



HEALTH QUALITY & SAFETY
COMMISSION NEW ZEALAND

Kupu Taurangi Hauora o Aotearoa

Family Violence Death Review Committee



He tao huata e taea te karo

Fourth Annual Report: January 2013 to December 2013

*'History, despite its wrenching pain,
cannot be unlived, but if faced with courage,
need not be lived again.'*

Maya Angelou (1928–2014)





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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- all of the Family Violence Death Review Committee regional panel members, and particularly the time, commitment and work of the participating agency members to gather and prepare agency records for the death reviews.

The Family Violence Death Review Committee also thanks the people who have lent their assistance and expertise to the writing of this report.





Foreword

Violence within families has serious long-term social effects and a profound impact on the health of all concerned, even in those cases not resulting in death. Addressing family violence is an issue of great concern to all New Zealanders and is therefore of particular importance to the Health Quality & Safety Commission. I welcome the Family Violence Death Review Committee's fourth annual report and commend the Committee for its dedication and commitment to shining a light on matters of such significance to society.

The report sets out information, findings and recommendations from data on all family violence homicides in the four years from 2009 to 2012, and from in-depth regional reviews of 17 family violence death events. It goes beyond previous reports. For the first time, the pattern of violence has been included in the analysis of all family violence deaths, which better addresses the context in which these distressing events occur. This broader brush provides insights into the responses required to prevent future deaths.

The report suggests the family violence workforce needs to think differently if it is to respond effectively and safely to people living with family violence. It recommends improved family violence training, a stronger response to risk factors, and changes in legislation to better support those victimised by family violence.

Normalising or minimising family violence fails people who are at risk of being killed. The report advocates campaigning to encourage safe and effective interventions by friends, family, neighbours and workmates.

The report has a strong focus on children, and the impact family violence has on them. In particular, it calls for more support for children left behind after their parents, caregivers, brothers or sisters have been killed by family members. Some of these circumstances are just horrifying: one parent dead, and the other in prison, for example.

The Committee and its Chair, Associate Professor Julia Tolmie, have engaged with the many individuals and groups involved in responding to family violence. Those consulted during the preparation of this report include people who have lost family members through family violence. It is very pleasing to see the broad level of support for the Committee's recommendations for change.

This report calls for families, communities and organisations in New Zealand to challenge the unacceptable levels of intergenerational violence in our families, and to work towards the prevention of further deaths and the development of a gentler and more functional culture in which all our children can grow up safely.

Professor Alan Merry ONZM

Chair, Health Quality & Safety Commission

June 2014





Chair's introduction

In 2013, the Family Violence Death Review Committee (the Committee) set up the last of its five regional death review panels. The Committee's tier two regional death review process is now fully operational nationally. In addition, the Committee continued to conduct regional death reviews – completing eight in-depth reviews in 2013. These reviews add to the rich body of qualitative information the Committee has been compiling about how the social sector responds to the most dangerous and chronic cases of family violence in Aotearoa New Zealand. The tier one database – which will store general information about every family violence death in Aotearoa New Zealand – has also been designed and will be built in 2014.

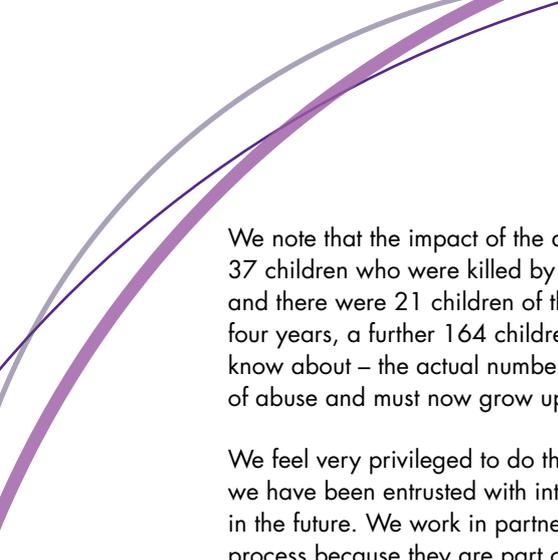
The social sector that responds to family violence consists of a wide range of governmental and non-governmental agencies and individuals, each of whom will have different pieces of information, engagement with different family members, different disciplinary mindsets and different powers, cultures, capabilities, capacities and constraints. Furthermore, practitioners working in the family violence crisis response sectors often make decisions in dynamic situations characterised by uncertainty and risk. Their everyday work environment generally includes large and complex caseloads, along with stretched or limited resources. Complexity and ambiguity can never be eliminated with the result that responding to family violence is not amenable to simplistic thinking or simple solutions. As described in this report, the purpose of the family violence death review process is to consider how we can strengthen the resilience of the multi-agency family violence system so it can respond more effectively in the face of this complexity.

Whilst the Committee strongly supports primary prevention strategies for addressing family violence, the death reviews show that, for a number of New Zealanders, violence has always been present in their lives. Children are conceived and born into families that are already characterised by dangerous abuse. Some women and children are living amidst gang cultures and are at risk of experiencing more frequent and extreme violence from abusive gang-affiliated partners, as well as greater levels of entrapment. If we are to be serious about tackling family violence then, in addition to developing primary and secondary prevention strategies, there is the need for an effective systemic response to chronic violence that works for all New Zealanders, and specifically those represented in our findings.

The Committee notes that practitioners, as well as family and community members, are at risk from the unacceptably high incidence and seriousness of family violence in Aotearoa New Zealand. For practitioners working within New Zealand Police, Child, Youth and Family and the Department of Corrections, for example, the abuse of children and adults is such a regular occurrence that it can be unintentionally normalised and minimised. The challenge for senior managers is to proactively ensure that, within their workforce, the unacceptable does not become acceptable.

Whilst the deaths from family violence documented in this report are small in number compared to some other types of death under review by companion committees (such as fetal and neonatal deaths), they are costly and largely preventable deaths. They also represent an undercount of even the most chronic cases of family violence. For example, Jacqueline Campbell¹ makes the point that for every intimate partner violence (IPV) homicide that occurs there are approximately eight or nine attempted IPV homicides. Captured in this report, although not counted in our core data on family violence deaths, are suicides by family violence homicide offenders when these take place immediately after the death event. Not captured are suicides by victims of family violence.

¹ J. Campbell and A.D. Wolf, *Guns and Domestic Violence Homicide*, Unpublished presentation reporting on findings of Multi City Intimate Partner Femicide Study, Johns Hopkins University School of Nursing, n.d.



We note that the impact of the deaths goes well beyond the individual victims involved. For example, the 37 children who were killed by a family member between 2009 and 2012 had 55 siblings and half-siblings and there were 21 children of the offenders who were not related to the children who died. Over the same four years, a further 164 children or step-children lost a parent through fatal IPV. These are the children we know about – the actual number is likely to be higher. These 240 children may well have also been victims of abuse and must now grow up having experienced serious loss and trauma at a young age.

We feel very privileged to do this work. We have the challenging responsibility of translating the information we have been entrusted with into positive learnings so that some of the tragedies of the past can be avoided in the future. We work in partnership with those agencies and individuals who participate in our review process because they are part of the multi-agency family violence system described in this report. Like us, they are committed to improving the response to family violence in Aotearoa New Zealand. We particularly wish to thank New Zealand Police, whose family violence death reviews provide much of the foundation for our tier-one data. And the work of the Committee would not be possible without the tireless efforts of our brilliant secretariat.

We congratulate the New Zealand Government for its commitment to the work of the Committee, to continuous quality improvement of the family violence system and to the fostering of a culture of transparency and learning in respect of the most egregious family violence tragedies.



Associate Professor Julia Tolmie

Chair, Family Violence Death Review Committee

June 2014

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Glossary of terms

The following is an explanation of a number of key terms used in this document.

Abuser	Generic term used to refer to the perpetrator of any form of abuse against adults and/or children.
Abusive (ex) partner	This term has been used when discussing intimate partner violence (IPV) to refer to the perpetrator (or predominant aggressor) and to indicate that the risk of IPV continues during and after separation.
Abusive parent/step-parent	This term has been used to refer to the perpetrator of child abuse and neglect (CAN). It can include both biological and step-parents.
Child abuse and neglect (CAN)	CAN (sometimes called child maltreatment), includes all forms of physical and emotional ill-treatment, sexual abuse, neglect and exploitation that results in actual or potential harm to the child's health, development or dignity. Within this broad definition, five subtypes can be distinguished – physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse and exploitation. ² Children's exposure to IPV is defined in section 3 of the Domestic Violence Act 1995 as psychological abuse of the child; as such it is included in the Committee's definition of CAN.
Family violence	The Taskforce on Violence Within Families ³ defines family violence as: a broad range of controlling behaviours, commonly of a physical, sexual and/or psychological nature, which typically involve fear, intimidation and emotional deprivation. It occurs within a variety of close interpersonal relationships, such as between partners, parents and children, siblings and in other relationships where significant others are not part of the physical household but are part of the family and/or are fulfilling the function of family. Common forms include: <ul style="list-style-type: none"> • violence among adult partners • abuse/neglect of children by an adult • abuse/neglect of older people aged approximately 65 years and over by a person with whom they have a relationship of trust • violence perpetrated by a child against their parent • violence among siblings.
Family violence workforce	All those working at all parts of the multi-agency family violence system who have the opportunity and responsibility to identify and respond to families experiencing family violence. This includes those working intensively with victims and family violence abusers, and also those who are likely to encounter various forms of family violence in the course of their work, such as teachers, psychologists or those delivering parenting programmes.
Femicide	Femicide is generally understood to involve intentional murder of women because they are women, but broader definitions include any killings of women or girls. Femicide is usually perpetrated by men, but sometimes female family members may be involved. Femicide differs from male homicide in specific ways. For example, most cases of femicide are committed by partners or ex-partners and involve ongoing abuse in the home, threats or intimidation, sexual violence or situations where women have less power or fewer resources than their partner. ⁴
Filicide	The term filicide denotes a form of homicide in which a parent deliberately kills his or her own child. ⁵

2 World Health Organization at www.who.int/topics/child_abuse/en/

3 See www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/action-family-violence/family-violence-indicators.html

4 World Health Organization at apps.who.int/iris/bitstream/10665/77421/1/WHO_RHR_12.38_eng.pdf

5 Centre for Suicide Prevention, 'Filicide: A literature review', *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, Manchester, University of Manchester, 2009.

Fratricide	The term fratricide denotes a form of homicide in which a person kills his or her brother.
Historical trauma	Historical trauma is related to major events, such as the processes and actions associated with the colonisation of indigenous people, and is connected to contemporary lifetime trauma, chronic stress, discrimination and family violence. ⁶
Intergenerational abuse	A pattern of interpersonal violence, abuse and/or neglect that is repeated from one generation to the next. It is evident in some families whether they are indigenous, immigrant, refugee or born in Aotearoa New Zealand.
Intrafamilial violence (IFV)	All forms of abuse between family members other than intimate partners or parents of their children. It includes abuse/neglect of older people aged approximately 65 years and over by a person with whom they have a relationship of trust, violence perpetrated by a child against their parent, violence perpetrated by a parent on their adult child and violence among siblings.
Intimate partner violence (IPV)	Any behaviour within an intimate relationship (including current and/or past live-in relationships or dating relationships) that causes physical, psychological or sexual harm to those in the relationship. Such behaviour includes: <ul style="list-style-type: none"> • acts of physical aggression – such as slapping, hitting, kicking and beating • psychological abuse – such as intimidation, constant belittling and humiliating • forced intercourse and other forms of sexual coercion • various controlling behaviours – such as isolating a person from their family and friends, monitoring their movements and restricting their access to information and assistance.⁷
Known to Child, Youth and Family	This can cover various circumstances. At one end of the spectrum it includes situations where there had only been one contact by someone to CYF asking for advice related to a child or young person which did not require a notification to be created or any action to be taken by social workers (therefore called a 'contact record'). At the other end of the spectrum it includes children and young people where there has been long-standing and intensive involvement, such as multiple assessments, family group conferences or even children being in care.
Matricide	The term matricide denotes a form of homicide in which a person kills their mother.
Multi-agency family violence system	This consists of all agencies providing services that are accessed by people experiencing, perpetrating and exposed to violence and abuse. It includes dedicated family violence services, legal and statutory services and mainstream services (for example education, health care, housing and income support), as well as less formal networks and services.
Neonaticide	The killing or murder of a child who is less than 24 hours old. ⁸
Offender	The person who caused the family violence death (as defined in the Committee's terms of reference), whether or not they are charged or convicted of an offence.
Overkill	Using violence far beyond what would be necessary to cause death. Overkill encompasses multiple stabbings, severe prolonged beatings and/or multiple violent methods (for example, strangulation, sexual violence and stabbing).
Parricide	The term parricide denotes a form of homicide in which a person kills their father, mother or close relative. The term is used in this report to specifically denote the killing of close relatives by a family member.

6 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.

7 E. Krug et al. (eds.), *World Report on Violence and Health*, Geneva, World Health Organization, 2002.

8 Centre for Suicide Prevention, 'Filicide: A literature review', 2009.

Patricide	The term patricide denotes a form of homicide in which a person kills their father. In this report the term also includes the killing of step-fathers.
Predominant aggressor	The person who is the most significant or principal aggressor in an IPV relationship, and who has a pattern of using violence to exercise coercive control.
Primary victim	The person who (in the abuse history of the relationship) is experiencing ongoing coercive and controlling behaviours from their intimate partner.
Social sector	All government and non-government agencies represented on, or funded by, members of the Government's Social Sector Forum – ie, social, justice, health and education and their contracted service providers ⁹ – and other government, non-government, voluntary or community agencies that provide social services, eg, Accident Compensation Corporation.
Sororicide	The term sororicide denotes a form of homicide in which a person kills their sister.
Strangulation	Strangulation is a form of asphyxia characterised by closure of the blood vessels and air passages of the neck from external pressure on the neck.
Traumagram	A traumagram maps an individual's (and their family's) experiences of trauma, such as CAN, sexual abuse and IPV, across extended families (including siblings and step-parents), as well as current and previous relationships. They include known children of the various adults, alcohol and other drug use, protection orders, Child, Youth and Family involvement, children in care and imprisonment associated with any particular family member. Traumagrams render visible patterns of violence, abuse and neglect across generations and in past and present relationships.
Uxoricide	The term uxoricide denotes a form of homicide in which one parent kills the other. It also often specifically refers to the killing of a wife by her husband.

