Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Family Violence Death Review Committee

He tao huata e taea te karo

Third Annual Report:
December 2011 to December 2012

Ngā mate aituā o tātou
Ka tangihia e tātou i tēnei wā
Haere, haere, haere.

The dead, the afflicted, both yours and ours
We lament for them at this time
Farewell, farewell, farewell

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Foreword

The Health Quality & Safety Commission (the Commission) is very pleased to release the Family Violence Death Review Committee's (FVDRC) third annual report. Family violence is a matter of great importance to all New Zealanders, and this report reflects the commitment and dedication of the FVDRC and the leadership of its Chair, Associate Professor Julia Tolmie.

While this is the FVDRC's third annual report, it is the first report of the current FVDRC, which was reformed at the end of 2011 with the appointment of seven new members. The report signals an exciting new phase of development, enabled by the foundation work of the former committee. It moves beyond description and focuses on action, making a number of strong recommendations based directly on evidence from death reviews.

The report summarises the development of the two-tiered family violence death review system. The first tier provides an overview of family violence deaths and family violence related deaths that occurred in 2009–10. The second tier provides in-depth reviews of a number of family violence deaths.

Over the last 18 months, three regional review panels were established and nine family violence death reviews completed. They provide chilling information and have informed the content and advice in this report. The regional reviews are undertaken in partnership with government and non-government organisations and cultural experts. An important part of collecting qualitative data on New Zealand's family violence response system is that actual system and practice improvements occur within the organisations as a direct result of their participation in the reviews.

In this report, the FVDRC makes recommendations for improvements in the following areas:

- inter-agency collaboration and information sharing in high risk family violence cases
- stopping violence programmes
- the response to victims in the aftermath of family violence homicides.

Family violence is a very important issue for government and society generally, and for the Commission in particular. While this FVDRC report examines family violence deaths, the deaths are only the tip of an iceberg of serious harm. Violence within families has serious, widespread and long-lasting detrimental effects on health and wellbeing. Addressing family violence is an essential part of improving health care.

Many organisations are involved in responding to these tragic cases, and wide stakeholder engagement has been very important in the development of the recommendations for this report. I would like to acknowledge the special effort made over the last few months, particularly by Associate Professor Tolmie, in engagement with:

- the Ministry of Justice
- the Ministry of Social Development (Child, Youth and Family)
- the Office of the Children's Commissioner
- New Zealand Police
- the Department of Corrections
- the Ministry of Health
- the National Collective of Independent Women's Refuges
- the National Network of Stopping Violence Services
- Jigsaw
- Victim Support

- Safer Homes in New Zealand Everyday (Shine)
- the Taskforce for Action on Violence within Families
- the New Zealand Family Violence Clearinghouse.

It is pleasing to see recommendations for change that are supported by such a wide range of key stakeholders across government and other sectors.

Many of the recommendations in the report also support a number of current government initiatives, particularly the work of the Taskforce for Action on Violence within Families, the Children's Action Plan and the *Delivering Better Public Services: Reducing Crime and Re-offending Result Action Plan*.

This FVDRC report shines light on a very important problem. Although family violence is not in any way unique to New Zealand, it is something that no New Zealander would want in our society. The imperative now is to increase the efforts already underway to address and substantially reduce the occurrence of family violence at all levels.

Professor Alan Merry, ONZM
Chair, Health Quality & Safety Commission
June 2013

Chair's introduction

This is the third report of the Family Violence Death Review Committee (FVDRC) and the first report from the committee as it was newly constituted in December 2011. Progress has been significant since the FVDRC's *Second Report*.[1] Most importantly, in 2012, we selected, trained and established three regional review panels. These panels completed nine in-depth death reviews. In 2013, we will continue this work by setting up additional panels and continuing to review deaths.

The regional death review panels set up in 2012 have generated both local and national recommendations. Many of the local recommendations have already been actioned at a regional level. This report contains some of the national recommendations that the FVDRC has chosen to progress. There are a number of other recommendations still being discussed by the FVDRC, and we envision more as we continue the death review process. The FVDRC has also made an effort throughout the year to contribute to policy development in a timely fashion by sharing evidence emerging from our death reviews in the form of submissions and presentations to appropriate review and reform bodies.

Among other activities, we have continued to gather core data about all family violence death events, develop data sets and memoranda of understanding with the agencies from which we collect such data, and planned how that quantitative data might be usefully organised for storage in a database. We are addressing how we might collect information about family violence death events from family and friends, and we have developed a set of questions about family violence that should enable us to gather data about the influence of family violence on deaths that are not ostensibly family violence deaths.

The work of the FVDRC over the year leading up to this report has been difficult and the workload immense. Such work is always emotionally gruelling and attempting to influence reforms to practice in the current fiscal climate is challenging given the lack of resources to commit to any new initiative. Moreover, we as a committee were being reviewed as part of an overall review of all of the four New Zealand mortality review committees. Uncertainty about the future shape of the mortality review programme has added to the challenge of establishing new processes and infrastructure.

In spite of these constraints and challenges, I speak for the FVDRC in saying we feel enormously honoured to do this work. We sit in a position of great trust and privilege. A family violence death event is a tragedy that affects everyone in the community. While such an event might trigger individual agencies to review their own areas of practice, we are in the unique position of being able to review the response of the system as a whole. We have the opportunity to develop recommendations based on evidence about what is actually happening. We also have the privilege of working with many other professionals who are dedicated to the safety of victims of family violence, including our wonderful advisors, our outstanding review team members, the agencies that dedicate enormous resources to the provision of data and our brilliant secretariat staff. These professionals and agencies have been totally committed in supporting the work of the FVDRC and for this we are more than grateful.

While the deaths reviewed by the FVDRC are small in number compared to those reviewed by the other mortality review committees, they are all preventable deaths. They also represent the tip of the iceberg in terms of the damage and costs to us as a society from family violence. For example, we know that New Zealand Police attended over 94,000 family violence incidents in New Zealand in 2011 and yet it has been estimated that only 18–20 percent of all family violence offences are actually reported to the police.[2] While the costs of responding to family violence and ongoing assessment and improvement of that response are not inconsiderable, they will be far outweighed by the costs of not responding, or not responding as effectively as we could, given the resources at our disposal.

1 Family Violence Death Review Committee, *Second Report: October 2009 to November 2011*, Wellington, Health Quality & Safety Commission, 2011.

2 B. Nimmo, *Stakeholder update: Police family violence process changes*, Wellington, New Zealand Police, 2012.

As the visible tip of the iceberg, family violence deaths are not only a measure of lethality but also an important barometer of the incidence of family violence. We can understand this via the concept of the 'dark figure' of crime. Every crime has what criminologists call a 'dark figure': the amount of crime that takes place in society, but is never reported to, or recorded by, the police.[3] The overall picture of family violence in society can be difficult to capture because it is infrequently reported to the police. As noted in the previous paragraph, only 18–20 percent of family violence incidents are estimated to be reported to the Police, suggesting a dark figure of 80–82 percent. Homicides, on the other hand, do not have a large dark figure because most crimes resulting in death come to the attention of police and attract significant New Zealand Police resources. The result is that while family violence incidents may appear to increase or decrease in any given year for reasons that have nothing to do with how many incidents are actually taking place (such as more people reporting such violence to the police or the police changing their recording or charging practices around family violence), homicides will be less affected by these matters and more likely to reflect the actual incidence of family violence matters that escalate to homicide.

Themes that have emerged in the death reviews we have conducted include:

- the need for an improvement in our whole-of-system response to family violence, which includes developing common understandings of family violence, common tools for assessing risk and clear procedures and support for interagency work
- the need to improve training in family violence across all professional disciplines where decisions may be made or advice given in cases involving family violence (including private therapists, social workers and judges)
- the need to understand and respond to family violence as a cumulative and relationship-based issue, which spans family networks, generations and serial partnerships, rather than on an incident-by-incident basis. This includes the need to develop a case management approach that prioritises victim safety when responding to cases involving family violence
- the need to improve screening and assessment processes for family violence across all sectors of the social services
- the need to improve public knowledge about the risk factors for lethal homicide
- the co-occurrence of intimate partner violence (IPV) and child abuse and neglect (CAN)
- the need to develop adequate strategies for particular communities affected by multi-generational trauma and levels of violence that make the word 'brutality' a more appropriate descriptor than 'violence'.

Some of these themes are given expression in the recommendations made in this report and will continue to find expression in recommendations to come.

It is important to remember that these issues belong to us as a community – not the individual front-line staff called upon to respond to cases involving family violence, who may be managing large caseloads with stretched and limited resources in complex, ambiguous and very dangerous circumstances.

Finally, I want to thank the New Zealand Government and the Health Quality & Safety Commission for their continued support for the FVDRC. There is now recognition from international human rights bodies that the failure to have adequate and effectively enforced protections for the victims of violence constitutes a state breach of their human rights: including their right to life and to be free of inhuman or degrading treatment.[4] Being prepared to look at what went wrong when the system did not function effectively and to think about what could be improved is clearly an important component of having an effective response to family violence.

Associate Professor Julia Tolmie

Chair, Family Violence Death Review Committee

June 2013

3 The United Nations Office on Drugs and Crime (UNODC) makes a similar argument about the dark figure of homicide in its 2011 *Global Study on Homicide*, p. 17. For more information on the dark figure of crime and how it can lead to under-reporting of crime see: C. Coleman and J. Moynihan, *Understanding crime data: haunted by the dark figure*, Open University Press, 1996.

4 See, for example, the following decisions of the European Court of Human Rights: *Kontrova v Slovakia* (application no. 7510/04), 2007; *Bevacqua and S v Bulgaria* (no. 71127/01), 2008; *Opuz v Turkey* (no. 33401/02), 2009; *ES and Others v Slovakia* (no. 8227/04), 2008; *Kalucza v Hungary* (no. 57693/10), 2012.

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Executive summary

The third annual report of the Family Violence Death Review Committee (FVDRC) provides an overview of the committee's work from December 2011 to December 2012.

Chapter 1 introduces the FVDRC's emerging data collection methods and the development of the regional review systems approach. The chapter covers emerging issues for the FVDRC over the year, including challenges posed by the tight definition of family violence deaths within the current terms of reference.

Chapter 2 highlights the significance of cultural and spiritual issues when reviewing family violence deaths. It also discusses the efforts being made by the FVDRC to develop culturally and spiritually sensitive and inclusive processes across all its systems of data collection and review.

Chapter 3 provides a picture of all family violence deaths that occurred in 2009–10, and some detail on family violence related deaths – those deaths that fall outside the FVDRC's terms of reference, but give us a fuller understanding of family violence deaths in New Zealand.

Chapters 4, 5 and 6 each focus on areas identified by the FVDRC as having potential for improvement and that will contribute to the prevention of family violence and family violence deaths. Chapter 4 focuses on strengthening multidisciplinary and multi-agency collaboration and information-sharing, particularly in high-risk cases. Chapter 5 focuses on stopping violence programmes and, in particular, key practice changes required for addressing victim safety when working with perpetrators. Chapter 6 focuses on improving support for victims in the aftermath of a family violence death, recognising that such a death is a potential intervention point for a family when other possible intervention points have been missed. If family members are appropriately supported at this time, and appropriate planning and care is in place, ongoing patterns of violent behaviour and intergenerational trauma within families may be addressed.

Recommendations:

In order to improve interagency collaboration to prevent family violence deaths in New Zealand, the FVDRC recommends that the Taskforce for Action on Violence within Families:

1. in partnership with the responsible agencies, develops a nationally consistent high-risk case management process
2. considers funding the development of national Family Violence Interagency Response System (FVIARS) training, for all professionals involved with FVIARS and all multi-agency, high-risk case management processes
3. along with lead agencies for the *Delivering Better Public Services: Reducing Crime and Re-offending Result Action Plan*,[5] uses the New Zealand Family Violence Clearinghouse principles for effective interagency collaboration,[6] to inform the development of a high-risk case management process and to strengthen the FVIARS processes.

In order to improve stopping violence programmes to better prevent family violence deaths in New Zealand, the FVDRC recommends that the Taskforce for Action on Violence within Families:

1. considers the provision of stopping violence programmes, and supports those programmes to be run in accordance with international best practice, which involves having parallel services for victims that focus on victim safety and enable victims' views to be sought as part of the ongoing assessment process
2. with the Ministry of Justice Domestic Violence Programmes Approval Panel, includes, as part of the programme accreditation, a service standard that requires programme providers to participate in multi-agency risk management, which includes checking participants' self-reported changes against other agencies' records

5 For more information, please see http://www.justice.govt.nz/publications/global-publications/b/better-public-services-reducing-crime-and-reoffending-results-action-plan.

6 C. Murphy and J. Fanslow, *Building collaborations to eliminate family violence: facilitators, barriers and good practice*, Issues Paper 1, Auckland, New Zealand Family Violence Clearinghouse, 2012.

3. considers developing evidence-based risk assessment tools that are properly funded and consistently used by all stopping violence programmes throughout New Zealand
4. considers the provision and availability of living free from violence programmes, which are developed to address the specific needs and experiences of women who have been abused by partners who are gang members or where there has been gang violence, intergenerational abuse and historical trauma.

In order to improve the treatment of victims in the aftermath of a family violence death, to help reduce intergenerational trauma and family violence morbidity and to prevent patterns of behaviour that are known to contribute to family violence deaths in New Zealand, the FVDRC recommends that:

1. the National FVIARS Working Group develops a formal multi-agency after-care process for intimate partner violence (IPV) and child abuse and neglect (CAN) deaths.

Chapter 1: Introduction to the family violence death review system

The Taskforce for Action on Violence within Families was established in June 2005 to advise the Family Violence Ministerial Team on (i) how to make improvements to the way family violence is addressed and (ii) how to eliminate family violence in New Zealand.[7]

In its First Programme of Action, the Taskforce indicated that it was working with the Ministry of Health to develop a 'consistent' death review process that would 'help government agencies, service providers and communities to form a better understanding of how and why deaths occur, so that we can change attitudes, systems and practices and prevent further deaths.'[8]

Consequently, the FVDRC was established in 2008 as an independent ministerial advisory committee hosted by the Ministry of Health. The Health Quality & Safety Commission assumed responsibility for mortality review following the New Zealand Public Health and Disability Amendment Act 2010, and the FVDRC is now hosted by the Commission. It is one of four New Zealand mortality review committees.

The FVDRC functions are to:

- review and report on family violence deaths, with a view to reducing the numbers of deaths and to continuous quality improvement through the promotion of ongoing quality assurance programmes
- develop strategic plans and methodologies that are designed to reduce family violence morbidity and mortality and are relevant to the committee's functions
- advise on any other matters related to family violence deaths that the Commission specifies.

In order to fulfil those functions, the FVDRC collects data on family violence deaths, reviews selected deaths via a multisectoral review process, identifies trends and patterns over time and makes local and national recommendations. (The FVDRC's terms of reference are set out in Appendix 1 of this report.)

The members of the FVDRC are family violence experts from a range of disciplines and industry sectors, chosen to bring a wide array of skills, background experiences and perspectives to the table. (See Appendix 2 for a list of current and past members.)

The FVDRC meets regularly with a number of advisors from key government and non-government agencies. Some of these are set out in its terms of reference: the Ministry of Justice, the Ministry of Social Development, the Office of the Children's Commissioner, New Zealand Police, Coronial Services and the Ministry of Health. The FVDRC recognised that additional representation was needed from the Department of Corrections and the family violence non-government sector (particularly in regards to victim advocacy, children's services and stopping violence programmes) and invited four additional advisors. Advisors provide the FVDRC with updates on what is happening in relevant government and non-government sectors, guidance on the development of the family violence death review system, and assistance with the development of recommendations that emerge from the local death review process.

While this report is the collective effort of the entire committee and secretariat, with input from the advisors, a few chapters have been written by particular committee members according to their specific areas of expertise. As a result, the reader might note slightly different voices throughout the report. Moreover, while gender-neutral language is used throughout this report (except when discussing specific factual instances or data that are gendered), the FVDRC recognises that in intimate partner homicides the majority of perpetrators are male and the majority of victims are female (see Chapter 3).

7 Taskforce for Action on Violence within Families, *The First Report,* Wellington, Ministry of Social Development, 2006, p. 2, http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/action-family-violence/reports.html#TheFirstReport1.

8 Taskforce, *The First Report,* p. 16.

Defining family violence

Varying definitions of family violence are used by different agencies throughout the family violence sector. Furthermore, varying definitions of what constitutes a family violence death create differences in the data produced by agencies such as New Zealand Police, the Ministry of Social Development and the FVDRC.[9]

The FVDRC terms of reference define a family violence death as: 'The unnatural death of a person (adult or child) where the suspected perpetrator is a family or extended family member, caregiver, intimate partner, previous partner of the victim, or previous partner of the victim's current partner'. Moreover, the following categories of deaths are expressly excluded from this definition: suicides and assisted suicides, deaths from chronic illness resulting from sustained violence and accidental deaths related to family violence incidents.

The FVDRC's definition of a family violence death is both under-inclusive and over-inclusive. It is under-inclusive in that it requires a family relationship between the perpetrator and the victim. Therefore, the deaths of innocent bystanders who attempt to intervene in order to protect a family violence victim are not counted in this definition. Suicides of the perpetrators in murder–suicides that are acts of family violence are expressly excluded, as are the suicides of victims of family violence who have been unable to negotiate safety for themselves or another, or to continue to live with the violence.

At the same time, the definition is potentially over-inclusive because what is meant by the exclusion of 'accidental deaths related to family violence incidents' is not clear, and the definition of a family violence death does not stipulate that a pattern of abuse ought to have existed prior to the death or that the death itself constituted an act of abuse. Most manslaughter homicides could be argued to be 'accidental' deaths because, while the perpetrator may have deliberately performed the unlawful act or omission that caused death, they do not need to have intended to kill or even to be aware that death was being risked by them to be guilty of manslaughter homicide. Ironically, this would mean that manslaughter homicides resulting from acts of family violence would be excluded from the definition because they fall within the phrase 'accidental deaths related to family violence incidents', while manslaughter homicides that do not result from family violence would be included within the definition of a family violence death. For example, accidentally smothering a child while sleeping could be considered an 'unnatural death' (and could result in a manslaughter conviction) where the perpetrator is a family member of the victim, thus falling within the FVDRC's definition because it is not 'related to a family violence incident' and is, therefore, not expressly covered by the exclusion for certain accidents. The committee has taken the position that intentional assaults that result in death – even though the death itself is not intended or risked – cannot have been intended to be caught by the phrase 'accidental deaths' in the terms of reference and are therefore not within the exclusion for accidental deaths if they result from family violence. Nonetheless the ambiguity in the definition makes it difficult for the FVDRC to establish clear guidelines on the classification of some types of accidental deaths.

In this report, the FVDRC has chosen to report the number of family violence deaths (homicides that fall within our terms of reference) and family violence related deaths (homicides or suicides that take place immediately after a family violence homicide but do not fall within our terms of reference) to address some of the issues of under-inclusion in our definition and provide a fuller picture of death resulting from family violence. Not included in our count of family violence related deaths are standalone suicides resulting from family violence.

FVDRC information collection powers and responsibilities

Under the New Zealand Public Health and Disability Act 2000 (the Act), mortality review committees are legally empowered to require organisations and individuals to provide a range of information in respect of deaths being reviewed. The Act permits professionals and agencies to provide requested information to the FVDRC without breaching the Privacy Act 1993 or the Health Information Privacy Code 2004, and the Act provides that information collected for the purpose of mortality review is not to be subject to the requirements of the Official Information Act 1982. While the committee has wide-ranging powers to access information, it is subject to very strict confidentiality requirements. It is not permitted to produce, disclose or record the

9 New Zealand Family Violence Clearinghouse, *Data Summary: Family Violence Deaths*, Data Summary 1, Auckland, New Zealand Family Violence Clearinghouse, 2012.

information other than 'for the purposes of carrying out the committee's functions' or in a few other narrowly defined circumstances.[10] For example, it may produce or disclose information that 'does not identify, either expressly or by implication, any particular individual.' Any member or agent of the FVDRC who breaches these provisions is subject to a $10,000 fine and professional disciplinary action.

Because of these strict confidentiality requirements, the FVDRC has chosen not to include case studies in this report, as is common in reports written by death review committees overseas. In fact, in order to avoid providing any information that could identify any particular individual, the FVDRC has deliberately not talked about specific cases we have reviewed – except in the most generic terms – unless the case details have already been openly disclosed via media reports.

Designing a two-tier system to review family violence deaths in New Zealand

The FVDRC has begun to develop a two-tiered death review system designed to collect a minimum set of quantitative data across all family violence deaths in New Zealand, while allowing some cases to be subject to additional intensive, multisectoral review.[11]

The quantitative data from the first tier seek to report general trends in family violence homicide over a period of time. From this data we can determine how many deaths are taking place and in which categories of family violence, the demographics of victims and perpetrators and the services with which they have been involved. However, such information, while useful in monitoring general trends over time (eg, whether family violence deaths are increasing or decreasing and the co-occurrence of different types of abuse), does not provide enough detail about what is happening and why in order to 'develop strategic plans and methodologies' designed 'to reduce family violence morbidity and mortality'.

For this reason the second tier of in-depth regional reviews are detailed case studies from which we can learn more about family violence and the family violence sector in New Zealand. Tier-two reviews provide insight into the operation of the whole range of agencies involved in each family violence death event, including patterns in their interactions with each other and the broader environment. Because these reviews look across all services, they are well suited to examine the complexity of what is occurring in the multi-agency 'family violence system' (see Appendix 3).[12]

In any FVDRC report, the deaths discussed in tiers one and two might not be from the same years. For example, this report provides tier-one data for the years 2009 and 2010, and tier-two data for 2010 and 2011. This is a result of the different processes and objectives involved in each tier of data collection. In terms of process, a complete set of data across all family violence deaths for a particular period in the first tier can take many years to become complete.[13] Tier-two reviews can, in the meantime, be commenced on individual cases prior to the point at which tier-one data on all cases is complete. In this report, we have chosen to report tier-one trend data for 2009 and 2010 so we can render more current the quantitative information provided in the previous reports on family violence homicides between 2002 and 2008.[14] On the other hand, in the tier-two death reviews that were conducted in late 2011 and 2012, we reviewed more recent deaths that had occurred in 2010 and 2011 so that agencies were not delayed in identifying and rectifying problematic practices following a death event and the recommendations and findings from these reviews still had some currency.

10 See clauses 4 and 5 of Schedule 5 of the New Zealand Public Health and Disability Act 2000.

11 The first two stages of the development of this system were described in detail in the FVDRC's *Second Report,* while this report elaborates on the work that has since continued in the development of this system.

12 Each regional review is, in fact, an in-depth case study that will provide information that cannot be gleaned from the tier-one data. While tier one helps to describe family violence in New Zealand (in terms of gender, socioeconomic status, location and so on), it does not provide the qualitative details that will allow us to understand 'just how and why things happen as they do' (M.B. Miles and A.M. Huberman, *Qualitative data analysis,* Thousand Oaks, California, Sage Publications, 1994).

13 It can take some time before a death emerges as a family violence homicide and, once a family violence homicide has been identified, legal proceedings will take additional time to be completed.

14 See Martin and Pritchard for data on 2002 to 2006, and the FVDRC *Second Report* for data on 2007 and 2008.

Despite the differences in timing, it is expected that information gathered from the two tiers of the FVDRC system will be complementary. For example, current data from tier one reveal a co-occurrence between intimate partner violence (IPV) and child abuse and neglect (CAN), which will be explained in greater detail in Chapter 3. In the tier-two reviews it is not uncommon to document individual cases where a child has been 'invisible' to providers that are offering services to the adults in that child's life for IPV. This is significant because:

> 'the danger to children in potentially lethal domestic violence cases may be mistakenly overlooked because the cases do not fit the traditional view of child abuse (because the mothers are the primary targets) or of domestic violence (because the children may be intended or unintended victims of domestic violence perpetrators). Child maltreatment and domestic violence are overlapping issues; however it appears that many individuals still view the problems in a dichotomous fashion.'[15]

The FVDRC's two-tier death review system in practice

Tier one

In order to report on both family violence deaths and family violence related deaths, the FVDRC has begun to gather information on all homicides. All homicides that have a family violence component are then counted as family violence related deaths. Those family violence related deaths that are determined to fall within the FVDRC's terms of reference are then re-categorised as family violence deaths.

Once the FVDRC has identified a family violence death event, it begins to collect a standard set of information on that event from particular government agencies. This is the core data set known as tier one.

Currently, tier-one data are gathered from:

- New Zealand Police family violence notifications and family violence death reviews
- coronial reports
- Ministry of Health's national collection
- sentencing reports, when available
- media reports.

The FVDRC has agreements with New Zealand Police, the Ministry of Justice, the Department of Corrections, Child, Youth and Family, the Ministry of Health and Coronial Services to collect data for both tiers, and hopes to add data from more agencies in time. These agreements include the specific data fields to be shared, as well as the methods and frequency by which the data will be transferred. The FVDRC has developed a reporting form for agencies that do not maintain such data in an easily accessible database.

It is anticipated that 2013 will be the first year that a relatively complete data set will be collected for every family violence event that takes place.

All data provided to the FVDRC are stored in secure electronic and paper-based systems at the Health Quality & Safety Commission offices. From 2002 to 2008, the FVDRC data were gathered by contracted researchers.[16] Since 2009, the secretariat of the FVDRC, based at the Health Quality & Safety Commission in Wellington, has collected the data.

Designing and establishing a family violence death review database to house this data continues. Multiple sources of detailed data about multiple factors (victims, perpetrators and death events) make this task complex, and it is important the data are stored in a way that allows easy analysis for annual reporting. Some information can take a long time to collect and new information can result in deaths being completely reclassified. The database needs sufficient flexibility to accommodate ongoing development.

15 P. Jaffe and M. Juodis, 'Children as victims and witnesses of domestic homicide: Lessons learned from domestic violence death review committees', *Juvenile and Family Court Journal,* vol. 57, issue 3, 2006.

16 The FVDRC houses the data collected by Martin and Pritchard for 2002–06 and Paulin for 2007–08. Due to inconsistencies in data collection, the data are not easily compared. See Appendix 5 of the FVDRC's *Second Report* for more information.

Tier two

From the core data collected for each family violence death event, the FVDRC determines which events will undergo additional analysis in the tier-two regional reviews. Selection for review is based on a prioritisation framework developed by the FVDRC (see Appendix 4).

Although the regional reviews are small in number, they are designed to provide insights and lessons that are applicable more broadly.

Each regional review of a family violence death event dedicates a day to the systematic review of the entire life story of any victim(s) or perpetrator(s) involved in the event, along with any agency involvement that has ever occurred with any parties directly involved in the family violence death event. The aim is to use the death event as a window on the systemic response to family violence, rather than to simply generate information about the particular case. An analytical framework allows the team to examine the ways in which the different agencies worked together, whether there were missed opportunities for effective intervention in respect of the family violence, and whether there were systemic factors which may have prevented effective interventions (see Appendix 3 for this framework).

Key representatives from the major government and non-government agencies called upon to respond to family violence, as well as experts in the field of family violence, have been selected to sit on the regional review panels. Any issues they have identified for action in the review process are known by them to be common practice within the field and not just exclusive to the particular death under review. This is significant because identifying 'typical' practice is crucial for the development of recommendations applicable to the wider family violence system.

During 2012, the focus was on reviewing fatal IPV and CAN deaths because these are the most prevalent types of family violence deaths. Moreover, during 2012, the FVDRC selected cases with considerable interagency involvement because the FVDRC only collects data from agencies. Until a process for collecting information from additional sources is developed,[17] cases with minimal agency involvement will not present with sufficient information to conduct an in-depth review.

Regional review panels

The in-depth reviews are undertaken by the FVDRC regional panels. Presently the FVDRC operates three regional panels, but aims to maintain five across the country in order to have the capacity to review any family violence homicide that is selected for an in-depth review. These panels will cover multiple police districts and district health board (DHB) areas.[18]

In 2012, the following three panels were established:

- Panel 1: Northland, Waitemata and Auckland City
- Panel 2: Wellington Central
- Panel 3: Counties Manukau.

In 2013, the remaining two panels will be established:

- Panel 4: Midlands (Waikato, Bay of Plenty and Eastern)
- Panel 5: South Island (Tasman, Canterbury and Southern).

17 The FVDRC is aware that, in most cases of family violence, family and friends will have greater insight into, and knowledge about, what happened than the agencies dealing with the family. However, making contact with family and friends is a process that must take place with extreme sensitivity in order to avoid further traumatising those who will have been deeply affected by the tragedy. There are international models for acquiring information from family and friends, and the FVDRC has started to develop a 'proxy informant process' in order to undertake this work.

18 The 12 New Zealand Police districts have been used to establish the panel boundaries. The boundaries of each police district can be viewed at http://www.police.govt.nz/district.

Each regional panel comprises:

- two Māori representatives
- one family violence non-governmental organisation (NGO) representative with expertise in CAN
- one family violence NGO representative with expertise in IPV
- a New Zealand Police representative
- a Department of Corrections representative
- a Child, Youth and Family representative
- health representatives.

