Domestic Violence Homicide Reviews: Preventable Deaths of Women in Australia

When viewed as the escalation of a predictable pattern of behaviour, domestic homicides can be seen as largely preventable deaths"

(David,2007)

Domestic Homicide: Preventable Deaths

- Domestic violence deaths exhibit predictable patterns and aetiologies; they are preventable *(Websdale 1999:61)*

- "Most predictable and preventable of homicides" *(Jaffe 2009 1st Canadian Conference on the Prevention of Domestic Homicide)*

The Killing of Women: Not an Occasional Occurrence

- 1400 women killed annually USA (*Websdale 2006)*
- 2 women killed every week UK (*Home Office National Domestic Violence Plan 2005)*
- Almost half femicides committed by current or former partner or boyfriend- (*WHO 2002)*
- On average 76 women killed annually are intimate partner (*NHMP 1989-90, 2002-03)*

The War on Women

Brian Vallee 2000-2006

Unites States:

4588	Soldiers killed by hostile forces and deaths of serving Police officers in line of duty
8000	Women shot, stabbed, strangled or beaten to death by intimates

Canada

101	Soldiers killed by hostile forces and deaths of serving Police officers in the line of duty
500	Women shot, stabbed, strangled or beaten to death by intimates

These comparisons are meant solely to draw attention to the ongoing scourge that continues to take the lives and to damage the minds and bodies of thousands upon thousands of women and children living in fear of the domestic terrorists in their own homes… *Vallee, 2007 " The War on Women"*

Domestic violence fatality review is a "deliberative process" to prevent further domestic violence and homicide, provide strategies to ensure safety & hold perpetrators and systems accountable

(Wilson & Websdale 2006:539)

Catalyst for Change…

Charon Report in San Francisco 1990

- conducted by the Commission on the Status of Women, City and County of San Francisco
- Joseph Charan murdered his wife, Veena Charan, on January 15, 1990, and then took his own life.
- Veena Charan had sought the support of various government agencies for a period of 15 months prior to her murder.
- violated the restraining order on several occasions & attempted to kidnap his son at the son's school

Catalyst for change…

- **investigation requested answers to three clusters of questions:**
- Policies and procedures relating to domestic violence- what are they and how adequate are they?
- Is there sufficient information sharing between departments/agencies
- Are there sufficient data to evaluate the effectiveness of the system? If not, what additional data need to be collected? What changes, if any, to current procedures can be adopted to avert future tragedies?

- **Conclusion-** the City of San Francisco failed Veena Charon
- First DVDR Team established 1998- Santa Clara County SF
- Currently 125-150 DVDR Teams established in the USA
- Canada- 2 DVDR Teams- Province of Ontario & British Columbia
- UK
- New Zealand
- Australia- Victoria & soon to be New South Wales

Domestic Violence Homicide/Death Review

- Multi- agency task force
- Detailed systemic review
- Identifies weaknesses in systems

•To reduce domestic violence homicides by improving service provision & systemic responses

•To compile and interpret accurate detailed data

What Does It Do?

Takes a broad view:

- Context surrounding incident
- Points of intervention
- Appropriate intervention
- Risk factors
- Action taken by agencies
- Effectiveness of actions

- Means of improving interventions
- policies and protocols
- Law/legislative reform
- Further prevention strategies

A Review DOES NOT…..

BLAME OR SHAME

A Domestic Violence Homicide Review is not..

- A Research Project
- Coronial Investigation

Death Review & Coronial Investigation: So, What's the Difference….?

- An inquest is **not a free-ranging inquiry** into all matters related to death. The job of the coroner is to make the following findings:
  - the person's identity
  - the date and place of the death
  - the manner and cause of the death
  - In essence, systemic issues can only be raised if they form part of the "manner and cause of death".
  - Case law- a line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as "causative"

Death Review & Coronial Investigation: So, What's the Difference….?

- Domestic Violence Homicide Review **is a free ranging enquiry**
  - Examine the incidents leading up to the fatality
  - Provides context taking into account history of violence
  - Recreates the time line of events – through the "eyes of the victim and the perpetrator" (Websdale 2009)
  - Review individual deaths or a group of deaths over a period to identify patterns and trends
  - Reviewing panel is representative of the community and includes government and non government agencies as well as reps from significant groups to provide specialist input e.g. faith community, CALD community, Aboriginal

Domestic Violence Homicide Review Team Outcomes…

- Broader perspective and knowledge about culture and context of domestic violence
- Domestic violence deaths are preventable
- Perpetrator is the one responsible for the death
- Recommendations for improvement of system responses
- Community education
- Best practice and innovative interprofessional approaches
- Concrete discussions for change