⁹ See www.msd.govt.nz/about-msd-and-our-work/publications-resources/corporate/statement-of-intent/2012/cross-agency-leadership.html

Executive summary

This report sets out information, findings and recommendations resulting from data collected on all family violence homicides that took place from 2009 to 2012 and 17 in-depth regional reviews (conducted during 2012 and 2013) of selected death events. In Chapter 2, the Family Violence Death Review Committee (the Committee) presents a statistical analysis of the 126 family violence homicides that occurred between 2009 and 2012. These are separated into three categories:

- 63 intimate partner violence (IPV) deaths
- 37 child abuse and neglect (CAN) deaths
- 26 intrafamilial violence (IFV) deaths.

The Committee found that from 2009 to 2012:

All family violence deaths

- **47 percent** of all homicide and related offences were family violence and family violence related deaths.
- **240** surviving children have been affected by exposure to fatal IPV and CAN.

IPV deaths

- **50 percent** of the IPV homicides happened after the couple had separated or where separation was planned.
- **44 percent** of the IPV deaths were due to 'overkill' – violence far beyond what would be necessary to cause death – encompassing multiple stabbings and/or multiple forms of violence.
- **96 percent** of the overkill offenders were male.
- Māori were **2.8 times** more often deceased and **2.5 times** more often offenders of IPV deaths than non-Māori, non-Pacific peoples.
- Of the 55 IPV¹⁰ death events with an apparent history of abuse in the relationship:
 - **93 percent** of women had been abused in the relationship¹¹
 - **96 percent** of men had been the abusers in the relationship¹²
 - **38 percent** of these IPV offenders (all male) had a police history of abusing one or more previous partners.

10 Excludes six uncertain deaths and two aberrational deaths.

11 Fifty-one women had a history of being abused in the relationship – 41 were killed by their abuser and 10 killed their abuser. See Table 4.

12 Fifty-three men had a history of being the abuser in the relationship – 43 killed the victim of their abuse and 10 were killed by the victim of their abuse. See Table 4.

CAN deaths

- **78 percent** of the children killed in CAN deaths were under five years of age.
- **46 percent** of the children killed in CAN deaths had a Child, Youth and Family history.
- **47 percent** of the offenders of fatal inflicted injury deaths of children were known to police for abusing the mother of the child or female carer.
- **76 percent** of the offenders of the fatal inflicted injury deaths of children were male and all the offenders of neonaticide and fatal neglectful supervision deaths of children were female.
- Māori and Pacific children were **5.5 times** and **4.8 times** (respectively) more likely to die from CAN than children of other ethnicities.
- Māori and Pacific adults were **4.9 times** and **5.3 times** (respectively) more likely to be the offenders of a CAN death than adults of other ethnicities.

IFV deaths

- **Māori died at 5 times** the rate of non-Māori, non-Pacific ethnicities as a result of IFV, and were **offenders 13 times** more often than non-Māori, non-Pacific ethnicities.
- **Almost 40 percent** of IFV deaths occurred in the most deprived residential areas (decile 10).

The Committee has documented system failures in many of the regional reviews. It is worth noting that these failures have not occurred just in respect of the abusive episode that resulted in death. In most of the reviews problematic practice can be observed over many years. There are multiple complex factors that contribute to the system's failure. These include the organisational practice of individual agencies,¹³ the collaborative practice of multiple agencies and the professional practice of individuals working within the system.

One contributing factor is how family violence is conceptualised within professional practice across a range of key disciplines and in the practice structures and systems within and between agencies. The Committee has concluded from the regional reviews that the family violence workforce¹⁴ needs to think very differently about family violence to be in a position to practise more effectively.

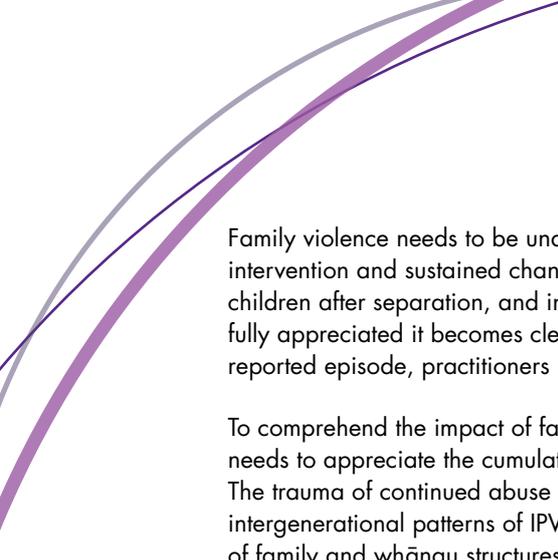
The key ways in which family violence needs to be reconceptualised are discussed in Chapter 3 and summarised below. This conceptual shift needs to inform professional education and training, policy development, assessment frameworks and processes within and between organisations.

IPV is best understood in terms of the coercive and controlling behaviours used by the predominant aggressor in the relationship. Coercion involves the use of force or threats to intimidate or hurt victims and instil fear. Control tactics are designed to isolate and foster dependence on the abusive partner and their lifestyle. Together these abusive tactics undermine a victim's ability for independent decision-making and inhibit resistance and escape. In practice, these tactics and their impact are easily missed when practitioners focus on the acts of physical assault within a relationship. Understanding family violence as only physical abuse can result in the very serious non-physical abuse of family members that children are exposed to, not being properly understood or responded to.

The Committee has defined IPV and CAN as entangled forms of abuse because an abuser's behaviour can defy categorisation as either CAN or IPV. There is often 'a double level of intentionality', whereby the abuse directed towards one family member (for example, a child) is at the same time intended to affect other family members (for example, the child's mother and siblings) in order to keep and/or increase control over them. Many children are experiencing a 'double whammy' – being exposed to IPV and being a direct victim of other forms of CAN. Agencies need to systematically incorporate both IPV and CAN within their assessment frameworks.

13 Including the influence of policies and procedures, assessment frameworks, training and supervision provision, and the influence of performance indicators.

14 See glossary of terms for the definition of the family violence workforce when used in this report.



Family violence needs to be understood as a harmful pattern of relating that, without appropriate intervention and sustained change, is likely to continue against current family members, ex-partners and children after separation, and in future relationships with new adult partners and children. When this is fully appreciated it becomes clear that, rather than responding to an individual victim and an individual reported episode, practitioners need to focus their thinking on how to prevent abuse from continuing.

To comprehend the impact of family violence and respond accordingly, the family violence workforce needs to appreciate the cumulative and compounding harmful effects of chronic and repeat victimisation. The trauma of continued abuse is often carried from one generation to another and can perpetuate intergenerational patterns of IPV and CAN when not addressed. Family violence is a disruption to the fabric of family and whānau structures and has a negative impact on many long-term health and social issues, for example, poor mental health, self-medicating with drugs and alcohol, suicide attempts and the inability to hold down employment.

The family violence workforce also needs to respond to family violence as a complex form of entrapment. Family violence operates with other structural inequities in a victim's life to undermine their attempts to keep themselves and their children safe within the relationship, to leave the relationship or to keep themselves safe post-separation. Entrapment can be experienced both individually and collectively. Many Māori women experiencing abuse are dealing with serious levels of victimisation and social entrapment, extreme economic deprivation and high levels of historical and intergenerational trauma. This trauma affects the victim, their extended family and support networks as well. Such forms of severe structural and social entrapment can leave some victims with very limited options for escaping the abuse.

Whilst the majority of those who commit a family violence homicide have been the abuser (predominant aggressor) in the history of the relationship, this is not always so. In a small subset of cases the Committee found that the person who committed the homicide was, in fact, the primary victim and the deceased was the predominant aggressor. In order to be prevention focused, all levels of the family violence response system need to determine who the IPV predominant aggressor and IPV primary victim are – regardless of who has used physical force on any particular occasion. This is necessary so that primary victims can be identified and effectively supported before serious harm or a fatality occurs. Identifying the primary victim can also interrupt repeat victimisation and ensure the predominant aggressor is held accountable.

The Committee believes there needs to be a shift in cases of serious family violence to a proactive systemic response in which services and the community become responsible for victims' safety. Safety planning needs to shift from the creation of a list of actions that victims take to 'empower' themselves and keep themselves safe, to generating collective actions that agencies can take to contain, challenge and change the abuser's behaviour. This is what makes a multi-agency family violence system response more effective than an 'empowerment model'.

The regional reviews have shown that informal networks of support are often in a position to facilitate help-seeking, but in order to provide protection they must be able to name behaviours as abuse and understand their potential lethality. Lethality risk indicators (such as specific threats to kill, non-fatal strangulation and extremely jealous, controlling partners) need to be recognised and responded to by family and friends, as well as practitioners, agencies and multi-agency initiatives. The normalisation and minimisation of family violence by some family members also needs to be addressed, as it can lead to family, friends and sometimes statutory services failing to appreciate how serious the situation is.

Finally, it is important that the family violence workforce is better informed about different forms of violence. Examples that emerge from the regional reviews are family violence in the context of gang involvement, forced marriage and 'honour'-based violence.

In Chapter 4, the Committee describes in greater detail the CAN deaths, as well as the impact family violence and a family violence homicide has on surviving children. The death of a parent or sibling in a family violence homicide is likely to be just one of a succession of traumatic experiences before and after the death event. Evidence from the regional reviews suggests that frequently insufficient thought is given to addressing the surviving children's current and future mental and physical health needs. There is also a need to focus on the risks that can emerge when new partners join a child's home. Furthermore, it is vital that practitioners assess step-fathers' roles as 'caregivers' when they enter a child's home or family.

The justice sector is a critical part of the multi-agency family violence system. In Chapter 5 the Committee notes several issues emerging from the regional reviews, in particular the timeliness of court proceedings in family violence cases and the limited consequences for breaches of protection orders. The Committee recommends two legislative reforms that would result in family violence victimisation being more effectively recognised in the justice sector.

First, non-fatal strangulation is frequently minimised by victims and does not typically leave external marks on the victim, yet it is extremely dangerous and has a significant physical and psychological impact on the victim. The regional reviews have found that the combination of high impact and low detection makes non-fatal strangulation a dangerously effective method of coercive control. Currently non-fatal strangulation tends to be prosecuted as a minor domestic assault. Having a specific criminal offence covering non-fatal strangulation would both highlight the behaviour as a red flag for future harm and fatality, as well as facilitating a more effective criminal justice system response for the purposes of offender accountability.

Secondly, the Committee has found that primary victims who kill predominant aggressors are not currently well served by the defences to homicide in Aotearoa New Zealand. The result is that primary victims of extreme, long-term abuse can end up serving long prison sentences for murder, rather than having their victimisation recognised in the criminal justice response to their crimes. Since the abolition of provocation in 2009, there have been no partial defences to homicide for such defendants. The New Zealand Law Commission's recommendation in 2001 that the defence of self-defence be modified so it is better available to such defendants has yet to be enacted.

In Chapter 6, the Committee concludes by highlighting three issues emerging from the regional reviews.

1. The need to strengthen professional education and training about family violence, which includes multidisciplinary education forums that promote collaborative practice.
2. The need to develop a national family violence service accreditation framework and a set of consistent practice standards across the social sector to address the current gap in family violence service providers' quality assurance processes.
3. The need for learning frameworks to be established within each organisation and across multi-agency forums to ensure near misses are understood and responded to appropriately before further serious harm or fatal violence takes place.

Throughout this report the Committee identifies opportunities to strengthen the system's resilience and enable organisations and practitioners to better respond to those living with family violence. The Committee has emphasised that family violence cannot be understood as a series of isolated incidents; it is a pattern of behaviour that spans a relationship and, often, multiple relationships – both simultaneously and sequentially. Family violence can also span multiple generations. There is also a larger harmful pattern of behaviour occurring at the society level. This is the unacceptable level of family violence occurring in Aotearoa New Zealand. In the decade from 2000 to 2010, New Zealand women experienced the highest rate of IPV, and specifically sexual violence from intimate partners, of any women in all Organisation for Economic Co-operation and Development (OECD) countries reporting.¹⁵

When these unacceptable levels of violence within our communities are considered together with what is known about the intergenerational progression of violence, Aotearoa New Zealand's collective resolve and commitment must be on interrupting the transmission of violence and trauma at all levels – individual, family/whānau, community and, most importantly, for future generations. This report provides an opportunity for people, practitioners, organisations and communities to act on these issues and turn them into the practice of violence interruption and, ultimately, prevention.

¹⁵ Thirty percent of women experiencing physical violence ever and 14 percent of women suffering sexual violence ever. These are the highest rates of all 14 OECD countries reporting. L. Turquet et al., *Progress of the World's Women: In Pursuit of Justice*, New York, UN Women, 2011.

Recommendations¹⁶

The Committee recommends the following:

1. The Campaign for Action on Family Violence deepens and extends its focus to encourage safe and effective interventions by friends, family/whānau, neighbours and workmates by:
 - addressing the normalising and minimising of family violence
 - educating the public about coercive control and IPV lethality indicators
 - emphasising the importance of contacting services when lethality risk factors are disclosed.
2. New Zealand Police further strengthens its family violence situational response and harm prevention agenda by:
 - identifying and proactively managing family violence offenders who are recorded as having abused multiple partners and/or step-/children
 - identifying and proactively supporting repeat victims who have been abused by one or more partners
 - supplementing the current suite of police risk assessment tools with an IPV lethality assessment
 - integrating the concepts of the primary victim and the predominant aggressor into police practice
 - ensuring that where a child is named on or covered by a protection order, a copy of this order is attached to the child's record.
3. All child survivors of a fatal family violence homicide should be considered to be vulnerable children and therefore should have access to assessment and support services as outlined in the Children's Action Plan. These children should have a comprehensive assessment of their needs (health, safety, well-being and educational) and appropriate follow-up. This will be facilitated by Child, Youth and Family or the newly emerging Children's Teams.

All of these vulnerable children and their family/whānau should continue to receive support from the appropriate service until a clear pathway for their ongoing care is established and the children have been shown to be making good progress in their physical and mental health and in their educational progress in their new care situation.

4. The Committee establishes a working group to develop a national Family Violence Death Aftercare Protocol. The protocol will focus on clarifying the roles and responsibilities of each organisation – and the process to be followed – to ensure safe and holistic care pathways are developed for both child and adult survivors of fatal family violence.
5. The Government considers an amendment of the Crimes Act to include non-fatal strangulation as a separate crime under part 8 of the Crimes Act 1961.
6. The Government:
 - considers modifying the test for self-defence set out in section 48 of the Crimes Act 1961 so that it is more readily accessible to homicide defendants who are primary victims of family violence
 - considers the introduction of a partial defence that can be utilised by primary victims of family violence¹⁷ who are not acting in self-defence at the time they retaliate in response to the abuse they have experienced
 - convene an advisory group of experts (on the defence of primary victims who kill the predominant aggressor) to inform its deliberations.
7. The judiciary, with the approval and strong recommendation of the Heads of Bench, in association with the Institute of Judicial Studies, implement family violence (IPV and CAN) education and training, as well as establishing a mechanism for refresher training.
8. The Ministry of Justice, in partnership with New Zealand Police, strengthen the criminal and appellate courts' ability to respond effectively to family violence charges by facilitating the provision of comprehensive information to judges to aid safe and robust decision-making.