A kaumātua is invited to attend each review meeting to maintain the kawa and tikanga of the rohe during the time of the meeting. Additional group members are co-opted on a case-by-case basis to ensure relevant expertise and local knowledge at each review. In addition, cultural advisors from Pacific peoples and refugee and migrant communities are approached on a case-by-case basis.

Outcomes from the death review process

The FVDRC terms of reference require the committee to not only review and report on family violence deaths, but also develop 'strategic plans and methodologies' designed to prevent future family violence deaths. The strength of the family violence death review process lies in the identification of underlying patterns of systemic factors via intersectoral review, and then collaboration with government agencies, the Taskforce for Action on Violence within Families, the Māori and Pasifika reference groups, the Delivering Better Public Services programmes, the Children's Action Plan and the NGO family violence sector to address these systemic issues.

On completion of each regional review, a confidential report with the findings and local and national recommendations developed by the regional panel is reviewed by the FVDRC. The FVDRC categorises the recommendations into three groups: those supported by the FVDRC and ready to be reported and publicised; those of interest to the FVDRC but held aside while additional evidence is collected and literature is consulted; and those not supported and, therefore, not carried forward. Recommendations from the first and second group are shared with the FVDRC advisors and key stakeholders for feedback and further refinement prior to their release (see Appendix 5 for more details of this process). These recommendations and findings form the basis of reports, submissions and presentations.

Moreover, the tier-two death reviews are designed to contribute to system improvement in additional ways.[19] Agency representatives involved in the in-depth reviews are in sufficiently senior positions to take the interagency insights, systems analyses and other learnings back to their agencies to implement changes in practice. As a result of our first death review, for example, one agency involved in the review conducted training sessions for the staff of another, while two other agencies met to talk about ways in which they could strengthen links for improved interagency work. Two of the 2012 death reviews resulted in government services undertaking reviews of their local organisational practice. Because the homicide victim was not the client of these services in each instance, the problematic practice that emerged in the death review had not been reviewed or addressed by these services.

We note that the role of the FVDRC is more modest than that of a think tank. Our aim is to develop and maintain a family violence death review system that collects reliable quantitative and qualitative data and develops evidence-based recommendations from our documentation of what is happening in practice. As a result, our recommendations suggest changes to the processes and programmes of action that currently exist in New Zealand, rather than the kind of wholesale reform that was, for example, introduced in Victoria.[20]

19 See M. Brandon et al., *A Study of recommendations arising from serious case reviews 2009–2010,* Research Report DFE-RR157, UK Department for Education, 2010.

20 See the Department of Planning and Community Development, Department of Human Services, Department of Justice and Victoria Police, *Victorian Family Violence Reforms – VPS Innovation Case Study,* 2010, http://www.egov.vic.gov.au/victorian-government-resources/case-studies-victoria/vps-innovation-case-studies/victorian-family-violence-reforms-vps-innovation-case-study.html.

The Victorian Government in Australia has modelled best practice by making a sustained effort to build an integrated response to family violence by departments, agencies and service providers working across and outside of government.[21] In 2005, a whole-of-government plan was launched in Victoria to reform service system responses to family violence. The first task was to build and legislate a shared understanding of family violence across all sectors, as well as to develop common risk assessments, risk management frameworks and complementary codes of practice to ensure consistent responses by individual agencies. Policy changes included centralising funding for services and evaluation to assess effectiveness. This innovative and comprehensive approach has been recognised at a local, national and international level due to the outcomes that have been achieved. The FVDRC notes that such an integrated response might also be desirable in New Zealand.

Progress of previous recommendations

In its *Second Report*, the FVDRC did not make any specific recommendations but did identify three issues of concern that were apparent across the pilot reviews.

The first issue of concern related to the recent release of convicted offenders because it had been noted that some of the perpetrators had very recently been released from prison prior to the death event. The FVDRC wrote: 'assessments of risk need to occur at the offender's initial engagement with the Department of Corrections, and extend right through to their release from prison, and the end of their supervisory period with community probation. The purpose of this risk assessment is to ensure that there is a risk management plan in place for the offender that addresses risks to other family members, and which can contribute to multi-agency family violence initiatives that focus on the safety of vulnerable (ex) partners, children or family members'.[22] After consultation with its advisors from the Department of Corrections, the FVDRC recognised that the Department was aware of these risks and was undertaking a review of its policy, procedures and practice in this area, including the provision of domestic violence intervention programmes.

Since the release of its *Second Report*, the FVDRC has learnt that over the last four years the Department of Corrections' Community Probation Services (CPS) has updated the model of practice and enhanced professional decision making for all staff. They have implemented a dynamic risk assessment tool that is used with all offenders on rehabilitative sentences and orders. The tool (Dynamic Risk Assessment of Offender Re-entry, or DRAOR) is used at each contact with the offender and has three subscales that include stable and acute risks as well as protective factors that enhance the development of prosocial support. The tool is used to assist with working to ensure compliance, and also to reduce the likelihood of re-offending and to minimise risk of harm to others, including partners, children, family members and other potential victims.

Probation practice has also been enhanced to provide staff with a wider range of practice tools and support to strengthen their engagement with offenders and to support offenders in building their capability to live offence-free lives. These include the use of motivational interviewing skills, relapse prevention and working to address alcohol and drug issues.

The second issue identified in the *Second Report* related to transitions of care, particularly from maternity care to Well Child providers. The Perinatal and Maternal Mortality Review Committee (PMMRC) and the Child and Youth Mortality Review Committee (CYMRC) have made recommendations regarding this issue, and the FVDRC supported those recommendations. The FVDRC notes that many other agencies also identified transitions of care in their submissions for the Green Paper on Vulnerable Children and these concerns were considered in the development of the Children's Action Plan.[23] As the Children's Action Plan will be implemented over the next five years, the FVDRC will continue its ongoing collection of information on transitions of care from its death reviews with the hope that the Action Plan leads to improved transitions between services for children and adults.

21 Other examples of integrated responses to family violence are the Duluth Domestic Abuse Intervention Project developed in Minnesota, USA (see Shepard, M.F. and Pence, E.L. (eds.), *SAGE Series on Violence against Women: Coordinating community responses to domestic violence: Lessons from Duluth and beyond*, Thousand Oaks, California, SAGE Publications, Inc, 1999, doi: 10.4135/9781452231952) and The 'Greenbook' Initiative (see The Greenbook National Evaluation Team, *The Greenbook Initiative Final Evaluation Report*, Fairfax, Virginia, ICF International, 2008).

22 FVDRC, *Second Report*, 2011, p. 16.

23 For more information see: http://www.childrensactionplan.govt.nz/children-s-action-plan.

Finally, the third issue of concern was the ability of first responders to assess the severity of family violence incidents. At the time of writing, New Zealand Police was in the process of introducing a new intimate partner risk assessment tool, and developing a risk assessment questionnaire for children.

Since the release of the *Second Report*, New Zealand Police has implemented a new situational response model for family violence, which has been operational since 1 July 2012. The model distinguishes between IPV and intrafamilial violence (IFV), and specifically collects risk information about children present, or children who normally reside at, an address police have attended in response to a family violence occurrence.

The Ontario Domestic Assault Risk Assessment (ODARA) is used when there has been physical violence (or a threat with a weapon) in an IPV context. The tool predicts the likelihood of a subsequent IPV assault. Police collect and share risk information about IFV occurrences and IPV contexts where ODARA does not apply.

ODARA is currently being evaluated to test its predictive accuracy in New Zealand, with a view to introducing ODARA data to the criminal justice system.

Structure of this report

In Chapter 2, we discuss cultural and spiritual considerations that are important for the review of family violence deaths. In the remaining chapters of this report we focus on outcomes.

In Chapter 3, we provide quantitative tier-one data on all family violence deaths that took place in New Zealand from 2009 to 2010. In Chapters 4–6, we provide some findings and recommendations from the tier-two regional review process. These are from nine reviews completed during late 2011 and all of 2012. The nine family violence death events involved 11 family violence deaths, primarily IPV and CAN deaths. Specifically, in Chapter 4, we recommend the development of a multi-agency case management process for high-risk family violence cases. In Chapter 5, we make recommendations to improve the manner in which the stopping violence programmes are linked into a multi-agency, whole-of-society response to family violence and improve the focus on victim safety. In Chapter 6, we discuss the need to improve the systemic response to those who have been victimised by family violence, but have survived a family violence homicide. Although these chapters contain recommendations to improve process and practice, the FVDRC would like to acknowledge the existing level of commitment to a multi-agency response to family violence amongst those professionals and agencies whose practices were reviewed. We note that many individuals and organisations committed precious time and resources to such processes even though they were not funded to do so.

In Chapter 7, we discuss two additional findings emerging out of the two-tier review system and set out the FVDRC's priorities for 2013.

Chapter 2: Cultural and spiritual issues for consideration[24]

When reviewing family violence deaths, the FVDRC acknowledges the importance of the embedded and unique cultural and spiritual positions of families and whānau. Understanding the cultural and spiritual issues and how these impact upon events is vital to understanding the need for diverse but relevant approaches to preventive activities. Understanding the related historical, social and emotional landscape that affects families and their members is equally important.[25] Ongoing violence within the context of families has a detrimental effect on their functioning, mental and social health, and spiritual wellbeing. In order to afford the utmost respect to those from different ethnic and cultural groups involved in family violence death reviews, cultural and spiritual issues need contemplation. In this chapter, we will provide background information on considerations with regard to the cultural and spiritual issues where deaths are the result of family violence.

Culture and spiritual wellbeing

The concept of wellbeing is both complex and multifactorial, involving determinants of health that include the cultural and spiritual wellbeing of people and their families. Websdale urges understanding of people's life-stories, particularly the historical, social and emotional milieu of their life and violence within their families.[26] This is important for: Māori, as New Zealand's indigenous people, whose history of colonisation has negatively impacted on the structure, role and function of whānau; refugees who live with the consequences of war and other adverse events; and immigrants who are faced with cultural conflict as they attempt to settle into a new country and community.

The way in which people relate within families and with others in wider society, and the way in which children are raised, is embedded in their culture of origin and the subsequent sociocultural interactions they may have. It sets the norms about what is considered acceptable and non-acceptable with regard to social interactions and behaviours. For the purposes of this chapter, culture[27] refers to the values, beliefs and practices that determine how groups of people uniquely understand and interact with the world, and its influence on people's attitudes and behaviours. Wepa says:

> 'Our way of living is our culture. It's our taken-for-grantedness that determines and defines our culture. The way we brush our teeth, the way we bury people, the way we express ourselves through our art, religion, eating habits, rituals, humour, science, law, and sport; the way we celebrate occasions (from 21sts, to weddings, to birthdays) is our culture. All these actions we carry out consciously and unconsciously.'[28]

Our cultural orientation begins with the family, caregivers and the environment we grow up in, and is subsequently influenced by the various groups and people with whom we interact. As a consequence, diversity exists within contemporary ethnic and cultural groups resulting from factors such as colonisation, immigration, acculturation, inter-ethnic marriages, and social and technological changes. Invariably, the culture of those belonging to ethnic and minority groups often differs from that of the dominant cultural group.

24 This chapter was written by FVDRC members Denise Wilson, Mala Grant and Fia Turner.

25 N. Websdale, *Familicidal hearts: The emotional styles of 211 killers,* New York, Oxford University Press, 2010.

26 Websdale, *Familicidal hearts,* 2010.

27 The terms culture, ethnicity and race can be used interchangeably, and the latter two are frequently used to refer to immigrant or minority groups (see W. Kymlicka, 'Multicultural citizenship', in Seidman, S. and Alexander, J.C. (eds.), *The new social theory reader: Contemporary debates,* London, Routledge, 2001, p. 212–22). Culture as described above is distinct from, although may be related to, race or ethnicity. Race usually refers to the broad social classification, primarily based on physical characteristics, of people into groups – for example, Caucasian, Asian and Polynesian. Ethnicity on the other hand, describes distinct groups of people that are united by similar beliefs, values, and political, religious, and lifestyle activities (see Kymlicka, 2001; D. Wepa, 'Culture and ethnicity: What is the question?', in Wepa, D. (ed.), *Cultural safety in Aotearoa New Zealand,* Auckland, Pearson Prentice Hall Health, 2005, p. 30–8). It is useful to note that ethnicity is often used as a proxy for culture (see A. Kasturirangan, S. Krishnan and S. Riger, 'The impact of culture and minority status on women's experience of domestic violence', *Trauma, Violence and Abuse,* vol. 5, no. 4, 2004, 318–32).

28 Wepa, 'Culture and ethnicity', 2005, p. 31.

When those agencies or people providing vital services to families affected by family violence (such as New Zealand Police, the Department of Corrections, social workers, health workers and teachers) function in an ethnocentric manner that is based on the dominant cultural beliefs and practices, they put those who belong to minority cultural groups at risk. Understanding the historical, social[29] and emotional landscape of these families is crucial to identifying factors that can support them, as well as factors that signal heightened risk. For example, understanding the social status of a woman and cultural expectations related to her child-rearing role prior to moving to New Zealand may provide insights into her struggle with a drastically changed role and expectations in being a mother. Also, understanding the immigration status of a woman who is attached to her partner's visa can provide a vital clue to the difficulties she encounters in order to keep both herself and her children safe.

Māori and colonisation

The processes of colonisation (such as education, assimilation and urbanisation) changed traditional culturally embedded values, beliefs and practices for many Māori whānau. Understanding the historical landscape for Māori whānau is important, chiefly because whānau violence was not condoned pre-colonisation, contrary to the 'cultural practice' often portrayed by popular stereotypes and promulgated in the media. Kruger et al named whānau violence as an '"imposter" tikanga' when referring to those whānau and communities where it had become normalised and viewed as a cultural practice.[30] Prior to New Zealand being settled and later colonised, it has been well documented that Māori held women and children within their whānau and hapū in high esteem.

> 'Their love and attachment to their children was very great; and that not merely to their own immediate offspring. They very commonly adopted children; indeed no man having a large family was ever allowed to bring them all up himself – uncles, aunts and cousins claimed and took them, often whether the parents were willing or not. They certainly took every physical care of them; and as they rarely chastised (for many reasons), of course, petted and spoiled them… The father, or uncle, often carried or nursed his infant on his back for hours at a time, and might often be seen quietly to work with the little one there snugly ensconced.'[31]

Wāhine were valued as bearers of the future generations, and tamariki equally valued as the future of Māori and hapū. Raising children was a collective responsibility placed on all those (men and women alike) within a whānau and hapū, unlike settlers where this role rested solely with the mother. Any incidents of violence against women and children within a whānau were not tolerated and were addressed swiftly and publicly.[32]

Over time, the processes of colonisation changed the structure and function of whānau, and consequently members' roles. The extended and collective nature of whānau was gradually decimated for many who were forced off their land, and cultural practices and te reo Māori were forbidden. In addition, the collective responsibility and obligation that all members had for ensuring the wellbeing of the whānau was replaced with Victorian hegemonic gender roles whereby men had 'ownership' over their wives and children. This essentially moved whānau affairs from the community's (public) eye into the private domain of individual homes.

Historical trauma related to major events, such as the colonisation of indigenous people, is connected to contemporary lifetime trauma, chronic stress, discrimination, and family violence.[33] Unquestionably, colonisation resulted in notable depopulation, rapid social change and profound cultural destruction, which not only impacted the identity of indigenous people[34] but also their social health, mental health and spiritual wellbeing.[35] This historical trauma continues to affect some individuals, whānau and communities. At an individual level, it

29 Social landscape includes key cultural beliefs, values and practices that pertain to how relationships are constructed and managed, and to child-rearing.

30 T. Kruger et al, *Transforming whānau violence: A conceptual framework,* 2nd edn., Wellington, Te Puni Kōkiri, 2004.

31 W. Colenso, 'On the Māori Races of New Zealand,' *Transactions of the New Zealand Institute,* vol. 1, 1868, pp. 5–75.

32 Kruger et al, *Transforming whānau violence,* 2004.

33 K.L. Walters et al., 'Bodies don't just tell stories, they tell histories: Embodiment of historical trauma among American Indians and Alaska Natives', *Du Bois Review: Social Science Research on Race,* vol. 8, no. 1, 2011, pp. 179–89.

34 K.L. Walters et al., 'Bodies don't just tell stories, they tell histories', 2011.

35 M.L. Walls and L.B. Whitbeck, 'Advantages of stress process approaches for measuring historical trauma', *American Journal of Drug and Alcohol Abuse,* vol. 38, no. 5, 2012, pp. 416–20; K.L. Walters et al., 'Bodies don't just tell stories, they tell histories', 2011; K.L. Walters, J.M. Simoni, and T. Evans-Campbell, 'Substance use among American Indians and Alaska Natives: Incorporating culture in an 'Indigenist' stress-coping paradigm', *Public Health Reports,* vol. 117, Suppl. 1, 2002, pp. 104–17.

manifests as impaired family dynamics and communication, mental health disorders (eg, anxiety, unresolved grief, post-traumatic stress disorder), substance abuse and interpersonal violence. At the community level, historical trauma might disrupt traditional customs, languages and practices within a whānau or community, and it might lead them to respond inadequately to some issues like CAN.[36] Families and communities that have strong cultural connections and spiritual wellbeing can moderate the negative outcomes of historical trauma, such as family violence.[37] Walters et al stress the importance of attending to the historical and sociocultural context of indigenous communities, because ignoring this can lead to misunderstandings and wrong interpretations of the salient factors involved.[38]

Immigrant and refugee populations

New Zealand is an increasingly multicultural society. This means many communities are now more ethnically diverse. Diversity is also evident within the various ethnic and cultural groups, due to acculturation, generational differences, and cross-cultural marriages and relationships. For those belonging to minority ethnic and cultural groups, some have retained their cultural traditions while others function in a bicultural manner – that is, they function within both their traditional culture of origin and the dominant culture. Cultural diversity is also evident within those ethnic groups coming to live in New Zealand from other countries, with the values, beliefs and practices differing between new immigrants and those who are first, second and third generation. In addition to retaining some traditional cultural ways, individuals may also adopt cultural norms reflective of the dominant New Zealand culture.

Acculturation leads to changes in people's ethnic and cultural identity, with challenges arising when their culture of origin conflicts with a new and different dominant culture. Immigration is a common context for acculturation to occur. It involves the formation of a bicultural identity where on one hand traditional beliefs and practices are retained, and on the other there is engagement within dominant cultural settings that leads to greater proficiency in the use of a new language, the development of social relationships with others outside one's traditional ethnic and cultural group, participation in dominant cultural activities and traditions, and the adoption of new beliefs and values.[39] Social and health outcomes are associated with cultural change, and the complex process of integrating into a new culture and community is not achieved by all – some are firmly attached to their traditional culture and language, and avoid interacting with those belonging to the dominant culture.[40]

Moving to a new country places additional stressors on families as they are confronted with:

- a new environment
- new ways of doing things (often including a new language)
- potentially unstable employment
- different gender roles and expectations
- different modes of raising children.

For example, with Pacific peoples families, the cultural orientation of those born in the islands and those born in New Zealand are not aligned, especially where increasing acculturation over the years highlights cultural differences. Often women adapt to a new country and integrate into their community with greater ease than their partners, which creates relationship tensions, particularly for those relationships where maintenance of traditional male roles and expectations become threatened.[41] Added to the sense of loss that occurs when moving from a familiar place to one that is foreign, are impacts on the cultural and spiritual wellbeing of the family and its members. Relocation to a new country requires establishing knowledge of a new community and new systems and, importantly, the development of vital support networks. When a family also lives with family violence, the task of re-establishing necessary knowledge and support mechanisms is compromised and leaves vulnerable members isolated and at risk.

36 K.L. Walters et al., 'Bodies don't just tell stories, they tell histories', 2011.

37 K.L. Walters, J.M. Simoni, and T. Evans-Campbell, 'Substance use among American Indians and Alaska Natives', 2002.

38 K.L. Walters, J.M. Simoni, and T. Evans-Campbell, 'Substance use among American Indians and Alaska Natives', 2002.

39 T. Salant and D.S. Lauderdale, 'Measuring culture: A critical review of acculturation and health in Asian immigrant populations', in LaVeist, T.A. and Issac, L.A. (eds.), *Race, ethnicity, and health: A public health reader*, 2nd edn., San Francisco, Jossey-Bass, 2013, pp. 253–90.

40 T. Salant and D.S. Lauderdale, 'Measuring culture', 2013.

41 T. Salant and D.S. Lauderdale, 'Measuring culture', 2013; H.S. Wallach, Z. Weingram and O. Avitan, 'Attitudes toward domestic violence: A cultural perspective', *Journal of Interpersonal Violence*, vol. 25, no. 7, 2010, pp. 1284–97.

Understanding the cultural milieu of new immigrant and refugee people, especially those arriving from patriarchial societies, is a vital part of undertaking family violence reviews. Settling into a new country is not only stressful but may also mean that family dynamics are challenged when men are unable to secure employment and support their families, and when women and children integrate more effectively into New Zealand.[42] In some instances, a woman's immigration status may be reliant on her partner's visa, which makes seeking help or leaving a relationship impossible. Despite women and children potentially adapting to a new country's cultural norms, identifying and responding to family violence can be deterred by past experiences of police in their country of origin, fear of being isolated if they report violence to New Zealand Police, and not having any contacts in their community. Immigrant and refugee populations come to New Zealand with different understandings about gender roles, the appropriate treatment of women and children, and parenting – their default is their culture of origin. For example, immigrants coming from patriarchial societies might retain different beliefs about the roles of men, women and children in public and private spheres. Such attitudes are more likely to remain entrenched if they socialise within their own cultural groups for support that, ironically, does not enable the learning of new cultural norms and behaviours.[43] Wallach et al contend that: 'Successful integration usually entails learning the new cultural norms, learning new behavior that fits the norms, and adapting the self-concept to these new norms and behavior. These adaptation processes are influenced by social forces and one's peers'.[44] Being mindful of the notion of acculturation is important in reviewing family violence related deaths, especially as it is problematic to measure the degree of acculturation.[45]

Intergenerational family violence

A pattern of interpersonal violence, abuse and/or neglect that is repeated from one generation to the next is evident in some families whether they are indigenous, immigrant, refugee or born in New Zealand. Intergenerational patterns of family violence may stem from adverse environmental or traumatic conditions. Commonly referred to as 'intergenerational trauma', it arises from extreme environmental and traumatic stress or events that people encounter that result in neuroendocrine and epigenetic changes in those affected, which are then transmitted from one generation to the next. As a consequence, it impacts future generations by disrupting physical, mental, social, and spiritual health and wellbeing, along with ways of coping, behaving and communicating with others.[46] Duran claims such trauma wounds a person's soul.[47] The literature relating to resilience[48] highlights that not all people manifest negative consequences of environmental and traumatic stress. However, for those who are subject to the intergenerational effects of adverse environments and trauma, intergenerational family violence can become mistaken for 'normal' cultural behaviours. Rather than tolerating and accepting family or whānau violence, Kruger et al stress that the violence must be understood as the 'denigration of tikanga and the transgression of whakapapa'.[49] Therefore, when reviewing family violence related deaths we must be mindful that intergenerational patterns of family violence are not explained as a cultural way of functioning.

Family violence as an adverse childhood experience with lifelong consequences is closely linked to intergenerational family violence. IPV and CAN damages not only the children involved, but also their mothers and caregivers.[50] Also, exposure to violence during childhood heightens the risk of intergenerational violence, with girls more likely to become victims and boys more likely to become perpetrators as adults.[51]

42 H.S. Wallach, Z. Weingram and O. Avitan, 'Attitudes toward domestic violence', 2010.

43 H.S. Wallach, Z. Weingram and O. Avitan, 'Attitudes toward domestic violence', 2010.

44 H.S. Wallach, Z. Weingram and O. Avitan, 'Attitudes toward domestic violence', 2010, p. 1285.

45 T. Salant and D.S. Lauderdale, 'Measuring culture', 2013.

46 E. Duran, *Healing the soul wound: Counselling with American Indians and other native peoples,* New York, Teachers College Press, 2006; E. Duran and B. Duran, *Native American postcolonial psychology*, Albany, NY, State University of New York, 1995; K.L. Walters et al., 'Bodies don't just tell stories, they tell histories', 2011.

47 E. Duran, *Healing the soul wound,* 2006.

48 See S.A. Graham-Bermann et al., 'Factors discriminating among profiles of resilience and psychopathology in children exposed to intimate partner violence (IPV)', *Child Abuse and Neglect,* vol. 33, no. 9, 2009, pp. 648–60; and B.W. Smith et al., 'The brief resilience scale: assessing the ability to bounce back', *International Journal of Behavioral Medicine,* vol. 15, no. 3, 2008, pp. 194–200.

49 T. Kruger et al, *Transforming whānau violence,* 2004, p. 10.

50 S. R. Dube et al., 'Exposure to abuse, neglect, and household dysfunction among adults who witnessed intimate partner violence as children: Implications for health and social services', *Violence and Victims,* vol. 17, no. 1, 2002, pp. 3–17.

51 C.L. Whitfield et al., 2003. 'Violent childhood experiences and the risk of intimate partner violence in adults: Assessment in a large health maintenance organization', *Journal of Interpersonal Violence,* vol. 18, no. 2, 2003, pp. 166–85.

Children exposed to abuse, neglect and dysfunction within their household are two to six times more likely to experience a number of adverse childhood experiences that cause lifelong social, physical and mental health problems,[52] with adverse childhood experiences being significantly associated with severity and duration of IPV.[53] IPV disrupts mothers' and caregivers' abilities to care for their children effectively. Anxiety, post-traumatic stress, depression, substance and alcohol abuse, and physical health problems can all interfere with their ability to attach and engage with their children.[54] Children are vulnerable to the negative effects of their environment. The quality of care they receive growing up undoubtedly influences their health, wellbeing and behaviour as they age. Poor-quality care can lead to poor parental attachment and/or mental health issues that limit their ability to attach and parent any future children.[55] It is crucial that adverse childhood experiences are recognised and addressed. Rather than explaining a mother's lack of engagement with services or avoidant behaviours as a 'cultural' practice, service providers should consider the mother's own potentially adverse childhood experiences.

Working with people from different ethnic or cultural groups

The FVDRC recognises the importance of effective engagement with people from different ethnic or cultural groups. Effective engagement is crucial to understanding the context and experiences of relevant whānau or family members leading up to a family violence related death. Therefore, thoughtful and respectful consideration needs to be undertaken prior to, and when, working with those from minority ethnic or cultural groups. Jahnke and Taiapa offer a useful reminder when working with those from another culture, stating that: 'Knowledge which makes sense in one particular cultural context cannot always be understood through the tools which govern the understanding of other belief systems and world views'.[56] Family violence carries stigma in some cultures, while in others violence against women and children appears to have greater acceptance. Fundamental to working with people from different ethnic or cultural groups is the premise that every culture has a worldview reflected in their values, beliefs and practices, which differs from one group to the next. People belonging to minority ethnic and cultural groups have values, beliefs and practices that differ from those generally accepted by the dominant cultural group in New Zealand. The dominant cultural norms govern the way most publicly funded community services involved in addressing family violence operate. As a consequence, minority ethnic and cultural groups can sit on the margins of society and be subjected to stereotyping, discrimination and unsubstantiated judgements. This makes for challenges in establishing relationships and understanding the context of events leading up to a family violence death.

Cultural competence

There are many definitions and understandings of 'cultural competence'. Essentially, it is about working with people in a way that is both respectful and inclusive of their unique cultural values, beliefs and practices.[57] Becoming culturally competent is a lifelong process[58] that requires those working in the area of family violence deaths to:

- examine their own knowledge, beliefs and attitudes, and the impact these can have when working with others from a culture different from their own
- act in a manner that aims to improve the outcomes of a death review for others in the review process
- integrate the family's key cultural practices into the review processes.

52 S.R. Dube et al., 'Exposure to abuse, neglect, and household dysfunction', 2002.

53 F. Lamers-Winkelman, A.M. Willemen, and M. Visser, 'Adverse childhood experiences of referred children exposed to intimate partner violence: Consequences for their wellbeing', *Child Abuse and Neglect,* vol. 36, no. 2, 2012, pp. 166–79.

54 K.J. Conron et al., 'A longitudinal study of maternal depression and child maltreatment in a national sample of families investigated by child protective services', *Archives of Pediatrics and Adolescent Medicine,* vol. 163, no. 10, 2009, pp. 922–30; R. Thompson, 'Mothers' violence victimization and child behavior problems: Examining the link', *American Journal of Orthopsychiatry,* vol. 77, no. 2, 2007, pp. 306–15.

55 K. Rikhye et al., 'Interplay between childhood maltreatment, parental bonding, and gender effects: Impact on quality of life', *Child Abuse and Neglect,* vol. 32, no. 1, 2008, pp. 19–34.

56 H.T. Jahnke and J. Taiapa, 'Maori research', in Davidson, C. and Tolich, M. (eds.), *Social science research in New Zealand: Many paths to understanding,* Auckland, Longman Pearson Education, 1999, p. 41 of pp. 39–50.

57 M. Durie, 'Cultural competence and medical practice in New Zealand', *Australian and New Zealand Boards and Council Conference,* Wellington, New Zealand, presented 21 November 2001; D. Wilson, 'The significance of a culturally appropriate health service for indigenous Maori women', *Contemporary Nurse,* vol. 28, no. 1–2, 2008, pp. 173–88.

