

Australian Domestic & Family Violence Clearinghouse

Exploring the Use of Domestic Violence Fatality Review Teams

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RESPONDING TO DOMESTIC VIOLENCE FATALITIES

On 15 January, 1990, Joseph Charan shot his estranged wife Veena outside their son's elementary school in San Francisco, California. He killed her in front of their little boy, then turned the gun on himself. This murder-suicide, by no means the only one to be committed in San Francisco that year, became a watershed domestic homicide case for the criminal justice and victim advocates' community across the United States of America (USA). Veena had reached out to a number of agencies in the fifteen months prior to her murder, obtaining restraining orders, custody orders, and making numerous complaints of assault, harassment and stalking by Joseph. He had attempted to kidnap their son and threatened to kill Veena on a number of occasions. Just before he murdered her, he was convicted of assault and given probation and four days' jail.

The Commission on the Status of Women, City and County of San Francisco, initiated a detailed investigation into the deaths, on a scale unprecedented in the country. That investigation identified key areas where systems and processes had failed Veena Charan. The investigation formed a rationale for the establishment of Domestic Violence Fatality Review Teams (DVFRTs) across California and gradually the rest of the USA (Websdale 2003).² The Charan investigation became the blueprint for DVFRTs, bringing the combined weight and resources of agency staff at the frontline of domestic and family violence to focus on the response systems, using the extreme case of domestic homicide as a magnifying glass.

The development of DVFRTs in the USA was also in response to statistics indicating that domestic violence was linked to a significant number of homicides across the country. Every year in the USA between 1000 and 1600 women are killed in domestic violence-related homicides (Websdale 2003), a phenomenon only recognised by law enforcement and victims' groups in the past few decades. The first DVFRT was established shortly after the Charan Report was completed in 1991 in California. Since that time, DVFRTs have become widespread across the country. DVFRTs have proven invaluable in identifying common weaknesses in systems and protocols responding to domestic violence, that have led to a fatality³. Teams have

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² DVFRTs have been established across the USA in the past decade. Similarly structured teams now review the deaths of children, the disabled and the elderly. The vast majority of counties (i.e. local government authorities) have established DVFRTs, with the remaining major centres and states looking to create their own DVFRTs in the near future (Websdale et al. 2006).

³ Note that in this context 'fatality' refers to all deaths in the context of domestic violence (including homicides, suicides and police shootings). 'Homicide' refers to the killing of one person by another, including deaths where the offender was ruled not guilty by some defence, such as insanity or self-defence.

gone on to recommend solutions and to identify patterns of weapons used, manner of death and even the number of previous domestic violence calls made to police prior to the fatality, providing an excellent resource about help-seeking behaviour, and constantly identifying potential improvements in service delivery. Through an examination of DVFRTs in the USA (where they have had the longest history and most extensive expansion), this paper explores the purpose and operation of DVFRTs, and considers the potential value of their application in Australia. The paper specifically examines the existing local response to domestic homicide and the potential contribution that DVFRTs could make to the prevention of fatalities.

Several different systems of investigation into violent death exist in Australia, such as those conducted by the police, coroners and the National Homicide Monitoring Program. However, none of these look at domestic and family violence-related fatalities specifically, or analyse a group of domestic homicides occurring in a selected time frame, searching for patterns and issues common among them. Proponents of DVFRTs in the USA have argued that they represent important tools in the effort to prevent domestic violence. The potential for their introduction in Australia is considered here to raise awareness and stimulate discussion.

DOMESTIC VIOLENCE FATALITIES IN AUSTRALIA

Before considering the applicability of DVFRTs for Australia, it is necessary to ascertain how significant a problem domestic violence-related homicide is. A domestic homicide is defined here as involving a perpetrator who is or was at one time in an intimate relationship with the victim or victims, such as a de facto or marriage partner. The definition of 'intimate relationship' is not standard across jurisdictions, with the definition being wide and inclusive in some jurisdictions, and quite narrow in others. Legal definitions of 'domestic relationship' are different across Australian states and territories, and most agencies working within a particular jurisdiction adopt that state or territory's legal definitions. The definitions are also subject to change, tending to become more inclusive over recent years. Therefore, as Mouzos (1999) asserts, a domestic homicide is always a family homicide but a family homicide is not always a domestic homicide, and this should be considered when analysing statistics in a given area.

Research indicates that women are more likely to be victims of domestic violence and men more likely to be perpetrators (see, for example, Australian Bureau of Statistics 2006). Men also perpetrate around 75% of Australian domestic homicides (Mouzos & Rushforth 2003). In the remaining 25% of domestic homicides committed by women, a significant proportion of women who kill their partners do so after a protracted history of severe and ongoing domestic violence previously perpetrated by the deceased partner. This has given rise to the recent acceptance of 'Battered Woman Syndrome' to support certain defences at law (Craven 2003).

Men, it would seem, kill for other reasons. The National Homicide Monitoring Program report for 2004–05 found that the majority (44%) of female victim homicides were killed as a result of 'a domestic altercation' (which includes arguments that arise based on jealousy, separation or termination of a relationship, and other domestic

arguments that may relate to infidelity, children and custody issues, alcohol fuelled domestic altercations and other issues between intimate or past-intimate partners) (Mouzos & Houliaris 2006, pp. 14–15).

Rates of homicide declined in Australia in the period 1990–2004, from approximately 2 per 100,000 to about 1 per 100,000 (Moffat & Poynton 2006).⁴ While Australia's rate of homicide internationally is comparatively low, the close association of domestic violence with the majority of intimate partner homicides is cause for concern (Mouzos & Rushforth 2003). Australia's homicide demographic is heavily domestic in nature, with intimate partner homicides accounting for 22% of all homicides in 2004–05 and family homicides accounting for 18% (Mouzos & Houliaras 2006, p. 19). Domestic violence is a primary factor in many of these. In an analysis of data from the National Homicide Monitoring Program, 38 of the 66 intimate partner homicides (58%) that occurred in 2004–05 had a recorded history of domestic violence (Mouzos & Houliaras 2006, p. 21).