¹⁶ The following is a summary of the Committee's eight recommendations. The full recommendations appear at the end of the chapter to which the recommendation relates.

¹⁷ Primary victims may be referred to as 'battered defendants' in other jurisdictions.

Chapter 1: Introduction

1.1 Overview of the report

This is the fourth annual report of the Family Violence Death Review Committee (the Committee). Whilst this report documents the Committee's activities during the 12-month period from January 2013 to December 2013, the tier-one and tier-two data are presented in a cumulative manner. Tier-one trend data for 2011 to 2012 has been added to the quantitative information provided in the previous reports on family violence homicides that took place between 2009 and 2010.^{18 19 20} Similarly, the emerging findings and national recommendations are drawn from the 17 regional reviews undertaken in 2012 and 2013.²¹

Progress on the Committee's work, together with progress on the implementation of the recommendations and emerging issues and priorities from the last report, are outlined in the following two sections of this chapter. The remainder of this chapter provides further detail and background for those who are not familiar with the activities of the Committee, the family violence death review process or the issue of family violence. We invite readers who are familiar with this material to move straight onto Chapter 2 after reading the next two sections of this chapter.

A quantitative overview of all family violence deaths from 2009 to 2012 in Aotearoa New Zealand is contained in Chapter 2. Chapter 3 explains how the family violence workforce needs to think differently about family violence in order to provide effective and safe responses to people living with family violence. Chapter 4 describes the impact fatal family violence can have on children. Chapter 5 sets out two key legislative changes that would result in better recognition of family violence victimisation in the justice sector.²² Chapter 6 discusses the need for education and training, a national service accreditation framework and practice standards and an approach to practice improvement that includes reviewing near misses. No intrafamilial violence (IFV) deaths were selected for regional review; as such the issues reported in Chapters 3 to 6 are specific to intimate partner violence (IPV) and child abuse and neglect (CAN). Breakout boxes have been used at selected points to emphasise particular text, to provide examples of promising practice and to outline what is required for safe practice.

1.1.1 Progress on emerging issues and priorities

The *Third Annual Report*²³ highlighted two findings that emerged from the regional reviews conducted in 2012 that were not covered in detail in that report. These issues have been considered further in this report.

Assessing the co-occurrence of IPV and CAN

The Committee noted that whilst the co-occurrence of IPV and CAN is high, the regional reviews were showing 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. This issue is explored in more detail in section 3.1.3 and in Chapter 4.

Interacting lethality factors

The Committee also noted that the interaction of different risk factors and vulnerabilities can change a victim's environment from one characterised by non-lethal violence to a situation that is potentially fatal. The family violence death reviews conducted during 2012 and 2013 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 Committee has reported on this issue in detail in Chapters 3 and 5.

18 J. Martin and R. Pritchard, *Learning from Tragedy: Homicide within Families in New Zealand 2002–2006*, Wellington, Ministry of Social Development, 2010.

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

20 Family Violence Death Review Committee, *Third Annual Report: December 2011 to December 2012*, Wellington, Health Quality & Safety Commission, 2013.

21 These 17 regional reviews involved 12 IPV death events (deaths of women and men) and 5 CAN deaths. One of the IPV deaths occurred in 2013, the remaining regional reviews were from the years 2009 to 2012. The Committee's prioritisation framework for the selection of individual cases for regional review can be found in Appendix 4 of FVDRC, *Third Annual Report*, 2013.

22 See Appendix 1 for detailed material supporting the issues raised in Chapter 5.

23 FVDRC, *Third Annual Report*, 2013.

In conclusion to the *Third Annual Report*²⁴ the Committee identified a number of areas for future focus. These are discussed further in this report.

- The improvement of family violence training for professionals across the family violence sector – including judges, coroners, social workers and private therapists (see Chapter 6).
- The need to address the links between intergenerational trauma histories and behaviour for victims and offenders (see sections 3.1.5 and 3.2.2).
- The distinction between primary victims and predominant aggressors (see section 3.1.2).
- The issues facing immigrant and refugee families (see section 3.3.2).
- The need to improve New Zealand Police’s enforcement of protection orders (see section 3.2.4).

The Committee makes submissions on key issues. An issue that has emerged as needing urgent attention is the constraint that concerns about privacy place on effective multi-agency practice around family violence and, in particular, the safety of victims. Accordingly, in 2013 the Committee made a submission on the Vulnerable Children Bill to the Social Services Select Committee. It submitted that safe outcomes for children and adults affected by family violence can only occur when services responsibly share information and work in an integrated way.

The Committee recommended that:

- the Vulnerable Children Bill and the Privacy Act be amended to include a presumption of information-sharing between agencies where child protection and family violence concerns are present
- the Privacy Commissioner develops cross-agency guidelines on sharing information in the context of family violence and care and protection. These guidelines need to be applicable to public sector services and non-government organisations.

1.1.2 Progress on previous recommendations

The Committee was pleased to note that the recommendations from the *Third Annual Report*²⁵ were generally well received by key government and non-government agencies. In its role as an independent statutory committee, the Committee has followed the progress made by agencies to implement the Committee’s recommendations. An overview on the progress made to date with the implementation of each recommendation is summarised in the following table.

²⁴ Ibid.

²⁵ Ibid.

**Outcomes of recommendations made in the Family Violence Death Review Committee's
Third Annual Report²⁶**

RECOMMENDATION	Lead agency	2013 response	Status	Commentary from lead agency
1. 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:				
a. In partnership with the responsible agencies, develops a nationally consistent high-risk case management process.	CYF	Supported action		<p>Child, Youth and Family (CYF) has reported: CYF continues to engage with sector partners in the consideration of cross-sector models of high-risk case management. Under the umbrella of the Children's Action Plan, CYF is partnering with other agencies to develop a system to improve outcomes for vulnerable children, including those involved in family violence.</p> <p>New Zealand Police has reported: The Family Violence Interagency Response System (FVIARS) is currently under review as part of the work plan for the Taskforce for Action on Violence within Families and is being led by CYF. Police have worked extensively with CYF, and other agencies and non-government organisations (NGOs) over the last 16 months to review and develop FVIARS. A high-level model has been agreed to in principle but all work on its development has been delayed.</p> <p>As of June 2014, the Ministry of Social Development has reported that these issues (under 1a, b and c) are under active consideration by Ministers as part of a wider interagency response to family violence.</p>
b. Considers funding the development of national FVIARS training, for all professionals involved with FVIARS and all multi-agency, high-risk case management processes.	CYF	Supported action		
c. Along with lead agencies for the <i>Delivering Better Public Services: Reducing Crime and Re-offending Result Action Plan</i> , ²⁷ uses the New Zealand Family Violence Clearinghouse principles for effective interagency collaboration to inform the development of a high-risk case management process and to strengthen the FVIARS processes.	CYF	Supported action		

²⁶ Ibid.

²⁷ Ministry of Justice et al., *Delivering Better Public Services: Reducing Crime and Re-offending Result Action Plan*, Wellington, Ministry of Justice, 2012.

RECOMMENDATION	Lead agency	2013 response	Status	Commentary from lead agency
2. 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:				
a. 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.	MOJ	Supported action		<p>Ministry of Justice has reported: As part of implementation of the Domestic Violence Amendment Act 2013 it is intended to:</p> <ul style="list-style-type: none"> • introduce victim-informed assessments in relation to non-violence programmes, where it is safe for the victim to do so • encourage the take-up and attendance in safety programmes by protected people at the earliest opportunity through changing the methods in which the initial approach is made • consider offering safety planning and safety advice at the time an application is first made for a protection order • enable access to safety programmes at any time during the tenure of the protection order • consider extending access to safety programmes to victims of defendants in criminal court domestic violence-related proceedings where there is no protection order • introduce a report-back to the victim wherever there is a safety concern and at the completion of the non-violence programme • encourage communication between the provider of a non-violence programme and the victim, through a safety programme provider, if appropriate, where it is safe to do so.
b. 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.	MOJ	Supported action		<p>Ministry of Justice has reported: The Domestic Violence Amendment Act 2013, when fully implemented, will disestablish the Domestic Violence Programmes Approval panel. The Ministry is creating new criteria for the Secretary of Justice to use when approving providers. These criteria rely on overarching principles and incorporate specific standards. One of the outcomes sought from the implementation project is increased collaboration between providers and other agencies. This includes developing processes for information-sharing and, for at least high-risk cases, ongoing liaison with other agencies.</p>
c. Considers developing evidence-based risk assessment tools that are properly funded and consistently used by all stopping violence programmes throughout New Zealand.	MOJ	Supported action		<p>Ministry of Justice has reported: As part of the principles-based Code of Practice, the Ministry expects to introduce a template for structured assessment (yet to be determined), which may include the use of risk assessment tools such as lethality assessments.</p>

RECOMMENDATION	Lead agency	2013 response	Status	Commentary from lead agency
d. 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.	MOJ	Supported action		Ministry of Justice has reported: The principles-based Code of Practice will include addressing the needs of women who have been abused by perpetrators with gang affiliations. The newly defined safety programme will be offered in three parts focused on immediate and longer term safety needs and planning. It will have the flexibility to match the needs of the individual and may cover issues such as gang violence, intergenerational abuse and historical trauma, where appropriate.
3. 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:				
a. The National FVIARS Working Group develop a formal multi-agency after care process for IPV and CAN deaths.	CYF	Supported action		No progress, as this recommendation was reliant on the high-risk case management process being developed and implemented (see 1a). This work will now be progressed through the development of a national family violence death aftercare protocol, outlined in Chapter 4 of this report.

Status legend:



Completed



Underway but not yet completed



No action taken

1.2 Background information

1.2.1 The Family Violence Death Review Committee

The Committee was established in 2008 as an independent ministerial advisory committee hosted by the Ministry of Health. The Health Quality & Safety Commission (the Commission) assumed responsibility for mortality review following the New Zealand Public Health and Disability (NZPHD) Amendment Act 2010, and the Committee is now hosted by the Commission. It is one of four mortality review committees. The overarching goal of the Committee is to contribute to the prevention of family violence and family violence deaths.²⁸ The Committee's functions are to 'review and report to the HQSC on family violence deaths, with a view to reducing the numbers of family violence deaths...' and to 'develop strategic plans and methodologies that are designed to reduce family violence morbidity and mortality...'

The members of the Committee are family violence experts from a range of disciplines across the social sector, chosen to bring a wide array of skills, background experiences and perspectives to the table.²⁹ The Committee 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:³⁰ 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 Committee recognised that additional representation was needed from the Department of Corrections, Ministry of Education and the family violence non-government sector (particularly in regards to victim advocacy, children's services and stopping violence programmes) and invited five additional advisors to work with the Committee. Advisors provide the Committee with an overview of what is happening in relevant government and non-government sectors, guidance on the development of the family violence death review process and help to develop recommendations that emerge from the regional review process.

The Committee operates five regional panels across the country that undertake regional reviews:

- Panel 1: Northland, Waitemata and Auckland City
- Panel 2: Wellington Central
- Panel 3: Counties Manukau
- Panel 4: Midlands (Waikato, Bay of Plenty and Eastern)
- Panel 5: South Island (Tasman, Canterbury and Southern).

Each regional panel comprises: two Māori representatives, one family violence 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 CYF representative and health representatives.

The Committee recognises the importance of effective engagement with people from different ethnic or cultural groups. This is crucial to understanding the context and experiences of relevant whānau or family members leading up to a family violence related death. A kaumātua (elder) is invited to attend each review meeting to maintain the kawa (customs) and tikanga (correct processes) of the rohe (region). Additional group members are co-opted on a case-by-case basis to ensure relevant expertise and local knowledge during each review. In addition, cultural advisors from Pacific peoples and refugee and migrant communities are approached on a case-by-case basis.

28 See www.hqsc.govt.nz/our-programmes/mrc/fvdr/about-us/terms-of-reference/ for the Committee's terms of reference 2011.

29 See Appendix 2 for a list of current and past members.

30 See www.hqsc.govt.nz/our-programmes/mrc/fvdr/about-us/terms-of-reference/ for the Committee's terms of reference 2011.

1.2.2 The family violence death review process

The Committee has developed a two-tiered death review system designed to collect a minimum set of information about all family violence deaths in Aotearoa New Zealand, while selecting some death events to be subject to additional intensive, multi-sectoral review.³¹

A standard set of information on all family violence homicides – collected from police and other agencies – is used to report general trends in family violence homicide over time. This is the ‘tier-one’ data. From these data, the Committee can determine how many deaths are taking place in each family violence category, the demographics of victims and offenders, and the services with which they have been involved. However, such information, while useful in monitoring general trends over time – for example, whether family violence deaths are increasing or decreasing, the co-occurrence of different types of abuse and how many offenders are predominant aggressors or primary victims in the abuse history prior to the killing – 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’.³²

Tier one: a standardised set of data for all family violence deaths in Aotearoa New Zealand.

Tier two: referred to in this report as regional review. An in-depth review of selected family violence deaths, chosen for their potential learnings.

A small number of deaths are therefore chosen for the more intensive tier-two (regional) review process.³³ The regional reviews closely resemble what Flyvbjerg defines as in-depth case studies from which more can be learned about family violence and the multi-agency family violence system in Aotearoa New Zealand. They are concrete, detailed narratives which involve practical (context-dependent) knowledge, undertaken collectively by the key agencies involved in the family violence response along with family violence and cultural experts.³⁴

The model informing the regional review process

A wide range of agencies have a role in reducing harm caused by the persistently high rate of family violence in Aotearoa New Zealand. This has produced a complex system of service provision. The regional review process aims to examine how this system is working. The emphasis of the review process 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 system is functioning more broadly – to provide a ‘window on the system’.³⁵

The aim of the regional review process is to work out why actions taken by practitioners made sense at the time. Rather than reviewing an individual’s practice, the focus is on identifying patterns within the current system that either facilitate or compromise good practice. The identification of underlying patterns of systemic factors provides a basis for considering how the whole system might be improved to prevent harm caused by family violence in Aotearoa New Zealand.

31 The development of this system was described in detail in the Committee’s second and third annual reports. This report elaborates on the work done to develop this system.

32 See www.hqsc.govt.nz/our-programmes/mrc/fvdr/about-us/terms-of-reference/ for the Committee’s terms of reference 2011.

