. completing an L17 to review previous L17 s relating to the same offender and where possible to contact the authors of previous L17s to ensure information regarding risk is shared and considered
    c. to check LEAP prior to completion of an L17 to ensure relevant criminal history, or other matters capable of affecting the risk assessment (including but not limited to other acts of violence with which the perpetrator has been charged, intervention orders obtained by other persons to which the perpetrator is the Respondent) are considered.

14. The Chief Commissioner of Police cease to use the current definition of 'recidivist' family violence offender and develop criteria for identifying 'high risk' family violence perpetrators that require intensive management. The definition of 'high risk' should be uniformly applied and responded to in all police regions to bring about:

    a. a warning flag in LEAP
    b. more intensive monitoring of the offender, including bail conditions
    c. execution of all warrants with respect to the offender to be treated as a priority.

15. The Chief Commissioner of Police amend Victoria Police Manual and other relevant operating instructions and if appropriate, the Code of Practice for the Investigation of Family Violence to require:

    a. a police prosecutor appearing in a remand/bail application to have available all previous L17s in relation to the offender to assist them in deciding whether to oppose bail and /or submissions with respect to bail conditions if bail is granted
    b. where practicable the informant in all family violence matters should be in court, or have communicated to the police prosecutor his or her views as to the future risk of family violence by the perpetrator, prior to any remand/bail application relating to the perpetrator
    c. all FVIOs be served on the Respondent with priority and where service can not be effected substituted service from the Court be obtained within 24 hours
    d. all warrants issued in relation to family violence related incidents be executed with high priority and entered onto LEAP within 24 hours of issue
    e. a benchmark period for the:
        i. commencement of a prosecution of family violence offences
        ii. authorisation of charges for the breach of an intervention order or family violence safety notice.
    f. police prosecutors, or other designated police officers to ensure affected family members are kept informed in relation to the progress and outcome of all FVIO proceedings, warrants, bail applications and criminal proceedings which relate to them and any other protected family members
    g. That whenever possible the same police prosecutor be assigned to both the criminal (including bail), and the family violence (civil) matters listed for Magistrates' Courts when the parties are the same in both - that is the applicant/victim and the perpetrator/accused.

The Department of Health and Human Services (DHHS)

16. DHHS incorporate in its Intake Phase practice where family violence services report family violence, that Child Protection requests a completed CRAF as part of its risk assessment and analysis.

17. DHHS introduce a requirement that CRIS notes include the full text of all CRAF risk assessments undertaken in relation to children for whom files are opened.

18. DHHS introduce a requirement that prior to, or when, undertaking a CRAF risk assessment, the DHHS obtain from Victoria Police all L17s relating to the child and their parents and any CRAF risk assessment undertaken by a specialist family violence service.

19. DHHS introduce a process whereby all CRAF risk assessments which indicate high risk of family violence to a child be provided to Victoria Police for consideration of bringing an application for a FVIO.

20. DHHS discontinue the practice of asking women at risk of family violence to enter into undertakings, which require them to supervise or manage the behaviour of the perpetrator of the family violence.

21. DHHS include in its standard practice of working with reports of family violence, such as where one parent is believed to be non-protective, a professional case conference be convened before closing a file. Such a requirement must exhaust (all best) efforts to:

    a. interview the alleged perpetrator of family violence to determine whether harm in relation to a child has been substantiated
    b. engage all agencies involved with the family to remediate the issue of services working in isolation and risk assessments being made with insufficient information
    c. develop a comprehensive and robust safety plan with dear roles and responsibilities as required.

22. That where the DHHS assess one parent to be 'protective' but the other is not, that the DHHS provide support to the protective parent, including in court proceedings, to manage the risk posed by the non-protective parent including, (where relevant and appropriate) by recommending that the other non-protective parent have no contact with the child.

23. DHHS provide greater guidance to family violence agencies about the circumstances in which a report to Child Protection should be made.

24. DHHS ensure its staff comply with its specialist practice resource *'Working with families where an adult is violent'* (2014) to ensure:

    a. when assessing the protective capacity of the non-offending parent, by analysing the protective factors and ensuring they have been weighted against the history
    b. assessing patterns and severity of harm perpetrated against them
    c. undertaking a comprehensive risk assessment of the perpetrator and their behaviour and that the department can demonstrate a robust approach to locating perpetrators that are evading service involvement or have no fixed address.

Magistrates' Court of Victoria

25. The Magistrates' Court of Victoria simplify the *'Information for Application for an Intervention Order'* form and integrate a checklist based on the CRAF for applicants to complete when making an application for a FVIO.

26. The Magistrates' Court of Victoria implement training for Registrars who interview applicants and prepare FVIO documentation, to apply the CRAF to ensure appropriate risk information is identified and included in the Application for an Intervention Order.

27. The Magistrates' Court of Victoria ensure its staff working in family violence matters receive specialist family violence training in relation to the CRAF and the process by which to undertake a risk assessment.