Another disturbing feature of domestic violence-related homicide is the incidence of filicide; that is, the killing of children by parents or custodians. On average, 25 children per year are the victims of homicide in Australia, with about a third of these deaths occurring in circumstances of domestic violence and/or family breakdown. Once again, men are responsible for the majority of killings, with 63% of child killings committed by fathers, as opposed to 37% by mothers (Mouzos & Rushforth 2003).

Although two-thirds of child homicides occur in circumstances where the motive cannot be determined, when they are viewed as part of a pattern of domestic violence the rate of child death directly attributable to an abusive parent and partner would seem to be very high. Mouzos and Rushforth (2003) argue that the ongoing abuse of a child certainly fits within the parameters of domestic violence and should be seen as such from a statistical viewpoint.

In this context, the figures around domestic homicides are of serious concern. When viewed as the escalation of a predictable pattern of behaviour, domestic homicides can be seen as largely preventable deaths. Given the particular factors surrounding homicide in this country, new approaches should be explored to prevent and investigate these deaths.

PURPOSE OF DVFRS

A DVFRS is a multi-agency taskforce that conducts a detailed review of domestic homicides, seeking to identify weaknesses in systems responding to domestic and family violence. The basic objectives of a DVFRS are twofold:

- to reduce domestic homicides by improving the service provision and systemic responses to domestic and family violence
- to compile and interpret accurate, detailed data concerning domestic homicides.

⁴ Interestingly, Australia has a comparable proportion of domestic homicides to the USA; that is, about 30% of homicides are considered to be domestic violence-related in the USA at a conservative estimate, as in Australia (Roehl *et al.* 2005).

DVFRTs take a broad view of domestic violence-related fatalities, viewing these deaths as a connected group rather than isolated events. This enables some prediction of behaviour in future instances and, at the least, an ability to collate more cohesive and accurate statistical information regarding domestic fatalities. They can examine the context in which such deaths occur, the escalation of violence and threats, and the response or lack of response by systems and protocols. The review of fatalities by DVFRTs provides the means for developing superior processes and systems to prevent as many deaths as possible and provides the means for compiling data central to the appropriate handling of domestic fatalities, assault and related issues.

In the course of their investigations, DVFRTs should be able to identify:

- the context surrounding incidents
- points of intervention
- points of appropriate risk assessment
- risk factors
- action taken by agencies or organisations
- effectiveness of these actions
- means of improving interventions
- policies and protocols that might strengthen responses
- law reform required and
- further prevention strategies.

By focusing on victims' contact with and access to intervention strategies and their effectiveness, DVFRTs can determine where failures in the system occurred. They can then make recommendations to improve access to services and interventions, as well as to improve the quality and effectiveness of services, in order to prevent future fatalities.

POSITIVE OUTCOMES RESULTING FROM DVFRT INVESTIGATIONS

Identifying fatality risk factors and points of intervention

DVFRTs were initially established in the USA as a response to what was widely seen as a failure by agencies at the frontline of domestic violence service delivery to adequately coordinate and provide care and protection to victims of domestic violence. As strikingly illustrated in the Charan Report, a more cohesive agency response was required to deal appropriately with both victims and perpetrators of domestic violence.

Through their investigations and analysis, DVFRTs can contribute to knowledge of what leads to domestic fatalities and, thereby, contribute to the development of prevention strategies. They are in a position to identify risk factors for domestic violence fatalities, associated with perpetrators and victims, and the context in which violence takes place. They can also identify points of intervention that may have prevented these devastating results.

For example, Hennepin County DVFRT (Minnesota, USA) identified strangulation as 'a significant lethality factor in [their] 2002 and 2004 reports'. In 2005, the Minnesota Legislature passed legislation making strangulation a felony offence, with far more serious penalties. The Hennepin County Attorney's Office then focused on strangulation cases, charging over 190 defendants since the legislation was passed (Hennepin County Report 2007).

The dynamics of domestic and family violence show predictable patterns; the violent incident itself is not a 'one-off'. Research and crime data indicate that domestic violence is likely to escalate in severity over time and sometimes in response to certain triggers; for example, during a victim's pregnancy or at and following separation (Laing 2004). In addition, studies of homicides and assault have identified specific risk factors associated with homicide; for example, threats of homicide or suicide, having homicidal or suicidal fantasies, having access to weapons, threats or assaults with a gun or other weapon, hostage taking, strangulation, depression or mental illness (e.g. Hart 1990; Campbell *et al.* 2003; Richards 2003). These studies have in turn led to the development of risk assessment or lethality assessment tools, such as the Danger Assessment tool (Campbell 1986), the Spousal Assault Risk Assessment Guide (SARA), developed by the British Columbia Institute on Family Violence and used widely in Canada, or the Risk Assessment Screening Tool (RAST) used in Tasmania (Winter 2006).

Far more still needs to be understood about the predictability of offender behaviour. To date, research has not successfully captured the unique complexities of every violent domestic relationship, due to the time and resource pressures involved in undertaking a review of individual fatalities. Even where agencies hold detailed information regarding the history and dynamic of a violent relationship, accessing this information is difficult; departments are usually unable or unwilling to share this information without legal compulsion. Significantly, a DVFRT can investigate a domestic fatality with a focus that is different to a typical criminal justice approach, where only those factors and evidence that ultimately will be admissible in a court of law are considered relevant. DVFRTs have the capacity to bring more scrutiny to individual cases and contribute to the knowledge base about risk factors for fatalities, the context surrounding these incidents and points of intervention that may have prevented the fatalities. This results in more focused, better informed risk assessment methods.

Identifying barriers to assistance and gaps in service

Many victims of violence experience barriers to assistance, such as language and cultural barriers, social and physical isolation or distrust of authorities, as well as barriers resulting from an uneven geographic spread of services. DVFRTs have the capacity to identify specific areas of need and the opportunity to address these (Websdale 2003). For example, Macomb County DVFRT in Michigan focused its report for 2006 solely on the identification of areas where each agency could improve response and interagency cooperation. The entire report is geared to recommendations addressing those issues (Macomb County Report 2006).