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

34 J. Chapman, *Systems Failure – Why Governments Must Learn to Think Differently*, 2nd edn., London, Demos, 2004.

35 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.

The following patterns, which highlight key interactions involving specific elements of the family violence system, are a starting point:

- family/whānau intergenerational experiences
- victim/offender interactions with informal support networks
- client³⁶/family interactions with practitioners
- practitioners' interactions with assessment tools
- practitioners' interactions with the organisational management system
- practitioners' thinking/reasoning
- communication and collaboration in multi-agency working and assessment
- the provision of services.

These patterns can interact in positive and negative ways. They are tested and adapted through the review process and there may be further patterns identified over time.

Learning from regional reviews

On completion of each regional review, a confidential report with the findings and local and national recommendations prepared by the regional panel is reviewed by the Committee. The written report from the regional reviews is also shared with the regional agents and relevant national agents of the Committee, including the advisors from key government and non-government agencies.³⁷ This is done in order to enable those agencies to determine the extent to which implementing these recommendations could improve their practice and to allow them to provide further feedback and refinement of the national recommendations prior to their release.

The Committee's annual report discusses common themes and trends that have emerged from the regional reviews conducted over the year prior and from previous years. The Committee's findings are based on the evidence from the regional reviews. Part of the regional review process involves considering these findings in the context of local and international literature on the issues. The report also sets out a number of future priorities and selected national recommendations that have emerged from the regional review process.

However, the regional reviews are designed to contribute to system improvement in additional ways. The regional review process requires those involved to reflect on the outcomes of their own agency's actions and to consider how they might modify their organisation's behaviours, beliefs and interventions on the basis of that reflective process. The regional panel members are senior representatives from key agencies within the family violence system, 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.

Furthermore, the Committee is developing a process to provide a formal feedback loop to agencies about key practice issues that emerge from the regional reviews but which are not appropriate to publicly report on. Practice issues from the regional reviews completed in 2012 have been coded and clustered, and the Committee will be providing feedback to individual agencies on matters relevant to each agency during 2014.

Finally, members of the Committee, the Lead Coordinator and the Chair of the regional review panels give presentations and feedback to professional groups and governmental review groups on issues emerging from the regional reviews that are relevant to their work.

³⁶ The term client is used here to refer to the victim or offender.

³⁷ Agents of the Committee are bound by confidentiality agreements showing that (in accordance with section 59E of the NZPHD Act 2000) they are liable to a fine up to \$10,000 and professional disciplinary action if they disclose confidential information.

1.2.3 Family violence – the issue

Family violence morbidity perpetuates intergenerational patterns of IPV³⁸ and CAN when not addressed. It is a disruption to the fabric of family and whānau structures and has a negative impact on survivors' long-term mental health (such as post-traumatic stress disorder, anxiety related disorders, depression, substance abuse and increased risk of suicidality), spiritual wellbeing, attachment to others and parenting capabilities.

There are three aspects of family violence prevention that are important to bear in mind when interpreting the ambit of the Committee's terms of reference.

1. Family violence prevention requires improvement of the social sector³⁹ response to people experiencing, perpetrating and exposed to violence and abuse.
2. The cases that the Committee is reviewing are those that have escalated to homicide. These are cases that clearly involve serious family violence.
3. Most importantly, as explained further in Chapter 3, family violence cannot be understood as a series of isolated incidents. Rather, it is a pattern of behaviour that spans a relationship and – not uncommonly – multiple relationships both simultaneously and sequentially. In a number of the family violence 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 abuse or victimisation by those who were impacted by it. A family violence death event represents an opportunity to intervene in order to address the safety, wellbeing and needs of the survivors and to prevent future family violence (see Chapter 4).

1.2.4 Family violence death definition

Varying definitions of family violence are used by different agencies throughout the social sector. Furthermore, varying definitions of what constitutes a family violence death create differences in the data produced by the Committee and agencies such as New Zealand Police, the Ministry of Social Development.⁴⁰

The Committee's terms of reference⁴¹ define a family violence death as: 'The unnatural death of a person (adult or child) where the suspected offender 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.

1.2.5 Cultural and spiritual considerations

In Chapter 2 of the *Third Annual Report*,⁴² the Committee discussed the importance of the embedded and unique cultural and spiritual positions of families and whānau when reviewing family violence deaths. A summary of the key points made in that chapter are repeated here in order to re-emphasise the importance of these matters.

The concept of wellbeing is both complex and multi-factorial, involving determinants of health that include the cultural and spiritual wellbeing of people and their families. Websdale⁴³ urges the understanding of people's life-stories, particularly the historical, social and emotional milieu of their life and violence within their families. This is important for Māori, as Aotearoa New Zealand's indigenous people, whose history of colonisation has negatively impacted on the structure, role and function of whānau; refugees who live with

38 The issue of intergenerational family violence was discussed in detail in FVDR, *Third Annual Report*, 2013, p. 24.

39 See glossary of terms for the definition of the social sector when used in this report.

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

41 See www.hqsc.govt.nz/our-programmes/mrc/fvdr/about-us/terms-of-reference/ for the FVDR terms of reference 2011.

42 FVDR, *Third Annual Report*, 2013.

43 N. Websdale, *Familicidal Hearts: The Emotional Styles of 211 Killers*, New York, Oxford University Press, 2010.



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.

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. 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) that differs from one group to the next. People belonging to minority ethnic and cultural groups may have values, beliefs and practices that differ from those generally accepted by the dominant cultural group in Aotearoa 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.

Thoughtful and respectful consideration needs to be undertaken prior to, and when, working with those from minority ethnic or cultural groups. Becoming culturally competent is a lifelong process⁴⁴ that requires those working in the area of family violence 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
- understand the historical, social⁴⁵ and emotional landscape of the families they are working with to enable them to identify factors that can support them, as well as factors that signal heightened risk.

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) work in an ethnocentric way (based on the dominant cultural beliefs and practices), they put those who belong to minority cultural groups at risk. An absence of cultural competence is likely to leave people feeling dissatisfied, disrespected, demeaned and disempowered – and lead to misunderstandings.

An example of this is the misunderstandings that often arise regarding intergenerational patterns of family violence.⁴⁶ Commonly referred to as 'intergenerational trauma', it arises from extreme environmental and traumatic stress that results in neuroendocrine and epigenetic changes in those affected. These are then transmitted from one generation to the next. As a consequence, family violence impacts future generations by disrupting physical, mental, social and spiritual health and wellbeing, along with ways of coping, behaving and communicating with others.⁴⁷ 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.

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

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

46 The issue of intergenerational family violence was discussed in detail in FVDRC, *Third Annual Report*, 2013, p. 24.

47 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, pp. 179–89.

1.2.6 Resistant problems and complex systems

Family violence is sometimes described as a 'wicked' problem,⁴⁸ meaning that it is a problem that is resistant to simple resolution. Attempting to remedy one part of the system which responds to a wicked problem, in isolation from other parts, can reveal or create unexpected further problems.

The multi-agency family violence system,⁴⁹ which consists of a wide range of governmental and non-governmental organisations and individuals⁵⁰ with different tasks, powers, procedures, cultures and disciplines, is best understood as a complex system. A complex system has a number of defined characteristics.

- 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 arise from the circumstances – they cannot be imposed.⁵¹
- 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.⁵²

The Committee's death review process is an opportunity to 'identify changes or enhancements to systems, policy and services'⁵³ that can strengthen the resilience of the multi-agency family violence system's capability to respond to family violence, including decreasing opportunities for siloed working and increasing networks of relationships.

Weick and Sutcliffe⁵⁴ state that resilience occurs when a 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'. A 'systems review', such as that adopted in the family violence death review process, can foster the growth of resilience in practitioners, organisations and communities, and do so in the longer term, rather than looking for 'quick fixes'.

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

49 See glossary of terms for the definition of the multi-agency family violence system when used in this report.

50 For example, justice, education, health (including general, mental and addiction), housing, counselling.

51 This is frequently referred to as emergence.

52 This means that we cannot forecast or predict what will happen. D. Snowden and W. Boone, 'A leader's framework for decision making', *Harvard Business Review*, vol. 85, no. 11, 2007, pp. 68–76.

53 See www.hqsc.govt.nz/our-programmes/mrc/fvdr/about-us/terms-of-reference/ for the Committee's terms of reference 2011.

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

Chapter 2: Family violence deaths from 2009 to 2012

In the four years from 2009 to 2012 in Aotearoa New Zealand:

All deaths

- **47 percent** of all homicides⁵⁵ were family violence and family violence related deaths.
- **139** people died from family violence and family violence related homicides⁵⁶ – an average of 35 per year.
- **126** deceased were within the Committee's terms of reference:
 - **63** IPV deaths
 - **37** CAN deaths
 - **26** IFV deaths.
- **40 percent** of all the deceased lived in the **most deprived 20 percent** of residential areas.

Children exposed to IPV and CAN deaths

- **77** children^{57 58} were present when an adult or child/ren was killed.
- **111** children and young people usually lived in the household where the death occurred and are likely to have been exposed to at least some, and often many, of the repeated episodes of family violence that preceded the fatal event.
- **240** surviving children^{59 60} have been affected by exposure to fatal family violence.

63 IPV deaths

- **50 percent** took place in the context of a planned or actual separation.
- **44 percent** were cases of 'overkill'.
- Māori were **2.8 times** more often deceased and **2.5 times** more often offenders of IPV deaths than non-Māori, non-Pacific peoples.
- **38 percent** of IPV deaths occurred in the **most deprived 20 percent** of residential areas.

History of abuse

Of the 55 IPV⁶¹ deaths with an apparent history of abuse in the relationship:

- **93 percent** of women had been abused in the relationship⁶²
- **96 percent** of men had been the abusers in the relationship⁶³
- **All six** of the Māori women who were offenders in the death event had been the primary victim in the relationship with the deceased.

55 This includes homicides and related offences.

56 In addition, there were 18 family violence and family violence related suicides in these four years.

57 CAN deaths – 36 children and 1 young person.

58 IPV deaths – 36 children, 3 young people and 1 adult child.

59 CAN deaths – sibling(s), half-sibling(s) or children of the offender.

60 IPV deaths – children, young people and adult children of the deceased and the offender.

61 Excludes six uncertain deaths and two aberrational deaths.

62 Fifty-one women had a history of being abused in the relationship – 41 were killed by their abuser and 10 killed their abuser. See Table 4.

63 Fifty-three men had a history of being the abuser in the relationship – 43 killed the victim of their abuse and 10 were killed by the victim of their abuse. See Table 4.

37 CAN deaths

- **78 percent** were under five years of age.
- **51 percent** of children died by fatal inflicted injury.
- **Men** were more likely to kill children by fatal inflicted injury.
- **Women** were more likely to kill children by neonaticide, filicide/parental suicide or fatal neglectful supervision.
- **46 percent** of children killed were known to CYF.
- Māori and Pacific children were **5.5 times** and **4.8 times** (respectively) more likely to die from CAN than children of other ethnicities.
- Māori and Pacific adults were **4.9 times** and **5.3 times** (respectively) more likely to be the offenders of a CAN death than adults of other ethnicities.

26 IFV deaths

- **Māori died at 5 times** the rate of non-Māori, non-Pacific ethnicities from IFV, and were **offenders 13 times** more often than non-Māori, non-Pacific ethnicities.
- **Almost 40 percent** of IFV deaths occurred in the most deprived residential areas (decile 10).

Methods

Data sources

The 2009 to 2012 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; CYF and the New Zealand Health Information Service (NZHIS).

The 2002 to 2006 data are taken from a report by Martin and Pritchard,⁶⁴ and the 2007 and 2008 data are from a report by Paulin.⁶⁵ For more information on family violence deaths that occurred in New Zealand from 2002 to 2008, see Martin and Pritchard and the Committee.

Numerator ethnicity data were obtained from the NZHIS from National Health Index (NHI) data. Where NHI ethnicity data was unknown, police ethnicity data has been used. This occurred for 18 deceased or offenders. Where a regional review has been undertaken and has established a different ethnicity from the NHI or police-recorded ethnicity, the regional review self-identified ethnicity has been used. This occurred with respect to one individual. Where there was more than one ethnicity recorded prioritisation has been applied according to the following hierarchy: Māori, Pacific peoples, Asian, all other ethnicities, NZ European.

Denominator data for ethnicity, age and gender are projections from Statistics New Zealand. Totals vary slightly due to variations in assumptions about population growth. Because this report includes data from 2009 to 2012, the total population presented in the tables is from 2009 to 2012. Rates have then been calculated per 100,000 people per year.

Socioeconomic status

Socioeconomic status has been measured using New Zealand deprivation deciles. The New Zealand Index of Deprivation 2006 (NZDep2006) is an area-based measure of socioeconomic deprivation using variables from the Census of Population and Dwellings 2006. The score, in this report, is assigned according to place of residence of the deceased, using meshblock unit and presented as a decile from least deprived (decile 1) to most deprived (decile 10). Each of the 10 deciles should make up 10 percent of the population.

64 J. Martin and R. Pritchard, 2010.

65 J. Paulin, *Homicide within Families in New Zealand 2002–2008*, Unpublished work commissioned by the Health Quality & Safety Commission, 2011.

Terminology

In this chapter the term 'deceased' is used to describe people who were killed in family violence events, and the term 'offender' is used for the person who took the deceased's life. This is to clarify the meanings as distinct from the terms 'victim' and 'abuser' because it is recognised that a deceased person or an offender may have been either a primary victim or a predominant aggressor in the intimate relationship. Offender includes those who have been convicted for homicide, those who have been found not guilty by reason of insanity or acquitted on the basis of self-defence, 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. On occasion, it also includes people who have been through a criminal trial and found not guilty because the Crown has been unable to provide proof to the high standard required in criminal proceedings. This will happen if there is strong evidence suggesting that a person committed the crime, there is no other person who is suspected of having killed the deceased and experts in the case believe that the person is the offender.

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 offenders in the numerator and the number of person-years 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.

2.1 Family violence and family violence related deaths from 2002 to 2012

From 2002 to 2012, there were 312 family violence deaths in Aotearoa New Zealand (Table 1). This equates to 28 per year on average. During this period family violence deaths accounted for between 25 percent and 52 percent of all homicide and related offences.