Making a Difference

- **Contra Costa County California-** centralised reporting system to improve data collection
- **Georgia-**improved compliance regulations for batterer programs
- **Hennepin County Minnesota**- Mental Health Task Force to improve screening of men for partner abuse
- **New Hampshire-** domestic violence training for continuing professional educational requirements in relevant disciplines
- **Ontario** – Developed comprehensive community education campaign "Neighbours, Friends & Family" to better inform community of how they can support

Lessons from Santa Clara County

Domestic Violence Deaths of Women Reduced

Santa Clara County Domestic Homicides
1997 -2007

	1997	2007
Asian Victims	**17**	
African American	**5**	
Hispanic	**12**	**3**
Caucasian	**14**	
Other	**3**	
Total Domestic Homicides	**51**	**3**

Source: Websdale, Town & Johnson, 1999, p65: Santa Clara Domestic Violence Council, 1997, p.5)

Separation as a Critical Risk Factor

Review of 72 domestic homicides (2002-2008)

- Actual/pending separation 81% of cases
  - 56% cases actual separation
  - 25% cases pending separation

Separated 3 months or less	45% (18 cases)
Separated 3-6 months	22.5% (9 cases)
Separated 6 months to a year	15% (6 cases)
Separated > 1 year	12.5% (5 cases) with 3 cases divorce proceedings initiated within 3 months of homicide
Length of separation unknown	5% (2 cases)

Ontario Domestic Violence Death Review Committee Annual Report 2008)

Separation as a Critical Risk Factor

Ontario findings are consistent with research findings

Period immediately after separation is the most dangerous period for abuse victims

Washington State Domestic Violence Fatality Board

- 47% domestic homicide cases involved victim separating from or attempting to leave perpetrator (2008 Report)
- 33% of adult victims and 43% child victims clients of Dept Social & Health Services' Division of Child Support prior to the homicide (1997-2006)

Critical Learnings: Understanding Risk Factors

- Prior physical abuse
- Separation
- Access to firearms
- Previous threats to use a weapon
- Stalking
- Previous episodes of choking/strangulation
- Sexual assault
- Escalating pattern of severity, frequency of violence
- Perpetrator suicidality

Scope of Domestic Homicide Review

Domestic Violence Related Deaths include:

- Known homicides involving intimate partners and family members
- Homicide involving deaths of others known to the victim/perpetrator e.g. new partners, friends, colleagues
- Homicide of persons as a direct result of a fatal incident e.g. police, bystanders
- Suicide of perpetrators either as homicide/suicide or suicide

Scope of Domestic Homicide Review

- Accidental deaths e.g. drowning, drug overdose, car accident, falls
- Chronic health problems e.g. stroke, cardiac disease, stress related cancers and health complications related to experiences of domestic violence
- Homeless women- experience of homelessness is contributed to domestic violence
- Sexual competitor killings
- Teen dating- rapidity of escalation to homicide

Scope of Domestic Violence Homicide Review

- Suicide of victims of domestic violence- accepted next category to be included
  - 1 in 4 female suicides are on a background of domestic violence
  - Sample of 176 attempted suicide
    - 29.5% were battered and
    - 22.2% one recorded incident in files
  - 25 cases reviewed 11 suicide cases were identified as occurring on a background of domestic violence

BEST PRACTICE PRINCIPLES FOR AN EFFECTIVE REVIEW MODEL

- Team Membership
  - Multi disciplinary
  - Multi agency
  - Diverse
  - Inclusive
- Statutory protections in place
  - Confidentiality
  - Compulsion to provide information, files, evidence, immunity from prosecution

BEST PRACTICE PRINCIPLES FOR AN EFFECTIVE REVIEW MODEL

- Creates time line of events
  - Conveys sense of movement
  - Identifies barriers and challenges faced by victim/offender
- Accountability
  - Recommendations coupled with reporting mechanism including follow up
  - Report is publicly available

BEST PRACTICE PRINCIPLES FOR AN EFFECTIVE REVIEW MODEL

- Accurate data collection
- Generates research
  - Builds on learnings
  - Contributes to a growing body of evidence
- Interdisciplinary dialogue
  - Development of best practice
- Informs & stimulates education, community awareness initiatives

Their deaths are not unpredictable, isolated events without context or warning. Most of the victims whose murders we discuss in this report reached out for help. They planned with friends, family, and co-workers. They went to therapists, attorneys, and health care providers. They called police. They went to court. They worked with domestic violence advocates. They stayed in shelter. They struggled to be mothers and friends and students and employees and volunteers and to contribute to their communities in the face of terrible violence from someone close to them…

"Now that We Know" Recommendations from Washington State Domestic Violence Fatality Review December 2008