DVFRTs may point to a need for translated material and interpreter services or mental health services in a particular location or for a specific community. They may also advocate for policy change, such as providing better information to victims to

enable them to assess their risk accurately or promoting screening mechanisms to advocates, courts, law enforcement, child protection workers and health and medical professionals. DVFRTs can raise awareness around the dimensions of domestic violence for particular groups, such as the impacts of domestic violence for businesses and their work-places, and the need for a response (Websdale 1999).

DVFRTs may encourage a dialogue between communities and authorities around domestic and family violence issues, through involving advocates, community organisations or victims of domestic violence as DVFRT members. They can also do this through the nature of their investigations, highlighting issues for different groups in the community; for example, by investigating the context of incidents or the barriers to accessing services for particular groups. In Australia this could raise issues for more isolated victims, such as those from Aboriginal and Torres Strait Islander communities, women from culturally and linguistically diverse backgrounds, women with disabilities and victims of same sex domestic violence.

Identifying system failures

The most tangible benefit of DVFRTs is their ability to identify practices, protocols, behaviours and attitudes associated with service and criminal justice response systems that lead to fatalities. A DVFRT can detect barriers to accessing services or agencies, and flaws in their responses. It can then apply that information to all domestic fatalities for a specified time, to establish whether the problem with the response is systemic or an anomaly; the Team can then recommend ways to rectify the problem.

To illustrate, the Macomb County DVFRT in Michigan identified family courts and local criminal courts as having a central role in addressing domestic and family violence, with no real system in place to address that role. The DVFRT made recommendations looking at the operation of those courts with respect to restraining orders, particular procedural issues and problems with jurisdictional overlap in geography and authority (Macomb County Report 2006).

In Australia, if a woman is shot and killed by her partner after taking out a restraining order against him, whilst in another location a five year old child is shot during a protracted custody dispute between his parents, no link will be made between the two fatalities. Police will investigate the two deaths as discrete homicides, not related or relevant to one another. The criminal justice system will behave similarly. This is a logical process as, factually and legally, the two deaths have nothing to do with one another. However, these deaths both occurred violently and as a result of domestic violence. Much could be gained from viewing these deaths as individual incidents in the context of others. DVFRTs can alter the way domestic homicides are viewed.

A DVFRT would review both deaths, and any others occurring within a prescribed period that were the result of domestic violence. It would look for any points in the events preceding the homicides, perhaps where police could have acted differently, where a medical practitioner could have reported something or where a court could have sentenced an offender differently. When these indicators are compared to the indicators identified in the other cases, previously undetectable patterns in systems' responses begin to emerge.

The broader lens of scrutiny brought by a DVFRT changes the view of domestic homicides from individual, discrete incidents to events that are part of a complex web of behaviours and interactions, often involving an array of individuals, organisations and agencies. By examining the context of a death, valuable information can be gathered and used to contribute to the improvement of systems and processes that may in turn assist in preventing future deaths.

Reviewing and evaluating domestic violence interventions

DVFRTs can contribute to research and policy development by reviewing interventions that target domestic violence. DVFRTs can provide a broad-based, systematic process of review to assess the impact of prevention or response approaches; this is particularly important where there is little or no evaluation of interventions. For example, the New Jersey DVFRT is central to the development, implementation and review of domestic violence policy in that state, having reviewed all the Attorney General's and Police Department's training and practice manuals, as well as a variety of other protocols regarding domestic violence from other agencies. In its 2003 report, the New Jersey DVFRT outlined the progress of those reviews (New Jersey DVFRT Report 2003).

In this country, integrated approaches to domestic violence adopted by the Australian Capital Territory, Tasmania and more recently Victoria, promise more even, timely and holistic responses to victims. A detailed review of domestic homicide cases over a specified period of time following the introduction of these approaches would allow identification of factors that contribute to domestic violence fatalities. This would help assess the effectiveness of these approaches.

For example, the ground-breaking 'Minneapolis' experiments conducted by Sherman (1996), showed that an increase in intervention by law enforcement positively reduced the rate of domestic violence. However, subsequent reproductions of that experiment in other cities, personally overseen by Sherman, showed that with offenders from some socio-economic groups, the arrests *increased* repeat violence, as much as 30%. Sherman (1996) has concluded that not enough is known about the geographical-social nexus impacting on local domestic violence; without that depth of information unique to each area, domestic homicide cannot be predicted or prevented with confidence. It is in this context that DVFRTs are most valuable. Over a period of time (and DVFRTs may review deaths as far back as is practical), it is possible to accumulate enough accurate data to give policymakers a better view of the effect of certain approaches. By combining detailed statistics with recommendations made by DVFRTs, communities may develop and refine systems and procedures to be more effective.

The ability of DVFRTs to review domestic homicides on a holistic basis and to provide police and other agencies with accurate information about trends and patterns in domestic homicides in that community, can improve interventions.

Advocating and procuring legislative and other reforms

While there is little definitive statistical information to indicate that the establishment of an effective DVFRT reduces domestic homicide by a significant rate, there is a

large amount of anecdotal evidence to support the positive effect a DVFR has on the quality of domestic violence investigation and the response from law enforcement and criminal justice systems. DVFRs report small victories that may or may not be attributable to the establishment of such Teams. The passing of an entire year without the death of any victim who held a restraining order (Santa Clara DVFR 2002) or securing a change to firearms legislation on a local level to prevent perpetrators having access to their firearms (County of San Diego DVFR 2004), are significant triumphs in the field of domestic violence; the role of DVFRs in advocating for and procuring such changes cannot be overstated.

For example, the San Diego DVFR, one of the earliest established, provides an interesting insight into domestic homicide over the past decade. While the sample is statistically very small, it is possible to see a trend emerging in domestic homicide in that area. The San Diego DVFR identified access to firearms as one of the single greatest concerns arising from the first review, given that of thirty-seven homicides in that period, twenty-two were committed with a firearm. The DVFR made a number of strong recommendations that were supported by Senator Christine Kehoe. As a consequence, the Senator introduced a Bill requiring domestic violence perpetrators to surrender firearms to police after a domestic violence incident (County of San Diego DVFR 2006). In the current review period, only eight of the twenty-five homicides were committed using a firearm, a reduction of about 50%. For the first time since the DVFR was established, more homicides were committed with knives than guns, and the number of homicides had dropped from thirty-seven to twenty-five in that period.