58 J. Campinha-Bacote, 'Coming to know cultural competence: An evolutionary process', *International Journal for Human Caring,* vol. 15, no. 3, 2011, pp. 42–8.

Therefore, acting in a culturally competent manner may involve, for example, engaging respectfully and meaningfully, enquiring about key cultural practices that need to be included in the review process, and ensuring that those key cultural practices are included in any processes used.

An absence of cultural competence is likely to leave people feeling dissatisfied with the process, disrespected, demeaned and disempowered – omitting vital cultural practices in a review process is a traumatising act in itself. It may seem easier to avoid exploring cultural issues, especially when little is known about someone's cultural background. However, this can impact on the integrity of reviews into family violence deaths. Policies and procedures to guide staff, alongside the provision of resources to aid individuals and groups to develop the necessary skills to conduct culturally competent reviews, helps. (See Appendix 3 for more information on how the FVDRC has sought to develop a culturally and spiritually sensitive regional review process.)

Chapter 3: **Family violence deaths in 2009 and 2010**

From 2002 to 2010, there have been 258 family violence deaths in New Zealand. This equates to 29 per year on average.

Table 1: Homicides and related offences, family violence deaths and family violence related deaths, New Zealand, 2002–10

	2002	2003	2004	2005	2006	2007	2008	2009	2010
Homicide and related offences[A]	80	67	62	73	64	66	67	97	78
Family violence deaths[B]	30	17	28	38	28	26	19	45	27
Family violence related deaths[C]	-	-	-	-	-	-	-	14	5

A This figure includes murder, manslaughter and homicide and related offences not further defined, but not attempted murder.
Source: National Annual Recorded Offences for the Latest Calendar Years (ANZSOC), New Zealand Police, Statistics New Zealand.
(All other data: FVDRC Data Collection.)

B Family violence deaths are homicides that fall within the FVDRC terms of reference. They are a subset of 'homicide and related offences'.

C Family violence related deaths are homicides, and sometimes suicides, that are related to family violence but fall outside the FVDRC terms of reference (eg, a bystander or intervener who died at the event but is not related to the victim). This data was not collected from 2002 to 2008.

Methods

Data sources

The 2009 and 2010 data in this chapter were extracted from the FVDRC Data Collection, which is housed at the Health Quality & Safety Commission offices in Wellington. The FVDRC Data Collection is developed by compiling data on each family violence death event from New Zealand Police; Coronial Services; Ministry of Justice; Child, Youth and Family; and the New Zealand Health Information Service (NZHIS).

The 2002–06 data are taken from a report by Martin and Pritchard (2010), and the 2007 and 2008 data are from a report by Paulin (2011). For more information on family violence deaths that occurred in New Zealand during 2002–08, see Martin and Pritchard (2010) and FVDRC (2011).

Numerator ethnicity data were obtained from the NZHIS from NHI data.

Denominator data for ethnicity, age and gender are projections obtained from Statistics New Zealand, and totals vary slightly due to variations in assumptions about population growth. Because the data in this report is for the years 2009 and 2010, the total population presented in the tables is for 2009 and 2010 combined. For example, in Table 5, the total population of 8,682,650 includes the total population of New Zealand in 2009 plus the total population of New Zealand in 2010.

Terminology

In this chapter the term 'perpetrators' is used to refer to the person or persons who committed the homicide, rather than the person who may have been the primary aggressor in any family violence that took place in the relationship prior to the killing. The term includes those who have been convicted for homicide as well as those who have been found not guilty by reason of insanity or acquitted on the basis of self-defence. It also includes those who are being investigated as lead suspects or have been charged and who therefore may be convicted once the investigation and subsequent criminal proceedings are complete. Occasionally, a person who has been through a criminal trial and has been found not guilty because the Crown has been unable to discharge the high standard of proof that must be met in criminal proceedings might still be included in this data as the perpetrator. This will happen when there is strong evidence suggesting that they committed the crime, there is no other person who is suspected of having committed the homicide and experts in the case believe that they are the perpetrator.

Small numbers

Where fewer than three individuals are represented in any cell in the analyses presented in this chapter, then the true number is not always given and rates are not estimated, both to protect identification of individuals and because these rates are not robust estimates.

Rounding

Percentages have been rounded to whole numbers where the denominator is less than 100. Rates have been rounded to two decimal places.

Statistical testing

The term 'statistically significant' means that a statistical test has been applied and that the p value is less than 0.05. This means that there is less than a 5 percent chance that the observed difference or association is not a real difference or association. Conversely, if a difference is said to be not statistically significant, then the p value is equal to or greater than 0.05. This means that there is a 5 or more percent chance that the observed difference is not a real difference. If the words 'statistically significant' are not used to describe a difference or association, it can be assumed that a statistical test has not been applied.

Confidence intervals

Ninety-five percent confidence intervals (CIs) for rates have been computed using the Exact method. The CI represents the degree of uncertainty around the point estimate of the rate for the particular period. This uncertainty depends on the absolute number of victims or perpetrators in the numerator and the number of people in the denominator population. The CI represents the limits within which the 'true' rate is most likely to lie. This calculation is necessary when numbers are small because the point estimate of the rate calculated from the data given may by chance have taken a wide range of values. The CI describes this range.

It is possible to compare rates by looking at the CIs. If the CIs for two rates do not overlap, it is likely that the rates are different. This is equivalent to the rates being statistically significantly different at the $p<0.05$ level. If the CIs do overlap, the rates may or may not be different.

Family violence and family violence related deaths from 2009 to 2010

The FVDRC has decided to report family violence deaths and family violence related deaths from 2009 and 2010 (see Table 1). As discussed in Chapter 1, family violence related deaths are those that do not fall under the FVDRC terms of reference. Normally, family violence related deaths are when (1) there is a victim that is not part of the family relationship, but has been killed while inadvertently becoming caught up in a family violence argument (often as an intervener or an innocent bystander) or (2) a perpetrator dies by suicide following the death of a victim. The inclusion of family violence related deaths means that some deaths have been captured even though they fall outside the FVDRC terms of reference. It also means that some death events are being reported as family violence related even if there is only one victim and that victim is not part of the family relationship. The FVDRC is reporting these deaths in order to provide a better understanding of the real cost of family violence death to New Zealand,[59] but will distinguish between these different types of deaths in order to adhere to the terms of reference. We do not report attempted homicides or standalone suicides.

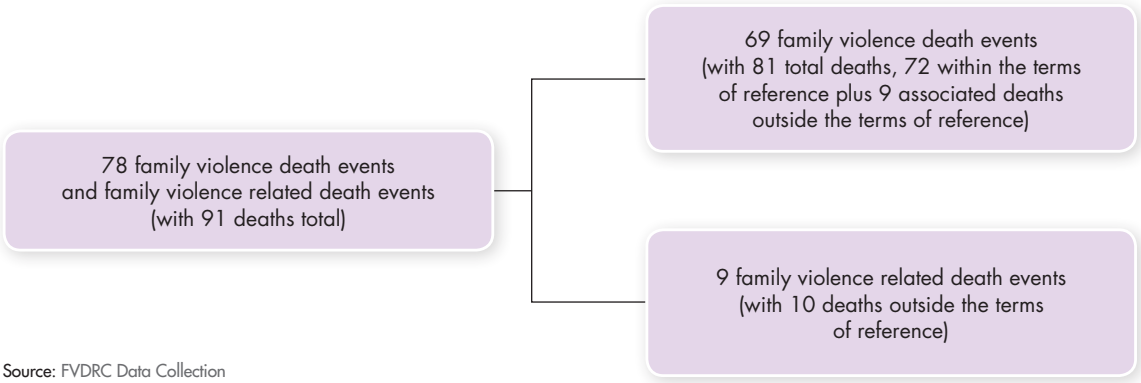
Family violence deaths and family violence related deaths are a subset of homicide and related offences. Family violence deaths plus family violence related deaths account for 52 percent of all homicide and related offences during 2009–10 (Table 1).

As Figure 1 shows, there were 78 family violence death events and family violence related death events for 2009 and 2010 combined. Of those, 69 were family violence death events, while the remaining nine were family violence related death events.[60]

59 The FVDRC recognises that there are even more deaths that might be undercounted as well, including: same-sex relationships where it was not known that the perpetrator and victim were in a relationship; homicides that have been classified as suicides or accidents; missing persons and unsolved homicides; and suicides of domestic violence victims. Furthermore, a fetal death would not be captured if it was not immediately obvious to police that the victim was pregnant.

60 Of these 78 events, eight are not considered family violence death events by New Zealand Police, but the FVDRC believes they are family violence death events according to the FVDRC terms of reference. In addition, there is one case police categorise as a family violence related event, but the FVDRC believes it is also a family violence death event per the terms of reference. On the other hand, there are four cases that New Zealand Police categorises as family violence death events, while the FVDRC categorises them as family violence related events. Lastly, there are two cases that New Zealand Police considers as family violence but the FVDRC does not include them as either a family violence death or a family violence related death.

Figure 1: Family violence death events and family violence related death events, New Zealand, 2009–10



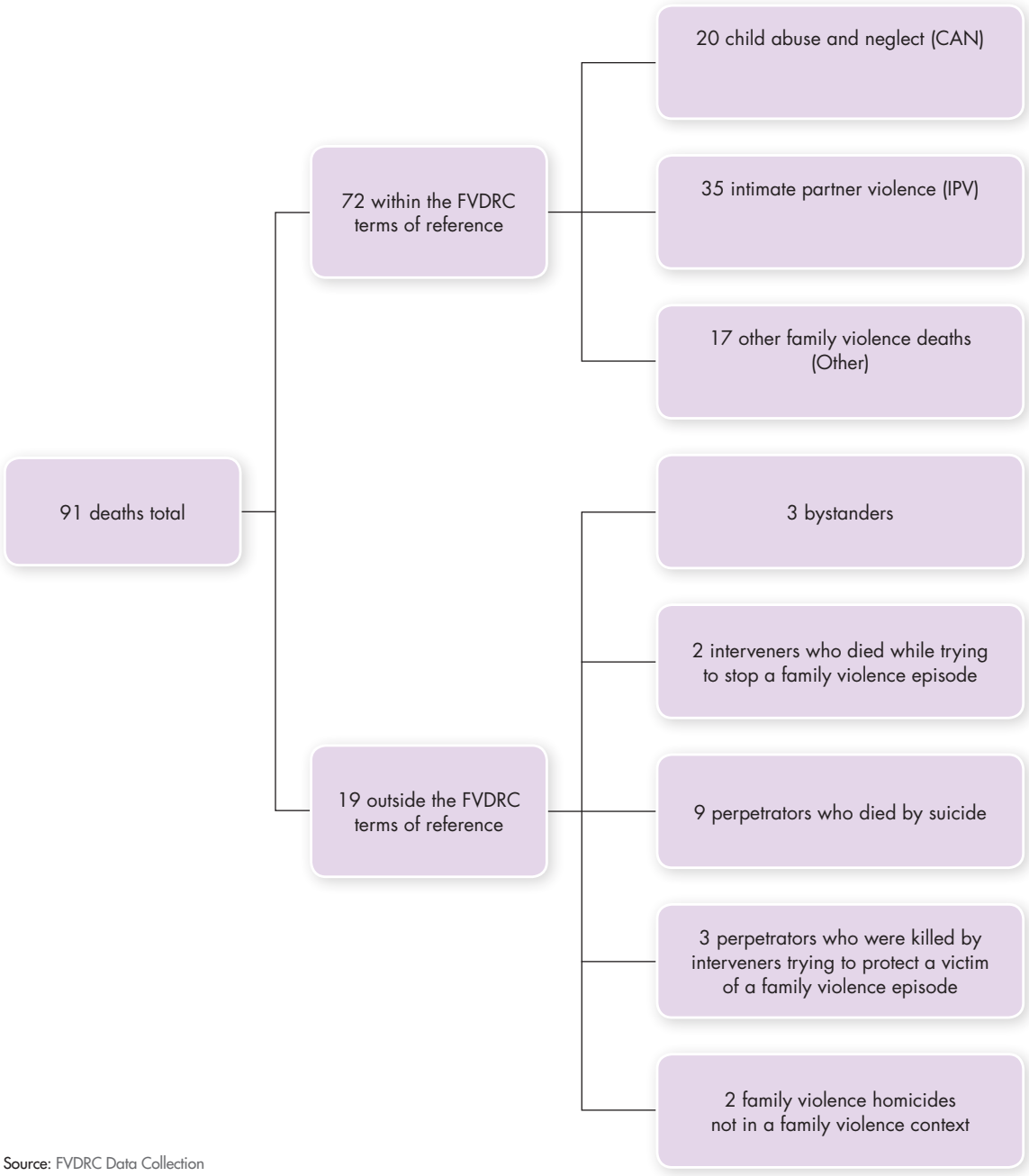
Source: FVDRC Data Collection

The 78 family violence and family violence related death events in 2009 and 2010 were associated with 91 deaths (see Figures 1 and 2). Of these 91 deaths, 19 fall outside the FVDRC terms of reference. These 19 deaths are primarily perpetrator suicides, but there are also suicide pacts, bystander deaths and intervener deaths.

The 72 family violence deaths within the FVDRC terms of reference can be categorised according to intimate partner violence (IPV), child abuse and neglect (CAN) and other family members (also known as intrafamilial, or IFV).

In the next section of this chapter, we will first report across all 72 family violence deaths. In the following sections, we will report on each of the three categories of death separately.

Figure 2: Family violence deaths and family violence related deaths, New Zealand, 2009–10



Source: FVDRC Data Collection

Family violence deaths from 2009 to 2010

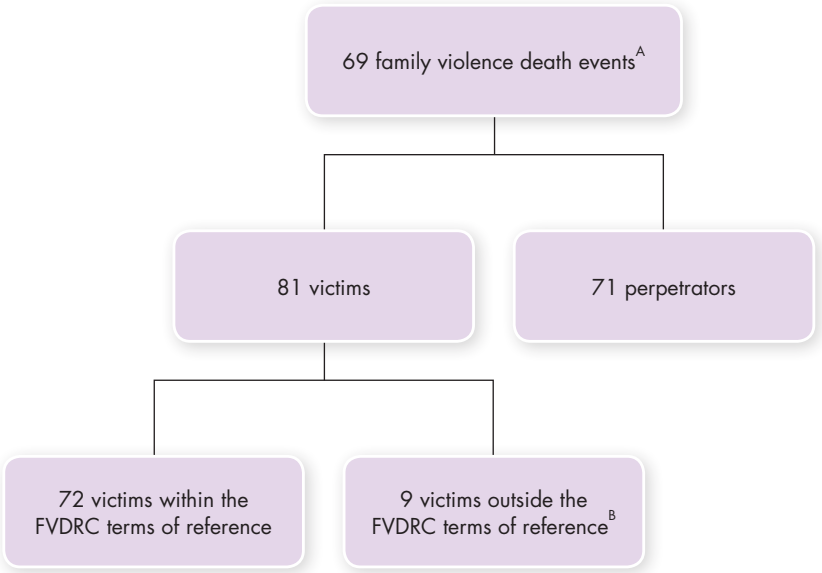
Of the 69 death events that fell within the FVDRC terms of reference (see Figure 3), there were 81 victims. Seventy-two of the victims fell within the FVDRC terms of reference, but nine did not.

The victim, in the 72 family violence deaths that occurred during 2009 and 2010 and fell within the FVDRC terms of reference, was killed by an intimate partner, previous partner, a partner's partner (current or past), parent, step parent, caregiver or other family member.

There were 71 perpetrators of these 69 family violence death events. Eight of these perpetrators died by suicide at the time of the death event.

The categories of victim and perpetrator used in this report identify the victim(s) who were killed by the perpetrator(s) in the death event. In reality, some of the victims appear to have been the primary perpetrators throughout the history of the familial relationship, while some of the perpetrators appear to have been the primary victim.

Figure 3: Family violence death events, victims and perpetrators, New Zealand, 2009–10



A Excluding family violence related death events (see Figure 1).

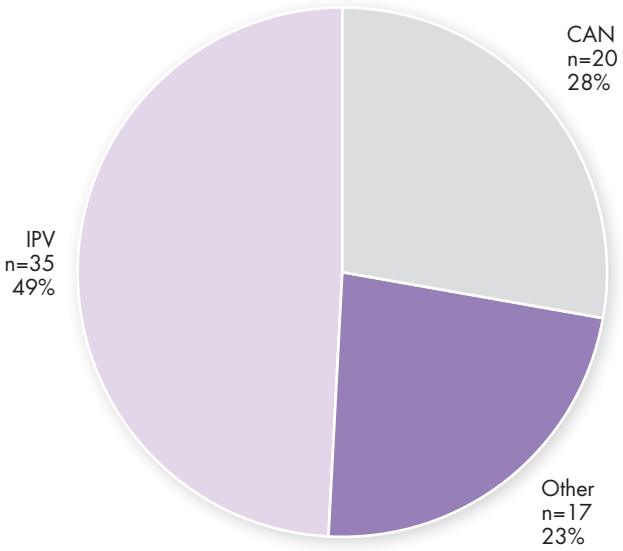
B Eight perpetrator suicides and one bystander. Because they died at the time of the family violence death event, the eight perpetrators are counted as victims of the death event.

Source: FVDRC Data Collection

i. Category and context of family violence deaths

Half (49 percent) of all family violence deaths in New Zealand during 2009 and 2010 were IPV related, while over one-quarter (28 percent) were CAN (see Figure 4).

Figure 4: Family violence deaths by type, New Zealand, 2009–10 (n=72)



CAN = child abuse and neglect
IPV = intimate partner violence
Other = other family member, also known as intrafamilial or IFV
Source: FVDRC Data Collection

Of the 72 family violence deaths, 22 appeared to be premeditated killings, while 40 did not appear to be premeditated but occurred during an act of family violence. For the remaining 10, there is not enough information to completely understand the context in which the death occurred. For three of those 10, the context of the death was not known. Meanwhile, for seven of those 10, the killing was a possible accident; while family violence might have been known to exist in the home, it is not clear that the death occurred during an incident of family violence. Six of these seven were child deaths.

Location

Table 2: Family violence deaths by police district, New Zealand, 2009–10 (n=72)

POLICE DISTRICT	Family violence deaths n=72
Auckland	6
Bay of Plenty	9
Canterbury	7
Central	9
Counties Manukau	7
Eastern	8
Northland	3
Southern	1
Tasman	2
Waikato	5
Waitemata	8
Wellington	7

Source: FVDRC Data Collection

There was a family violence death event in every New Zealand Police district during 2009 or 2010 (Table 2). We must be cautious in comparing across New Zealand Police districts, however, because the numbers are small. Over time, the FVDRC anticipates the numbers to become large enough to calculate reliable rates per New Zealand Police district.

Cause of death

Table 3: Cause of family violence deaths, New Zealand, 2009–10 (n=72)

CAUSE		Family violence deaths n=72	
		n	%
Assault	Without a weapon	22	30
	With a weapon	9	13
Stabbing		16	22
Shooting		10	14
Strangulation or suffocation		8	11
Other[A]		7	10

A Other includes causes of death such as drowning, deliberate reckless driving, medical overdose and medical neglect.

Source: FVDRC Data Collection

In five of the 10 shootings, the gun was a licensed firearm (see Table 3). In four, the gun was not a licensed firearm. For one, that information was not available. Nine of the 10 were shotguns.

Outcome for perpetrators

Of the 71 perpetrators, eight died by suicide at the death event (Table 4) and, because they were deceased, were not subject to prosecution. Twenty-nine of the 63 remaining perpetrators (29/63; 46 percent) were found guilty of murder and sentenced, while 22 (22/63; 35 percent) were found guilty of manslaughter plus other charges and sentenced. For five of the deaths, the suspected perpetrator is still being processed by the legal system and a final outcome is pending. In three of the cases, the perpetrator was acquitted (by reason of insanity or self-defence), but was still understood to have been responsible for the killing. For four deaths, the person responsible for the killing has not yet been identified and charged but for each case the perpetrator was most likely a family member and so has been included as such in this report.

Table 4: Outcomes for perpetrators of family violence deaths, New Zealand, 2009–10 (n=71)

OUTCOMES		Perpetrator outcome n=71	
		n	%
Legal outcome	Murder	29	41
	Manslaughter/Other charges	22	31
	Acquitted	3	4
Suicide[A]		8	11
Unresolved/Outcome pending		5	7
Unknown		4	6

A Death events in which the perpetrator died by suicide at the event are not processed via the legal system.

Source: FVDRC Data Collection

ii. Demography of victims and perpetrators of family violence deaths

Ethnicity

The rates per year of NZ Māori victims (Table 5, Figure 5) and perpetrators (Table 6, Figure 6) of family violence deaths are significantly higher than those of non-Māori and non-Pacific peoples. The higher rates for Māori as victims and perpetrators are apparent across all categories of family violence death although it is not statistically significant for IPV.

The numbers are small for Pacific peoples victims and perpetrators, so it is not possible to comment on differences. The numbers of deaths in each category of death are sometimes fewer than three, and in these instances the data are not provided because the estimates are not robust.

Table 5: Ethnic-specific rates (per 100,000 people per year) of family violence death by type of family violence, New Zealand, 2009–10

	Total population n=8,682,650		Total victims n=72			Victims of CAN n=20			Victims of IPV n=35			Victims of other family violence n=17		
	n	%	n	%	rate	n	%	rate	n	%	rate	n	%	rate
NZ Māori	1,316,790	15.17	29	40	2.20	10	50	0.76	11	31	0.84	8	47	0.61
Pacific peoples	552,715	6.37	4	6	0.72	s	s		s	s		s	s	
Other	6,813,145	78.47	36	50	0.53	8	40	0.12	21	60	0.31	7	41	0.10
Unknown			3	4		s	s		s	s		s	s	

s = small numbers

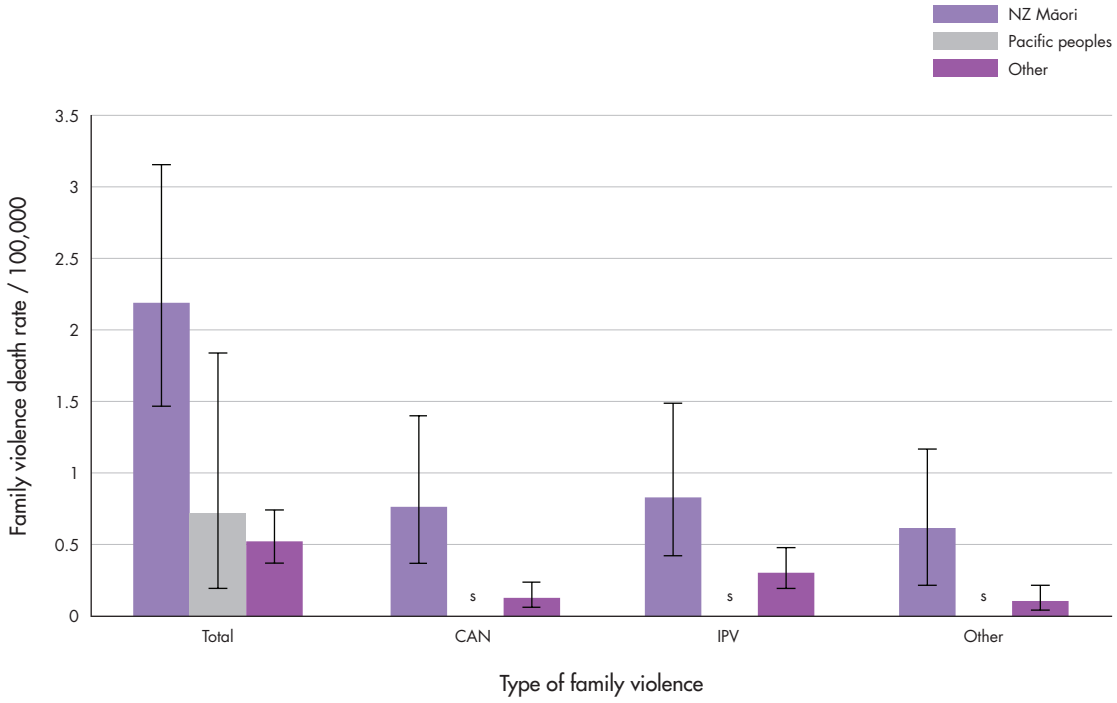
CAN = child abuse and neglect

IPV = intimate partner violence

Other includes New Zealand European, Other European, Middle Eastern, Latin American or African, East Asian, Southeast Asian or Indian.

Source: Numerator: New Zealand Health Information Service (NZHIS) from NHI data. Denominator: Statistics New Zealand.

Figure 5: Ethnic-specific rates (per 100,000 people per year) of family violence death by type of family violence (with 95% confidence intervals), New Zealand, 2009–10



s = small numbers

CAN = child abuse and neglect

IPV = intimate partner violence

Source: Numerator: New Zealand Health Information Service (NZHIS) from NHI data. Denominator: Statistics New Zealand.

Table 6: Ethnic-specific rates (per 100,000 people per year) for perpetrators of family violence death by type of family violence, New Zealand, 2009–10

	Total population n=8,682,650		Total perpetrators n=71			Perpetrators of CAN n=18			Perpetrators of IPV n=37			Perpetrators of other family violence n=16		
	n	%	n	%	rate	n	%	rate	n	%	rate	n	%	rate
NZ Māori	1,316,790	15.17	28	39	2.13	8	44	0.61	11	30	0.84	7	44	0.53
Pacific peoples	552,715	6.37	6	8	1.09	s	s		4	11	0.72	s	s	
Other	6,813,145	78.47	34	48	0.50	7	39	0.10	21	57	0.31	7	44	0.10
Unknown			3	4		s	s		1	3		s	s	

s = small numbers

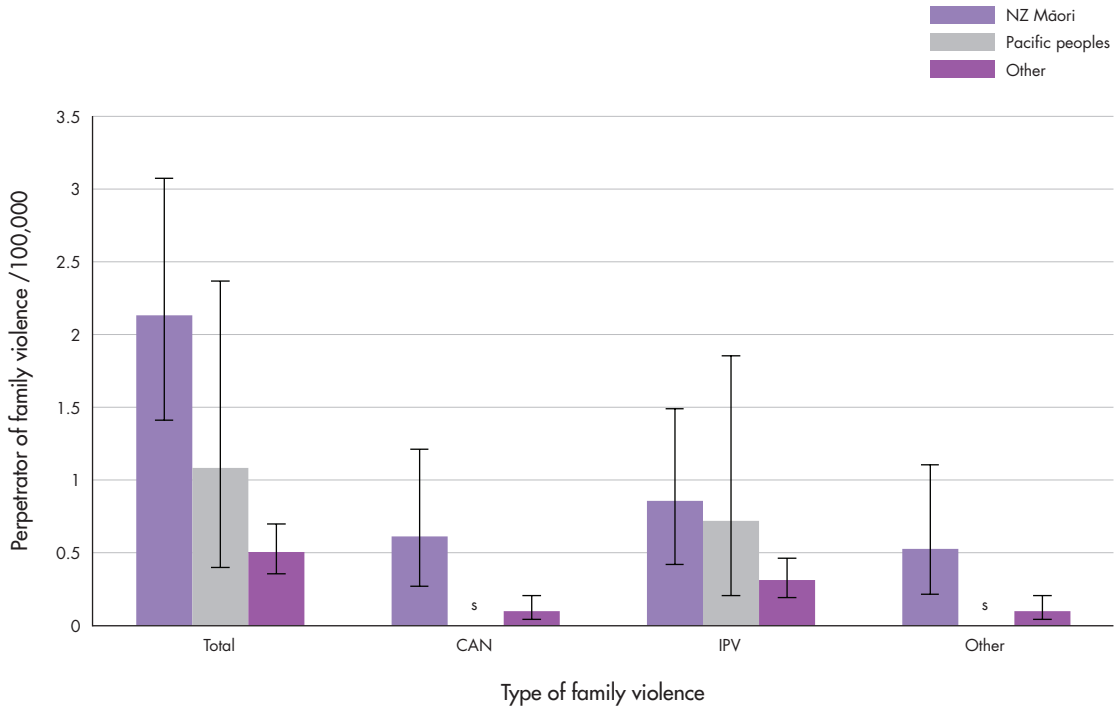
CAN = child abuse and neglect

IPV = intimate partner violence

Other includes New Zealand European, Other European, Middle Eastern, Latin American or African, East Asian, Southeast Asian or Indian.

Source: Numerator: New Zealand Health Information Service (NZHIS) from NHI data. Denominator: Statistics New Zealand.

Figure 6: Ethnic-specific rates (per 100,000 people per year) for perpetrators of family violence death by type of family violence (with 95% confidence intervals), New Zealand, 2009–10



s = small numbers

CAN = child abuse and neglect

IPV = intimate partner violence

Source: Numerator: New Zealand Health Information Service (NZHIS) from NHI data. Denominator: Statistics New Zealand.

Place of birth

Eleven of the victims (15 percent, 95% CI 8-26) and seven of the perpetrators (10 percent, 95% CI 4-19) were born overseas. This is not too dissimilar from the 2006 Census data, which showed that overseas-born people living in New Zealand make up 23 percent of the country's population overall.[61]

Gender

For these family violence deaths that occurred during 2009 and 2010, there was no significant difference in the gender of victims of family violence death overall, although gender ratio did vary by category of death (Figure 7).[62] Overall, there were 39 female victims (54 percent) and 33 male victims (46 percent) (Table 7; Figure 7).