28. The Magistrates' Court of Victoria ensure its Applicant Support Workers complete the CRAF with the affected family member in Family Violence Intervention Order cases, and supply the completed risk assessment to Victoria Police.

29. The Magistrates' Court of Victoria revise the form and content of FVIOs to ensure they are written in clear and unambiguous language. This should include clarity in relation to the operation of section 68R of the *Family Law Act 1975.*

**Responses**

State of Victoria and Department of Health and Human Services

The Victorian Government advised that the Royal Commission into Family Violence (RCFV) would progress the implementation of a large proportion of the recommendations made by the Coroners Court.

The Victorian Government further advised that they had commenced work to:

1. develop a consistent and shared understanding of what constitutes 'high risk' in a family violence context
2. determine an effective way of assessing high risk cases of family violence
3. establish 'information-sharing arrangements for high risk cases'
4. implement an advocacy support for victims to navigate relevant services
5. review the circumstances in which Child Protection Practitioners use undertakings, provide relevant training to all Child Protection Practitioners
6. amend relevant Child Protection policies to highlight the circumstances in which it is appropriate to request that parents complete an undertaking
7. introduce regulations that requiring the development of a case plan for all substantiated Child Protection matters and for case conferences to be convened before case closure
8. consider the intersection between the Children's Court of Victoria and the Family Court of Australia, in view of empowering the Children's Court to make parenting orders where a protection application has been issued
9. review the guidance provided to family violence agencies as to when to report a concern to Child Protection
10. consider how to improve family violence training of Child Protection Practitioners
11. undertake a comprehensive review of the CRAF, with the view to use the findings of this evaluation, in conjunction with those of the RCFV, to enhance the tool
12. expand training in the use of the CRAF and to strengthen information sharing across organisations
13. identify a way to document the roles, responsibilities, policies, procedures and risk assessment tools that are aligned with the CRAF
14. implement the Risk Assessment and Management Panels (RAMP) across Victoria and to ensure that professionals are provided with appropriate training and the ability to share information within these settings.

Attorney General of Victoria

The Premier of Victoria advised that the implementation of recommendation 11 had commenced and that the implementation of this recommendation would be informed by relevant findings from the Royal Commission into Family Violence.

Family Law Council

The Family Law Council advised that they had suggested a similar recommendation in their 2015 report on *Families with Complex Needs and the Intersection of the Family Law and Child Protection System* for the Attorney-General. The Family Law Council further noted that the Attorney-General had since introduced the *Family Law Amendment (Financial Agreement and other Measures) Bill 2015* which enabled state and territory courts to suspend or vary existing parenting orders when making an interim family violence protection order.

Victoria Police

Victoria Police advised that they had implemented recommendation 14a and were in the process of determining the feasibility of:

1. providing copies of all L17s to relevant agencies within the family violence system
2. implementing a process to guide members to review previous L17s and LEAP records when responding to a family violence incident
3. amending the risk assessment practices of police so as to ensure that high risk perpetrators of family violence are identified by police
4. improving communication 'and the provision of information to support police prosecutors and police lawyers' and whether there are opportunities for the Family Violence Court Liaison Officer to be available at all court locations
5. expediting the service of Family Violence Intervention Orders and setting timeframes for the hearing of FVIOs
6. utilising the same police prosecutor for both criminal and civil family violence matters. Victoria Police advised that they would collaborate with the Magistrates Court of Victoria to 'ensure there are no inadvertent delays to justice caused by scheduling issues when attempting to align criminal and civil matters, and manage issues for police prosecutors managing increased caseloads.'

Victoria Police noted that due to resourcing, it would be unfeasible for police members to contact all previous authors of an L17 prior to completing a family violence risk assessment.

Furthermore, in response to recommendation 14b and c, Victoria Police advised that members had been asked 'to submit a whereabouts flag for outstanding Complaint and Warrants for a Family Violence Intervention Order within 24 hours' and noted that longer term IT solutions were being sought.

In response to recommendation 15d, Victoria Police noted that process changes 'to rectify issues with the timely recording of warrants' had been implemented.

Victoria Police further noted that the current Victims Charter and Code of Practice required police members to notify victims of the progress of their matter before the court and that, in consideration of the coronial finding into this matter, Victoria Police would take steps to ensure officer compliance with their obligations.

Magistrates' Court of Victoria

In response to recommendation two, 25, 26, 27 and 28, the Magistrates' Court of Victoria advised that they had reviewed the information for Application for an Intervention Order form to simplify its contents and to incorporate elements of the CRAF into the document.

In addition, the Magistrates' Court of Victoria advised that registrars had undertaken family violence training and that the CRAF was completed by applicant support workers when meeting with affected family members applying for a Family Violence Intervention Order. It was identified that best practice guidelines for all court support workers were currently in development.

In response to recommendation 29, the Magistrates' Court of Victoria advised that the Court was in the process of examining the 'language of the standard conditions to family violence intervention orders.'