These statistics show a trend away from firearms but the DVFR 'observed increasingly aggravated and brutal attacks on victims, especially in cases of stabbing and strangulation' (County of San Diego DVFR 2006). While this change in the apparent choice of weapon raised new concerns about the use of other methods to kill, a conclusion could be drawn that access to firearms has become more limited for perpetrators. It is difficult to know whether this trend was due to the focus on removing firearms from domestic violence perpetrators. However, the DVFR had at least identified a shift in the nature of domestic homicides in the area and the data collected and collated is far more detailed and accurate as a result of the DVFR's work.

Facilitating inter-agency relations and cooperation

DVFRs have been shown to assist greatly in improving interagency relations and cooperation, leading to a far more cohesive approach to domestic violence. For example, the New Jersey DVFR included the implementation of a 'coordinated community response to domestic violence' as one of its key recommendations (New Jersey DVFRB 2003), and other DVFRs tend to adopt a similar approach.

As Teams are comprised of members from different agencies, those members can network well and provide contacts for each other in agencies, between which there may have been little or no contact before. Additionally, Team members are exposed to the practices, procedures and knowledge of members from different agencies, through the review process. All members of the DVFRs gain useful knowledge and understanding about the functions and operations of other agencies. For example, members representing the law enforcement agencies glean useful working

knowledge of child protection services during review meetings and vice versa, leading to improved understanding and cooperation between agencies. In addition, some DVFRTs may invite members of victims' families to work with them (as does the San Diego DVFRT), exposing members to the families' experiences as a way of increasing their understanding of the issues involved.

This exchange of knowledge and the review process itself appear to result in members returning to their workplaces and initiating changes, prior to a DVFRT making formal recommendations. To illustrate, the Hennepin DFRT in Minneapolis, USA, recognised that a number of changes to systems and procedures 'occur as a result of Team members going back to their respective organizations with knowledge gained through direct involvement in the review process' (Hennepin County DFRT 2007), allowing for faster and more organic improvements in the response to domestic violence. Typically, DVFRTs in the USA establish strong interagency relationships, gather and collate accurate, detailed data and have become powerful, evidence-driven advocates, effecting positive change to systems and procedures responding to domestic violence.

CRITERIA AND SCOPE

Each DVFRT model applies different criteria to establish which deaths will come within the scope of review. Most US models include any homicide, murder-suicide or 'blue suicide' (i.e. where police have shot a person after deliberate provocation). Some models apply narrower criteria, such as the Arizona DVFRT that reviews only murder-suicides. This state has the highest rate of murder-suicides in the USA and murder-suicides are usually adjudicated within twelve months of the event, thus reducing delays (Arizona CADV 2002).

DVFRTs do not generally study accidental deaths or severe assaults and attempted murders. However, some smaller counties in the USA do include these cases. This is largely, it appears, to have sufficient cases to produce meaningful statistics and to provide a more accurate picture of domestic violence in their area. Contra Costa County in California aimed to review every domestic violence-related fatality from 1997 to 2000 and identified thirty-one cases for review. After identifying such a small number of cases, Contra Costa DVFRT relaxed the criteria required for a death to be reviewable and included all domestic violence-related deaths not attributable to natural causes (Contra Costa County DVDRRT 2005), providing a more useful sample of cases for analysis.

The mission of a DVFRT is narrowly defined and concerned with patterns of violent behaviour consistent with domestic or family violence, resulting in death. As such, it is logical to restrict the scope of a Team to cases where a death occurred as a direct result of the actions of a person who may be legally defined as having a 'domestic relationship' with the victim.

While it would be valuable to widen the criteria for reviewable cases to non-fatal incidents, such a broad application of a DVFRT model in Australia might result in a huge overload of cases. For example, there are over 25,000 domestic violence-related assaults reported to police per year in NSW alone (People 2005) and an Australian Bureau of Statistics report estimated about 405,000 women are assaulted nationwide each year, the majority by a man they know (ABS 2006). To include non-

fatal incidents, even where a very serious injury was occasioned, may result in an unsustainable workload of cases to review in the depth required. While there may well be value in reviewing these cases, it may be only possible in jurisdictions where a very low number of fatalities occur.

The scope of a DVFRT and the criteria used to identify reviewable cases are often determined by financial constraints, staffing resources and time constraints. Where time and staff are available, it is possible to review a broader scope of cases, including, for example, all attempted murders where the offender was related to the victim or all suicides where domestic violence was a contributing factor. There are several categories of fatality which are not included in the majority of 'reviewable deaths' criteria for DVFRTs across the USA. Those categories are suicides of domestic violence victims, the killing of people peripheral to the primary domestic relationship and the homicides of professionals who assisted a domestic violence victim to leave an abusive partner. The review of these deaths could add useful knowledge to an understanding of domestic-related fatalities but they are usually not included because of the resource constraints.

There is a strong association between experiencing domestic violence and depression (Hegarty *et al.* 2004) and suicide (Stark & Flitcraft 1995; Seedet *et al.* 2005; Stewart 2005). Conservative estimates of female suicides in the USA show that about one-third of women who kill themselves have a medical history documenting domestic violence (Nudelman & Rodriguez Trias 1999). The suicides of victims of domestic violence are reviewed by some DVFRTs in the USA, where resources allow and there is a willingness to include suicides in the scope of the reviews (Websdale *et al.* 2003). In Australia, 477 female suicides were recorded in 2003 (Australian Bureau of Statistics 2004). In this context, it appears appropriate to include a review of suicides, especially if the victims or their children are known to have been abused prior to the suicide.

Another possibility is the inclusion of suicides occurring in conjunction with a homicide incident. Australian research shows that a number of domestic homicides involve the suicide of the offender, with approximately 60% of murder-suicides occurring in a 'family setting, especially partners', (Carcach & Grabosky 1998). The same research showed that where a homicide victim is the ex-spouse of the offender, the offender is 4.6 times more likely to commit suicide than other perpetrators, and 3.2 times more likely where the victim is his current partner. Those odds increase to 9.7 when the victim is the offender's child.