Forty-seven perpetrators (66 percent) were male and 21 perpetrators (30 percent) were female. This difference in the gender of perpetrators was statistically significant (Table 7; Figure 8).

Among IPV deaths, there were more female victims (69 percent) than male.[63] Males were significantly more often perpetrators (76 percent) of IPV than females (Table 7; Figures 7 and 8).

Among CAN cases, there were no statistically significant differences seen in the gender of victim or perpetrator.

Among other family violence deaths, there was an over-representation of males as both victims (82 percent) and perpetrators (69 percent), but this difference was not statistically significant.

Table 7: Gender-specific rates (per 100,000 people per year) for victims and perpetrators of family violence death by type of family violence, New Zealand, 2009–10

	Total population		Total			CAN			IPV			Other family violence		
	n	%	n	%	rate	n	%	rate	n	%	rate	n	%	rate
Victim	**8,688,300**		**n=72**			**n=20**			**n=35**			**n=17**		
Male	4,264,500	49.08	33	46	0.77	8	40	0.19	11	31	0.26	14	82	0.33
Female	4,423,800	50.92	39	54	0.88	12	60	0.27	24	69	0.54	3	18	0.07
Perpetrator	**8,688,300**		**n=71**			**n=18**			**n=37**			**n=16**		
Male	4,264,500	49.08	47	66	1.10	9	50	0.21	28	76	0.66	11	69	0.26
Female	4,423,800	50.92	21	30	0.47	8	44	0.18	9	24	0.20	3	19	0.07
Unknown			3	4		1	6					2	13	

CAN = child abuse and neglect

IPV = intimate partner violence

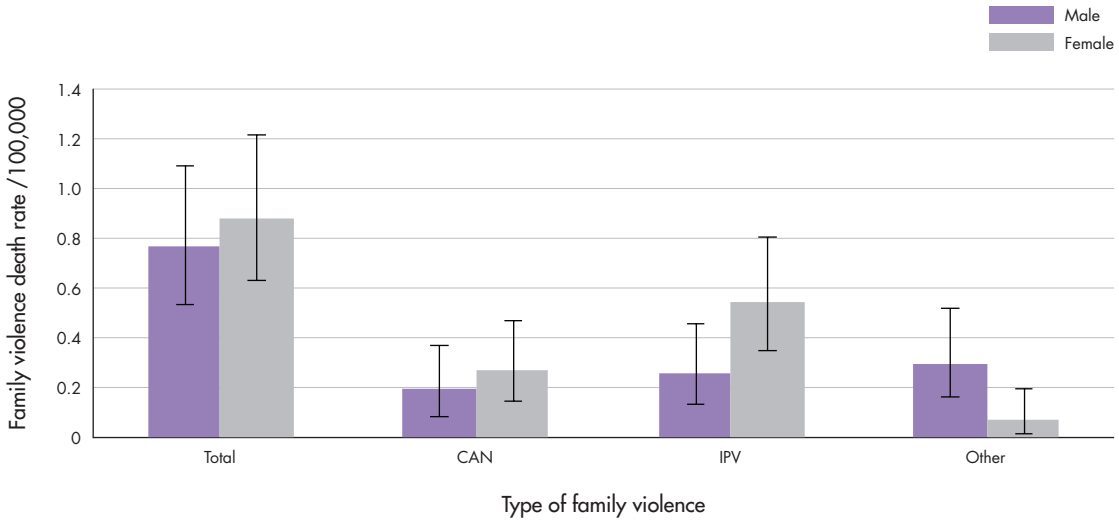
Source: Numerator: FVDRC Data Collection. Denominator: Statistics New Zealand.

61 For more information, see the Ministry of Social Development's *Social Report 2010* at http://www.socialreport.msd.govt.nz/people/people-born-overseas.html.

62 Note that we are using the word 'perpetrator' here to refer solely to the death event. As we note below, in seven of the eight cases where the female was the perpetrator in IPV deaths, she was the primary victim in the preceding relationship.

63 This might be different if the primary victims of relationship abuse who were counted in this data as perpetrators for the purpose of the death event were classified as victims instead.

Figure 7: Gender-specific rates (per 100,000 people per year) of family violence death by type of family violence (with 95% confidence intervals), New Zealand, 2009–10

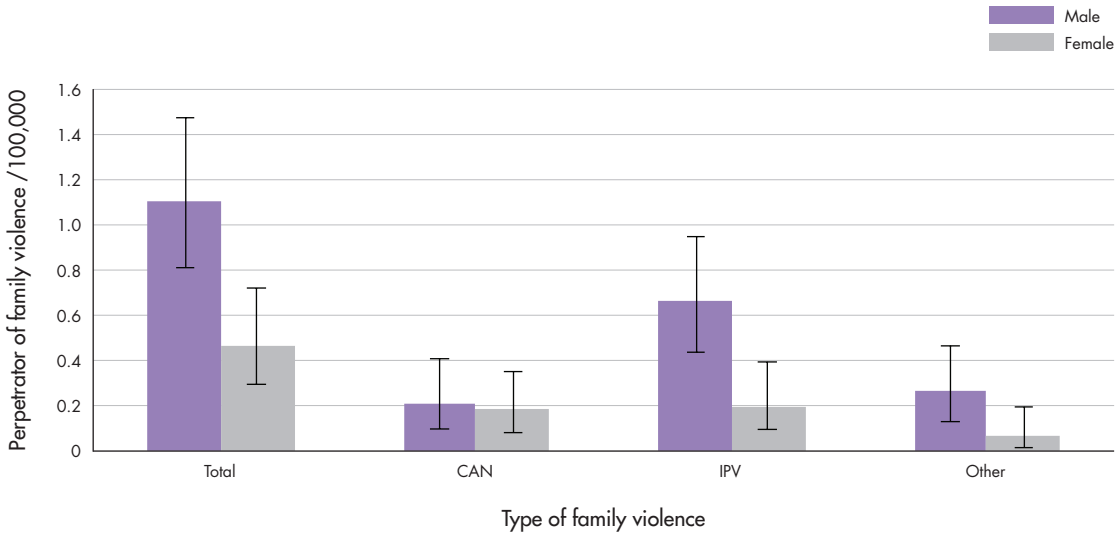


CAN = child abuse and neglect

IPV = intimate partner violence

Source: Numerator: FVDRC Data Collection. Denominator: Statistics New Zealand.

Figure 8: Gender-specific rates (per 100,000 people per year) for perpetrators of family violence death by type of family violence (with 95% confidence intervals), New Zealand, 2009–10



CAN = child abuse and neglect

IPV = intimate partner violence

Source: Numerator: FVDRC Data Collection. Denominator: Statistics New Zealand.

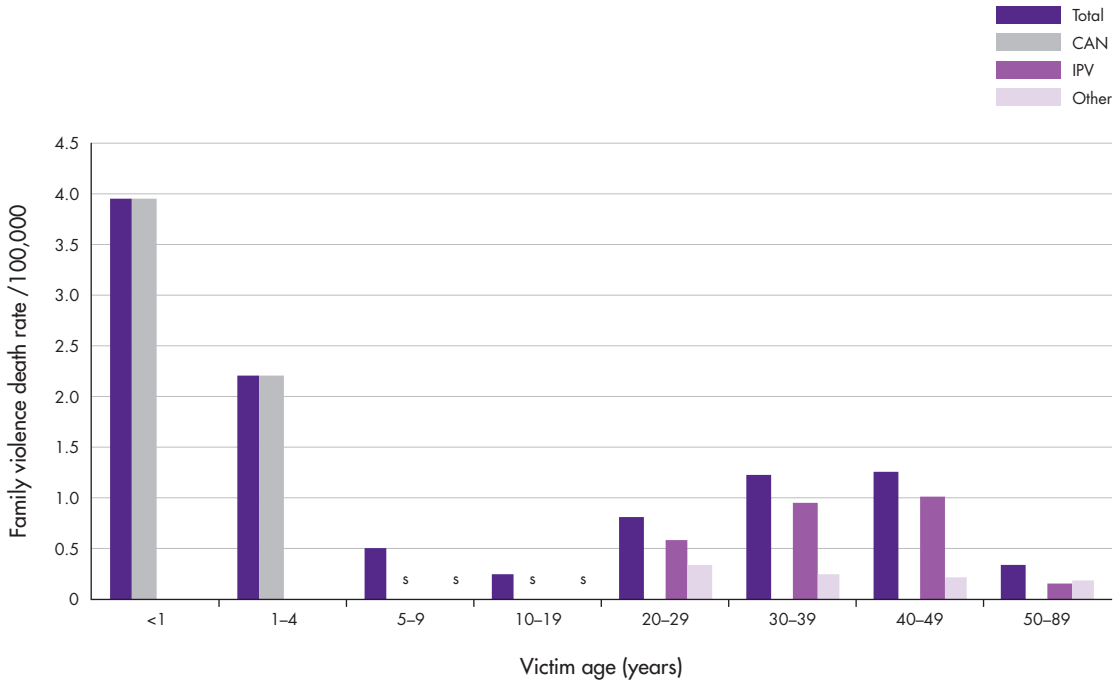
Table 8: Age-specific rates (per 100,000 people per year) of family violence death by type of family violence, New Zealand, 2009–10

	Total population <90 years n=8,695,860		Total victims n=72			Victims of CAN n=20			Victims of IPV n=35			Victims of other family violence n=17		
Age (years)	n	%	n	%	rate	n	%	rate	n	%	rate	n	%	rate
<1	126,650	1.46	5	7	3.95	5	25	3.95						
1–4	496,420	5.71	11	15	2.22	11	55	2.22						
5–9	574,300	6.60	3	4	0.52	s						s		
10–19	1,233,840	14.19	3	4	0.24	s						s		
20–29	1,211,540	13.93	11	15	0.91				7	20	0.58	4	24	0.33
30–39	1,141,520	13.13	14	19	1.23				11	31	0.96	3	18	0.26
40–49	1,269,610	14.60	16	22	1.26				13	37	1.02	3	18	0.24
50–89	2,641,980	30.38	9	13	0.34				4	11	0.15	5	29	0.19

s = small numbers
CAN = child abuse and neglect
IPV = intimate partner violence
Source: Numerator: FVDRC Data Collection. Denominator: Statistics New Zealand.

There were 22 child victims under 20 years of age, and 50 adult victims (Table 8). Five child victims were under one year of age, and 16 under five years of age.

Figure 9: Age-specific rates (per 100,000 people per year) of family violence death by type of family violence, New Zealand, 2009–10



s = small numbers

CAN = child abuse and neglect

IPV = intimate partner violence

Source: Numerator: FVDRC Data Collection. Denominator: Statistics New Zealand.

Table 9: Age-specific rates (per 100,000 people per year) for perpetrators of family violence death by type of family violence, New Zealand, 2009–10

	Total population <90 years n=8,695,860		Total perpetrators n=71			Perpetrators of CAN n=18			Perpetrators of IPV n=37			Perpetrators of other family violence n=16		
Age (years)	**n**	**%**	**n**	**%**	**rate**	**n**	**%**	**rate**	**n**	**%**	**rate**	**n**	**%**	**rate**
<1	126,650	1.46												
1–4	496,420	5.71												
5–9	574,300	6.60												
10–19	1,233,840	14.19	5	7	0.41	s			s			s		
20–29	1,211,540	13.93	21	29	1.73	9	50	0.74	4	22	0.33	8	50	0.66
30–39	1,141,520	13.13	19	26	1.66	5	28	0.44	12	67	1.05	2	13	0.18
40–49	1,269,610	14.60	13	18	1.02	s			10	56	0.79	s		
50–89	2,641,980	30.38	10	14	0.38	s			9	50	0.34	s		
Unknown			3	4		s			s			s		

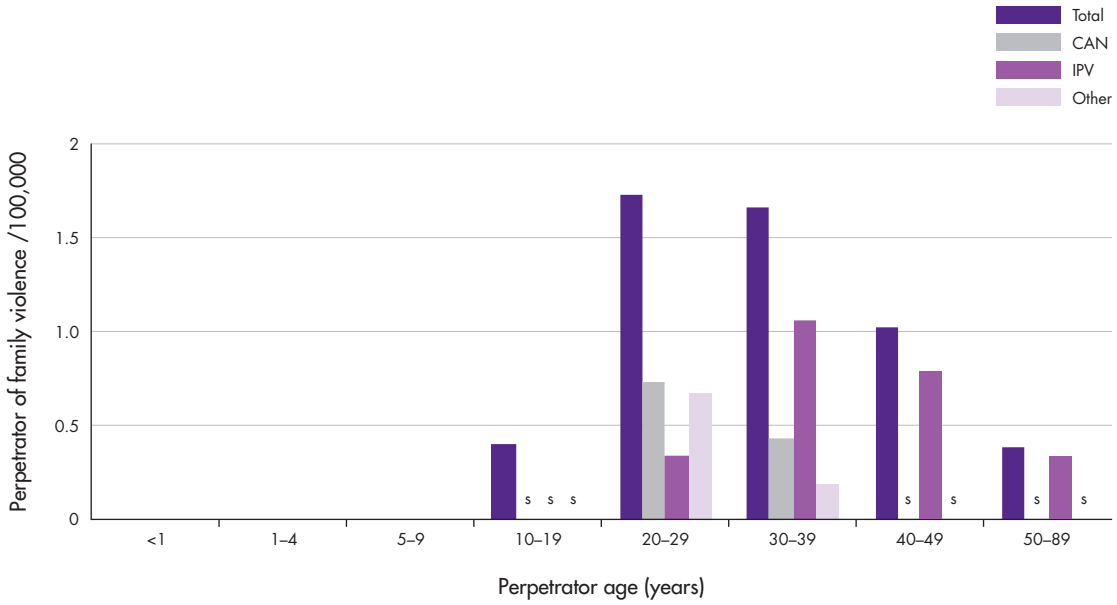
s = small numbers

CAN = child abuse and neglect

IPV = intimate partner violence

Source: Numerator: FVDRC Data Collection. Denominator: Statistics New Zealand.

Figure 10: Age-specific rates (per 100,000 people per year) for perpetrators of family violence death by type of family violence, New Zealand, 2009–10



s = small numbers
CAN = child abuse and neglect
IPV = intimate partner violence
Source: Numerator: FVDRC Data Collection. Denominator: Statistics New Zealand.

Perpetrators were more often in the age band from 20 to 39 years compared to younger or older age categories (Table 9, Figure 10).

Socioeconomic deprivation

Socioeconomic deprivation data are not provided in this report.

It is difficult to report actual deprivation for victims and perpetrators because deprivation is generally measured using the home address. It is not unusual for family violence victims and perpetrators to change addresses often or have multiple addresses at the same time, causing uncertainty about whether the addresses maintained in agency records are accurate.

Intimate partner violence deaths in New Zealand from 2009 to 2010

There were 35 IPV family violence deaths in New Zealand from 2009 to 2010 (see Figures 2 and 4).[64] Moreover, there were seven additional family violence related deaths connected to the 35 family violence deaths (eg, perpetrator suicides and bystanders). There were, therefore, 42 deaths in total. Only the 35 that fall within the FVDRC terms of reference are analysed here. As noted below, there were child deaths, not analysed here, that took place in an environment of IPV.

Table 10: Gender of perpetrators and victims of IPV deaths, New Zealand, 2009–10 (n=35)

	Female victim n=24	Male victim n=11
Male perpetrator	23[65]	3
Female perpetrator	1	8

Note that some death events might have more than one victim or more than one perpetrator. This table only considers the main perpetrator and does not consider any accomplices.

Source: FVDRC Data Collection

Twenty-three (66 percent) of the IPV homicides involved a male perpetrator and a female victim, while eight (23 percent) involved a female perpetrator and a male victim (Table 10).

Of the eight homicides with a female perpetrator and a male victim, in seven of the cases agency records evidenced an extensive history of IPV suggesting that the female was the primary victim throughout the relationship, while the male was the primary perpetrator of this abuse. While this suggests that in one of the eight cases the female was the primary perpetrator of family violence given that she was the perpetrator of the homicide, the hidden nature of family violence means that we should be cautious about arriving at this conclusion without access to the accounts of family and friends which would provide more information about what was taking place.

In all four of the homicides where the victim and the perpetrator were of the same sex, the killings were related to heterosexual relationships that involved coercion, control and/or sexual jealousy.

Fifteen of the IPV deaths appeared to be premeditated killings, while 19 did not appear to be premeditated but occurred during an act of family violence. For the one remaining IPV death, there is not enough information to completely understand the context in which the death occurred.

Based on information from New Zealand Police reports, nine of the perpetrators were overheard to say that they were going to kill the victim prior to the death event.

Six of the deaths were murder-suicides, meaning the perpetrator died by suicide at the time of the death. Stabbing was the most common means by which the victims were killed (13/35, 37 percent) followed by assault with or without weapon (11/35, 31 percent combined) (Table 11).

64 There are two IPV deaths included here that New Zealand Police does not count as family violence. New Zealand Police counts one as family violence related and the other one as a non-family violence related homicide.

65 In one of these homicides, there is not enough evidence to find any perpetrator guilty, but all of the suspected perpetrators are male and the death appeared to be premeditated.

Table 11: Cause of IPV deaths, New Zealand, 2009–10 (n=35)

CAUSE		Intimate partner violence deaths n=35	
		n	%
Assault	Without a weapon	6	17
	With a weapon	5	14
Stabbing		13	37
Shooting		6	17
Strangulation or suffocation		4	12
Other[A]		1	3

A Other includes causes of death such as drowning, deliberate reckless driving, medical overdose and medical neglect.

Source: FVDRC Data Collection

Police history

Fourteen of the perpetrators had a history of family violence in prior relationships that was known to New Zealand Police, as did 10 of the victims (Table 12). It is important to note, however, that the victims of this death event were not always the victims of previous events, nor were the perpetrators of this death event always the perpetrators of previous events. Some had been both perpetrators and victims of violence at different times in the past with different family members (partners, parents, siblings, etc).

Six of the perpetrators had provisions in place in New Zealand to protect their previous partners from them, and one had such a provision overseas.

Twenty-one of the perpetrators had criminal records known to New Zealand Police. Fifteen of the 21 perpetrators with criminal records (71 percent) had convictions for violent offending.

Fifteen victims had criminal records, but the only ones who had convictions for violent offending were in seven of the cases where the male victims of the death event were the primary perpetrators throughout the intimate partner relationship.

In 18 relationships, New Zealand Police were aware of a history of violence between the victims and the perpetrators in the relationship that had the death event. New Zealand Police records indicated that seven of the perpetrators in this death event were actually the primary victims over the course of the relationship with the perpetrator.

In 25 relationships, family and friends disclosed knowledge of family violence in interviews conducted by New Zealand Police following the death event. This suggests that there were at least seven events with a history of family violence known to family and friends that was not known to New Zealand Police.

Most notably, in eight of the relationships, there were provisions in place to protect the victim from the perpetrator. Six of these were protection orders, one was a no trespassing order and one was a bail condition preventing the perpetrator from residing at the same address as the victim.

Table 12: Family violence and criminal history of victims and perpetrators of IPV deaths as known to police, New Zealand, 2009–10

	FV history with previous partners	Criminal record prior to the death event	FV history in this relationship	Previous call-outs for domestic disputes (violent and non-violent)	Provisions in place to protect a previous partner	Provisions in place to protect the victim from the perpetrator	FV history in this relationship known to family, friends or co-workers
Victim				**n=35**			
Yes	10	15					
No	17	18					
Unknown	8	2					
Perpetrator[A]				**n=34**			
Yes	14	21[B]			7[C]		
No	16[D]	11			27		
Unknown	4	2			0		
Current relationship				**n=34**			
Yes			18	15		8	25
No			16[E]	19		26	7
Unknown			0	0		0	2

Shaded areas not applicable

FV = Family violence

A One intimate partner violence perpetrator is unknown so n=34.

B One of the perpetrators did not have a criminal record in New Zealand, but did appear to have one overseas. This information became known, not when the perpetrator immigrated to New Zealand, but during the New Zealand Police investigation following the death event.

C One of these provisions was for a previous partner overseas, not in New Zealand.

D One of the perpetrators did not have a history of family violence known to New Zealand Police, but did have a history of family violence known to police overseas. In addition, for another perpetrator, another government agency appeared to have knowledge of family violence that was not known to New Zealand Police.

E There is one couple who had a New Zealand Police report that was not recorded as family violence at the time. In retrospect, this report should have been classified as family violence.

Source: FVDRC Data Collection

Nineteen of the 35 deaths (54 percent) occurred within the context of separation. While for some cases the separation had only recently been discussed as a possibility, for others it was imminent. Of the separations that had already occurred, only a few were recent. A few had occurred in the more distant past, but the victim and perpetrator still had strong ties to one another, often due to children and finances. These statistics challenge the notion that leaving an abusive relationship is a guarantee of safety.

The co-occurrence of IPV and CAN

In eight of the IPV deaths (23 percent), children either witnessed the death or were in the home at the time of the death according to data from the police reports.

In 17 of the relationships (49 percent), the couple had at least one child, while some had more than one. In addition, in at least seven of the relationships, one of the partners had a child from another relationship. This suggests that a number of children, while not actually involved in this particular death event, would have lived in a home with a history of family violence and will continue to live after the event with one parent deceased and possibly another parent in jail. In addition, the next section on CAN deaths demonstrates that some CAN deaths occur in the context of, or as a result of, IPV.

Child family violence deaths in New Zealand from 2009 to 2010

During 2009 and 2010, there were a total of 22 family violence and family violence related deaths of children (falling within the categories of CAN, non-CAN other family member and bystander).

Twenty-one of the child victim deaths fell within the FVDRC terms of reference.

Fourteen (66 percent) of the 21 children, or their siblings or parents, were known to Child, Youth and Family according to the New Zealand Police Family Violence Death Reports, while four were not. For three more, this information was not known.

Twenty of the child deaths were due to CAN. There were three adult deaths associated with these CAN death events; these were all parent suicides occurring at the time of the child death(s).

The five children under one year of age were killed by fathers, mothers and mothers' partners. Due to the small numbers, it is not possible to draw conclusions about the context of these five death events. In the majority, the caregivers appeared unable to cope with the demands of a young infant. This was sometimes complicated by the caregiver's mental health issues and/or a co-occurring context of IPV.

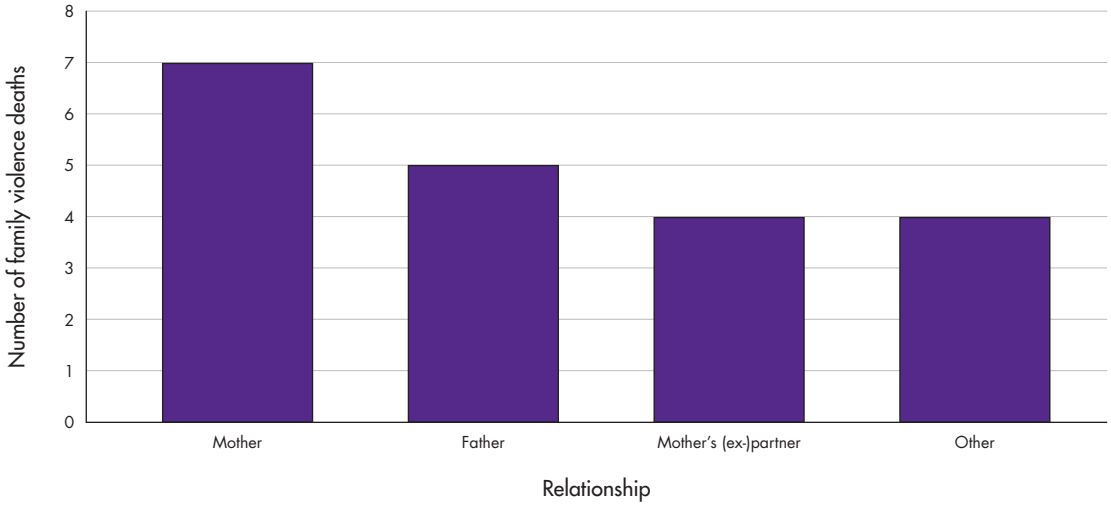
Six of the 12 children aged between one and five years died by assault during physical punishment. Three of the children aged between one and five were killed by a parent with mental health issues. It was not clear whether the death of the remaining three children aged between one and five was premeditated or occurred during an act of family violence.

All three of the children aged over five, died in a murder-suicide that occurred as the parents were separating. This suggests these deaths were IPV related.

The most common cause of death was assault (10 cases). Four children died by suffocation. Other causes of death included reckless driving (possibly deliberate), drowning and medical neglect.

According to Police reports, 11 of the CAN deaths (55 percent) appeared to happen in an environment of IPV between the caregivers and/or amidst a separation.

Figure 11: Perpetrator's relationship to the victim in CAN deaths, New Zealand, 2009–10 (n=20)

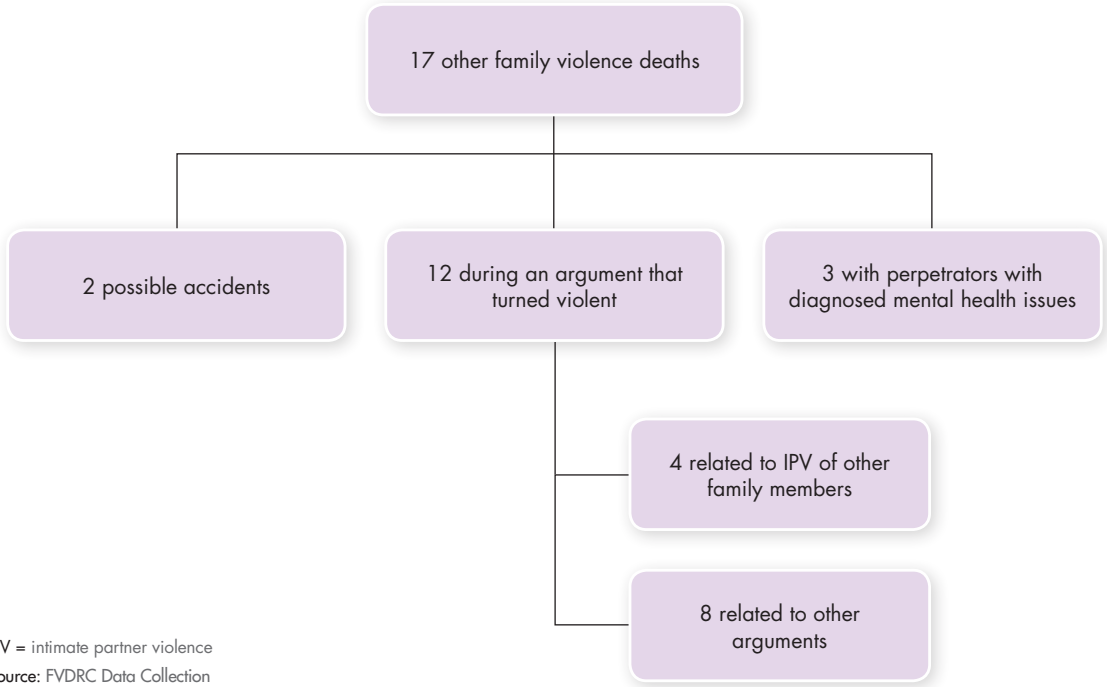


Source: FVDRC Data Collection

Other family violence deaths in New Zealand from 2009 to 2010

There were 17 other family violence deaths that occurred during 2009 and 2010 (Figure 12). Most victims and perpetrators were related (uncles and nephews, brothers, sisters, cousins, or parents and adult children) but the death was not IPV or CAN.

Figure 12: Other family violence deaths by category, New Zealand, 2009–10



IPV = intimate partner violence
Source: FVDRC Data Collection

Eighty-two percent of victims and 69 percent of perpetrators of other family violence deaths were male; almost half were NZ Māori and almost half non-Māori, non-Pacific peoples (Tables 5, 6 and 7).

The perpetrators were generally between the ages of 20 and 29 (Table 9). The majority of these death events were non-premeditated and occurred during an argument, often at a large social gathering.

As Figure 12 shows, four of these deaths are related to IPV of other family members.

Chapter 4: Multi-agency collaboration and information-sharing for high-risk cases

There is widespread agreement that a multi-agency approach is essential in order to respond effectively to family violence. Consequently, New Zealand has developed considerably in terms of multi-agency initiatives and practice. Examples of such multi-agency collaboration include, but are not limited to, the Te Rito Collaboration and Family Violence Strategy, the establishment of the Taskforce for Action on Violence within Families, the Family Violence Interagency Response System (FVIARS) and the Whānau Ora framework.

Most notably, the FVIARS brings together a range of agencies in response to New Zealand Police-reported family violence incidents. In spite of limited funding for the FVIARS system, agencies commit their own resources to participate in this process, which attests to its value. The FVDRC understands there are many forms of FVIARS operating across the country, and examples of good multi-agency practice. (For more information on the FVIARS system in New Zealand and recent examples of promising interagency collaboration, see the text box on page 49.)