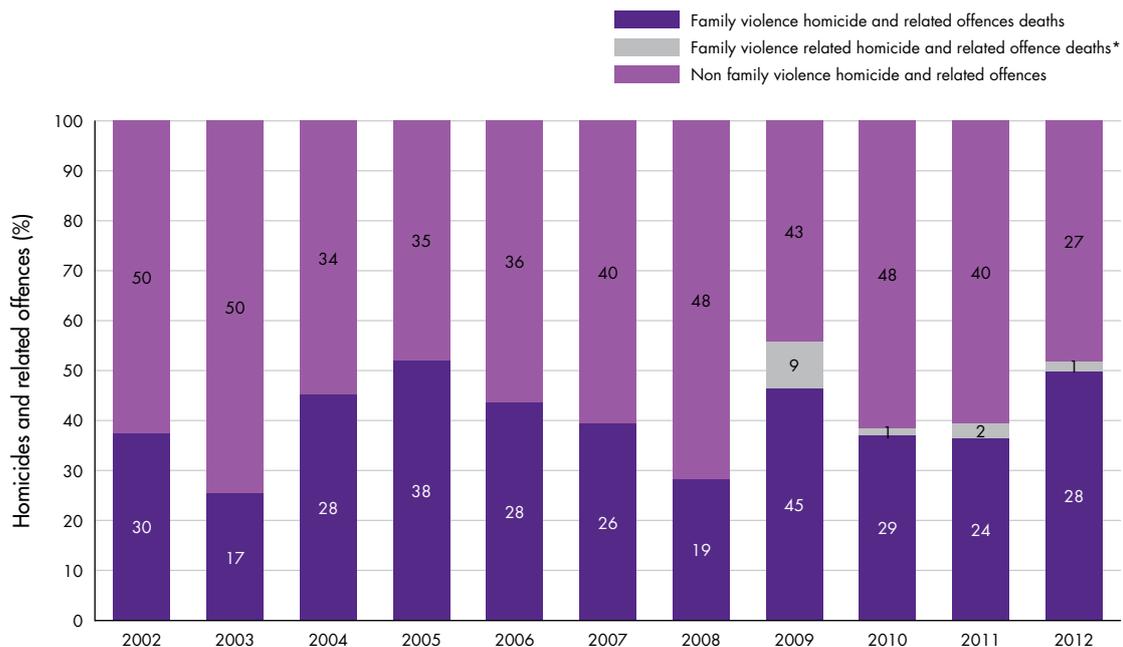
Table 1: Homicides and related offences, family violence deaths and family violence related deaths, New Zealand, 2002–12

HOMICIDES AND RELATED OFFENCES	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
Family violence deaths*	30	17	28	38	28	26	19	45	29	24	28	312
Family violence related deaths†	NA	9	1	2	1	13						
All other homicides and related offences	50	50	34	35	36	40	48	43	48	40	27	451
Total of all homicide and related offences‡	80	67	62	73	64	66	67	97	78	66	56	776
Excluded cases (Family violence related deaths that were not homicides or related offences) n=18												
Family violence related deaths that were suicides								5	6	4	3	18

- * Family violence deaths are homicides that fall within the Committee’s terms of reference (see www.hqsc.govt.nz/our-programmes/mrc/fvdrcc/about-us/terms-of-reference/). They are a subset of ‘homicide and related offences’. Source: FVDRCC Data Collection.
- † Family violence related deaths are homicides, and sometimes suicides, that are related to family violence but fall outside the Committee’s terms of reference (eg, a bystander or intervener who died at the event but is not related to the victim). These data are invariably an undercount as there are many deaths, particularly involving suicide, that are family violence related but the history of family violence preceding the death was not known to the Committee or other agencies. These data were not collected from 2002 to 2008. Source: FVDRCC Data Collection.
- ‡ This figure includes recorded murder, manslaughter and homicide and related offences not further defined, but not attempted murder or driving causing death. Source: National Annual Recorded Offences for the Latest Calendar Years (Australian and New Zealand Society of Criminology), New Zealand Police, Statistics New Zealand.

Family violence deaths and family violence related deaths are a subset of all homicide and related offences. In the four years from 2009 to 2012, there were 139 family violence and family violence related homicides and related offences – an average of 35 (47 percent) of all homicide and related offences per year (Figure 1). In addition there were 18 family violence related deaths by suicide.

Figure 1: Burden of family violence and family violence related deaths in homicide and related offences, New Zealand, 2002–12



* Data collected only from 2009 onwards.

Normally, family violence related deaths are when:

- there is a deceased victim who is not part of the family relationship, but who has been killed while inadvertently becoming caught up in an episode of family violence (often as an intervener or a bystander)
- an offender dies by suicide following the death event.

As discussed in Chapter 1 of the *Third Annual Report*, family violence related deaths are those that are related to a family violence episode but do not fall under the Committee's terms of reference. The Committee is reporting these deaths in order to provide a better understanding of the burden of fatal family violence in Aotearoa New Zealand,⁶⁶ but will distinguish between family violence deaths and family violence related deaths in order to adhere to the terms of reference. The Committee does not report attempted family violence homicides or standalone suicides (for example, when a victim of family violence commits suicide).

2.2 Family violence and family violence related deaths from 2009 to 2012

In the following sections, the Committee reports on family violence deaths and family violence related deaths from 2009 to 2012 in more detail.

2.2.1 Family violence death events

One family violence death event can involve more than one deceased person and/or more than one offender. From 2009 to 2012, there were 135 family violence and family violence related death events (Figure 2). There were 157 deceased as a result of these death events – 31 of these deceased were family violence related deaths and so fall outside the Committee's terms of reference.

The Committee's terms of reference covered 122 death events:

- 106 death events resulted in one death
- 12 death events resulted in two deaths – 11 involved a killing and a suicide, and one involved a bystander also being killed
- 3 death events each involved two killings and a suicide
- 1 death event involved two killings and two suicides.

Deceased

In the 122 death events and 126 deaths that came within the Committee's terms of reference:

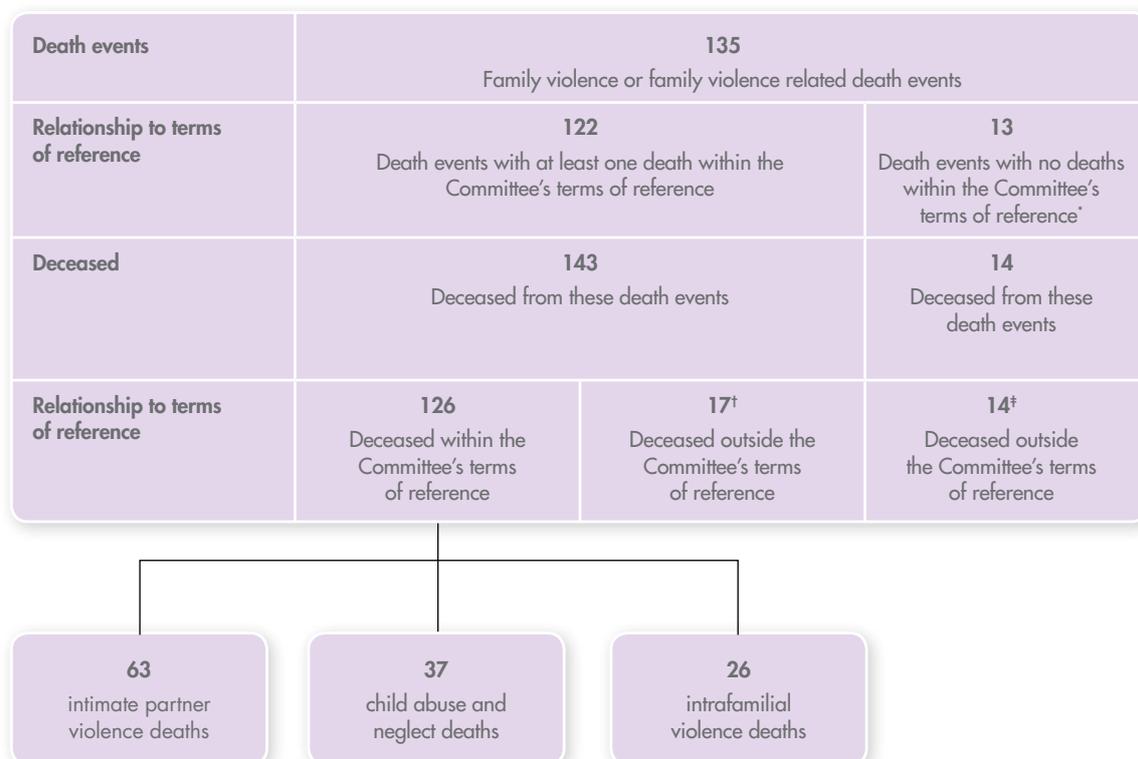
- 63 were IPV deaths
- 37 were CAN deaths
- 26 were IFV deaths.

Offenders

In the 122 death events, there were 124 offenders – 15 committed suicide at the time of the death event, so their deaths fall outside the Committee's terms of reference.

⁶⁶ The Committee recognises that there are more deaths that are not counted, including same-sex relationships where it was not known that the offender and victim were in a relationship, homicides that have been classified as suicides or accidents, missing persons and unsolved homicides and suicides of IPV primary victims. Furthermore, a fetal death would not be captured if it was not immediately obvious to police that the victim was pregnant.

Figure 2: Family violence and family violence related death events and deceased, New Zealand, 2009–12



* The death is, however, related to a family violence episode.

† Seventeen deceased were family violence related deaths and hence did not come within the Committee's terms of reference – 15 were offenders who committed suicide, one was a suicide of an adult four days after the death event, which also included an offender suicide, and one was a bystander.

‡ There were 14 deaths related to 13 death events where none of the deaths fell within the Committee's terms of reference:

- Two bystanders were killed (but no one else was).
- Two interveners, who tried to stop fights, were killed in the process (but no one else was).
- Three predominant aggressors were killed by interveners, who were preventing them from assaulting the primary victim.
- Two assisted suicides.
- One offender who died by suicide after assisting one of the suicides.
- Two sudden unexplained infant deaths that were family violence related.
- One person who committed suicide following an episode of family violence.
- One person who died from an accidental fall during a drunken, seemingly non-violent family argument.

2.3 Family violence deaths from 2009 to 2012

Half (50 percent) of the 126 family violence deaths in Aotearoa New Zealand from 2009 to 2012 were IPV, whilst almost one-third (29 percent) were CAN (Table 2).

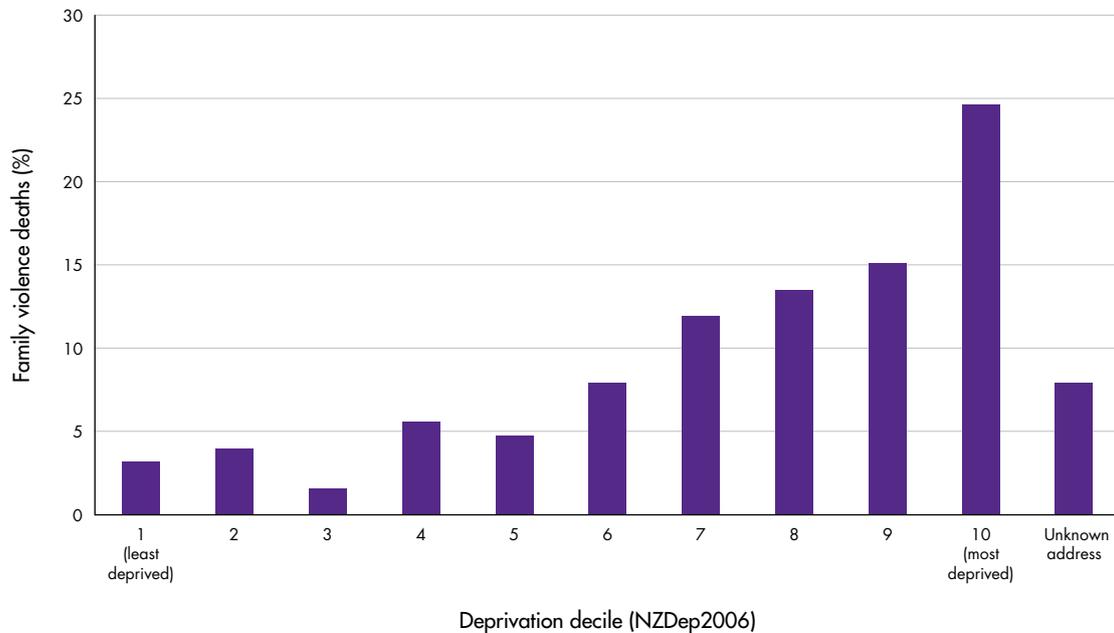
Table 2: Family violence deaths by type, New Zealand, 2009–12

CATEGORY	Family violence deaths n=126	
	n	%
Intimate partner violence (IPV)	63	50
Child abuse and neglect (CAN)	37	29
Intrafamilial violence (IFV)	26	21

2.3.1 Socioeconomic status and location of family violence deaths in New Zealand 2009–2012

Deprivation deciles are available for 116 of the 126 deceased from 2009 to 2012, whose address was known.

Figure 3: Deprivation decile (NZDep2006) for deceased in family violence deaths, New Zealand, 2009–12



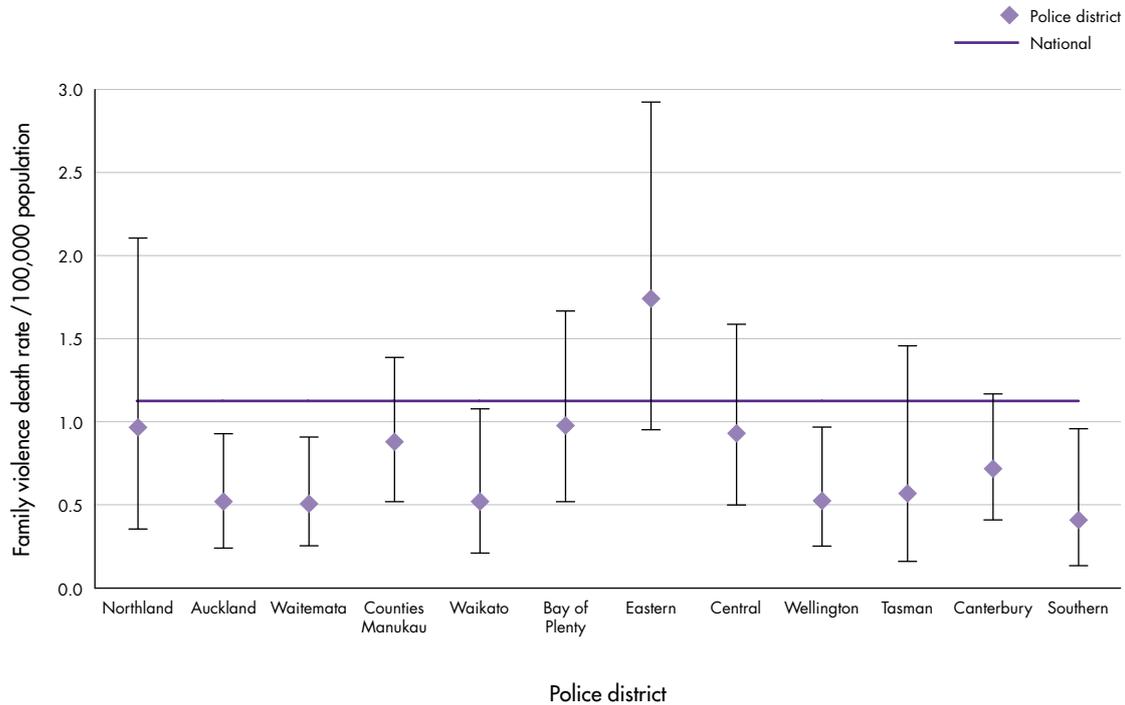
The distribution of population deciles assigned to the residential addresses of family violence deceased shows a markedly skewed picture when compared to the expected distribution of 10 percent of New Zealand residents per decile. One-quarter of deceased lived in the most deprived 10 percent of residential areas and 40 percent in the most deprived 20 percent of residential areas. This suggests that family violence deaths occur more commonly among people living in areas of high socioeconomic deprivation.