Similarly, some homicides occur where the victim or victims are peripheral to the primary relationship. A significant proportion of homicides occur between 'other family members...[such as] cousins, in-laws, grandparents and other family members' (Mouzos & Rushforth 2003). On average, eleven homicides fitting this category are committed in Australia each year, as a result of the abused person's family or friends providing protection and support, while the victim separates from the perpetrator or seeks protective options (Mouzos & Rushforth 2003).

The last category of death that could be considered is homicides and violent deaths involving a person professionally linked to the primary violent relationship. Counsellors, police, solicitors and family court judges have all been targeted by perpetrators looking to exact revenge on those seen as enabling the escape of their

partners. While these killings are relatively rare, the inclusion of such deaths in the scope of a DVFRT may provide an opportunity for the examination and identification of systemic failures, that may have occurred in the time preceding the death.

COMPOSITION

With rare exception, the DVFRTs established across the USA have a similar structure. Set up like a governmental advisory board, a 'lead agency' anchors each DVFRT; that is, one organisation or government department with the responsibility, resources and interest in the area will administer and support the DVFRT. The approach taken in the USA is that the lead agency is removed from frontline work in the field so that it is able to direct reviews of the procedures of all agencies involved in that work, without prejudice. The Attorney-General's department in each state in the USA is often a natural first choice, in that it is typically the best suited to assume the role of lead agency and has no direct stakeholder status in the area of domestic violence.⁵

The agencies included in a DVFRT are generally drawn from both government and non-government sectors, including 'representatives from law enforcement, health and welfare government agencies, lawyers, including the equivalent of Australian Directors of Public Prosecutions, the coroner's office and a range of non-government sector services' (Stewart 2005). Such a multi-agency approach ensures both a broad range of perspectives and access to the information amassed by each sector. Some DVFRTs also include advocates for victims and women, as well as government agencies involved in the area of domestic violence. The inclusion of advocates may allow a DVFRT to be able to provide more wide-ranging and pertinent recommendations.

OPERATIONAL ISSUES

DVFRTs seek to review deaths which fit a pre-determined set of criteria, utilising a multi-agency, multi-disciplinary investigative approach looking at a number of factors identified in each death. The four key tasks of a DVFRT are to:

- identify deaths that occurred in the context of domestic or family violence
- review individual deaths, seeking to identify points in the chronology of each violent relationship where appropriate intervention may have assisted the victim or perpetrator, thus avoiding the fatality or fatalities
- review all the homicides which have occurred in a particular time period, looking at the deaths as a statistical group and identifying trends, patterns and issues arising from that analysis
- provide a comprehensive report when required, making recommendations to the agencies and organisations involved in domestic and family violence, the government, legal system and the wider community. These recommendations are targeted towards all stakeholders, having identified systemic and

⁵ This may not be the case where the operation of the courts is part of the responsibility of the Attorney-General's Department.

procedural issues, and seek to remedy those problems with the aim of preventing deaths occurring in a similar situation in the future (Websdale 2006).

Fundamentally, death reviews ‘...are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts’ (Canada DVDRC 2005). A DVFRT seeks to investigate the events prior to the death, the circumstances surrounding the death, and action that may be taken to prevent deaths occurring in similar circumstances in the future. Most significantly, DVFRTs are able to view a group of deaths in one sitting. They are able to identify patterns in method or circumstances where a coroner or court could not, being usually unable to consider more than one case at a time during an inquest (Websdale 2003).

DVFRTs are also only interested in systemic and procedural weakness, not the actions or negligence of individuals. Unlike investigations conducted by coroners and criminal courts, the individual is not the responsible agent; it is the operating procedures, laws and systems in place at the time of the death that come under scrutiny. For example, a police officer may decline to apply for an Apprehended Domestic Violence Order on behalf of a victim who is later killed by her partner. In this case, a DVFRT would seek to understand whether this decision was part of a wider issue (such as a lack of police training or flawed legal powers), rather than seeking to establish fault on the part of the individual officer.

Each DVFRT sets its own guidelines and methods of review, the form of which is dependent on the locality, rate of domestic homicide, political climate, current responses to domestic and family violence by stakeholders, and the resources available to it. Typically, a DVFRT receives a referral from the criminal justice agency primarily responsible for the investigation into the fatality, be that state or federal police, or the coroner. The brief of evidence compiled by the investigators is turned over to the DVFRT for the duration of the review, along with any information gathered by investigators that is relevant to the fatality but for legal reasons was not able to be included in the evidence presented to the court.

Generally, the information relied upon in a review of a domestic homicide is contained in the official reports and brief of evidence. Whilst the brief of evidence compiled by police is usually detailed, professional and extremely thorough, it is sometimes necessary to conduct investigations into areas not covered by the brief, such as interviewing friends, family, co-workers and health professionals about the history of the relationship between the victim and offender. Anecdotal and hearsay evidence of past domestic violence history is usually inadmissible in court, and it would waste time for police to seek that kind of information. However, in the context of a review, this information is often crucial to understanding how the homicide occurred and what systemic changes would make another homicide in similar circumstances less likely.

The role of a DVFRT is not to conduct a fresh investigation into the fatality. DVFRTs rely almost solely on the evidence already obtained by professional investigators under government direction and legal provision. Police have adequate powers to procure documents, statements and physical evidence in the course of a homicide investigation that a DVFRT need not duplicate.

However, there are often areas of the relationship dynamic or particular events preceding the fatality that the initial investigation has not thoroughly explored and that

require further examination. Each DVFRT determines how that follow up is conducted. The accepted protocol in the majority of the US DVFRTs, such as those in Hennepin County, Minnesota and San Diego County, California, is that investigations are undertaken by members of the Team suitably qualified to do so. Police, prosecutors, coronial investigators, lawyers and various other DVFRT members undertake the required exploration of identified issues, rather than retaining outside investigators at extra cost. The resultant body of information gathered about a particular fatality is far more multifaceted than the brief of evidence alone.