In all but two of the nine FVDRC reviews undertaken, the FVIARS process was triggered at some point.[66] In its current form, however, the FVIARS process was not able to provide a multi-agency response sufficient to address the imminent or longer-term safety issues of these particular high-risk cases. This was so even though risk indicators for lethal homicide in all instances were presented to at least one of the agencies that had contact with the family prior to the death (including agencies that were not involved in the FVIARS process).

This finding suggests a need for a nationally consistent, multi-agency case management process that can be initiated for high-risk cases. The FVDRC supports the development of a two-tiered approach:

- the FVIARS process, initiated by New Zealand Police-reported family violence occurrences, which is directed at triaging family violence cases to the agency or process which can appropriately respond
- a separate multi-agency case management process for high-risk cases that can be initiated by referrals from a range of agencies, including from the FVIARS process.

The FVDRC believes the development of a national case management process for high-risk cases is timely on three accounts. First, it is understood that during 2013 the National FVIARS Working Group will consider what a high-risk case management system may look like, and how this may work in practice, particularly with respect to the FVIARS process and the development of multidisciplinary children's teams as part of the White Paper for Vulnerable Children.[67]

Second, the mandate of the *Delivering Better Public Services: Reducing Crime and Re-offending Result Action Plan*[68] is to identify new ways of working, and to increase collaboration across agencies. One of the specific actions of this plan is to support repeat victims, in particular to enhance responsiveness to repeat victims of family violence.[69]

Third, the recent Privacy Amendment Act 2013 includes legislative changes that are designed to encourage information-sharing and collaboration across agencies, particularly in instances where there is serious threat to the life or health of an individual.

66 We note that the location of the death reviews that we conducted relate to only seven FVIARS groups and they were all groups operating in the larger metropolitan areas.

67 We note that there is a number of separate multi-agency systems that are currently under development and review. It is important that the co-occurrence of IPV and CAN is factored into the interface and interconnection between these systems.

68 Ministry of Justice, *Delivering Better Public Services: Reducing Crime and Re-offending Result Action Plan*, Wellington, Ministry of Justice, 2012.

69 Ministry of Justice, *Delivering Better Public Services Reducing Crime and Re-offending Result Action Plan*, 2012.

The FVIARS process

The FVIARS process was established in 2006. The original agreement was that New Zealand Police, Child, Youth and Family, and Women's Refuge would meet to review all Police Family Violence Investigation Reports (POLFVIRs). Other agencies such as Victim Support can provide support to victims in the event Women's Refuge is not available. A 2010 evaluation from the Ministry of Social Development's Centre for Social Research and Evaluation reports that 'FVIARS case management teams may also include representatives from other government and community agencies' (Centre for Social Research and Evaluation, *Evaluation of the Family Violence Interagency Response System*, Wellington, Ministry of Social Development, 2010, p. 4). Agencies that may or may not be involved in a FVIARS process can include those from different sectors of health, the Department of Corrections and the stopping violence sector.

By 2012, there were FVIARS processes in almost all New Zealand Police districts, and more than 60 examples nationally with variable operation, purpose and membership. In some districts, the FVIARS process has operated as a simple information-sharing and agency referral process for all POLFVIRs (known as a volumes approach). In other districts, the volumes approach has been supplemented by a specific high-risk case meeting.

Evaluation of the FVIARS process

The 2010 evaluation of the FVIARS process by the Ministry of Social Development concluded that FVIARS appeared to improve relationships between agencies and the efficient use of agencies' resources. It also appeared to provide a more accurate picture of individual cases with risks of future violence and to produce positive outcomes for adult and child victims, for offenders and for the management of notifications. However, the report identified a 'need for developing a result-based database to test these outcomes, an interagency national-level monitoring and evaluation framework, success indicators across agencies, and a common risk assessment framework'.

There is little information readily available about the number, membership practices and protocols of the various operating FVIARS groups or any evidence of whether the groups (or certain groups) are having a positive impact on the families that they consider and aim to help.

Other recent, promising examples of interagency collaboration

In August 2011, a memorandum of understanding (MoU) between DHBs, Child, Youth and Family, and New Zealand Police was agreed. The purpose of this MoU is to set out the mutual commitment of the parties to a collaborative working relationship, and to ensure that health and safety outcomes for children and young people are met within each party's legislative and funding responsibilities.

Moreover, in August 2012, an 'Operational Level Agreement: Requests for information from Child, Youth and Family by Community Probation Services (CPS)' was agreed. This agreement assists CPS to request and receive information from Child, Youth and Family to assist its assessment of an offender.

The National FVIARS Working Group's review of the FVIARS process

The National FVIARS Working Group is considering what triage processes, referral pathways and (multi-) agency responses should be initiated after a police-reported family violence occurrence.

The FVDRC supports the review and strengthening of the FVIARS process. Interagency information-sharing, analysis and risk assessment needs to be robust within the FVIARS process if it is to accurately identify those cases which need to be referred into a high-risk case management process.

While the FVDRC recognises the need for a range of support pathways for family violence occurrences reported to New Zealand Police, it recommends that any police-initiated referral process include a risk and needs assessment, undertaken by either the police or an appropriately skilled family violence professional.

The need for an additional multi-agency case management process for high-risk cases

Important components of a nationally consistent case management process for high-risk cases are:

- the inclusion of key agencies, including New Zealand Police, Child, Youth and Family, non-governmental family violence agencies, the Department of Corrections and the Ministry of Health
- multi-agency referral entry
- the use of common risk assessment tools (including risk assessment for lethality)
- multi-agency risk management, safety planning and case review
- a dedicated coordinator.

In this section of the report, we explain why a separate process for high-risk cases is necessary, and describe what some of the features of such a process might be.

1. A separate case management process is needed because high-risk cases require additional time and consideration

Complex, high-risk cases require time for practitioners to develop a holistic understanding of the family's situation (past and present) and plan for safety.

From the regional reviews in which a FVIARS process was initiated, it was apparent that FVIARS meetings, especially in the large metropolitan areas, have so many POLFVIRs to consider that capacity issues limit the time available to review each case and engage in robust risk assessment and management. The particularly high-risk cases did not get the detailed consideration and discussion they warranted, and such cases were often not re-reviewed or brought back to the meeting unless another family violence incident was reported to the police.

A multi-agency response process for high-risk domestic violence cases has been introduced in a number of other jurisdictions. For example, in England there are Multi-Agency Risk Assessment Conferences (MARACs) in which statutory and voluntary agency representatives meet to share information about high-risk victims of domestic violence in order to produce a coordinated action plan to increase victim safety.[70] The European Commission has also produced materials on good practice and capacity-building to encourage multi-agency partnership in the identification, assessment and safety management of high-risk domestic violence cases. Examples of high-risk processes can also be found in Australia,[71] Canada [72] and the United States.[73]

70 Co-ordinated Action against Domestic Abuse (CAADA) has developed 10 principles of an effective MARAC (CAADA, *The MARAC guide 2010 – from principles to practice,* Bristol, CAADA, 2010). There is some evidence to suggest that MARACs have the potential to improve victim safety and reduce revictimisation (N. Steel, L. Blakeborough and S. Nicholas, 'Supporting high-risk victims of domestic violence: a review of multi-agency risk assessment conferences (MARACs)', *Research Report 55,* London, Home Office, 2011, p. ii; A. Robinson, *Domestic Violence MARACs (Multi-agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: A process and outcome evaluation,* Cardiff, Wales, Cardiff University, 2004).

71 For Western Australia, see Department for Child Protection, *The Western Australian Family and Domestic Violence Case Management and Coordination Services Governance and Operations Manual,* Perth, Western Australian Government, 2011. For South Australia, see Council of Australian Governments, *National Plan to Reduce Violence against Women and Their Children,* 2012, pp. 46–7.

72 In Canada, jurisdictions such as Nova Scotia and British Columbia also have high-risk case coordination protocols (see V. Singer, 'Keeping Victims Safe in Halifax: A Coordinated Approach', *Risk Assessment, Risk Management and Safety Planning Knowledge Exchange,* Centre for Research and Education on Violence Against Women, University of Guelph, Canada, presented 17–19 October 2010; British Columbia, *Violence Against Women in Relationships Policy,* 2010).

73 In the United States, there is a range of integrated responses to family violence, including the Duluth Domestic Abuse Intervention Project developed in Minnesota (see Shepard, M.F. and Pence, E.L. (eds.), *SAGE Series on Violence against Women: Coordinating community responses to domestic violence: Lessons from Duluth and beyond,* 1999).

2. Clear multi-agency referral pathways into the process are needed because some high-risk cases may not come to the attention of police

Although New Zealand Police is called to a significant number of family violence related events,[74] most family violence incidents will not come to its attention.[75] In addition, serious and complex family violence disclosures can be made to other agencies. It is recommended, therefore, that a report to the police should not be the only means by which cases are referred into a high-risk process. Instead clear pathways and standard forms and procedures for other agencies to refer into such a process would seem desirable.

It was noted that agencies outside the FVIARS process (such as health, refugee services or education) may be the only agencies privy to crucial information or be alone in having ongoing contact with victims in particular cases. In one death review, the victim had disengaged with agencies involved in the FVIARS process in an attempt to manage and contain the escalating risk that the perpetrator was presenting to her and her children. However, the victim remained engaged with agencies outside the FVIARS process and was disclosing facts to those practitioners which indicated that she was at high risk of being the victim of a lethal homicide. Unfortunately, the professionals she was disclosing to had no referral pathways back into the FVIARS process.

3. Key agencies need to be around the table if a high-risk process is to operate effectively

It was noted in the death reviews undertaken that, while agencies met together and shared information, collaboration generally took place within 'clusters' of agencies rather than between all relevant agencies across the system.

Examples of agencies that may have crucial information, relationships and capacities in particular cases, but are often lacking around the table in the FVIARS processes, are the Ministry of Health (including general health, mental health and drug and alcohol services) and the Department of Corrections. Other relevant agencies may be Work and Income New Zealand (WINZ), refugee support agencies, the Ministry of Education, Housing New Zealand[76] and providers from the stopping violence programmes sector.

The death reviews provided instances where the information base the FVIARS agencies were working with would have substantially broadened and potentially led to different outcomes had the Department of Corrections or health services been involved and information shared. For example, in some reviews, while significant disclosures were being made in the course of alcohol and drug treatment or to the general health practitioner, this information was not available to the FVIARS agencies. Another possible outcome of these agencies' involvement is that the capacity of the FVIARS process to implement certain actions may have been enhanced. In a number of death reviews, CPS was not provided with crucial information about the perpetrator or the victim by agencies involved with FVIARS, even though that person was on sentence at the time.

4. Protocols and professional practice around information-sharing need development

Information-sharing and storing (including minute-taking) need clear and consistent protocols so that agencies are confident about taking information into a multi-agency process. The individuals being discussed also need to be confident that the information is not going further than it should. Such protocols should indicate clearly what information can be taken from the meetings, how and when it can be used and shared, and with whom it can be shared. There is also a need for clear guidance around when and how victims are informed or not informed (eg, when doing so would compromise their safety) about the occurrence of a multi-agency process for their high-risk case.

74 In 2011, the police responded to more than 94,000 family violence incidents (Nimmo, B., *Stakeholder update,* 2012).

75 In 2009, the police learned about only 32 percent of assaults and 7 percent of sexual offences, and victims were less likely to report offences committed against them when the perpetrator was known to them (Ministry of Justice, *The New Zealand Crime and Safety Survey: 2009 Main Findings Report,* Wellington, Ministry of Justice, 2010, pp. 44–7). In 2006, it was found that people were less likely to report offences committed against them by their partner (21 percent), when compared to similar offences committed by a stranger (31 percent). Of those offences committed by partners that were judged as the most serious, 35 percent were reported to the police, as opposed to 50 percent of similar offences at the same level of seriousness committed by a stranger (P. Mayhew and J. Reilly, *The New Zealand Crime & Safety Survey: 2006*, Wellington, Ministry of Justice, 2007).

76 N. Steel, L. Blakeborough and S. Nicholas, 'Supporting high-risk victims of domestic violence', 2011.

The potential to prevent family violence by sharing information is dependent on what is *shared*, what is *understood* and what *action* is taken in response to the sharing of information. Reder and Duncan highlight that, while clear and relevant information-sharing policies are important, these are only a partial solution and the 'psychology of communication also needs to be considered'.[77]

Reder and Duncan posit that interagency communication would improve if *all* professionals acquired a 'communication mindset' as part of their core skills and devoted training time to the development of interpersonal skills for communicating – acquiring the techniques to enable good communication, such as:

- checking that the other person has understood
- avoiding jargon
- monitoring how one conveys information and listens to another
- summarising the key points from conversations
- knowing how to write detailed yet succinct notes
- having the capacity to make a synopsis of a case so essential information is prioritised over incidental.

Professionals need to remember the concept, 'I am part of a system', so it becomes automatic thinking.

> 'Communication is also a systemic mindset, because each individual must remain aware of the existence of other relevant people and of the need to impart information to them. Hence, each individual needs to conceptualise themselves (and the case) as linked into a web of other people and agencies, so that they are constantly asking themselves: who else is relevant to this issue and in what way? Who will be affected by actions that I take in relation to this case? Who else needs to know what I know? And, who else may know what I don't know?'[78]

5. Clear thresholds of risk and the use of common, validated tools for risk assessment are needed

There are challenges involved in talking across cultures, different institutional boundaries and disciplines. The process of doing so requires training, consistent procedures and shared understandings. Such a process needs to be underpinned by the provision of family violence and risk assessment training for all participating multi-agency practitioners.

Thresholds of risk for referral into a high-risk process must be clear. The tools used to make that risk assessment must be shared across all agencies involved, relevant to the task at hand and evidence based. In some of the death reviews we conducted, although a number of risk indicators for lethal homicide were present (eg, detailed threats to kill – one of the strongest risk factors consistently linked to homicide) these cases were not identified and responded to as potential homicides. In some cases under consideration, the lack of a common framework for understanding and talking about risk was not conducive to the agencies involved in the FVIARS process arriving at a common understanding of the risks involved.

6. Robust multi-agency analysis is needed in high-risk cases

Sometimes there was a lack of robust analysis within the FVIARS process of the strength of the evidence informing the different agencies' understandings of events. The fact that agency representatives meet and information is exchanged does not always result in shared understanding and effective intervention; the willingness of individuals and agencies to collaborate is not enough on its own.

Different professionals working with the family came to the FVIARS process with different understandings of the situation and the level of risks involved, and different ideas about the best way forward. Some agencies (differing from case to case) had a better sense of the situation (including the risks) than others.

In order to work together to make quality decisions, practitioners need to share their professional assessments and their thinking. They should communicate the strength of evidence that informs their judgements and spend time processing this information until they arrive at shared understandings.

77 P. Reder and S. Duncan, 'Understanding communication in child protection networks', *Child Abuse Review*, vol. 12, 2003, pp. 82–100, p. 95.

78 P. Reder and S. Duncan, 'Understanding communication in child protection networks', 2003, p. 94.

While this takes more time, it provides a valuable safety mechanism by enabling others to amplify or challenge both the factual accuracy and interpretation of the situation.

The reviews indicated that often agencies did not explain their professional reasoning processes or work towards achieving a common understanding. This problem was exacerbated in several instances by professional hierarchies and a lack of prior interagency relationships. What this meant was that some agencies' understanding of the situation carried more weight than others, even though in some instances their assessments were less accurate than professionals perceived to be further down the hierarchy.

7. A holistic and cumulative understanding of family violence must be taken when sharing information and assessing risk

A number of the family violence death events reviewed involved chronic histories and patterns of abuse, including abuse from multiple partners or in respect of multiple victims. These histories of abuse were not well captured within the FVIARS meetings. Risk needs to be assessed holistically, but this is challenging when working in a high volume environment. Chronic involvement with services makes it hard for agencies within the FVIARS meetings to share the depth and detail of information they have on their files, particularly when time is limited. The natural tendency for practitioners, especially when there is a significant history, is to focus on the recent incidents and the most recent victims and perpetrators, rather than considering those incidents in the context of a person's whole history.

The incident-based response to family violence, which is often adopted in the criminal justice process, can exacerbate the problem. It was evident in some death reviews that New Zealand Police did not view some of the families in the FVIARS process as high risk, simply because the last incidents reported to it had attracted a low-risk assessment and it was these events that had triggered the FVIARS process. In these cases the risks were associated with the length of involvement with the police, the seriousness of the previous incidents and the cumulative intensity of the abuse. It is hoped that the ODARA process will result in a more long-term appraisal of risk by the police in IPV cases.[79]

Historical information, the cumulative impact of abuse on the victim and her children, and the risks and dangers present in an abusive relationship are missed when family violence is represented as a series of individual discrete incidents or when the dots are not joined between patterns of behaviour across multiple relationships of victimisation or perpetration.

For high-risk cases, a specific case management process contextualising incidents within the perpetrator's overall pattern of abuse or a victim's experience of multiple abusive partners would help. Furthermore, information that is analysed and brought to the table needs to move beyond an incident-based approach to family violence.

8. There is a need for comprehensive, multi-agency safety plans

In the cases reviewed, there was a need for a comprehensive multi-agency safety plan because each agency is limited in what it can do. Safety plans need to clearly state the risk and safety issues, identify the named practitioners who are actually involved with the family and can potentially be contacted to provide support, and identify what each agency's role and responsibility is in implementing the plan. Timeframes for completion and review, and designation of who is responsible for monitoring the plan, are needed.

In the FVIARS process, sometimes there was only a record of which agencies were involved with the family, rather than what interventions were in place. Furthermore, outputs were often treated as safety outcomes. For example, in most of the reviewed deaths where a FVIARS process was triggered, the plan was that one agency would make contact (or make a home visit); this contact, which is effectively an output, was frequently interpreted as an outcome. In some reviews, when the FVIARS agencies' attempts to engage with victims were unsuccessful, the multi-agency response was to disengage with the victim. However, there was no improved safety outcome – the cases remained very high risk and eventually resulted in homicide. When the client either did not engage or disengaged with the agencies involved in FVIARS, there were no

79 Although it is relevant to note that ODARA predicts reassault rather than homicide.

robust processes in place to identify other agencies that were working with the victim who could assist in monitoring their safety and updating the police family violence coordinator about their situation.

When practitioners are working with high-risk victims or perpetrators of family violence, who may also have mental health or substance abuse issues, the responsibility for facilitating engagement and staying involved should be on services rather than on the client. Services need to create a web of support around the client, and try multiple ways of engaging and staying involved (in the short and long term).

Furthermore, when high-risk clients disengage from specialist family violence services, professionals need to inform the remaining services that they are no longer directly involved. The services that are still involved need to be aware that it is their responsibility to re-refer back to, or consult with, specialist and statutory family violence services if the risk increases or the situation changes.

Where lethality risk factors are evident, professionals need to be proactive and develop safety plans that do not place all the responsibility on the victim to initiate action. Safety plans should include concurrent planning to consider what actions are to be initiated if the agencies do not hear from the victim.

Potential harm to children should always be considered when designing safety plans. As the data in Chapter 3 demonstrates, IPV frequently co-occurs with CAN[80] and, in itself, has a harmful effect on children who are in the relevant household.[81]

9. The need for ongoing case review

As was found in the death reviews, victims' analyses and decision-making processes are complex and change as their circumstances change, their hopes and fears shift, they gather more information, and service responses are found to be effective or lacking. Risk is dynamic so service responses must also be fluid and risk regularly reviewed. Regular case review also supports practitioners to stop and consider the bigger picture – past and present – and check the strength of evidence, or lack of evidence, informing their plans and decision-making.

10. The need for inter-meeting coordination

For a high-risk process to function effectively, a meeting coordinator with the time and mandate to facilitate the multi-agency work between meetings, to maintain an overview of what is happening with respect to each case (monitoring the implementation and review of agreed actions and plans), and to act as a point of contact for agencies, would help. In some of the death reviews undertaken, there appeared to be no one person with responsibility in the FVIARS process for ensuring that tasks were completed or bringing matters back to the meeting if risks changed or there was disengagement by the victim.

Recommendations

The FVDRC recommends that:

1. the Taskforce for Action on Violence within Families, in partnership with the responsible agencies, develops a nationally consistent high-risk case management process.

The recommendation is for this process to be supported by a permanent core membership consisting of key agencies including New Zealand Police, Child, Youth and Family, NGO family violence agencies, the Department of Corrections and the Ministry of Health (including primary health, mental health and drug and alcohol services). It is suggested that this process connect into the Better Public Services Support Repeat Victims work as it will contribute to achieving targets to reduce rates of violent crime and reoffending.

80 K. Stasiak et al., 'Incubated in Terror: Children Living with Domestic Violence', *Te Awatea Review*, vol. 2, 2004, pp. 3–5.

81 K. Richards, *Children's Exposure to Domestic Violence in Australia*, Canberra, Australian Institute of Criminology, 2011. Children who have witnessed IPV or been directly maltreated are more likely to attempt suicide (three times more likely) and experience learning and behavioural difficulties, mental and physical health problems, alcohol and drug dependency, criminal activity, imprisonment, truancy, teen pregnancy and poor educational achievement.

To enable effective risk management and the development of good working relationships, these professionals need regular meetings.

National high-risk case management guidance and tools will also need development to include:

- referral threshold criteria and a multi-agency referral form
- common risk assessment tools to enable a shared language and understanding of risk
- a multi-agency safety plan template for the integrated risk management and monitoring of high-risk cases
- interagency information-sharing protocols
- information that specific agencies should bring to the meeting, and the internal preparation and analysis required by that agency prior to attending the meeting
- the range of actions that each specific agency can consider initiating for high-risk situations
- processes for the regular review of cases
- monitoring and evaluation processes to measure the safety outcomes for people whose situations have been risk-managed and reviewed.

There needs to be a high-risk meeting coordinator with family violence expertise and the mandate to (i) initiate and facilitate the work in between meetings, (ii) maintain an overview of what is happening with respect to each case (meaning that agreed actions are completed within agreed timeframes) and (iii) ensure there is ongoing and continuous sharing of information and cooperation between agencies and individuals.

This high-risk case management process should be reviewed regularly by all key partners, at the operational and strategic level. This should include a quality review process, with a commitment to use the qualitative review findings to inform future decision-making.

2. the Taskforce for Action on Violence within Families considers funding the development of national FVIARS training, for all professionals involved with FVIARS and all multi-agency, high-risk case management processes.

The recommendation is for family violence training to cover:

- child development, attachment, adverse childhood experiences and recognising CAN
- understanding the dynamics, complexities and lethality risk indicators for IPV, including women's use of violence and identifying the primary victim and primary perpetrator
- co-occurrence of IPV and CAN, and the impact of abuse on parenting
- chronic and cumulative patterns of harm
- understanding the impact of post-traumatic stress disorder and trauma
- cultural conceptual models for understanding and addressing violence
- cultural awareness
- risk assessment regarding assault and lethality indicators
- thresholds of risk for referral into a high-risk case management process
- who the high-risk agency representatives are and their roles
- the role of each service.

3. the Taskforce for Action on Violence within Families and the lead agencies for the *Delivering Better Public Services: Reducing Crime and Re-offending Result Action Plan* use the New Zealand Family Violence Clearinghouse principles for effective interagency collaboration,[82] to inform the development of a high-risk case management process and to strengthen the FVIARS processes.

82 C. Murphy and J. Fanslow, *Building collaborations to eliminate family violence*, 2012.

Chapter 5: **Stopping violence programmes**

Responding adequately to family violence includes assisting victims to recognise abuse, recover from trauma and develop strategies for keeping themselves and their children safe, as well as providing education to abusers in order to challenge their belief systems and to assist them in developing alternatives to the use of violence and control in their intimate relationships.[83] In New Zealand this is attempted through the provision of stopping violence programmes.[84]

The FVDRC acknowledges the important work undertaken by the stopping violence sector, as well as the inherent difficulties involved in undertaking such work and the unrealistic expectations often loaded onto the sector. We acknowledge the many facilitators skilfully navigating the difficult job involved in getting onside and building relationships with perpetrators in order to work with them in effecting change, without colluding with their abusive behaviours.[85] This sector has evolved considerably over time. It was, until relatively recently, largely a voluntary workforce, and is still primarily a part-time workforce.

In six of the nine regional death reviews completed to date, stopping violence programmes were a key component in the family violence system that worked with the families concerned. Issues emerging around the provision of the programmes that resonated with broader themes we observed in the death reviews were:

- the need for proper evidence-based assessments to be completed, which in this instance includes the need to have victim input
- the need for a case management approach to be taken in respect of family violence, which in this instance means the need to develop safety plans for victims
- the need to improve interagency information-sharing and collaboration across all service providers in relation to family violence, which includes the need to strengthen the information-sharing between the stopping violence programmes and other relevant agencies.

In addition, there is the need to develop living free from violence programmes to address the specific needs and experiences of women who have been abused by partners who are gang members or where there has been gang violence, intergenerational abuse and historical trauma.

The complexity of family violence and of the New Zealand family violence system makes it impossible to draw simple cause and effect relationships between unsafe practice in any particular case and the death under review. At best we can say that unsafe practice in the sector was one of multiple factors in these cases that may have prevented the family violence system responding more effectively to address the violence before it escalated to homicide.

Introduction to the programmes

Pathways into the programmes

In New Zealand, there are multiple pathways for referring a family violence perpetrator into a stopping violence programme. Some of these pathways mandate attendance, while others result in voluntary attendance. Different government agencies are responsible for regulating and funding a range of referral paths:

- the Family Court will generally direct the respondent to attend a programme under the Domestic Violence Act 1995 when making a protection order (unless there is 'good reason' for not doing so)

83 The UK organisation Respect offers a good explanation of why communities need to work with domestic violence perpetrators (Respect, *Domestic Violence Perpetrators: Working with the cause of the problem,* London 2010).

84 We will use the term 'stopping violence programme' to refer to all those programmes which are attended as a result of the range of referral processes described. The correct terminology for the programmes may differ slightly depending on the referral pathway. For example, programmes attended by the perpetrator after a protection order is made are 'respondent programmes'. The primary objective of all of these programmes is to prevent the continued use of family violence by the perpetrator.

85 G. Dixon and K. O'Connor, *Facilitating Domestic Violence Programmes: Listening to voices from the field,* Wellington, Relationship Services Whakawhanaungatanga, 2010.

- a person can also be required to attend a programme by the District Court in its criminal jurisdiction (including when it is sitting as the Family Violence Court) when they are sentenced for a domestic violence offence and a protection order is made
- the District Court also makes referrals to programmes after a guilty plea to a domestic violence offence but before sentencing, in which case attendance is voluntary but successful completion of the programme will influence the sentence received
- mandatory referrals are made from CPS for those who are serving sentences of supervision, intensive supervision or home detention, or who are on parole or released on conditions after a sentence of imprisonment
- the Ministry of Social Development refers abusers and victims into community programmes.

In addition, individual people may recognise that they need help and self-refer into a group or individual programme.

Funding for attendance will depend on the referral pathway into the programme in any particular case. If a protection order is made or the programme is a referral from the criminal courts, then the programme is funded by the Ministry of Justice. Referral pathways set in process by CPS and the Ministry of Social Development will be funded by those agencies. When an individual decides to attend a programme, they must fund attendance.

When a protection order is made, protected persons are also entitled to attend programmes without cost but the uptake of such programmes in New Zealand has generally been fairly low.[86] There may be a number of reasons for this. For example, many victims will be in crises at this point – including dealing with the effects of any post-traumatic stress – and responding to basic survival issues involving shelter and food for themselves and their children. Robertson et al also found in 2007 that the Family Court's promotion of protected persons programmes to protected persons 'varies around the country.'[87] Protected persons can also request that their children attend a children's programme, which are designed to assist children in dealing with the effects of family violence.[88]

The Domestic Violence (Programmes) Regulations 1996

The Domestic Violence (Programmes) Regulations 1996 (the Regulations) set out the basic requirements and standards that must be adhered to for the provision of programmes to participants to a Protection Order. For example, regulation 33 prescribes the number of respondent programme sessions which have to be attended – for group programmes, with a maximum of 16 people, there must be between 30 and 50 session hours in total, lasting up to three hours each session; meanwhile, for individual programmes there are to be between nine and 12 session hours.[89]

The Regulations also set out an approval process for providers and programmes. The Ministry of Justice and the Department of Corrections require approval under the Regulations before they will enter into contracts with programme providers for the provision of programmes.

86 In 2007, Robertson et al. estimated that 36 percent of protected persons nationally attend programmes based on Ministry of Justice statistics for the year 2003 and 2004 (N. Robertson et al., *Living at the Cutting Edge: Women's Experiences of Protection Orders, Volume 1: The Women's Stories*, Hamilton, New Zealand, University of Waikato, 2007). In 2008, it was stated, 'Ministry of Justice notes that over the past three years only about 20 percent of protected persons and 10 percent of entitled children have attended a programme. This is despite efforts the Family Court has undertaken to encourage participation by sending regular reminders to protected persons over the three years that they and their children are eligible for a programme. Lawyers are also required under the DVA to advise their clients of their right to attend a programme' (New Zealand Government, *Review of the Domestic Violence Act 1995 and Related Legislation – Paper Three: The Role of the Courts under the Domestic Violence Act 1995,* Ministry of Justice, 2008). There is a discussion of recruitment and take-up in G. Maxwell, A. Anderson and T. Olsen, *Women Living without Violence: An evaluation of programmes for adult protected persons under the Domestic Violence Act 1995,* Wellington, Ministry of Justice, 2001, pp. 83–92. Also see F. Cram et al., *Evaluation of Programmes for Maori Adult Protected Persons under the Domestic Violence Act 1995,* Wellington, Ministry of Justice and Department for Courts, 2002, pp. 50–4.