Socioeconomic status is known to be associated with ethnicity and age. It is not possible to know from these analyses what the independent effects of each of these variables are on the risk of family violence death. However, Māori and Pacific peoples generally are more likely to live in the most deprived residential areas in Aotearoa New Zealand: 24 percent of Māori and 36 percent of Pacific peoples live in the most deprived 10 percent of residential areas, and 41 percent of Māori and 57 percent of Pacific peoples live in the most deprived 20 percent of residential areas (NZDep2006).

Another association with socioeconomic status can be seen in the geographical breakdown of where the 126 family violence deaths occurred (Figure 4).⁶⁷ The rate in the Eastern region is the highest, followed by Northland and Bay of Plenty. These three areas are known to have the highest proportion of socioeconomic deprivation in the country.

⁶⁷ This is the police district where the deceased died. We must be cautious in comparing across New Zealand Police districts, however, because the numbers are small.

Figure 4: Family violence death rates (per 100,000 people per year) by police district* (with 95% CIs) (compared to the national rate), New Zealand, 2009–12



* See www.police.govt.nz/about-us/structure/districts for a map of New Zealand Police districts.

In the following sections of this chapter, the Committee will report across all 126 family violence deaths that fall within the Committee’s terms of reference in each of the following categories:⁶⁸

- IPV
- CAN
- IFV.

2.4 IPV deaths from 2009 to 2012

There were 63 IPV deaths in Aotearoa New Zealand from 2009 to 2012 (Figure 2 and Table 2). There were 9 additional IPV-related deaths connected to the 63 IPV deaths (offender suicides and a bystander death). There were, therefore, 72 IPV and IPV-related deaths in total. Only the 63 that fall within the Committee’s terms of reference are reported on here. There were also child deaths that took place in the context of IPV. These are discussed in section 2.5 under CAN deaths.

Nine (14 percent) of the IPV deaths occurred in the context of gang involvement (see Chapter 3, section 3.3.1).

2.4.1 Gender of deceased and offenders of IPV deaths

In IPV deaths, three-quarters of offenders were men and almost three-quarters of the deceased were women. Among the 46 female deceased, 44 (96 percent) were killed by their male intimate partner. Two women (4 percent) were killed by women. One of these killings occurred in a same-sex relationship.⁶⁹

⁶⁸ Appendix 3 contains a series of data tables where all forms of family violence death are reported together.

⁶⁹ The Committee recognises that same-sex family violence deaths are likely to be undercounted, as it may not have been known that the offender and victim were in a relationship.

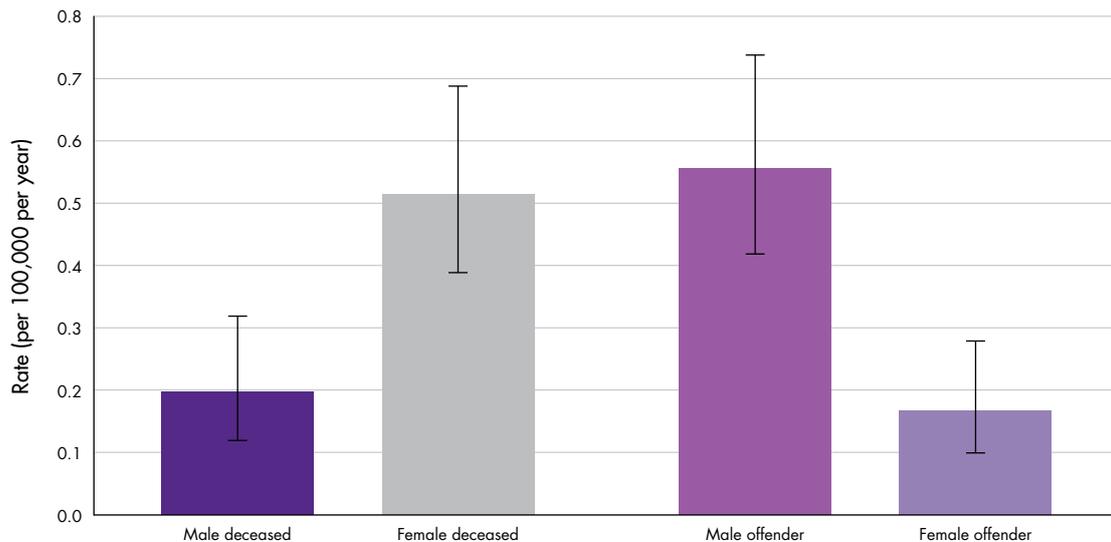
Among the 17 male deceased, 13 (76 percent) were killed by their female intimate partner. In four deaths (24 percent) men were killed by other men. Three of these men were killed by their female partner's ex-/new partner, and the offenders all had histories of abusing these women. In the remaining case, a man killed a male friend who had an affair with his wife.

Table 3: Gender-specific rates (per 100,000 people per year) for deceased and offenders in IPV deaths, New Zealand, 2009–12

GENDER	Total New Zealand population 2009–12 n=17,522,200		IPV deceased n=63			IPV offender n=63		
	n	%	n	%	rate	n	%	rate
Male	8,607,100	49.12	17	27	0.20	48	76	0.56
Female	8,915,100	50.88	46	73	0.52	15	24	0.17

IPV = intimate partner violence.

Figure 5: Gender-specific rates (per 100,000 people per year) for deceased and offenders in IPV deaths (with 95% CIs), New Zealand, 2009–12

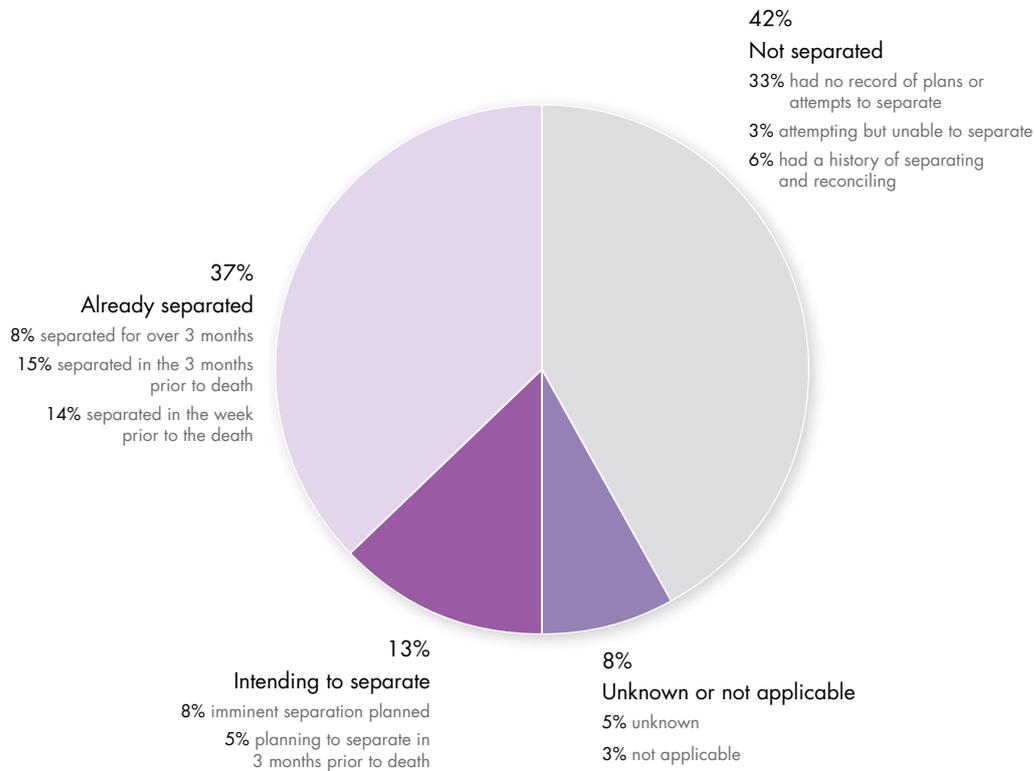


2.4.2 Relationship status at the time of the IPV death

Separation status at time of homicide

Of the 63 IPV deaths, police records suggested that 31 (50 percent) took place in the context of a planned or actual separation. For a further 21 (33 percent), there were no police records showing that the people involved were planning to separate. Six couples (9 percent) had a recorded history of separating and reconciling or the primary victim had attempted but was unable to separate (ie, had left multiple times but the predominant aggressor had always found where the primary victim had moved to).

Figure 6: Separation status for deceased and offenders in IPV deaths, New Zealand, 2009–12



IPV = intimate partner violence.

2.4.3 Abuse history in relationship and role in the IPV death⁷⁰

Section 3.1.2 contains an in-depth discussion about the importance of understanding who is the predominant aggressor or primary victim in the history of the relationship prior to the death. Table 4 shows the abuse history of the relationship before the 63 IPV deaths. In the 55 IPV deaths where information was available to determine who was the predominant aggressor and the primary victim in the abuse history,⁷¹ there were 41 cases involving a deceased female. In all these cases the woman was the primary or suspected primary victim. Forty of these women were killed by a male predominant or suspected predominant aggressor. One woman was killed by a female predominant aggressor.

Ten female primary or suspected primary victims killed a male predominant or suspected predominant aggressor. One male primary victim was killed by a female predominant aggressor.

Two new male partners were killed by their female partner's ex-partner, who had been the predominant aggressor in the relationship. One new male predominant aggressor was killed by his female partner's ex-male predominant aggressor (this woman had been abused by both men).

Of the 55 deaths where information about the abuse history was available:

- 51 (93 percent) involved female primary or suspected primary victims and 1 involved a male primary victim
- 53 (96 per cent) involved male predominant or suspected predominant aggressors and 2 involved female predominant aggressors.

⁷⁰ See Appendix 4 for the Committee's predominant aggressor and primary victim classification criteria for IPV deaths.

⁷¹ This analysis has been undertaken on the police family violence death review reports plus agencies' records from the regional reviews.

Table 4: Abuse history in the relationship and role in the death event of offenders in IPV deaths, New Zealand, 2009–12

ROLE OF OFFENDER IN THE RELATIONSHIP AND ROLE IN THE DEATH EVENT	IPV deaths n=63	
	n	%
Male predominant aggressors		
Male predominant aggressor kills female primary victim	32	51
Suspected male predominant aggressor kills suspected female primary victim	8	13
Male predominant aggressor kills female primary victim's new male partner	2	3
Male ex predominant aggressor of female primary victim kills new male predominant aggressor	1	2
Female primary victims		
Female primary victim kills male predominant aggressor	9	14
Suspected female primary victim kills suspected male predominant aggressor	1	2
Female predominant aggressor		
Female predominant aggressor kills male primary victim	1	2
Female predominant aggressor kills female primary victim	1	2
Aberrational cases[†]	2	3
Uncertain cases[‡]	6	10

IPV = intimate partner violence.

* Total percentages add up to 102 percent due to the effect of rounding to whole numbers.

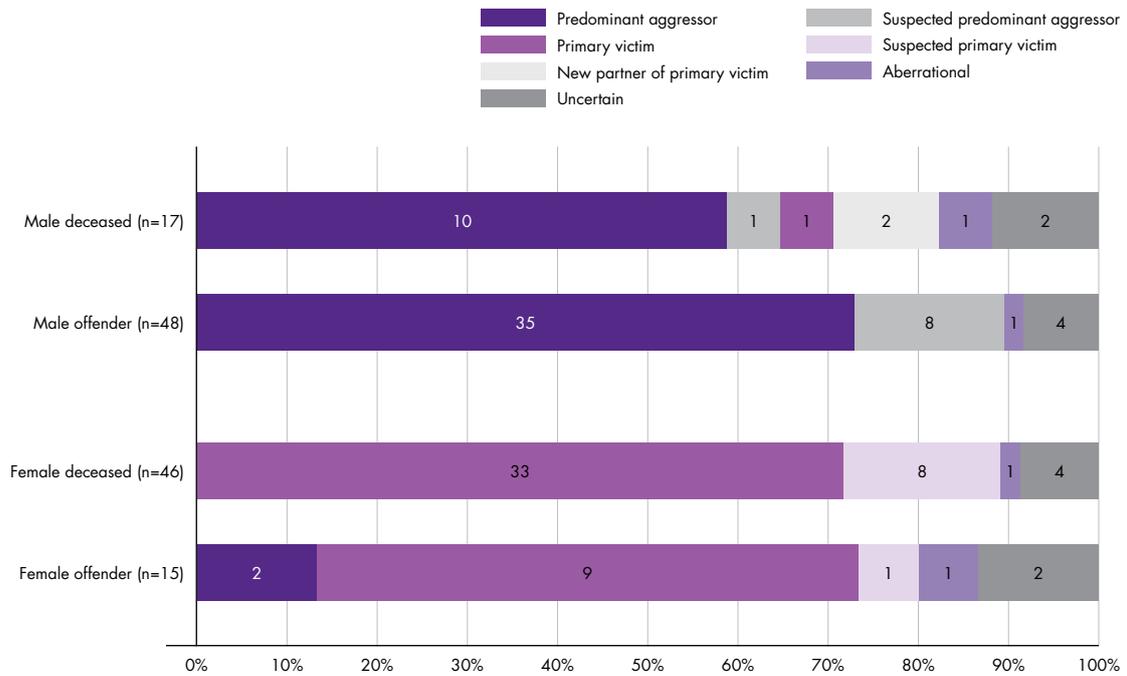
† Some cases have aberrational features. Whilst there may have been an intimate relationship between the offender and the deceased, the killing does not appear to be an act of family violence. For example, cases in which the offender appears to be a serial killer, or has killed for material gain. The Committee has labelled these as aberrational cases. Of the two aberrant IPV cases, one involved a male intimate partner killing a female intimate partner, and the other a female intimate partner killing a male intimate partner.