DVFRTs in the USA are generally supported by a legislative package which provides investigative powers and places restrictions on members of the DVFRT. Legislation also requires the publication of a report by a DVFRT; this is usually done annually and must adhere to strict confidentiality rules. Reports may include recommendations made by a DVFRT to address issues identified by the review process. For example, a DVFRT may recommend the confiscation of firearms from defendants issued with restraining orders, mandatory attendance at a perpetrator program as part of sentencing for domestic violence perpetrators or the provision of enhanced support for families undergoing family court proceedings.

LEGISLATIVE REQUIREMENTS

It is important that legislation be enacted to support the creation of a DVFRT, to provide its structure and frame of reference, and to establish the necessary legal framework for access to confidential case information. Legislation preceded the majority of DVFRTs established internationally, with each Team being given investigative powers regarding access to medical and criminal records, briefs of evidence, and other relevant information such as reports by children's services and psychologists (Websdale 2006). Those DVFRTs established with the assistance of grants tend to conduct reduced reviews, such as the Arizona DVFRT which looks only at murder-suicides (Arizona Coalition Against Domestic Violence 2002).⁶

US legislation typically sets out rules and creates offences regarding confidentiality, the production of reports and the authority of the DVFRT to make recommendations. (Websdale 2003). A number of primary issues are addressed by legislation:

- confidentiality and protection of the sensitive information involved in the investigation of a violent death
- the manner in which the agencies involved will share information with the DVFRT
- DVFRT access to information and restrictions placed on divulging information to external parties
- the structure, composition and authority of the DVFRT, along with its meeting and reporting requirements.

Legislation for DVFRTs in the USA generally follows a model similar to that of the *Texas Statutes Health and Safety Code 2001*, Chapter 672 or the *California Penal*

⁶ In 1999, the Arizona Coalition Against Domestic Violence received a grant from the Arizona Community Foundation to establish a DVFRT.

Code, sections 11163.3–11163.5. The legislation, while being general in terms of information-gathering, leaves open the definition of ‘relevant’ information. It is quite specific regarding the confidentiality of that information beyond the DVFRT meetings and reports, and provides for offences if those rules are breached. The Texas Statute includes a list of those who may serve as a member of a DVFRT and guidance about who will lead it, what the scope will be (in terms of reviewable fatalities) and what information may be procured.

Confidentiality may be secured within a DVFRT by the use of confidentiality agreements. Santa Clara County, California, side-stepped the most prominent issue of confidentiality amongst Team members and the use of information shared by the member agencies by having all members and all who are otherwise associated with the DVFRT, such as investigators and expert advisers, sign confidentiality agreements (Santa Clara County DVCDRC 2002).

Beyond confidentiality issues, where a multi-agency DVFRT is created the next challenge is to coordinate the workings of different agencies in the most efficient and professional manner possible. Interagency relationships are often cumbersome and poor, so it is a great challenge to create legislation that assists with the removal of bureaucratic hurdles and provides a conduit for interagency cooperation.

In a review of international literature concerning DVFRTs, commissioned by the NSW Attorney-General’s Department, Stewart (2005) makes the observation that there is a definite ‘need for a comprehensive package of legislation to address a number of issues and to amend legislation in relation to others’. Without a comprehensive set of laws exempting DVFRTs from concerns relating primarily to privacy and confidentiality, and the provision of strict rules binding members from releasing the information obtained, it is unlikely a DVFRT would receive any cooperation from involved agencies.

The issues arising from requiring access to information of such a sensitive and confidential nature are complex and varied. For an average investigation, a DVFRT may need access to the following information, with each case requiring different information depending on the circumstances and antecedents:

- the brief of evidence compiled by police, including statements, interviews, photographic evidence, post-mortem reports, video evidence, maps and plans of scenes, transcripts of listening devices and telephone intercepts, and results of physical evidence testing such as DNA, fingerprints and drug tests
- any information gathered or recorded by police during the investigation but not included in the brief due to laws of evidence, including investigative notes, applications for warrants, Apprehended Violence Orders and forensic procedures denied by the court, and any other information gathered by police not admissible in court
- medical records, dental records, psychological and psychiatric records, hospital admissions and prescriptions written for those involved in the incident, any counselling sessions attended or contact made with medical or mental health services
- records of any civil proceedings, Family Court proceedings, criminal records, police intelligence reports relating to the perpetrator/s and victim/s, immigration records and applications, driver’s licences and applications, firearms licences

and applications, as well as registered firearms, security licences and applications

- all relevant records kept by solicitors, barristers, accountants, financial institutions, telephone companies, Australia Post and couriers, utilities, conveyancers, mediators, private investigators, child care providers, schools and tertiary education providers, and any other professional utilised by the victim/s and/or the perpetrator/s
- briefs of evidence for charges arising from previous domestic violence incidents, including court transcripts and sentencing comments by presiding magistrates and judges in those matters, probation and parole records, prison records and psychological assessments conducted in prison
- all evidence included in briefs compiled for the coroner, and relevant hearings into the death or deaths, including the findings and comments of the coroner at the completion of the inquest
- all relevant records arising from any other Royal Commission, inquest, Ombudsman's review, internal police investigation, Police Integrity Commission inquiry, Child Death Review Team report, Parliamentary Inquiry and private investigation.

This is by no means an exhaustive list but it gives some idea as to the complexity and depth of any investigation into a violent death, especially where the death is to be reviewed in terms of the preceding circumstances, not the death itself. Issues concerning the protection of identities, privacy and privilege laws, the DVFRT's power to procure records regardless of the level of cooperation offered by agencies or parties, and the need to produce recommendations and reports without compromising the right to privacy of victims, perpetrators and their families, form the foundation for legislative support (Stewart 2005).

It is important that legislation effectively remove, wherever possible, the ability for agencies to impede or block the review of a domestic violence-related death. As a DVFRT is investigating systemic, procedural and legal issues prior to the death under review, it is possible that agencies adversely mentioned may seek to impede the Team's access to the relevant information.