87 N. Robertson et al., *Living at the Cutting Edge,* 2007.

88 As noted above, in the 2008 *Review of the Domestic Violence Act 1995 and Related Legislation – Paper Three: The Role of the Courts under the Domestic Violence Act 1995* it was suggested that only 10 percent of children eligible attend a children's programme (New Zealand Government, *Review of the Domestic Violence Act 1995 and Related Legislation – Paper Three: The Role of the Courts under the Domestic Violence Act 1995,* Ministry of Justice, 2008, p. 15).

89 There is an ongoing need for culturally competent facilitators who can provide culturally appropriate programmes as needed.

Although the Regulations are limited in their application to programmes attended through particular referral pathways, they have a strong informal impact across the stopping violence programme sector. This is because programme providers who accept mandated respondents as a result of a Protection Order pathway will need to adhere to the Regulations, but will also have perpetrators in their programmes attending via other referral routes. The core set of principles which will direct their practice in respect of all perpetrators that they work with will, therefore, need to be compliant with the Regulations.

We note that in the six regional death reviews in which a stopping violence programme was attended, there were perpetrators who had attended a number of such programmes through different referral pathways at different points in time in respect of one or, in some instances, multiple victims. Of the six cases in which a stopping violence programme was attended, in only one had the perpetrator always entered the programme through a referral path that was not governed by the Regulations. However, the programme he attended was offered by a programme provider that was also receiving referrals governed by the Regulations.

Additional practice requirements of the National Network of Stopping Violence Services programmes

Some providers are members of the National Network of Stopping Violence Services (the Network). These providers are expected to comply with the practice standards of the Network, as well as agreeing to feed back information that can be used to compile statistics and information about any complaints. In exchange, the Network offers member providers resources and training opportunities.

Although the Network is the biggest cooperative of agencies providing stopping violence programmes in New Zealand, a significant percentage of the agencies that the Ministry of Justice and CPS contract with are outside the Network and will, therefore, not be subject to its practice standards.

The Network's equivalent in the UK is an organisation called Respect,[90] although Respect provides an accreditation process for stopping violence programmes while the Network in New Zealand does not. The aim of Respect is to guarantee that, if a programme is accredited under its standards, then that programme is providing a safe service that complies with best practice as it is understood in the research literature.

Issues emerging from the FVDRC death reviews

For all six of the death reviews undertaken in which stopping violence programmes were attended, there was evidence suggesting that the provision of the programmes was not aligned with international best practice and, as a result, might be considered unsafe. The FVDRC notes that these practice issues are not addressed in the proposed reforms set out in the Family Court Proceedings Reform Bill.

1. No interface with victims: No information from or to victims

In all six of the reviews where stopping violence programmes had been attended by the perpetrator prior to the death event (sometimes multiple times), not one of the victims had been contacted by the programmes for their input. This finding is not unusual because stopping violence programmes in New Zealand do not generally seek input from the victim. The result, however, is that the victim's experience of the perpetrator's ongoing behaviour is not included in any risk assessment at the point of intake, during attendance, upon completion or afterwards. As a consequence, programme providers will not know if the client is continuing to abuse their partner or ex-partner and are in most instances entirely reliant on perpetrator self-report in assessing risk or change.

Furthermore, the information that the victim is acting on when making decisions around their safety and the safety of their children is dangerously incomplete when they are not informed about what is happening in the programme. Victims do not know if their partner/ex-partner is attending the programme and are vulnerable to being given inaccurate or misleading information about the programme – for example, that they are to blame for the violence and should modify their behaviour. Furthermore, victims commonly assume they are safer while their partners or ex-partners are attending programmes and may need to be warned that attendance at a stopping violence programme is no guarantee that the abuse will stop.

90 Respect is the UK membership association for domestic violence perpetrator programmes and associated support services. The primary aims of a Respect-accredited service are: safety; assessing and managing risk; a coordinated community response; diversity and equal access to services; promoting respectful relationships; accountability; and social change. For more information, see http://www.respect.uk.net/.

In the tier-two death reviews, we saw evidence of programme providers' opinions being given weight in crucial decisions that impacted on victim safety even though those opinions were based entirely on positive (and inaccurate) self-report of change from the perpetrator. We also saw evidence in the death reviews of women choosing to stay in violent relationships because they believed their partner was attending a programme and addressing his issues, even in instances where their partners had in actuality stopped attending.

According to Respect, *minimum* standards of safety in the provision of a stopping violence programme include the need for an Integrated Support Service (ISS) for partners, provided by either the agency itself or an agency working in partnership.[91] An ISS for victims is described by Respect as:

> 'a linked parallel service that runs alongside a perpetrator programme for the duration of a perpetrator's attendance. This service aims to have regular contact, either by telephone or face to face with both current and ex partners (particularly when there are children) to enable a better assessment of risk, to provide information about legal and support services, to provide where possible supportive counselling and to dispel any expectations of change being rapid or guaranteed.'[92]

There are several noteworthy aspects of this. The ISS is required to make persistent and proactive contact with partners and ex-partners of someone attending a stopping violence programme. This means taking the initiative and making repeated efforts to contact women referred to the ISS rather than waiting for them to make contact themselves. There is recognition that victims of domestic violence will be in a state of crises and so practical help – advocacy, support and information – is offered around a range of issues, including safety assessments and planning, and child contact arrangements.

The result of regular contact is that ISS staff can provide information to the partner or ex-partner of someone attending the programme about the nature, possible impact and limits of the programme. They are obliged to inform them as soon as possible (and within a week) if there is an unexplained absence, a second consecutive absence (explained or not), if their partner is assessed as unsuitable for the programme, and when he completes the programme or is suspended from it.

Victims are also able to pass information about any new incidents of abuse or violence to the stopping violence programme. They agree on how this information will be used to enhance their safety, making sure it does not put them at further risk. Victims can also use the monitoring and oversight function of the programme to help them leave the relationship safely if this is something they wish to do. It is worth noting that in highly dangerous situations one of the advantages of the perpetrator attending a stopping violence programme is that session attendance means they are out of the house and agencies working with the family know it is a safe time to contact the victim.

Extreme care must be taken to ensure that contact with victims is made in a manner safe for them, information provided is used safely and victims are not exposed to coercive pressure from the perpetrator because the perpetrator knows that contact is being made. These issues have been addressed by Respect in the infrastructure through which contact must be made and in their Minimum Practice Standard that governs contact and information-sharing.[93] Training for practitioners and accountability structures must also be in place if safe practice is to be the norm.

In New Zealand there are opportunities for information exchange between stopping violence programme providers and victims. First, information can be disclosed with the authority of the person who disclosed the information to the programme provider.[94] Secondly, there is provision for information-sharing between

91 Respect, *Respect briefing paper on unsafe domestic violence perpetrator interventions,* London 2010.

92 Respect, *Respect briefing paper on unsafe domestic violence perpetrator interventions,* 2010.

93 Respect, *The Respect Safe Minimum Practice Standard,* London 2012, sec. B3.

94 Section 43(4)(e), Domestic Violence Act 1995.

programme providers that provide programmes to people who are subject to, and protected by, the same protection order 'if the provider reasonably believes that disclosure to another programme provider is necessary to further the primary objective of the programme'.[95] However, this kind of information exchange will be dependent on the respondent and the protected person both attending programmes and, as noted above, the uptake for protected persons programmes has been low. Even when protected persons do complete a programme it will often take place at a different time from that attended by the respondent. Victims of family violence who do not have a protection order will not have access to a protected person programme. Thirdly, there is provision for programme providers to share information that is disclosed to them if they reasonably believe '(on reasonable grounds) that disclosure is necessary to prevent or lessen a serious threat to public safety or the safety of any person'.[96]

Recent amendments to the New Zealand Privacy Act 1993 permit an agency to disclose personal information where that is necessary to prevent or lessen a serious threat to the life or health of the individual concerned or another individual.[97] A serious threat is defined in section 2 of the Privacy Act 1993 to mean 'a threat that the agency reasonably believes to be a serious threat having regard to all of the following: (a) the likelihood of the threat being realised; and (b) the severity of the consequences if the threat is realised; and (c) the time at which the threat may be realised.' Once a perpetrator is attending a stopping violence programme, it is likely that the threshold for a serious threat will be met, given that multiple acts of family violence have usually already occurred and the recidivist nature of family violence makes further violence highly likely.

In addition to these provisions for information-sharing, regulation 28(2)(f) of the Domestic Violence (Programmes) Regulations requires that programmes for protected persons 'assist the protected person to develop realistic expectations of behavioural and attitudinal change in the respondent or associated respondent'. A protected person who chooses not to attend a protected persons programme, or a victim of family violence who does not have a protection order, will not receive this input.

Although the Regulations do not require programmes to contact victims, the National Network of Stopping Violence Services' Manual (the Manual) has provisions requiring members to make contact with partners and other programme providers working with partners/ex-partners and children. However, this does not always happen in practice.[98]

According to the Manual, as part of the pre-programme engagement, the worker is directed to ascertain the name, address and contact number of the client's partner, ex-partner, children or other family members to whom the perpetrator has been violent.[99] Clients attending respondent programmes are required to sign a consent form to contact being made. Workers are directed to get agreement from course participants that they may report to partners if there is a failure to attend[100] so, if the perpetrator drops out or misses a group, the agency is to make contact with the victim and inform them.

95 Section 43(4)(f), Domestic Violence Act 1995.

96 Section 43(4)(d), Domestic Violence Act 1995.

97 Section 6, principles 10(d)(ii) and 11(f)(ii), Privacy Act 1993; Privacy Amendment Act 2013.

98 The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual*, 2002, sec. B17–19 & C20. Partner contact is stated to serve a five-fold purpose:

(1) To ascertain the safety of partners and children;

(2) To ascertain other support and information needs of partners and children;

(3) To give accurate information about the programme and the perpetrator's participation;

(4) To provide workers with information about the impact of the programme material on life at home and any changes or concerns that are noted;

(5) To provide a forum to hear the women's stories about what is happening at home.

99 We have been advised that obtaining victim details through the perpetrator is often intimidating and frightening for victims.

100 The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual*, 2002, sec. C25.

The Manual also requires agencies to have a system to contact partners and assess safety.[101] Contact is directed to take place prior to or during the engagement phase with partners and family members to seek information about current levels of safety.[102] Matters which should be discussed with the victim include:

- having an escape route from the house
- having belongings packed
- having some money set aside
- having a safe place to go
- having the emergency telephone number ready
- whether a protection order should be obtained
- resources that are available in the community
- a safety plan for the children, including access to passports and birth certificates.

It is required that the case worker discourage the victim from making a decision to return or stay based on their partner's participation in the respondent programme and to discuss with them 'indicators of change'.[103] The agency is directed to make every reasonable effort to ensure partners and family members know about the content of the programme and what the perpetrators are learning.

Ongoing contact with partners and family members (where possible) is also required, to monitor ongoing risk and safety factors. Contact with partners and family members should be based on their willingness to participate and 'take place in the most acceptable manner which may include through a support person'.[104] If the victim expresses ongoing interest, the worker should contact them twice during the programme to check safety and report progress. If, during the programme, it is perceived that there is a threat to the victim, they will be contacted even if they did not want contact to be alerted of the threat.[105]

After the programme is completed, agencies are directed to make contact again to check safety and see if the victim wants to have input into the evaluation of the programme.

While the processes around making contact with partners, ex-partners and family members could be further refined to address the safety issues involved in how the contact is made and the information used,[106] the clear intention – which is to proactively seek input from partners and provide them with information about progress, as well as advocacy and safety support – is in accordance with minimum standards of safety. However, the FVDRC has been informed that, unlike in the past, it is no longer consistent practice for stopping violence programmes that belong to the National Network of Stopping Violence Services to contact the protected person using a woman's worker in the stopping violence network or a women's refuge.[107] Programme staff understand that the Family Court and the Ministry of Justice domestic violence advisors have directed them not to contact protected persons, thus changing the Network's practice.[108]

2. Information from and to other sources: a joined-up response?

Picking up on the themes of Chapter 4 related to collaboration and interagency networking, the death reviews also suggested that programmes are not consistently linked into the network of other agencies working with the same family, or that might have been available to work with the same family. As a result, information that could be fed into the programmes or obtained by the programmes from other key agencies (such as police or mental health) is not. For example, in some death reviews there were multiple police call-outs while the perpetrator was attending a stopping violence programme of which the provider was unaware.

101 The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual,* 2002, sec. C8.

102 The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual,* 2002, sec. C7.

103 The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual,* 2002, sec. C22.

104 The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual,* 2002, sec. C19.

105 The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual,* 2002, sec. C23.

106 Clear protocols to make the experience of providing input safe for victims would be desirable.

107 Facilitators in the study by Dixon and O'Connor expressed concern that they were often 'working blind' – not seeing the 'whole picture', and they expressed concern about working with a perpetrator without being able to monitor the effects on the victim (G. Dixon and K. O'Connor, *Facilitating Domestic Violence Programmes,* 2010, p. 72).

108 Our research suggests that there is no Practice Note or formal direction issued by the Family Court to this effect. Robertson et al also note that programme providers were reporting to them that state agencies were prohibiting or failing to pass on details that would facilitate victim contact (Robertson, N. et al., *Living at the Cutting Edge,* 2007).

In the UK, programme providers receive relevant preliminary information from the referring courts at the point of intake. If the referral follows a criminal conviction, the programme provider receives a list of previous convictions and the victim's details for safety reasons. Also supplied is a copy of the latest summary of facts, any risk assessments undertaken and a probation report. If the person is referred via the equivalent of New Zealand's Family Court process, the provider receives a copy of the entire court file, including any available reports.

Respect also imposes a range of requirements designed to ensure that programme provision occurs within the context of a coordinated community response to the affected family.[109] There are provisions for routine screening with other agencies that may be involved in the case. For example, routine screening of the local authority children's social care department must be undertaken in respect of all referrals to the programmes where there are children in the relationship. There are also provisions requiring routine screening for criminal justice involvement in respect of clients referred to stopping violence programmes.

If there is social service involvement with the children, the client attending the programme is required to provide the name of the social workers involved. The programme provider is then required to make proactive attempts to obtain and share information about key concerns and risks of harm to the victim and the children. If the children are at risk then a written plan for intervention in order to safeguard the children must be prepared, with provisions for sharing information and review dates. If a perpetrator attending a programme is involved in Family Court proceedings, there is a risk assessment and the programme provider is required to make its views on progress and changes in risk available to the court and to the expert assessor. Programme providers must also develop effective referral pathways to agencies responding to alcohol and drug misuse and to mental health agencies.

In New Zealand not all programme providers will have access to the Police Incident Reports detailing the history of family violence when they receive referrals from the court. Programme providers do not get the Summary of Facts or the Probation Report. We saw evidence of programme providers receiving referrals with little contextual narrative or history and minimal information about dangerousness.

There is no requirement in the Regulations that programme providers link with other agencies to, for example, make regular requests to New Zealand Police for information and updates on incidents involving those attending the programmes.[110]

And while the National Network of Stopping Violence Services' Manual contains general statements about the need for programme providers to liaise and build relationships with relevant agencies working with women and children, there are no requirements to routinely screen for information about specific clients attending the programmes. For example, programme providers are directed to 'actively seek a working relationship with Child, Youth and Family, and in particular, site managers, community liaison social workers and child protection staff'.[111] Member agencies will also 'maintain close links with other agencies in the community that are working to enhance the safety of women and children' and will 'liaise with other stakeholders in the family violence field' and 'be involved in the development of interagency protocols'.[112] They are also directed to have an accountability relationship with services supporting those victimised by the men's violence.[113]

The Manual also indicates that, prior to accepting a man for participation in a respondent programme, the provider must liaise with approved services (such as alcohol and drug services).[114] Where substance abuse issues are identified these must be addressed first or concurrently.[115]

109 There are also requirements for more general interagency cooperation around policy development (Respect, *Domestic Violence Perpetrators: Working with the cause of the problem,* 2010, p. 3).

110 Section 6, principles 10(d)(ii) and 11(f) of the Privacy Act 1993 would also govern information-sharing processes here. Clearly robust interagency information-sharing and risk management is necessary to respond effectively to the threat of ongoing family violence.

111 They will also 'establish and maintain relationships with child focused agencies in their community' (The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual,* 2002, sec. B5).

112 The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual,* 2002, sec. B9.

113 The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual,* 2002, sec. C25. For example, they must invite refuge/survivor groups to be involved in selection of workers, registration of trainees and complaints processes.

114 The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual,* 2002, sec. C7.

115 The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual,* 2002, sec. C8.

The death reviews demonstrate the pressing need to ensure that stopping violence programmes in New Zealand do not continue to operate in what has been described as 'an information vacuum'.

3. Management of risk: risk assessment and victim safety plans

In a number of the death reviews, there was no proper risk assessment and no safety plan developed in respect of the victims. This point relates to those already discussed because, without adequate information, including information from victims, and without the programmes linking into a broader interagency response, it is impossible to accurately assess risk or to develop and implement appropriate safety plans. We saw evidence of programme providers developing safety plans for clients who were violent to their partners, suicidal and separating from those partners. While this is appropriate, given that these are also risk factors for family violence homicide,[116] it would be recommended that programme providers also develop a safety plan for the protected person.

Respect considers that minimum standards of safety for the operation of a stopping violence programme include 'a system of risk assessment and management'.[117] Programmes it accredits must use *evidence-based risk assessment tools*. Providers must use the tools and communicate outcomes with a clear understanding (and communication) of the limitations of the tools. Because risk is not static, regular reviews of risk are required.

Assessments of risk inform a case management approach in which providers work collaboratively with ISS staff. The ISS also communicates with other professionals to manage risk within a multi-agency context. The need for a safety plan is essential because it is unrealistic to expect stopping violence programmes to be sufficient in and of themselves to prevent violence.[118]

In New Zealand under the Regulations, respondent programme providers assess the client at the point of intake and are obligated under regulation 26(g) to conduct ongoing review of the needs, accountability, difficulties and progress of people attending the programme.[119] However, there is no requirement to make an initial and ongoing assessment of the risk to victims using evidence-based tools, no standard risk assessment tools to be used by everyone, and no requirement to develop a safety plan for victims.

Furthermore, when a respondent is mandated by the court to attend a programme, generally a laminated card handed to the judge indicates programme completion or non-compliance. A written report, while prepared by some programmes, is not standard protocol and there are no requirements for a detailed assessment of risk and observed change. Generally the person who has attended the programme will be asked a range of questions by the judge – for example, they might be asked to talk about one or two things they learned from the programme or the importance of being a positive role model for their children.

While the National Network of Stopping Violences Services' Manual could be more specific about using evidence-based risk assessment tools with awareness of their limitations, it does state that, 'All men who are referred to the programme will be assessed for their levels of dangerousness, motivation and needs'. Furthermore, each programme is required to 'have an ongoing process of identifying levels of risk and potential risk to partners and family members'.[120]

If the programme provider becomes aware that a breach of a court order has occurred, they are directed to notify the respective referral agencies responsible for sanctions. If the agencies do not take appropriate action, the programme provider is directed to follow up to see why and, if these failures are persistent, take them to local networks of police, the Family Court, Community Corrections, Women's Refuge or similar.[121] There are also protocols to follow if child abuse disclosures are made.

116 See J.C. Campbell, *Danger Assessment*, Baltimore, MD, John Hopkins University School of Nursing, 2004, https://doj.mt.gov/wp-content/uploads/2011/05/dangerassessment.pdf.

117 Respect, R*espect briefing paper on unsafe domestic violence perpetrator interventions,* 2010.

118 S. Little, *What Do We Know About the Effectiveness of Domestic Violence Programmes for Respondents? A Literature Review,* Wellington, Criminal and Youth Jurisdiction Team, District Courts, Ministry of Justice, 2009, p. 13.

119 The assessment form used is required by the approval guidelines to show an overview of historic and current violence used/experienced; an overview of recent or current danger issues and details of how these will be managed; information covering influencing factors such and drug and alcohol use, mental health, head injury etc; and how suitability for the programme will be assessed.

120 The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual*, 2002, sec. C3, C6.

121 The National Network of Stopping Violence Services (NZ) Inc, *Member Agencies' Policies, Standards and Practices Manual*, 2002, sec. C23.

While the Manual requires initial and ongoing risk assessment and the discussion of safety plans with the victim, as well as ongoing action around victim safety, as noted above the current inability to include information from victims in making risk assessments or to liaise with victims around safety reduces the effectiveness of these requirements.

4. Inappropriate substitutes to stopping violence programmes

The FVDRC notes that it saw evidence of perpetrators and victims being sent to couple counselling multiple times rather than to a stopping violence programme, even in circumstances where there had been an aggravated assault on the victim.

Couple counselling is usually inappropriate in situations where there is a history of family violence. It is unlikely that a victim of family violence will be able to speak frankly in such a process without making herself extremely unsafe. Nor will she be able to hold the perpetrator accountable for his behaviour, avoid being made at least partially responsible for her own victimisation, or to withstand pressure to minimise the abuse. Couple counselling to resolve family violence is not the best use of public resources and appears to be unsafe practice. It also fails to address the effect of violence on the children.

There was also evidence of victims and perpetrators repeatedly being sent to other services, such as drugs and alcohol services or parenting programmes, in circumstances where there was a need for a referral to a stopping violence programme as well.

5. Living free from violence programmes for women dealing with gang violence, intergenerational abuse and historical trauma

A number of the cases for which we completed death reviews involved chronic multi-generational abuse and trauma for both the perpetrator and the victim, often exacerbated by serious disadvantage, mental health and/or addiction issues. Gang associations were another factor that emerged as greatly impacting the level of violence that a victim faced, as well as the difficulty she experienced in negotiating safety for her or her children or in leaving the relationship. Such cases are not uncommon in New Zealand and suggest a need for living free from violence programmes developed to address the specific needs and experiences of women who have been abused by partners who are gang members or where there has been gang violence, intergenerational abuse and historic trauma. The levels of trauma and danger, the long-term and chronic nature of the abuse issues and the multiple intersections of disadvantage experienced by these women make it unlikely that mainstream programmes can be effective in such cases. What is needed are facilitators who are experienced and skilled in working with such women, longer-term programmes and referral pathways that do not require the obtaining of a Protection Order.

Recommendations

The FVDRC recommends that:

1. the Taskforce for Action on Violence within Families considers the provision of stopping violence programmes, and supports those programmes to be run in accordance with international best practice, which involves having parallel services for victims that focus on victim safety and enable victims' views to be sought as part of the ongoing assessment process.

2. the Taskforce for Action on Violence within Families and the Ministry of Justice Domestic Violence Programmes Approval Panel includes, as part of the programme accreditation, a service standard that requires programme providers to participate in multi-agency risk management, which includes checking participants' self-reported changes against other agencies' records.

3. the Taskforce for Action on Violence within Families considers developing evidence-based risk assessment tools that are properly funded and consistently used by all stopping violence programmes throughout New Zealand.

4. the Taskforce for Action on Violence within Families considers the provision and availability of living free from violence programmes, which are developed to address the specific needs and experiences of women who have been abused by partners who are gang members or where there has been gang violence, intergenerational abuse and historical trauma.

Chapter 6: **Aftermath of a family violence death event**

> 'Children bereaved by the death of one parent at the hands of the other … in effect lose both parents. The children are then uprooted, losing their home and, quite often, their familiar routine in essential relationships. The combined effects of trauma, dislocation and loss are traumatic, but little has been written so far about such tragedies and the implications for everyone concerned in the future of the affected children.'[122]

In the aftermath of a family violence death, there should be general recognition of the significance of the trauma experienced by those left behind and an appropriate investment of resources made into their safety, support and recovery. Survivors can include children and adults who have had a parent killed, parents who have had a child killed, the new caregivers for children who have lost their parents, victims who have retaliated against the violence and killed their abusers, and those 'at one remove'[123] such as ex-partners, close friends, extended family and whānau, and involved professionals. The trauma for these survivors will often include a long exposure to IPV and/or CAN prior to the homicide.

The intergenerational impact of abuse is clearly evident in the tier-two death reviews.[124] The death review process often identifies forms of abuse that span three generations of families and whānau. In five of the death reviews, chronic childhood sexual abuse from family members was experienced by five of the adult female victims of IPV and two of the adult male perpetrators. These childhood histories of sexual abuse were obtained from agencies and independent practitioners' records and are, no doubt, an under-representation of the experiences of this form of abuse for the involved victims and perpetrators.

It concerned the FVDRC that in all but one of the death reviews completed in 2012, the surviving victims did not appear to have their trauma and safety issues adequately addressed. In many instances, this meant that victims did not appear to be receiving appropriate trauma or recovery support, or had to be extremely proactive in order to receive it. The death reviews also evidenced a few instances where some survivors were overlooked following the incident and continued to be trapped in situations where they were at risk of further abuse without any services or support. We elaborate on these issues in this chapter. We note that there were also primary victims who had retaliated against their violent partners and were nonetheless imprisoned for significant periods of time. This had implications not only for them, but also for their children.

The primary functions of the FVDRC involve reporting on, and developing recommendations and strategic plans to contribute to the reduction of, family violence deaths. However, the terms of reference also set out an additional overarching goal, which is to 'contribute to the prevention of family violence', and an additional function of the FVDRC is to 'develop strategic plans and methodologies that are designed to reduce family violence morbidity' (see Appendix 1 for the FVDRC terms of reference).

Family violence morbidity includes the negative impact of the violence on survivors' long term mental health (eg, post-traumatic stress disorder, anxiety-related disorders, depression, substance abuse and increased risk of suicidality), spiritual wellbeing, attachment to others and parenting capabilities. Importantly, family violence morbidity perpetuates intergenerational patterns of IPV and CAN when left unattended.

There are three aspects of family violence prevention that are important to bear in mind when interpreting the ambit of the FVDRC's terms of reference. The first is that family violence prevention requires improvement of the social services sector response to families in trouble that frequently endeavour to conceal that fact. The second is that the cases the FVDRC is reviewing are those that have escalated to homicide. These are cases that are clearly signalled as involving serious family violence. Finally and most importantly, family violence cannot be understood as a series of isolated incidents. Rather, family violence is a pattern

122 J. Harris-Hendriks, D. Black and T. Kaplan, *When Father Kills Mother: Guiding Children Through Trauma and Grief*, London, Routledge, 1993, cited in P. Jaffe and M. Juodis, 'Children as victims and witnesses of domestic homicide: Lessons learned from domestic violence death review committees', *Juvenile and Family Court Journal*, vol. 57, issue 3, 2006.

123 L. Regan et al., 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire, *Final Report to the Engleshire Domestic Violence Homicide Review Group*, Child and Woman Abuse Studies Unit, London Metropolitan University, 2007.

124 See Chapter 2 for a discussion of intergenerational abuse.

of behaviour that spans a relationship and, not uncommonly, multiple relationships both simultaneously and sequentially. In a number of the death reviews, there was a history of family violence that had spanned multiple generations.

A family violence death event cannot, therefore, be separated from the abuse that preceded it, nor does it signal an end to the negative impact of that abuse for the survivors or an end to the experience of perpetration or victimisation by those who were impacted by it. A family violence death event, therefore, represents an opportunity to intervene in order to address family violence morbidity and to prevent future family violence.

Trauma support and safety issues for survivors

1. Needs of surviving children

As noted in Chapter 1, the nine tier-two death reviews involved 11 deaths. Overall, there were 12 children and young people living in the homes at the time of these homicides. A further 26, who were the children of the victims and/or perpetrators of the intimate partner homicide, were not living in the home at the time of the homicide, but were impacted by the homicide nevertheless: some were adults; some were living with their other parent; and others had been removed by Child, Youth and Family.

A similar picture emerges in the tier-one data reported in Chapter 3. In eight of the 35 intimate partner deaths, a child was in the home at the time, with some actually witnessing the killing. In a further 17 of the deaths, the couple involved in the intimate partner homicide had at least one child, while in a further seven, one of the couple had at least one child from another relationship.

The safety and recovery of surviving children is, we acknowledge, of paramount concern to all; however, safety issues can be unintentionally overlooked in the aftermath of a death event. For example, it is important to ensure that checks are made before a child whose primary caregiver has died is placed with a person against whom a protection order has been made, as the child may also be protected by that order.

Often children have lost both parents, one through death and the other to the prison system. Caregivers need ongoing support to understand how these children's experiences of abuse might impact on their behaviour. Caregivers also need professional support and guidance to appreciate the importance of supporting children to attend therapeutic support services. In some of the death reviews, caregivers thought it was in the child's best interest to put everything behind them and not talk about their experiences, which resulted in the child not being taken to therapy sessions.

Caregivers also need support in what is often a major life change for them as well. Some caregivers, as an example, have older children and had not expected to parent small children again.