‡ For deaths in which a regional review has not been completed, the Committee does not have access to the full range of agency records for the families in question. As such, there are cases for which the Committee is unable to say whether there was a history of abuse. These cases are classified as 'uncertain', meaning that more information about the history between the couple would be necessary before it could be determined whether an abuse history is present and whether one party is the predominant aggressor in that history. Of the six uncertain cases, three involved male intimate partners killing their female intimate partner. One involved a female intimate partner killing a male intimate partner. Two further cases involved people who were not intimate partners; in one a man killed another man, and in the other a woman killed another woman.

The abuse history of both the deceased and the offender in the 63 IPV deaths is shown by gender in Figure 7.

The abuse histories of the 63 IPV deceased show that 65 percent were female primary or suspected primary victims, with only one male primary victim.

Figure 7: Abuse history in the relationship of deceased and offender in IPV deaths, New Zealand, 2009–12 (data derived from police records)*



IPV = intimate partner violence.

* There were 53 male predominant aggressors or suspected predominant aggressors who killed; one of these male predominant aggressors killed the new predominant aggressor of his ex-female primary victim. Hence there being a total of 54 male predominant aggressors or suspected predominant aggressors.

Abuse history and ethnicity of deceased and offender in IPV deaths

Forty-five percent of Māori deceased, all the Pacific peoples deceased and 75 percent of deceased other ethnicities were female primary or suspected primary victims. Māori men were over-represented as deceased predominant aggressors. Forty percent of all Māori deceased men were the predominant aggressor in the relationship compared to 5 percent of other ethnicities. The abuse history of 15 percent of Māori deceased was unknown and hence these results are likely to be an under-representation of the actual situation.

Table 5: Association between abuse history and ethnicity of deceased in IPV deaths, New Zealand, 2009–12*

DECEASED'S ABUSE HISTORY PRIOR TO THE HOMICIDE	Ethnicity of deceased									
	Deceased n=63		Māori n=20		Pacific peoples n=4		Other† n=37		Unknown n=2	
	n	%	n	%	n	%	n	%	n	%
Primary victims										
Female primary victim	33	52	7	35	4	100	22	59		
Female suspected primary victim	8	13	2	10	–		6	16		
Male primary victim	1						1			
Male suspected primary victim	–									
New male partner of female primary victim	2						2			
Predominant aggressors										
Female predominant aggressor	–									
Female suspected predominant aggressor	–									
Male predominant aggressor	10	16	8	40			2	5		
Male suspected predominant aggressor	1						1			
Excluded deaths										
Aberrational cases	2						2			
Uncertain cases	6		3	15			1		2	

* Percentages are not shown for small numbers unless required for the related text commentary.

† This includes NZ European, Asian, MELAA (Middle Eastern, Latin American or African) and all other ethnicities not including Māori and Pacific peoples.

Māori women were also over-represented as primary victims who were offenders in the death event (Table 6). Thirty-three percent of all Māori offenders were the female primary victim in the relationship compared to 8 percent of female primary victim offenders of other ethnicities.

Among Māori offenders, 55 percent were male predominant aggressors or suspected predominant aggressors compared to 71 percent of men from other ethnicities.

Table 6: Association between abuse history and ethnicity of offenders in IPV deaths, New Zealand, 2009–12*

OFFENDER'S ABUSE HISTORY PRIOR TO THE HOMICIDE	Ethnicity of offender									
	Deceased n=63		Māori n=18		Pacific peoples n=7		Other† n=37		Unknown n=1	
	n	%	n	%	n	%	n	%	n	%
Primary victims										
Female primary victim	9	14	6	33			3	8		
Female suspected primary victim	1						1			
Male primary victim	–									
Male suspected primary victim	–									
New male partner of female primary victim	–									
Predominant aggressors										
Female predominant aggressor	2						2			
Female suspected predominant aggressor										
Male predominant aggressor	34	54	8	44	5		21	57		
Male suspected predominant aggressor	8	13	2	11	1		5	14		
Male ex-predominant aggressor of female primary victim‡	1						1			
Excluded deaths										
Aberrational cases	2						2			
Uncertain cases	6		2		1		2		1	

* Percentages are not shown for small numbers unless required for the related text commentary.

† This includes Asian, MELAA (Middle Eastern, Latin American or African), NZ European and all other ethnicities not including Māori and Pacific peoples.

‡ This man killed the female primary victim's new male predominant aggressor.

2.4.4 Police recorded IPV history for IPV deaths

Table 7 considers the police recorded IPV history for the offenders and deceased (110 people in total) in the death event relationship and in their prior intimate relationships with other partners.

In the 55 deaths with a police recorded IPV history prior to the death event:⁷²

Primary victims

- 25 of the female primary or suspected primary victims (47 percent) were known to the police as IPV victims in the death event relationship
- 13 of the female primary or suspected primary victims (25 percent) were known to the police as IPV victims in their previous relationship(s)
- 5 of the female primary or suspected primary victims (9 percent) were known to the police as having been abused in both their death event relationship and their previous relationship(s).

⁷² The Committee is only reporting on the police recorded history in 55 cases because in the other 8 cases (6 uncertain and 2 aberrational) information on the police history in the case is not available. The Committee is therefore not able to state with certainty whether there was any history or not.

Predominant aggressors

- 25 of the male predominant or suspected predominant aggressors (46 percent) were known to the police as IPV offenders in the death event relationship
- 20 of the male predominant or suspected predominant aggressors (37 percent) were known to the police as IPV offenders in their previous relationship(s)
- 6 male predominant or suspected predominant aggressors (11 percent) had a known history of abusing their current and previous partner(s).⁷³

A more detailed examination of the cases in Table 7 shows that 13 female primary or suspected primary victims and 12 male predominant or suspected predominant aggressors (23 percent of the people involved) had no police recorded history of IPV.

Table 7: Police recorded IPV history of deceased and offenders of IPV deaths, New Zealand, 2009–12

DECEASED/OFFENDERS	Police recorded IPV history in death event relationship			Police recorded IPV history in previous relationships				
	No	Yes		No	Yes			
Death events n=55 People n=110	No records	PV	PA	No records	PV Victim to one	PV Multiple abusive partners (two or more)	PA Abused one previous partner	PA Abused multiple partners (two or more)
Primary or suspected primary victims								
Female n=51	27	24 [#]	0	36* 1 unknown	10	3		1
Male n=1			1					
Female PV [†] whose new male partner was killed by ex male PA n=2	1	1		2				
Predominant or suspected predominant aggressors								
Female n=2	1	1		2				
Male n=52	26		24	32 [‡]			14	6 [§]
Male kills PV's new partner n=2	1		1	2				
Excluded death events and people								
Aberrational death events n=2 People n=4								
Uncertain death events n=6 People n=12								

PV = primary victim(s).

PA = primary aggressor(s).

* This includes many victims who had been in long-term abusive relationships with the same abusive partner for many years, as well as some female migrants and refugees to Aotearoa New Zealand, where it is unknown whether there was a police history of abuse by previous partners in their country of origin.

† In this context, this table refers to the police history of the female primary victim and the ex-predominant aggressor.

‡ Some of these men were migrants and refugees to Aotearoa New Zealand, so any police abuse history of previous partners in their country of origin is unknown.

§ This includes one predominant aggressor who killed another predominant aggressor. They had both abused the same primary victim and one had abused three other intimate partners.

Grey highlight indicates key trends.

73 A study undertaken by the New Zealand domestic violence agency Shine on 513 domestic abuse victims who reported to the Auckland City Police District in the month of December 2009, found that 61 percent had prior domestic violence reports to the Auckland City District Police in the previous five years. There were 188 people (35 percent) who experienced between two and four previous occurrences, 92 people (18 percent) had experienced 5–9 occurrences and 42 people (8 percent) had experienced 10–20 occurrences. J. Drumm and C. Moss, *Domestic Violence Victimisations in the Police Auckland City*, Auckland, Shine, 2014. New Zealand Police states that only 18–25 percent of all domestic violence cases are reported to police: as such the findings of this study significantly under-represent the actual incidence of re-victimisation in domestic violence cases.

2.4.5 Method of killing and abuse history of the offender of IPV deaths

In 28 (44 percent) of the 63 IPV deaths, the method of killing was the phenomenon identified in international research as 'overkill'^{74,75} (Table 8). Overkill involves the use of violence far beyond what would be necessary to cause death and encompasses multiple stabbings and/or multiple forms of violence. Male predominant aggressors were involved in 26 (93 percent) of the 28 overkill deaths, whereas only one overkill death involved a female predominant aggressor. The remaining overkill death involved a man killing another man. By way of contrast, in 80 percent of the cases where a female primary victim killed the male predominant aggressor a knife was used to inflict one or sometimes two stab wounds.

Table 8: Association between method of killing and abuse history of offenders in IPV deaths, New Zealand, 2009–12

ABUSE HISTORY OF OFFENDER AND ROLE IN DEATH EVENT	Number of deaths n=63	Method of killing						
		Shot	Stabbed (one or two times)	Set on fire	Assault/Assault with a weapon [†]	Strangulation	Overkill	Other [‡]
Male predominant aggressor kills female primary victim	40	7	1	2	1	3	24	2
Male predominant aggressor kills female primary victim's new male partner	3				1		2	
Female primary victim kills male predominant aggressor	10	1	8 [#]		1			
Female predominant aggressor kills primary victim	2				1		1	
Excluded deaths								
Aberrational cases	6	1	3	1			1	
Uncertain cases	2					1		1

* Known predominant aggressors have been combined with suspected predominant aggressors and known primary victims have been combined with suspected primary victims.

† A weapon other than a gun or a knife.

‡ This includes deaths, such as a forced drowning or poisoning.

Grey highlight indicates the method of killing that was most common.

In the 28 overkill deaths:

- One form of violence (assault or stabbing) was used in 16 (57 percent) of the deaths.
 - Two deaths involved the deceased receiving multiple injuries caused by being beaten, punched, kicked and stomped on.
 - Six deaths involved the deceased being seriously assaulted multiple times with a weapon⁷⁶ all over the body and/or to the head.
 - Eight deaths involved the deceased being stabbed in multiple parts of their body (two deceased were stabbed 3–7 times, two deceased were stabbed 11–12 times, three deceased were stabbed 17–26 times and one deceased was stabbed 50+ times).

⁷⁴ See glossary of terms for the definition of 'overkill' as used in this report.

⁷⁵ Roehl et al state that overkill was first described by Wolfgang in 1958 as two or more acts of shooting or stabbing or beating the victim to death. They reference several North American studies, which found that the majority (46–90 percent) of women in intimate partner homicides are the victims of overkill, compared to 12 percent or less of males. J. Roehl et al., *Intimate Partner Violence Risk Assessment Validation Study*, NIJ 2000WTVX0011, US Department of Justice, 28 March 2005, p. 13.

⁷⁶ Weapons used in the different cases included an iron bar, a baseball bat, a garden ornament, an axe and chair legs.

- Two forms of violence were used in seven (25 percent) of the cases.
 - Four deaths involved the deceased being seriously assaulted over their body including the head (up to 26 injuries) and being stabbed (3–18 times).
 - In one case the deceased was stabbed and shot.
 - In one case the deceased was assaulted and experienced another form of violence.⁷⁷
 - In one case the deceased was stabbed (30+ times) and experienced another form of violence.
- Three forms of violence were used in four (14 percent) of the deaths.
 - Two deaths involved the deceased being assaulted all over their body, being stabbed 4–8 times and an act of strangulation.
 - In two deaths the deceased was assaulted, stabbed (3–36 times) and experienced another form of violence.
- Four forms of violence were used in one death.
 - The deceased was stabbed, strangled, set on fire and experienced another form of violence.

2.4.6 Outcomes for offenders of IPV deaths

Of the 63 offenders, eight committed suicide at the time of the death event (Table 9) and were therefore not subject to prosecution. Of the remaining offenders, 31 out of the 55 (56 percent) were found guilty of murder and sentenced, while 10 (18 percent) were found guilty of manslaughter plus other charges and sentenced. For eight of the deaths, the suspected offender is still being processed by the legal system and a final outcome is pending. In three of the cases, the offender was acquitted (by reason of insanity⁷⁸ or self-defence), but was still understood to have been responsible for the killing. For two deaths, the person responsible for the killing has not yet been charged but for each case the offender was most likely an intimate partner and so has been included as such in this report.

Table 9: Outcome for offenders in IPV deaths, New Zealand, 2009–12

OUTCOMES		IPV n=63	
		n	%
Legal outcome	Murder	31	49
	Manslaughter/Other charges	10	16
	Acquitted	3	5
Suicide		8	13
Unresolved/Outcome pending		8	13
Other		1	2
Unknown		2	3

IPV = intimate partner violence.

⁷⁷ Another form of violence includes being bound/restrained and/or body mutilation, or the deceased being sexually assaulted.

⁷⁸ This was one of the IPV overkill deaths. Of the remaining 27 overkill deaths, 3 were murder-suicides so there was no resulting prosecution, 20 offenders were convicted of murder, 1 was convicted of manslaughter, 2 cases are still progressing through the courts and in 1 case the offender has fled the country.

2.4.7 IPV murder-suicides and attempted murder-suicides

Twelve (19 percent) of the 63 IPV deaths involved a suicide or attempted suicide. All those who committed or attempted suicide were men. In 7 of the 12 deaths, a male predominant or suspected predominant aggressor, who had killed a female primary or suspected primary victim, also committed suicide. In a further four deaths, a male predominant or suspected predominant aggressor attempted suicide after killing a female primary or suspected primary victim. In the remaining death event, a male partner killed his female partner and then committed suicide. It is uncertain what the abuse history was in this relationship.