INTRODUCING DVFRTS IN AUSTRALIA: ISSUES TO CONSIDER

Amid the growing number of statewide and whole of government strategies and programs in Australia aimed at preventing and responding to domestic and family violence, there have been calls from a number of quarters to consider the introduction of DVFRTs. The Victorian Law Reform Commission (2005) recommended that the Victorian Government introduce a DVFRT in that state (p. 417). The NSW Ombudsman (2006) similarly recommended the establishment of a domestic violence death review process (p. 81).

Some domestic violence services and advocates have also shown strong support for establishing DVFRTs. Domestic Violence Victoria (the peak body for women's domestic violence services) and the Federation of Community Legal Services (Victoria) have launched a Family Violence Justice Reform Campaign to lobby for the uptake of the Victorian Law Reform Commission's recommendations. In NSW the

Domestic Violence Coalition and in Queensland the Domestic Violence Death Review Action Group have both lobbied their state governments to introduce DVFRTs. To date, no Australian state or territory government has established DVFRTs, despite most jurisdictions having well-established Child Death Review Teams or similar processes.⁷

If DVFRTs are to be established in Australia, the scope of cases covered by the DVFRT would require careful thought. The number of domestic homicides fluctuates across Australian jurisdictions. Some states with greater numbers of homicides, such as NSW, Victoria and Queensland, would need strict criteria relating only to homicides and murder-suicides. Others, such as the Northern Territory and Tasmania, with less than ten homicides in total on average per year (Mouzos 2001a), might consider relaxing the criteria to include suicides and perhaps attempted murders. Each jurisdiction would need to evaluate their individual situation and establish criteria accordingly. It would, therefore, be useful to examine a number of DVFRTs in the USA, in areas with both large and small populations, when looking at DVFRT models suitable for the Australian context.

An operational issue for consideration is whether DVFRTs would duplicate existing work; that is, whether the role performed by a DVFRT is already being performed by a number of other agencies. While it is true that all suspicious deaths are investigated by the police and coroner in each jurisdiction across Australia, some are not the subject of either an inquest or a full investigation leading to a criminal trial.⁸ The only analysis of homicide undertaken annually is that by the National Homicide Monitoring Program (NHMP), which looks at overall trends, patterns and rates of homicide state by state. The NHMP relies primarily on statistical data obtained from a variety of sources and cannot review individual cases in any depth (Mouzos 2005).

Each domestic violence-related fatality, while being investigated thoroughly by law enforcement and, later, the criminal justice or coronial system, is still viewed in Australia as a discrete event. Knowledge gained from review of mistakes or procedural problems in one event is not then applied across all domestic violence-related fatalities. Even when a coroner makes recommendations, they relate to one incident and cannot possibly take into account the number of other deaths resulting from domestic violence that have occurred within that year. Coronial recommendations, while carrying a great deal of weight in the community, can only be made in the context of the inquest at hand. Because these recommendations are not collated and because problems in the response to domestic violence are not viewed holistically, certain issues can 'fall between the cracks'.

⁷ For example, NSW Child Death Review Team, Victorian Child Death Review Committee, Queensland Child Death Case Review Committee, Western Australian Child Death Review Team and South Australian Child Death and Serious Injury Review Committee.

⁸ A murder-suicide, though often the subject of an inquest, is not guaranteed an inquest. The wishes of the family, as well as the wider community need, are taken into account. The Coroner decides whether an inquest is held. In the case of suicides alone, very rarely would there be an inquest. Where a case has been investigated and there is not enough admissible evidence to provide a reasonable prospect of conviction, the DPP will usually not proceed with charges. There are a number of domestic violence related murders that are not given a trial hearing, despite the identity of the assailant being known. An example of this situation is an offender being ruled 'unfit to plead' on the basis of illness or insanity.

One example that highlights this issue is provided by the NSW coronial findings into the murder of Margo Attia by her husband, Hossam Attia, and his subsequent suicide on 19 October 2001. The Coroner's findings focused on government mental health services and the three psychiatrists involved in Mr Attia's care. A number of recommendations were made to improve the service delivery of the state mental health system. No mention was made of police inaction or lack of training in domestic violence that also contributed to these fatalities (NSW State Coroner's Inquest findings 2003). The nature of coronial inquests is such that only certain factors must be determined. It is not possible for inquests to focus on any matter other than those pertaining directly to identifying the core problems resulting in the fatality and the time, manner and location of death. A DVFRT is able to delve much deeper and identify secondary issues, which may be primary issues in other deaths.

The role of an ombudsman is another possible point of overlap. An ombudsman's functions can include 'reviewing reviewable deaths' and undertaking systemic reviews of deaths. However, these reviews are neither focused the same way as a DVFRTs, nor are they conducted in the context of the other reviewable deaths occurring in that time period. So, for example, reviews of child deaths by the NSW Ombudsman's Office are undertaken to establish if any fault can be laid on the foster carers, Department of Community Services workers or systems, parents and so on. These reviewable deaths fall into a narrow category focused solely around children under State care. In addition, those deaths are treated discretely, that is, unless a particular issue repeats itself obviously, those deaths aren't compared by the Ombudsman. The NSW Child Death Review Team, in contrast, conducts data collection and collation, and the analysis of that data to identify patterns and trends in deaths.

An ombudsman's role is focussed on complaint investigation and oversight; it is an investigative body looking to examine agency systems, oversee investigations or review the delivery of services. The function of a DVFRT is different from a complaints or integrity commission, and separate in focus to an ombudsman. The dual purpose of the DVFRT is to review domestic violence fatalities and collate data about them. A DVFRT is a multi-agency team looking for improvement in service-delivery and a reduction in domestic violence fatalities. Its purpose is holistic and positive, focusing on systemic issues as opposed to individual performance.

It might be possible for an ombudsman's office to be a lead agency or form a DVFRT in its own right. However, the central reason an ombudsman exists is to investigate complaints about government agencies, so it may send a negative message to agencies that need to co-operate fully with a DVFRT. If agencies believe the DVFRT is a fault finding exercise aimed at exposing flaws in the agencies themselves, rather than looking to improve systems and prevent domestic homicides, there may be far less assistance given.