2. Needs of adult surviving children

In the aftermath, it can be easy to miss the needs of adult children because, for instance, they may be estranged from their parents or the services involved with them may not be aware of the circumstances surrounding their parent's death.

These surviving adults must not be overlooked because it is quite probable that they were children and young people who grew up witnessing IPV and experiencing CAN. They are now adults who are often involved with services such as Child, Youth and Family; New Zealand Police; the Department of Corrections; and mental health and substance abuse services. This is due to their own childhood experiences of such violence and trauma and, often, their current experiences of either perpetrating violence against their intimate partners and children, or experiencing violence from their intimate partners.

A family violence death provides an opportunity to intervene and protect the next generation, especially when their family and whānau-intergenerational risks, vulnerabilities and patterns of harm are well known to services or are uncovered during the police family violence death review process. Therefore, it is very important that adult surviving children are offered support after losing a parent (perpetrator or victim) to a family violence death event.

3. The need for a multi-agency after-care process

In order to ensure that the needs of survivors are addressed in the aftermath of a family violence death, interagency work – both information-sharing and case management – is essential in the after-care process.

The FVDRC's death reviews have evidenced that it is generally not possible to put a thorough support plan in place without professionals meeting to identify all of the people (children and adults) and services that must be considered following a family violence death event.

Therefore, the FVDRC recommends that the National FVIARS Working Group develop a formal multi-agency after-care process for IPV and CAN deaths. The purpose of this process would be to address the safety and wellbeing needs of surviving family and whānau. New Zealand Police currently undertake immediate after-care processes in conjunction with partner agencies, but this recommendation is for the consideration of longer term safety and wellbeing needs.

It is suggested that this process be initiated by New Zealand Police in a timely manner after a homicide. Because New Zealand Police is the lead agency when a homicide occurs, its initial involvement is important as it is in a position to notify partner agencies of the homicide event, while effectively managing any confidentiality requirements around the homicide investigation processes, especially when the perpetrator may not have been immediately identified or arrested (as is often the case with CAN deaths, but rarer for IPV deaths).

It is also suggested that this process be integrated into the development of the multi-agency case management approach for high-risk cases so that resources are not duplicated. Multi-agency membership is critical, as each service brings specific expertise with respect to safety and/or wellbeing, and both these aspects need to be addressed. The group membership of the after-care process should include senior practitioners from: the Department of Corrections; Child, Youth and Family; New Zealand Police; the Ministry of Education; the Ministry of Health; the Ministry of Justice; Victim Support; local non-governmental family violence services; and therapeutic professionals. This process needs to be responsive to, and integrate, children's and family members' perspectives.

It is recommended that this multi-agency after-care process will:

- identify the surviving adults and children connected to the death event
- address any immediate safety issues for surviving children and adults
- develop multi-agency safety and support plans (longer term) for surviving adults, children and caregivers
- agree on regular intervals when these plans will be reviewed
- identify the relevant services and independent practitioners involved, and ensure they are aware of the death
- ensure professionals who may be experiencing vicarious trauma are supported
- consider the support needs of the wider community.

This formal after-care process will not duplicate or replace individual agencies' own response pathways, for example, Child, Youth and Family planning a family group conference. Rather, this process will enable the collaboration of all the different services involved in order to effectively address the safety and wellbeing needs of surviving family and whānau, as well as others who may be affected by the death. It will also ensure that each individual service is aware of the family's history of abuse and trauma, and that the relevant information about the impact on each family member's wellbeing is understood and recorded appropriately by each agency. As an example, the police may need to add a suicide risk warning to a person's police family violence file.

Recommendation

In regards to the issues raised in this chapter related to family violence homicide survivors, the FVDRC recommends that:

1. the National FVIARS Working Group develops a formal multi-agency after-care process for IPV and CAN deaths.

Chapter 7: **Emerging issues and priorities for 2013–14**

The FVDRC concludes this report by highlighting two other findings emerging from the tier-two death reviews that further develop themes woven throughout this report. The first is the need to assess the co-occurrence of IPV and CAN, while the second is the need for professionals and community members to understand the common lethality risk factors for IPV homicide. We finish by briefly identifying some areas of focus for the FVDRC in 2013.

1. Assessing the co-occurrence of IPV and CAN

As noted throughout this report, the co-occurrence of IPV and CAN is high.[125] However, the practice emerging from the death reviews demonstrates that these two forms of abuse are frequently not assessed or addressed in an integrated way by many of the services (adult or child) involved.

Agencies often have a specific focus on one family member, and this directs their practice. It affects how practitioners engage (or not) with the adult partners and children, and how information is gathered and interpreted. In other instances, agencies may be working with some or all of the family members, but can lack an understanding about the dynamics of IPV, and the co-occurrence with CAN, which can lead to dangerous practice. For example, attempting to work with abusive men in the absence of any professional training about how to connect with, and hold them accountable for, their abusive behaviour towards their partner and children can unintentionally result in significantly increasing the risks for these women and children.[126]

While the FVDRC would encourage agencies to incorporate both forms of abuse within their assessment frameworks, this needs to occur in a systemic manner. Allocation of sufficient time and resources would help practitioners learn how to safely engage, to collect the information required by their assessment forms and to *analyse* the information collected.[127] It is important to consider the gaps in information, the risks these gaps potentially pose, why there may be conflicting stories about the level of abuse within a family and what a victim's retraction of abuse allegations might mean in the wider context. Rather than seeking simplicity, practitioners need to *seek complexity*, as the families with whom they frequently work have many overlapping issues.

The FVDRC intends to discuss agencies' assessment frameworks and the quality of assessments with specific agencies over the course of 2013.

2. Interacting lethality factors

Risk is dynamic and the interaction of different risk factors and vulnerabilities can change a victim's environment from one characterised by non-lethal violence to a situation which is potentially fatal.

There were two interacting IPV lethality indicators clearly evident in seven of the nine death reviews. These were the presence of an extremely possessive and controlling partner in the context of actual or imminent separation (initiated by the victim). In five of these death reviews, threats to kill an adult intimate partner were also made. These threats were known to agencies and/or family members.

In the Campbell et al research[128] on risks for intimate partner homicide, women whose partners threatened them with murder were 15 times more likely than other abused women to be killed. Women who had a violent partner who was constantly jealous were nine times more likely to be killed than other abused women. This research also evidenced that having been separated from an abusive partner after living together was associated with

125 The co-occurrence of child physical abuse and IPV is estimated as ranging between 30–66 percent depending upon the study. See M. Hester, C. Pearson and N. Harwin, *Making an impact: Children and domestic violence: A reader*, London, Jessica Kingsley, 2007; J.L. Edleson, 'The overlap between child maltreatment and woman battering', *Violence Against Women*, vol. 5, no. 2, 1999, pp. 134–54; C. Humphreys and R. Thiara, *Routes to Safety: Protection issues facing abused women and children and the role of outreach services,* Bristol, Women's Aid Federation of England, 2002; L. Radford and M. Hester, *Mothering through domestic violence,* London, Jessica Kingsley Publishers, 2007.

126 F. Mederos, *Accountability and Connection with Abusive Men: A New Child Protection Response to Increasing Family Safety,* Massachusetts Department of Social Services, Family Violence Prevention Fund, 2004.

127 See E. Munro, *The Munro Review of Child Protection: Final Report – A child-centred system:* 87, London, Department of Education, 2011.

128 J.C. Campbell et al., 'Assessing risk factors for intimate partner homicide', *National Institute of Justice Journal,* vol. 250, 2003, pp. 14–19; J.C. Campbell et al., 'Risk factors for femicide in abusive relationships: Results from a multi-site case control study', *American Journal of Public Health,* vol. 93, no. 7, 2003, pp. 1089–97.

a higher risk of intimate partner femicide as was having ever left, or asking the partner to leave. Furthermore, the risk of intimate partner femicide was increased nine-fold by the combination of a highly controlling abuser and the couple's separation after living together. Campbell et al note that while other studies have revealed the same risks posed by estrangement, their research further explicates the findings by identifying highly controlling male partners as presenting the most danger in this situation.

A second set of interacting lethality risk factors that emerged from the death reviews were suicidal perpetrators, in the context of actual or imminent separation. Suicidal perpetrators may be homicidal as well. When there is known IPV in the relationship, and one partner presents with depression, suicide attempts and/or other mental health issues, the safety of their partner and any children must also be considered.

Although the risks posed by possessive and controlling partners in the context of actual or imminent separation are well evidenced in the international and to some extent national research,[129] the findings from the death reviews indicated that these interacting risk factors were often either not recognised as potentially lethal by practitioners or not adequately responded to by practitioners, agencies and multi-agency initiatives.

The community (families and whānau, neighbours, friends and work colleagues) also need education. Informal networks of support may often be aware of controlling and possessive behaviours, but do not perceive these behaviours as IPV or as being potentially dangerous.

In the future, the FVDRC would welcome the opportunity to work in partnership with organisations such as the New Zealand Family Violence Clearinghouse and the Campaign for Action on Family Violence in considering how to best to inform and educate practitioners and communities about these lethality indicators.

3. Priorities for future work

In this report, the FVDRC has recommended:

- a multi-agency process for high-risk cases that can take a case management approach to the most dangerous cases of family violence
- aligning practices in the stopping violence sector with international best practice, including developing consistent evidence-based risk assessment tools, parallel services for victims to support victim safety and input, and linking the stopping violence sector into the broader multi-agency response to family violence by enhanced information-sharing
- a multi-agency process for the safety and recovery of surviving victims in the aftermath of a family violence homicide.

The regional reviews are a rich source of detailed information about the current systemic response to family violence in the most serious of cases. The FVDRC is in the process of refining findings and recommendations emerging from these reviews. The FVDRC intends to prioritise family violence deaths involving Māori whānau, as it recognises that family violence is a significant concern for Māori, particularly when death is a consequence. Future areas of focus for the FVDRC also include:

- the improvement of family violence training for professionals across the family violence sector – including judges, coroners, social workers and private therapists
- the need to address the links between intergenerational trauma histories and offending behaviour for victims and perpetrators[130]
- the distinction between primary victims[131] and primary aggressors
- highlighting the issues facing immigrant and refugee families
- the need to improve the New Zealand Police's enforcement of Protection Orders.

129 J. Martin and R. Pritchard, *Learning from Tragedy,* 2010. An analysis of the trends for couple-related homicides between 2002 and 2006 identified that a woman is in greatest danger of being killed when she threatens or proceeds with a separation.

130 The FVDRC is utilising the Adverse Childhood Experiences research to understand more about the early life experiences of the people's lives and deaths which are subject to review. See V.J. Felitti et al., 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study', *American Journal of Preventive Medicine,* vol. 14, 1998, pp. 245–58.

131 Primary victims may be referred to as 'battered defendants' in other jurisdictions.

We conclude by noting the dedication and commitment of New Zealand professionals across many sectors to the safety of family violence victims and the prevention of family violence. We have benefited from this commitment in the outstanding support we have had from the New Zealand Police; the Department of Corrections; Child, Youth and Family; the Ministry of Justice; the Ministry of Health; refugee support services; interpretation and cultural services; the National Collective of Independent Women's Refuges; non-governmental family violence services; the Coronial Services; and independent therapeutic practitioners, in compiling data, accessing information, seeking advice, providing sector updates and in reviewing deaths and processing recommendations.

In hindsight, it is easy to notice what could be improved. It is also important to acknowledge the thousands of professionals stretching already extended resources to participate in multi-agency processes. These professionals recognise the need for collaborative action to address family violence.

Appendix 1: Family Violence Death Review Committee terms of reference

The role of the Committee

1. The Family Violence Death Review Committee ('the Committee') is a Mortality Review Committee, appointed under section 59E of the New Zealand Public Health and Disability Amendment Act 2010 ("the Act") by the Health Quality & Safety Commission (HQSC).

The functions of the Committee

2. The Committee's functions are to:
    - 2.1. review and report to the HQSC on family violence deaths, with a view to reducing the numbers of family violence deaths, and to continuous quality improvement through the promotion of ongoing quality assurance programmes
    - 2.2. develop strategic plans and methodologies that are designed to reduce family violence morbidity and mortality, and are relevant to the Committee's functions
    - 2.3. advise on any other matters related to family violence deaths that the HQSC specifies.[132]
3. In order to fulfil its functions, the Committee will:
    - 3.1. report and make recommendations at a local and national level on system, policy and practice improvements to contribute to the reduction of family violence deaths
    - 3.2. monitor the number, categories and demographics of family violence deaths
    - 3.3. identify patterns and trends in family violence deaths over time
    - 3.4. make available to researchers data about family violence deaths within the privacy and confidentiality restrictions on the Committee
    - 3.5. liaise with any other mortality review committees appointed by the HQSC to assist, on mutual agreement, with reviews of deaths that are within the scope of those other committees.
4. In order to perform its functions, the Committee will:
    - 4.1. collect data and information from relevant sources on circumstances leading up to and surrounding family violence deaths
    - 4.2. review the circumstances surrounding family violence deaths, including system and agency practice interventions/processes
    - 4.3. conduct specific reviews/investigations into clusters/subgroups of family violence deaths
    - 4.4. undertake and/or support local family violence death reviews.

Guiding principles

5. The overarching goal of the Committee is to contribute to the prevention of family violence and family violence deaths.

132 Paragraphs 2–2.3 of 'The Functions of the Committee' are derived from section 59E of the New Zealand Public Health and Disability Act 2000.

6. In addition, when undertaking its functions, the Committee will:

   6.1. be sensitive to, and respectful of, victims and their families, and minimise the revictimisation and trauma that death reviews may cause

   6.2. keep information and data secure, and protect confidentiality

   6.3. operate in a culturally appropriate, sensitive, and responsive manner

   6.4. be objective, impartial and have a systemic focus on learning in order to improve/enhance current and future systems, policy and practice

   6.5. develop, enhance and foster interagency collaboration, trust and networking in the family violence sector

   6.6. formulate clear, meaningful and practical recommendations, developed from a 'non-blaming' perspective

   6.7. support and protect individual and agency death review participants

   6.8. ensure that local family violence death review processes are undertaken in accordance with the values and principles set out in these Terms of Reference.

Definition of family violence death

7. For the purposes of these Terms of Reference, a family violence death is:

   7.1. The unnatural death of a person (adult or child) where the suspected perpetrator is a family or extended family member,[133] caregiver,[134] intimate partner, previous partner of the victim, or previous partner of the victim's current partner.

8. The following categories of deaths are initially excluded from this definition:

   8.1. suicides

   8.2. assisted suicide (based on pact)

   8.3. deaths from chronic illness resulting from sustained violence

   8.4. accidental deaths related to family violence incidents.

Definition of family violence death review

9. For the purposes of these Terms of Reference, a family violence death review is:

   9.1. a systematic analysis of the lives of victims, perpetrators and their families, and events leading up to and factors surrounding death(s), by a combination of agencies and disciplines in a confidential and culturally safe environment.

10. The purpose of the review is to identify changes, or enhancements to, systems, policy, and services that may contribute to the prevention of family violence deaths.

Composition of the Committee

11. The Committee will have a maximum of eight members appointed by the HQSC.

12. All members will have knowledge of, or expertise in, family violence issues.

133 'Family or extended family member' is used in the broadest sense and includes whānau, hapū, mother, father, child, sibling, grandparent, aunt, uncle, step-parent, foster-parent etc.

134 'Caregiver' refers to a person living in a 'domestic' relationship with, and providing care for, the victim.

13. The Committee's membership may include:
    - 13.1. members with expertise in mortality review systems
    - 13.2. members with expertise in social science and/or health research
    - 13.3. members with experience as a social worker or a family violence case worker
    - 13.4. members with knowledge of, or experience in, service provision or operational policy in the social sector
    - 13.5. members who are experts in the field of child abuse and protection issues
    - 13.6. members who are registered health practitioners or registered clinical psychologists
    - 13.7. members who are lawyers with expertise in family violence law
    - 13.8. members with knowledge of family violence issues from a service user/family perspective
    - 13.9. Māori members with knowledge of family violence issues, or experience in working with Māori families affected by family violence
    - 13.10. members of other ethnic groups with knowledge of family violence issues, or experience in working with families affected by family violence.

14. The Committee will be assisted by six government advisors. This will enable those departments' information, expertise and advice to be available to the Committee, so that the Committee's discussions and debates are fully informed. The advisors are accountable to their department, and are not members of the Committee. The advisors will be nominated by the Chief Executive, or their equivalent, from the following agencies:
    - 14.1. the Chief Coroner's Office
    - 14.2. the Ministry of Health
    - 14.3. the Ministry of Social Development
    - 14.4. the Ministry of Justice
    - 14.5. New Zealand Police
    - 14.6. the Office of the Children's Commissioner.

15. The Committee may appoint sub-groups or establish working parties relevant to its agreed work plan and it may co-opt expertise as necessary to assist any sub-groups, within its budget.

16. The Committee may appoint 'agents' to assist it to collect information relevant to the performance of any of the Committee's functions.

Terms and conditions of appointment

17. Members of the Committee are appointed by the HQSC for a term of office of up to three years. The terms of office of members of the Committee will be staggered to ensure continuity of membership. Members may be reappointed from time to time.

18. Unless exceptional circumstances are identified and these agreed upon by the Committee and by the HQSC, no member may hold office for more than six consecutive years. Such circumstances include an exceptional need for continuity of knowledge and skills, for example, if three or more members are leaving the Committee at the same time. In such circumstances, a member's term may be extended for up to one year.

19. Unless a person sooner vacates their office, every appointed member of the Committee shall continue in office until their successor comes into office.

20. Any member of the Committee may at any time resign as a member by advising the HQSC in writing.

21. The HQSC may, by written notice, terminate the appointment of a member or Chair of the Committee.

22. The HQSC may from time to time alter or reconstitute the Committee, or discharge any member of the Committee, or appoint new members to the Committee for the purpose of decreasing or increasing the membership or filling any vacancies.

Chair and Deputy Chair

23. The HQSC will appoint a member of the Committee to be its Chair. The Chair will preside at every meeting of the Committee at which they are present.

24. The Committee may appoint one of its members to be Deputy Chair.

Duties and responsibilities of a member

25. The following sections set out the HQSC's expectations regarding the duties and responsibilities of a person appointed as a member of the Committee. This is intended to aid members of the Committee by providing them with a common set of principles for appropriate conduct and behaviour and serves to protect the Committee and its members.

26. As an independent statutory body, the Committee has an obligation to conduct its activities in an open, ethical, and responsible manner within the parameters of its functions as set out in these Terms of Reference.

General

27. The Committee members should have a commitment to work towards reducing family violence and family violence deaths.

28. Members are expected to make every effort to attend all Committee meetings and devote sufficient time to become familiar with the affairs of the Committee and the wider environment within which it operates.

29. Members have a duty to act responsibly with regard to the effective and efficient administration of the Committee and the use of Committee funds.

30. Members attend meetings and undertake Committee activities as independent persons responsible to the Committee as a whole. Members are not appointed as representatives of professional organisations and or particular community bodies. The Committee should not, therefore, assume that a particular group's interests have been taken into account because a member is associated with that group.

Conflicts of interest

31. Members must perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest. Proper observation of these principles will protect the Committee and its members and will ensure that it retains public confidence.

32. When members believe they have a conflict of interest on a subject that will prevent them from reaching an impartial decision or undertaking an activity consistent with the Committee's functions, they must declare that conflict of interest and withdraw themselves from the discussion and/or activity.

Confidentiality

33. The maintenance of confidentiality is crucial to the functioning of the Committee.

34. Members must note the statutory requirements in section 59E of the Act, which prevents disclosure of 'information' as it is defined in clause 3 of schedule 5 of the New Zealand Public Health and Disability Act 2000. Under that clause, information means any information:

    34.1. that is personal information within the meaning of section 2(1) of the Privacy Act 1993; and

    34.2. that became known to any member or executive officer or agent of a Mortality Review Committee only because of the Committee's functions being carried out (for example, because it is contained in a document created, and made available to the member or executive officer or agent, only because of those functions being carried out), whether or not the carrying out of those functions is completed.

35. The Committee is not subject to the Official Information Act 1982.

Meetings of the Committee

36. Meetings will be held at such times and places as the Committee or the Chair of the Committee decides.

37. When the Committee has eight members, at least five members must be present to constitute a majority. When the number of appointed members is less than eight, a quorum is the number of members constituting a majority.

38. Every question before any meeting will generally be determined by consensus decision-making. Where a consensus cannot be reached a majority vote will apply. In the case of equality of votes on an issue, including the Chair's own vote, the Chair may choose to exercise a casting vote.

39. Subject to the provisions set out above, the Committee may regulate its own procedures.

Performance measures

40. The Committee will be performing effectively when it provides relevant and timely advice to the HQSC based on research, analysis and consultation with appropriate groups and organisations.

41. The Committee must:

    41.1. agree in advance to a work programme with the HQSC

    41.2. achieve its agreed work programme

    41.3. stay within its allocated budget.

Reporting requirements

42. The Committee is required to:

    42.1. keep minutes within the privacy and confidentiality restrictions on the Committee of all Committee meetings which outline the issues discussed and include a clear record of any decisions or recommendations made

    42.2. provide the HQSC with a report, on an annual basis or as otherwise required by the HQSC, on its progress in carrying out its functions. The report will set out the Committee's activities, compare its performance to its agreed work programme, and summarise any advice it has given to the HQSC. The report will be tabled by the HQSC in the House of Representatives pursuant to section 18 (4) of the NZPHD Act.

Servicing of the Committee

43. The HQSC will employ staff to service the Committee, sufficient to meet the Committee's statutory requirements, out of the Committee's allocated budget.

Fees and allowances

44. Members of the Committee are entitled to be paid fees for attendance at meetings. The level of attendance fees are set in accordance with the State Services Commission's framework for fees for statutory bodies (2006) and the Cabinet Office Circular CO (06) (08).

45. The Chair will receive payment consistent with Group 4 Level 2 of the Cabinet Office Circular CO (06) 08, $450 (GST exclusive), per day working for the Committee (plus half a day's preparation fee for any Committee meetings). The Chair is entitled to an allowance of two extra days per month to cover additional work undertaken by the Chair.

46. The attendance fee for members is consistent with Group 4 Level 2 of the Cabinet Office Circular CO (06) 08, $320 (GST exclusive), per day working for the Committee (plus half a day's preparation fee for each meeting).

47. The attendance fee for full Committee teleconferences and sub-committee meetings is calculated on a pro rata basis (the hourly rate will be calculated at one seventh the daily rate).

48. Actual and reasonable travel and accommodation expenses of the Committee, while on Committee business, will be met from the Committee's budget.

Establishment issues

49. During its first year of operation, the Committee must address establishment issues including:

    49.1. developing mechanisms and protocols for family violence death reviews

    49.2. determining the availability, reliability and validity of existing data collection processes

    49.3. determining what, if any, additional data could reasonably be collected from whom, and for what purposes, in order that the Committee can undertake its functions

    49.4. deciding on definitions to be used for each piece of data during collection, analysing and reporting

    49.5. establishing functional relationships with:

        49.5.1. the Child and Youth Mortality Review Committee and the Perinatal and Maternal Mortality Review Committee

        49.5.2. new and existing local non-statutory mortality review committees

        49.5.3. other agencies that conduct family violence mortality reviews

        49.5.4. the Family Violence Interagency Response System

        49.5.5. key stakeholders in the family violence sector

    49.6. establishing processes to ensure security of 'information' as that term is defined in clause 3 of Schedule 5 of the NZPHD Act

    49.7. determining how the Committee will operate in a culturally appropriate, sensitive and responsive manner

    49.8. due to the potentially distressing nature of some of the material to be considered by the Committee, establishing processes to ensure Committee members will be well supported, such as offering opportunities for confidential counselling.

Review of the Committee

50. A formal review and evaluation of the Committee and these Terms of Reference will be undertaken by the HQSC, starting in 2012. The aim of the evaluation will be to ensure alignment between principles, purpose and processes of the Committee and to identify potential improvements. In particular, the definition of 'family violence death' should be reassessed, with a view to broadening the definition to include those deaths currently excluded under section 8 of these Terms of Reference.

Appendix 2: **FVDRC members**

Current membership

Name	Position	Organisation
Julia Tolmie (Chair)	Associate Professor of Law	University of Auckland
Dawn Elder (Deputy Chair)	Professor of Paediatrics and Child Health	University of Otago, Wellington
Ngaroma Grant (Deputy Chair)	Project Manager	Te Arawa Whānau Ora Collective
Miranda Ritchie	National Violence Intervention Programme Manager	Health Networks Ltd
Barry Taylor	Professor of Paediatrics and Child Health	University of Otago, Dunedin
Fia Turner	Clinical Practice Manager	Genesis Youth Trust (Police Youth Development Programme)
Paul von Dadelszen	District and Family Court Judge	Family Court
Denise Wilson	Associate Professor Māori Health	Auckland University of Technology

Past members

Wendy Davis (Inaugural Chair)

Brenda Hynes

Patrick Kelly

George Ririnui

Alison Towns

Rob Veale

Vaoga Mary Watts

Advisors

The committee is also supported by advisors from Coronial Services of New Zealand, the Department of Corrections, the Ministry of Health, the Ministry of Justice, the Ministry of Social Development, New Zealand Police, the Office of the Children's Commissioner, the National Collective of Independent Women's Refuges, the National Network of Stopping Violence Services and Jigsaw.

Appendix 3: The analytical framework for the regional reviews

As highlighted in Chapter 1, the purpose of undertaking the tier-two death reviews is to identify changes or enhancements to systems, policy and services that may contribute to the prevention of family violence and family violence deaths.[135] This appendix outlines in greater detail the analytical framework of the tier-two death review process and describes why this framework and structure has been put in place.

The importance of in-depth qualitative reviews

Flyvberg states that if you want to 'understand a phenomenon in any degree of thoroughness – say, child neglect in the family… – what causes it, how to prevent it, and so on, you need to do case studies… The main strength of the case study is depth – detail, richness, completeness, and within-case variance.'[136]

The FVDRC's death reviews closely resemble what Flyvberg defines as in-depth case studies. They are concrete, detailed narratives which involve practical (context-dependent) knowledge. Furthermore, these reviews provide the appropriate context within which detailed analyses can be collectively undertaken and interpreted.[137] The in-depth nature of the review process fosters the emergence of a complex picture of the organisations', practitioners' and people's behaviours, interactions and interconnections.

The family violence death review model

The family violence death review model is based on the systems model developed by Eileen Munro, Sheila Fish and Sue Bairstow of the UK Social Care Institute for Excellence (SCIE).[138] This model has adapted learnings from engineering (aviation) and health system review practices and applied these to the multi-agency child protection environment.

Internationally, the engineering and health sectors share a similar history to child protection where mistakes and tragic outcomes lead to reform efforts that unintentionally create new complications or produce disappointing levels of improvement. However, the engineering and health sectors, by utilising a systems approach and looking at the wider context in which practitioners work, have developed new methods of understanding front-line practice and discovering what contributes to the quality of performance. These approaches are leading to more effective reforms.

Adapting systems review models

Transporting review models across different sectors and countries is difficult. Attentive adaptations are required to take account of key similarities and differences between the sectors and countries. The following three key differences from engineering and health have all been factored into the adaptation of the SCIE model to the multi-agency child protection environment. We have made further adaptations to apply the SCIE model to the family violence (IPV and CAN) environment in New Zealand.

(a) Family violence involves multi-agency work, rather than team work located in one sector or organisation

The 'team' working with one family or whānau where there are concerns about family violence is scattered across various agencies. While all the agencies share the long term goal of maximising the safety and wellbeing of those at risk, they can each have differing intermediate goals, ways of working and working relationships with different family members. This adds complexity to any analysis of how they work together and the contribution each makes to the final outcome.

135 Family Violence Death Review Committee Terms of Reference. Points 9, 9.1 and 10.

136 B. Flyvbjerg, 'Case Study', in Denzin, N.K. and Lincoln, Y.S. (eds.), *The Sage Handbook of Qualitative Research*, 4th edn., Thousand Oaks, California, Sage, 2011, pp. 301–16.

137 J. Chapman, *Systems Failure — Why Governments must learn to think differently,* 2nd edn., London, Demos, 2004.

138 Please see: S. Fish, E. Munro and S. Bairstow, *SCIE Report 19: Learning together to safeguard children: developing a multi-agency systems approach for case review,* London, Social Care Institute for Excellence (SCIE), 2008; S. Fish, E. Munro and S. Bairstow, *SCIE Guide 24: Learning together to safeguard children: developing a multi-agency systems approach for case review,* London, Social Care Institute for Excellence (SCIE), 2009; Social Care Institute for Excellence (SCIE), *SCIE At a glance 01: Learning together to safeguard children: a 'systems' model for case reviews,* London, Social Care Institute for Excellence (SCIE), 2012.

The multi-agency family violence system can be understood as a complex system. A complex system has the following characteristics:[139]

- It involves large numbers of interacting elements.
- The interactions are non-linear, and minor changes can produce disproportionately major consequences.
- The system is dynamic, the whole is greater than the sum of its parts, and solutions cannot be imposed; rather, they arise from the circumstances.[140]
- The system has a history, and the past is integrated with the present; the elements evolve with one another and with the environment; and evolution is irreversible.
- Though a complex system may, in retrospect, appear to be ordered and predictable, hindsight does not lead to foresight because the external conditions and systems constantly change.
- In a complex system the agents and the system constrain one another, especially over time.[141]

Within complex adaptive systems, the dominant mode of response is non-linear. This is because as a situation is evolving the effect of actions taken is uncertain. [142]

(b) The quality of relationships with families and whānau matters in family violence work

Professionals dealing with family violence need to form relationships with family or whānau to gain information and to support them to change. Many people coming into contact with child protection and domestic violence services face problems that are compounded by their marginalised positions in society. How practitioners ask questions and what they ask about can either confirm people's worst fears, reinforce shame and guilt, or can assist them to clarify their situations and to appreciate their strengths and resilience. A poor relationship with a client may lead to a practitioner missing key information, or the family and whānau disengaging.

(c) Limits of the knowledge base in family violence work – uncertainty and ambiguity

Since family violence is a 'wicked problem', there will always be degrees of ambiguity and uncertainty when trying to address it.[143] Practitioners working in the child protection and IPV crisis response sectors often make decisions and take action in dynamic situations characterised by uncertainty and risk. These characteristics are part of the everyday work environment, which generally includes large and complex caseloads along with stretched or limited resources. Complexity and ambiguity can never be eliminated; they are inherent features of these organisations and their environments. This is why complex adaptive systems, such as the multi-agency family violence system, can be categorised in the domain of what Snowden calls the 'unknown unknowns'.[144]

Recognising this uncertainty and complexity, a systems review of this type can foster the growth of resilience in practitioners, organisations and communities, and do so in the longer term rather than looking for 'quick fixes'. Simply putting procedures in place will not necessarily generate optimal outcomes, as the needs and circumstances of children and adults are so varied that procedures cannot fully encompass the variety. Hence, formal procedures are always fallible, requiring the practitioner's skill and judgement to implement them successfully.

139 D. Snowden and W. Boone, 'A leader's framework for decision making', *Harvard Business Review*, vol. 85, no. 11, 2007, pp. 68–76.

140 This is frequently referred to as *emergence*.

141 This means that we cannot forecast or predict what will happen.

142 J. Chapman, *Systems Failure,* 2004.

143 The term 'wicked' is used, not in the sense of evil, but rather its resistance to resolution. Australian Public Services Commission, *Tackling Wicked Problems: A Public Policy Perspective,* Canberra, Commonwealth of Australia, 2007.

144 Simple Contexts: The Domain of Best Practice. Simple contexts are characterized by stability and clear cause-and-effect relationships that are easily discernible by everyone. This is the realm of 'known knowns'. Complicated Contexts: The Domain of Experts. Complicated contexts may contain multiple right answers, and though there is a clear relationship between cause and effect, not everyone can see it. This is the realm of 'known unknowns'. Complex Contexts: The Domain of Emergence. In a complex context, right answers can't be ferreted out. This is the realm of 'unknown unknowns'. In this domain we can understand why things happen only in retrospect. Instructive patterns, however, can emerge. Chaotic Contexts: The Domain of Rapid Response. In a chaotic context, searching for right answers would be pointless: The relationships between cause and effect are impossible to determine because they shift constantly and no manageable patterns exist—only turbulence. This is the realm of unknowables (D. Snowden and W. Boone, 'A leader's framework for decision making', 2007).

Key skills in family violence work are the ability to engage and communicate with vulnerable people and make complex interpretations of information about the circumstances and needs of children and adults. Hence, any family violence systems review model needs a balance between developing resources or procedures to help people avoid mistakes, and considering appropriate resources to help practitioners build expertise and response capability.[145]

Key concepts of the systems approach

(a) A window on the system

A family violence death review provides a 'window on the system.'[146] The emphasis is less on learning lessons from a particular death and more on using a single death event to gain insights into how the multi-agency family violence systems are functioning more broadly.

The purpose of the review process is to 'identify changes or enhancements to systems, policy, and services'[147] that can strengthen the resilience of the multi-agency system response to family violence, by decreasing opportunities for siloed working and increasing networks of relationships. This purpose is based in the understanding that a more nuanced set of interagency sensors is a better match for complex lives. Weick states that resilience occurs when the system continues to operate despite failures in some of its parts: 'the resilient system bears the mark of its dealings with the unexpected not in the form of more elaborate defences but in the form of more elaborate response capabilities'.[148]

A commitment to developing system resilience requires a willingness to question what is happening at the macro and micro levels. Consequently, a key part of the review process is to gain a deeper understanding not only of *what* has been going wrong but *why* the system has evolved this way.

(b) No blame

The systems approach is sometimes referred to as the 'no-blame' approach, but this term can mislead if it is assumed that by employing this approach there will be no assessment of individuals' practices and, hence, no accountability.

During the process of preparing for FVDRC death reviews, if agencies do uncover unacceptable professional practice, this should be addressed through their own disciplinary processes. However, the overwhelming majority of problematic practice identified through the review process is common professional behaviour that holds considerable potential for learning. It is suggested that agencies develop what Reason describes as a 'just culture' in the sense of 'an atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety related information – but in which they are clear about where the line must be drawn between acceptable and unacceptable behaviour'.[149]

Furthermore, a systems approach is built on the understanding that you cannot blame one practitioner for a family violence death, because these tragedies arise from a chain of events and the complex interaction of *multiple* factors over time. Blaming one individual deflects attention from deeper, systemic issues, such as the organisational environmental constraints in which the practitioner was working.

Human error is the starting point of the review process, not the conclusion. The focus is not on assessing people's professional practice in a vacuum; it takes into account the context of their work environment and how their standard of performance is influenced by the nature of the organisational climate of their agency, their interactions with other practitioners, the tasks they were undertaking and the available assessment tools designed to support them.

145 G. Klein, *Streetlights and Shadows: Searching for the Keys to Adaptive Decision Making*, Cambridge, Massachusetts, MIT Press, 2009.

146 C.A. Vincent, 'Analysis of clinical incidents: a window on the system not a search for root causes', *Quality and Safety in Health Care*, vol. 13, 2004, pp. 242–3.

147 Family Violence Death Review Committee Terms of Reference. Points 9, 9.1 and 10.

148 K. Weick and K. Sutcliffe, *Managing the Unexpected: Resilient Performance in an Age of Uncertainty*, 2nd edn., San Francisco, John Wiley & Sons, Inc, 2007.

149 J. Reason, *Managing the Risks of Organizational Accidents*, Brookfield, Vermont, Ashgate, 1997.

The systems approach aims to explore the *interaction* of the individuals with the wider context to understand why things developed in the way they did. Importantly, it is also focused on identifying what is working well and *patterns of good practice*.

(c) Sense-making

The FVDRC understands that those who choose to work with people affected by family violence want to help these people, rather than allow them to be hurt. This is also a key assumption in the systems approach, which posits that – at the time – people's behaviour would have seemed sensible, including those actions or decisions that later turned out to be mistaken or to lead to unwanted outcomes.

Practitioners working with people experiencing or perpetrating family violence are 'sense-making'. Snowden defines sense-making as *how we make sense of the world so we can act in it.*[150] Sense-making is most often needed when our environment is changing and presenting us with situations for which we might not be prepared or which are ambiguous. The concept of sense-making emphasises that people try to make things rationally accountable to themselves and others (contextual rationality).

When considering agencies' and practitioners' practice, a key focus of the review process is on reconstructing how the situation looked to practitioners at the time, in order to understand how people were making sense of an evolving situation.[151] This involves trying to understand why someone acted in a certain way, including what factors in the system contributed to their actions seeming like the *sensible or right thing to do at the time*.

What the situation looked like for each practitioner involved will differ according to various factors, including:

- what information was available to them
- their engagement with the client, family and whānau
- their engagement with other professionals
- what bodies of knowledge, experience and training they drew on to make sense of things
- what supervision they were receiving
- the goals they were trying to achieve
- the conflicting priorities they may have been juggling.

The review model needs to be responsive to these various factors and how these competing demands are perceived and managed by practitioners.

The family violence death review process

Key stages in the review process

(a) Cultural and spiritual considerations

Determining the culturally embedded values, beliefs and practices of the regional review panel members requires a trusting relationship that enables people to share information about themselves, their life and their cultural perspectives. The principles underpinning working with those from different ethnic or cultural groups within the FVDRC regional review process are:

- maintaining the safety of those involved in the review as a prime concern
- conducting reviews and review process(es) in a culturally acceptable manner for the person(s) involved in the review
- avoiding confusion and misunderstanding by keeping the processes surrounding the review(s) simple
- enabling people involved in reviews to speak in their native language, when there are speakers of languages other than English (although this has not yet needed to occur).

150 D. Snowden, *What is sense making?*, Cognitive Edge Network, 2008, http://cognitive-edge.com/.

151 *Hindsight bias.* Munro relays that psychology research has revealed that we are profoundly influenced by knowing the outcome when we look back at past events. Hindsight can make us overestimate what other people should have been able to anticipate or see at the time. When reviewing cases we need to be cognisant of this hindsight bias (E. Munro, 'A Systems Approach to Investigating Child Abuse Deaths', *British Journal of Social Work*, vol. 35, 2005, pp. 531–46).

Undertaking reviews with those belonging to different ethnic or cultural groups needs careful planning. We consider the engagement process, seek to ensure the process is safe, and take care of the people involved and the information they share.

The process of engagement begins by consulting an appropriate cultural advisor to ensure the processes within the review(s) are both culturally appropriate and acceptable. The consultation process may be ongoing throughout the processes of setting up, conducting and finalising the reviews.

(b) Opening a review meeting

Each review meeting opens with a karakia that acknowledges the dead, the afflicted, and the importance of telling their stories, as well as focusing on the aspirations of the review process and the professionals involved.

(c) Understanding people's lives

The review process starts by considering the lives of the people involved, including:

- their experiences of abuse (ie, severity, cumulative harm and at what stages of the developmental pathway this occurred)[152]
- who these people are, or were, in the context of their family, whānau, community and culture
- their relationships and connections with their family and whānau
- the neighbourhoods and communities they lived in
- their experiences of structural and societal issues such as poverty.[153]

(d) Creating multi-agency narratives

The review process then identifies who knew what was happening, what agencies were involved and the organisations' and practitioners' understandings of what was occurring.

Practitioners approach and perceive the same situation, and the people involved, from different perspectives. This may be influenced by, for example, their professional discipline, the specific purpose of their agency, the cultural framework that informs their work, and their personal experiences. These differences in perception may be large or small. Understanding the 'why' questions about multi-agency working requires capturing these different multi-agency perspectives.

Each agency representative at the local review has the opportunity to share their piece of the jigsaw – tell their story of how their agency understood the situation, the client, family and whānau, including any factors that impacted on practice and service provision.

In order to capture these differing perspectives, the review process constructs a set of multiple chronologies, rather than a single story or timeline. This involves creating separate lines for the victim and perpetrator, family, whānau, community members and each agency. The result is a layered picture that documents (relative to each other) who was involved and when, what they knew (or did not know), what they did and which services they were working with.

A focus on sense-making in the death reviews requires panel members to consider how people saw things, what contributory factors[154] influenced their 'sense-making' and how these processes impacted on practitioners' behaviour and practice, and shaped organisational practice.[155]

152 The life course approach recognises the importance of the timing of exposure to abuse – gestation, early childhood, childhood, adolescence and adulthood, as well as understanding the way in which factors associated with increased risk can accumulate from childhood and be reinforced across the life course, or even generations.

153 The Ecological Model represents the levels of influence that contribute to violent behaviour, or can contribute to preventing violence. See J. Hosking et al., 'A life course approach to injury prevention: a 'lens and telescope' conceptual model', *BMC Public Health,* vol. 11, no. 695, 2011. In this paper the authors propose a 'lens and telescope' model that integrates traditional injury prevention and life course approaches. For the purposes of the review framework this lens and telescope model has been applied to the integration of the ecological model of violence prevention and the life course model.

154 That is, personal aspects, aspects of their role, conditions of work and team factors.

155 See K. Weick, K.M. Sutcliffe and D. Obstfeld , 'Organizing and the process of sensemaking', *Organization Science,* vol. 16, no. 4, 2005, pp. 409–21; K. Weick, 'The Collapse of Sensemaking in Organizations: The Mann Gulch Disaster', *Administrative Science Quarterly,* vol. 38, no. 4, 1993, pp. 628–52.

(e) Key practice episodes

While creating the timeline, the review panel identifies which specific parts of the multiple chronologies require further analysis. These selected parts are called 'key practice episodes'.

Key practice episodes are those:

- considered significant by the panel to understanding the way the case developed and was managed
- points at which actions were taken that had a decisive effect on the development of the case, whether positive or negative.

Considering the practice in these episodes involves assessing the adequacy of the thinking and actions taken at each episode, and looking at the bigger picture – at what information could have been used to inform the process – to consider whether its use might have led to a different outcome.

(f) Identifying underlying patterns of systemic factors

Instances of problematic practice or good practice may appear different in different deaths, but underneath they can have much in common because the quality of assessments, multi-agency working and engagement with people is influenced by the same factors.

It is these similarities or *patterns* that need identification in family violence death reviews, for while the surface characteristics may be specific to a particular death, the assumption is that the generic patterns reappear in many family violence situations. They can be either constructive patterns of influence or patterns that create unsafe conditions in which poor practice is more likely. (See Appendix 6 for an explanatory diagram.)

The FVDRC has adapted the SCIE framework for understanding the influences on practice, and has created additional patterns. (See the text box entitled 'A framework for understanding the influences on practices' on page 86.)

Each pattern has several different aspects, which may or may not be present in each death review. For example, under *Patterns in communication and collaboration in multi-agency working and assessment*, the different aspects include, but are not limited to, factors that can be organised under the headings:

- multi-agency mandate
- information-sharing
- understanding the nature of the situation
- clarity of roles and responsibilities (of the practitioners involved)
- difference of opinions and professional hierarchies
- overestimating the remit of service provision of different agencies
- the importance of knowing each other
- referral procedures and cultures of feedback.[156]

The focus is always on the interaction between the client, the family and whānau, the practitioners and different parts of the system, and how these interactions can reinforce each other or overlap in many ways. These patterns are not a prescription of what should be found in each death review; some patterns may be more significant in some reviews than in others. They are a starting point, and will be tested and adapted through the review process.

156 (a) Are the multi-agency systems sufficiently integrated to strengthen the safety net around the client, children and family or whānau?
- *Is there support from management and governance levels to support multi-agency working? Is there adequate resourcing?*
- *Is there clarity of purpose, shared aims and objectives?*
- *Are there formal systems in place to coordinate service delivery?*

(b) How do practitioners share information and work together to provide a consistent response?
- *What do practitioners need to be told in order to be able to work together?*
- *How is information understood by multi-agency practitioners?*
- *What practical multi-agency guidance supports agencies to work together and share information?*

(c) How did multi-agency practitioners understand the situation?
- *What was the quality of the analytical work involved in making sense of the situation and the strength of evidence informing the decision-making?*

A framework for understanding the influences on practice

Underlying patterns of systemic factors that influence good or problematic practice

1. Patterns in family and whānau intergenerational experiences

How did intergenerational family and whānau experiences impact on the outcomes in this case?

2. Patterns in victim and perpetrator interactions with informal support networks

Who knew what was happening? How did their understanding of the situation and ability to provide support impact on the outcomes in this case?

3. Patterns in client[157] and family interactions with practitioners

What were the client's, children's, family's and whānau's experiences of practitioners?
How did these experiences impact on their help-seeking and decision-making?

4. Patterns in practitioners' interactions with assessment tools

How did the organisation's assessment framework and tools, and their use, influence:
(a) the practitioners' understanding of what was happening with the client, children, family and whānau
(b) the decision-making and management of the situation?

5. Patterns in practitioners' interactions with the organisational management system

How has the organisation:
(a) supported high-quality practice with this client, family and whānau
(b) prioritised responsiveness to family violence?

6. Patterns in practitioners' thinking and reasoning

For example, were tendencies such as failure to review decisions and plans, drift into failure and tunnel vision apparent in this case?

7. Patterns in communication and collaboration in multi-agency working and assessment

What were the key points or opportunities in this case for multi-agency assessment and decision-making:
(a) in response to incidents and crises
(b) in the longer-term, day-to-day work?

What was the quality of the collaborative working and multi-agency decision-making?

8. Patterns in the provision of services

Were there intervention and prevention service opportunities that may have contributed to better outcomes?

(d) Which agency has the overall responsibility for implementing, monitoring and reviewing the plan/situation?
- *How much shared responsibility is there? What part if any do the other agencies consider they play?*

(e) What system is in place to protect against the chance of conflicting opinions being repressed?
- *Are professional hierarchies undermining good practice?*
- *Are conflicts of opinion repressed or is there a shared culture in which it is acceptable and even desirable to query each other's assessments?*

(f) Was there a lack of understanding between agencies about the respective services they provide?

(g) How do practitioners get to know each other?
- *Do practitioners know whom to contact?*

(h) Are there established cultures across agencies of giving acknowledgement or feedback about action taken in response to referrals, whether by individuals or multi-agency panels?
- *If you refer a case to a service, how do you know they have engaged with the client, family or whānau?*
- *Are there agreed processes for addressing problematic practice?*
- *How often do agencies feed back about good practice?*

157 The term client is used here to refer to the victim or perpetrator.

(g) Findings and recommendations

The purpose of the death reviews is to inform *future* practice and prevention strategies. Identifying underlying patterns of systemic factors supports the formulation of findings and recommendations from the regional family violence death reviews. The following questions guide the formulation of findings and recommendations:

- Is this death review complete, or should we recommend further review? If so, what more do we need to know? Are there key perspectives missing?
- What was working well?
- What underlying patterns of systemic factors stood out in this case?
- How widespread are the issues beyond the particular case under review?
- How relevant are these issues? Are they important for future safety when providing services?
- Where in the system can change be initiated? Is this at the local and/or national level? (Have there already been changes in services and systems since this death?)
- Are there recommendations to be made to specific organisations?
- What are our best recommendations for helping to make these changes?
- To what degree could this death have been prevented?

(h) Closing

At the end of each review meeting, there is a roundtable check-in that provides each member with the opportunity to share any closing thoughts with the group.[158] The meeting is brought to a close with a karakia whakamutunga by one of the members or a kaumātua.

Safety of the review and the processes used are thought about carefully. Respectful care is taken of the people involved and of the information shared. The Regional Review Chair and the Lead Coordinator try to always be mindful of the spiritual and mental wellbeing of the review panel members, as they may also have histories of trauma.

158 Prior to participating in the death review process, the Regional Review Chair and Lead Coordinator check that each panel member has appropriate supervision in place. As part of the panel orientation, panel members are provided with *Taking Care of Those Working on Family Violence Death Reviews*, written by Dr Alison Towns. This document provides guidance on how to prevent any adverse outcomes due to exposure to traumatic material.

Death reviews as systemic learning environments

The regional review process provides a safe, collegial environment for the review panel members[159] to share their expertise, constructively challenge, and learn from each other's perspectives and practice.

For Chapman, systemic learning involves practice and reflection on one's own experience, and requires people to be willing to work jointly with those who have other perspectives. He emphasises that two 'core aspects of systems thinking are gaining a bigger picture… and appreciating other people's perspectives on an issue or situation'.[160] In his experience, practitioners' inability to grasp the bigger picture or a different perspective are not usually due to lack of information, but rather in the way that they think and the assumptions that they make – both of which he says are frequently unknown to the practitioners themselves. The regional death reviews provide a forum in which to develop and hone a shared understanding of the bigger picture, not just in relation to the particular death reviewed, but also in relation to current, general responses to situations of family violence.

The family violence death review process requires those involved to reflect on the outcomes of their own agency's actions and consider how they might modify their organisational behaviours, beliefs and interventions on the basis of that reflective process. The panel members are senior representatives, and this systemic learning process will also influence the way they think and practise in their own work, in their organisation, and in the broader multi-agency environment.

The continuous, reflective learning environment provided by the review process is extremely valuable because, as Flyvbjerg states, 'context-dependent knowledge and experience are at the very heart of expert activity'[161] and in-depth case studies are a method of acquiring this knowledge. The death reviews become part of these panel members' expert professional experience.

159 The level of people who participate are not the practitioners directly involved in the case, but rather senior agency representatives with some degree of oversight.

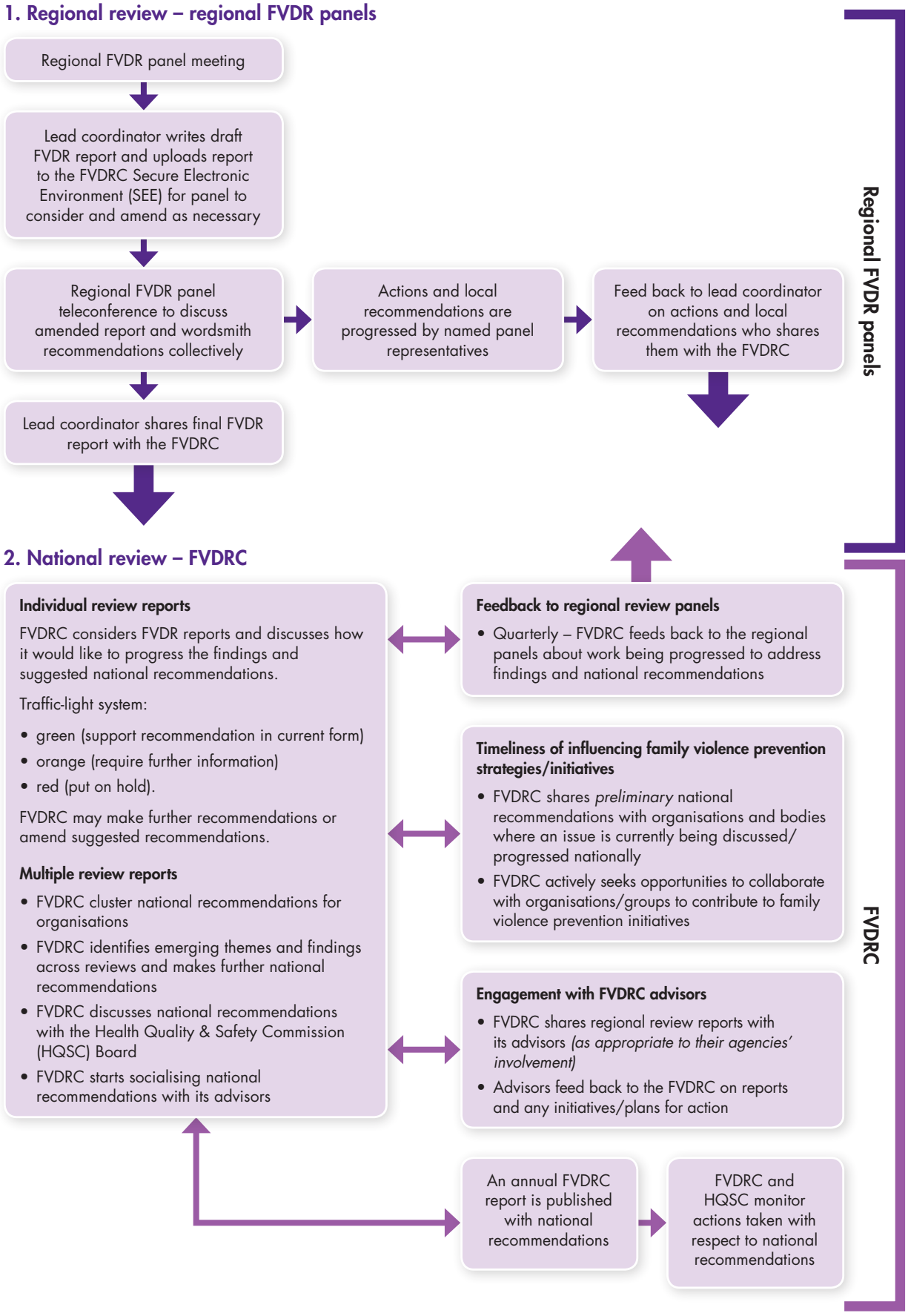
160 J. Chapman, *Systems Failure,* 2004.

161 B. Flyvbjerg, 'Five Misunderstandings about Case-Study Research', *Qualitative Inquiry,* vol. 12, no. 2, 2006, pp. 219–45.

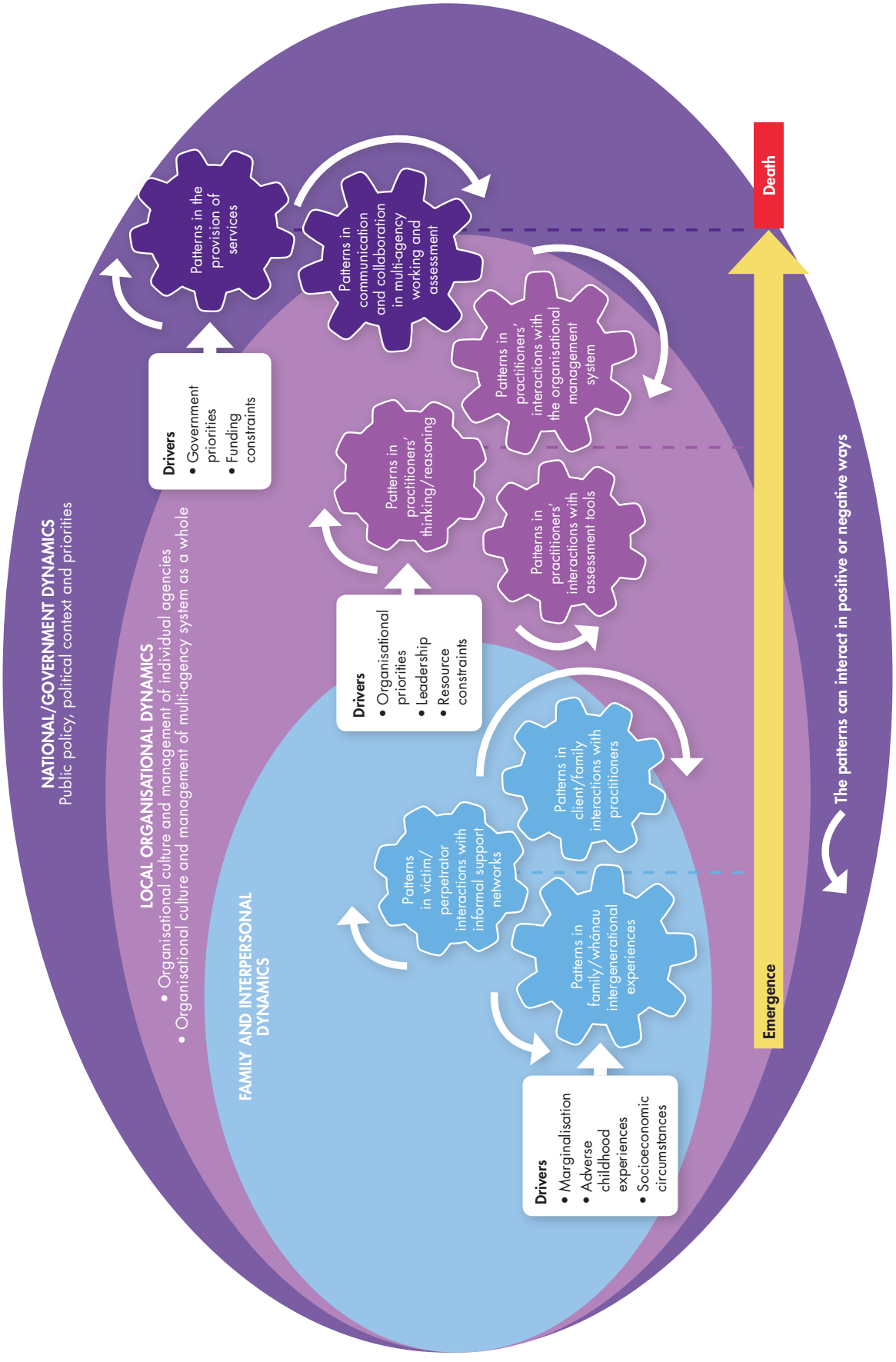
Appendix 4: The FVDRC prioritisation framework for regional review

No	Considerations	Examples
1	**Trends**	Issues that suggest a trend: • refugee and migrant deaths, degree of acculturation, immigration • primary victim killing a primary perpetrator • step-child killed by mother's new partner • women who have had multiple abusive partners • murder–suicide deaths
2	**Personal demographics**	Gender, age, ethnicity, same sex, location
3	**Other agencies or groups that might review the death**	Office of the Chief Social Worker practice reviews High-level internal inquiries within government departments Other Mortality Review Committees
4	**Number of agencies involved** *(until we have developed processes to gather information from proxy informant sources)*	Potential for organisational learning and change
5	**Timing**	Where is the homicide in the criminal justice processes? Is the death under a coroner's inquest? Agencies' internal management review processes for serious and sentinel events
6	**Types of death – *common or rare***	CAN IPV Other family violence deaths
7	**Children exposed to IPV and/or the co-occurrence of CAN and IPV**	Post-support issues for children whose parent(s) have been murdered and/or committed suicide
8	**Fit to expertise of the FVDRC**	
9	**Location and practical costs of the review**	

Appendix 5: Progression of recommendations from the FVDRC regional panels



Appendix 6: Dynamics considered in FVDRC regional reviews



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