While the criminal justice systems in each Australian state and territory are fundamentally the same, the domestic homicide situation is unique to each state and territory, with a distinctive mix of domestic violence legislation, police powers, government policy, population demographic and resource allocation in each area. Each state and territory has specific areas of significance and it is impossible to recommend any one particular model of DVFRT for all local areas. It is only possible to recommend certain approaches and considerations that should be taken into

account, given the experiences of other countries over the past few years.

For example, about one-third of the Northern Territory's population is Aboriginal or Torres Strait Islander (ABS 2004). There is an extremely high rate of homicide in this population group. Homicide rates generally average eight to twelve per 100,000, compared to the national average of one per 100,000. Of the six homicide victims in the Northern Territory in 1999–2000, four were Indigenous, a pattern similar to that of previous recorded years (Mouzos 2001b). Therefore, a DVFRT in the Northern Territory would need a number of members with significant connections to Aboriginal and Torres Strait Islander communities, and the authority from those communities to represent their interests accurately. In Tasmania, a significant domestic violence factor appears to be the availability of firearms and it would therefore be helpful to include an expert in that area on the roster for a Tasmanian DVFRT.

Funding and resourcing issues also require consideration. Funding and staffing a DVFRT requires a large time commitment from DVFRT members and the resources required to collect, collate and review cases, and produce reports are not insignificant. Costs could be absorbed by participating agencies or agencies could contribute to the resourcing of DVFRTs. Consideration would also need to be given to identifying an appropriate lead agency in each jurisdiction.

A suitable legislative framework would need to be developed in each state and territory which decided to adopt DVFRTs as a means of combating domestic violence. The most appropriate blueprints for legislation of this nature are those governing the powers of the coroner in each jurisdiction, as well as of existing death review teams. DVFRTs need the legislative power to require cooperation and full disclosure of information pertaining to particular people, locations and actions undertaken, while maintaining a completely transparent and confidential working relationship with each member agency. The specific manner in which this is achieved can only be identified by those working within that state or territory system.

Protecting the privacy of victims and their families is another key challenge. Keeping confidential information within the confines of the DVFRT is paramount. There are certainly legislative avenues which may be pursued, as in California and Florida where offences relating to the leaking of information by DVFRT members were created. Confidentiality agreements are also an option (Macomb County FRT 2006). Some DVFRTs are governed by legislation which requires members to sign a confidentiality agreement, such as Santa Clara DVFRT in California. While confidentiality can never be guaranteed, the risk of sensitive information being released can be greatly reduced. The majority of DVFRT members would be used to working in an environment of confidentiality, and the risk of criminal and civil action should be enough to deter those who consider releasing information.

The overall effectiveness of a DVFRT is dependent, ultimately, on political and community will. Although DVFRTs in the USA make recommendations in every report to their Attorneys-General, legislature and communities as to how domestic homicide can be prevented, it is up to decision-makers to implement those recommendations. Recommendations are not always implemented; for example, contentious areas such as gun control have generally been ignored by US officials. The role of a DVFRT is to advise and recommend but, because there is no requirement to follow that advice, the effectiveness of a DVFRT can be undermined by inactive or unconcerned decision-makers.

In the review of research for this paper there was little evaluation material concerning the operation of DVFRs in the USA. Most Teams have been running a few short years and the advisory nature of DVFRs makes it difficult to link changes in patterns of domestic homicide solely to the operation of the DVFR. It is, therefore, not possible to provide concrete evidence of the value of the investment of resources and time in maintaining DVFRs. If introducing DVFRs into Australia, either as a pilot or long term initiative, it would be prudent to incorporate an evaluation process. This could identify expected outcomes and targets, assess the functioning of the DVFRs and the costs involved, and review methods and procedures to ensure positive consequences for victims, their families and workers in the field.

Finally, any decision to establish DVFRs in Australia should be preceded by consultation. In 2006, the UK Home Office released a consultation document on the establishment of DVFRs in that country. A public consultation period of three months allowed stakeholders to comment on the process and methodology for reviews (UK Home Office 2006). That feedback was then incorporated into the design and implementation of DVFRs in the UK. Should Australian jurisdictions consider the introduction of DVFRs, a similar consultation process would enable stakeholders to learn about these bodies and processes, and to contribute to their development.

CONCLUDING COMMENTS

While domestic homicide does not occur at a high rate in Australia when compared with other countries, its very nature provides opportunities to prevent the deaths of domestic and family violence victims and perpetrators in the future. Domestic violence-related fatalities are presently being dealt with as tragic but discrete events, not as part of a wider pattern of abuse.

Domestic violence victims are vulnerable individuals who are often isolated from services and support. Their powerlessness may be less obvious and less well understood than that of a child or a person with a disability or mental illness (for whom death review committees or teams already exist in Australia). This may be because, despite its pervasive occurrence, domestic violence is still obscured by secrecy and shame. However, domestic violence is a significant and serious public health issue, with VicHealth (2005) citing it as the leading contributor to death, disability and illness in Victorian women aged between fifteen and forty-four years. Domestic homicide is preventable and there are good reasons to invest resources to better understand the causes of violent behaviour and the risks that precede fatalities, and to develop more effective prevention and intervention response measures.

The introduction of DVFRs in Australia could expand our knowledge of how domestic and family violence is affected by current policies and legislation. Domestic and family violence occurs in complex situations involving socio-economic, psychological, sexual, racial and geographic factors, the combinations of which are unique to every single violent relationship (Websdale 1999). Only through continued analysis of domestic homicides and related deaths can those factors be appropriately identified and strategies implemented with measurable outcomes.

Each Australian state and territory has its own legal framework and service provision for dealing with the pressing issue of domestic and family violence. The introduction of DVFRTs in Australia would need to be tailored to suit individual jurisdictions' domestic violence demographic, with a legislative framework that supports the aims of the DVFRT, as decided by its founding members. As demonstrated in the USA, DVFRTs work most effectively in local areas, dealing with local agencies, police and stakeholders. It is not useful to attempt to apply a set model to every state or territory.

A great deal is still unknown about the context of domestic and family violence homicide in Australia, including how effective prevention approaches are. A next step should be the in-depth review of the extremes of family and domestic violence, so that lessons learnt could be applied to the more common violence perpetrated against victims living with fear every day.

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