2.4.8 Ethnicity, age, gender and socioeconomic status of IPV deceased and offenders

Ethnicity

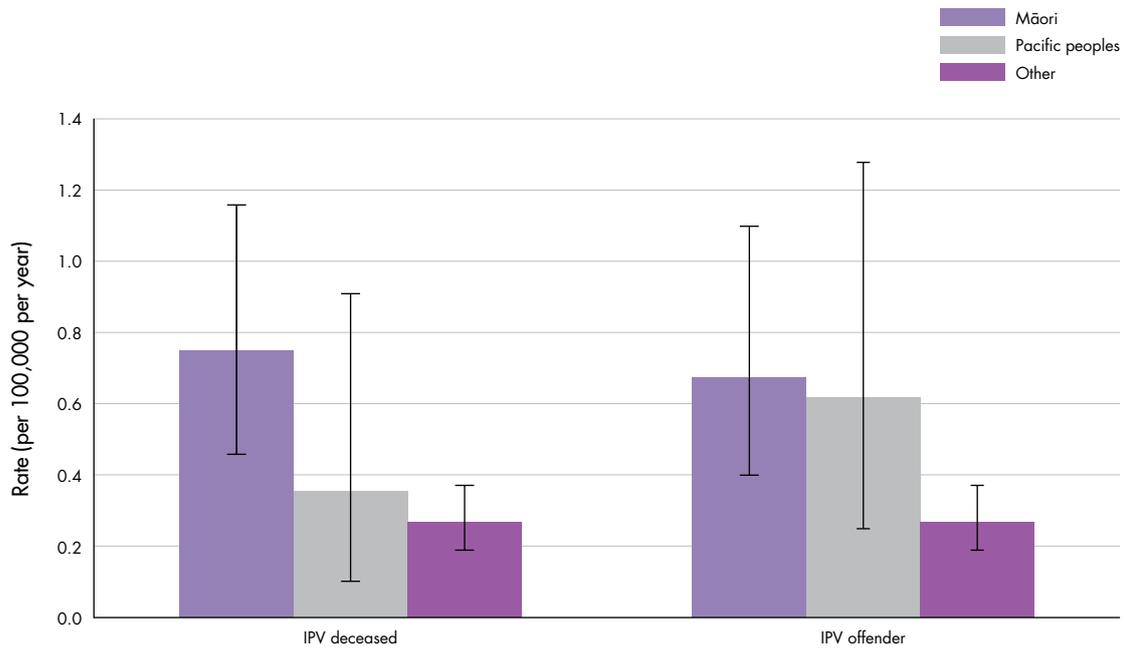
Māori were significantly more likely (2.8 times) to be the deceased of an IPV death event and significantly more likely (2.5 times) to have been the offender when compared to those of other (non-Pacific) ethnicities. The primary victim-predominant aggressor analysis (Table 6) provides further context for this, showing that all the Māori women who were offenders in the death event were the primary victims in the abuse history of the relationship.

Table 10: Ethnic-specific rates (per 100,000 people per year) for deceased and offenders in IPV deaths, New Zealand, 2009–12

PRIORITISED ETHNICITY	Total New Zealand population 2009–12 n=17,522,000		IPV deceased n=63			IPV offender n=63		
	n	%	n	%	rate	n	%	rate
Māori	2,659,700	15.18	20	32	0.75	18	29	0.68
Pacific peoples	1,128,100	6.44	4	6	0.35	7	11	0.62
Other	13,734,200	78.38	37	59	0.27	37	59	0.27
Unknown			2	3		1	2	

IPV = intimate partner violence.

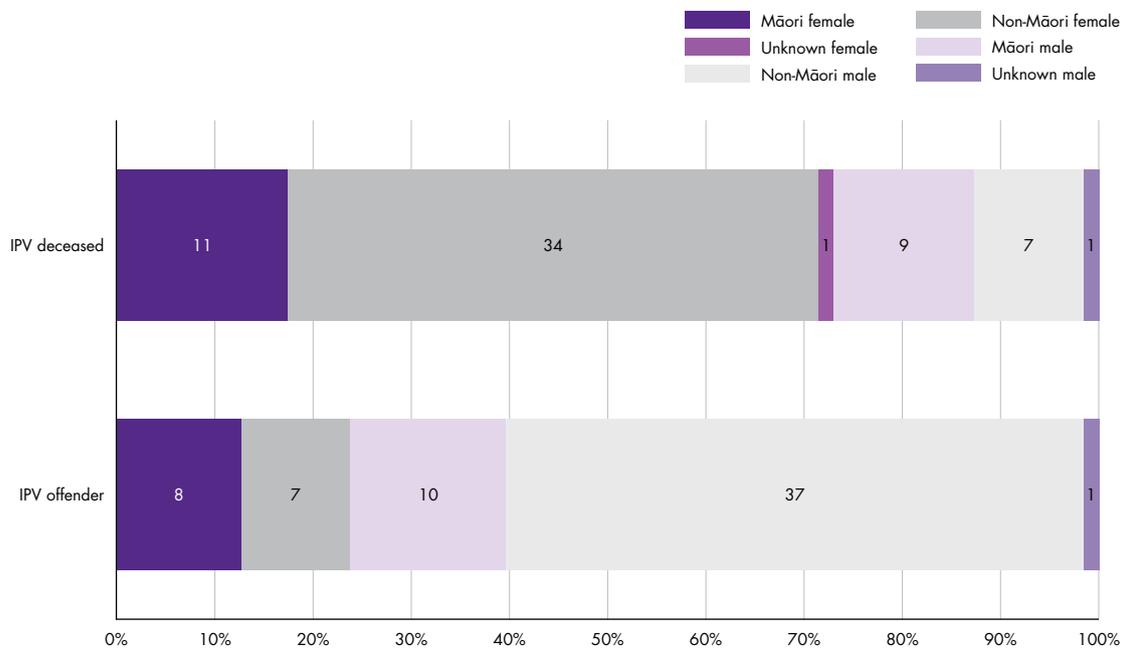
Figure 8: Ethnic-specific rates (per 100,000 people per year) for deceased and offenders in IPV deaths (with 95% CIs), New Zealand, 2009–12



IPV = intimate partner violence.

Association between gender and ethnicity of IPV deaths

Figure 9: Gender and ethnicity of deceased and offenders in IPV deaths, New Zealand, 2009–12



IPV = intimate partner violence.

Age of IPV deceased and offenders

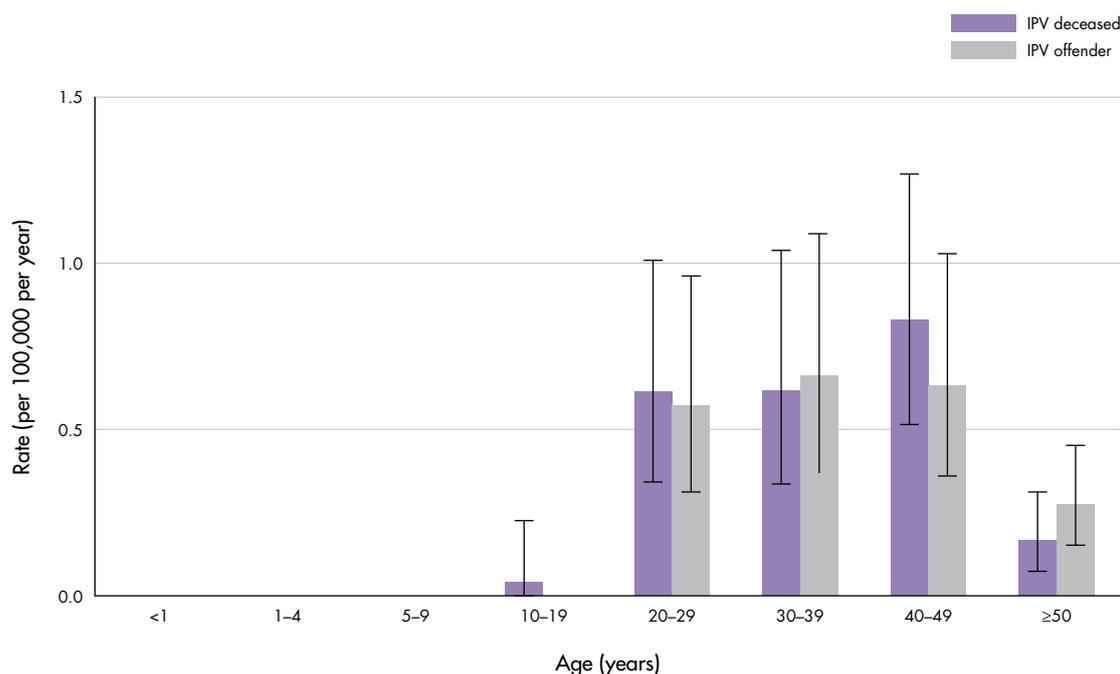
In IPV deaths most deceased were aged from 20 to 49, with significantly fewer either below or above these ages. Offenders ranged in age from 20 to 50 years and beyond (Table 11).

Table 11: Age-specific rates (per 100,000 people per year) for deceased and offenders in IPV deaths, New Zealand, 2009–12

AGE	Total New Zealand population 2009–12 n=17,522,200		IPV deceased n=63			IPV offender n=63		
	n	%	n	%	rate	n	%	rate
<10 years	2,396,560	13.68	–			–		
10–19 years	2,450,360	13.98	1	2	0.04			
20–29 years	2,439,990	13.93	15	24	0.61	14	22	0.57
30–39 years	2,264,920	12.93	14	22	0.62	15	24	0.66
40–49 years	2,525,760	14.41	21	33	0.83	16	25	0.63
≥50 years	5,444,480	31.07	9	14	0.17	15	24	0.28
Unknown			3	5		3	5	

IPV = intimate partner violence.

Figure 10: Age-specific rates (per 100,000 people per year) for deceased and offenders in IPV deaths (with 95% CIs), New Zealand, 2009–12

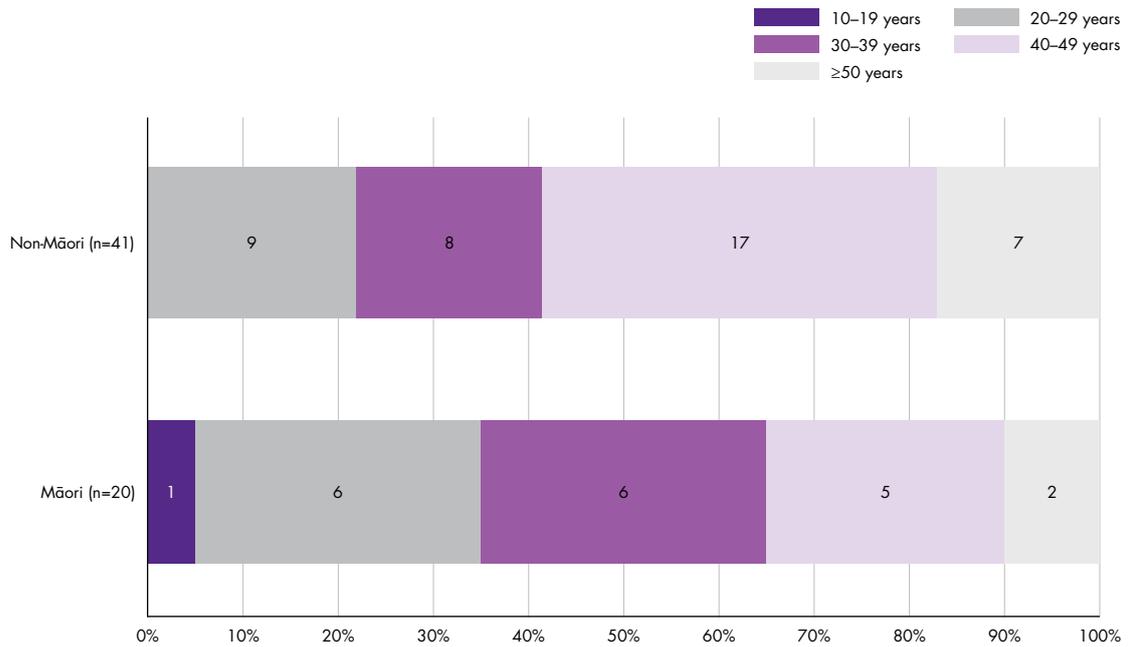


IPV = intimate partner violence.

Association between age and ethnicity of IPV deceased

Of the 63 IPV deceased, 46 were women and 17 were men. In Figure 11, men and women deceased are included together because numbers of men were small. There were four Pacific peoples deceased and so these are included with non-Māori deceased. The distribution of age of the deceased in IPV is skewed more towards younger deaths among Māori than non-Māori, with more Māori killed under the age of 40 compared to 40 years and older. This may be explained by the age distribution of the Māori population as a whole rather than indicating that the risk of death is higher among younger Māori.

Figure 11: Age and ethnicity of deceased in IPV deaths, New Zealand, 2009–12*

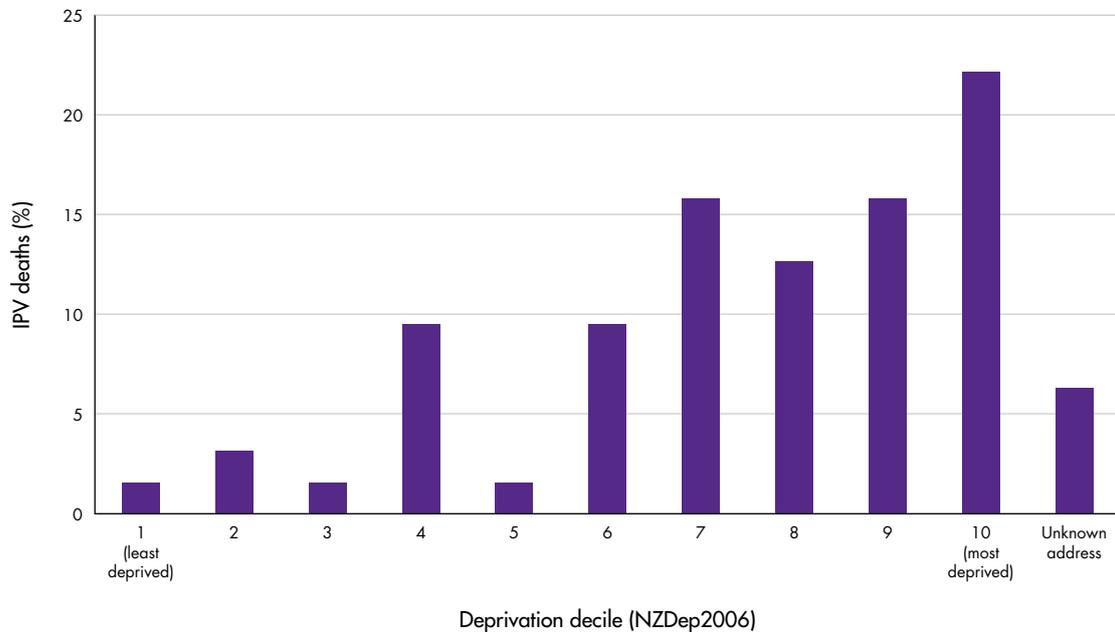


IPV = intimate partner violence.

* The ethnicity and age are unknown for two deceased and hence these cases have been excluded from Figure 11.

Socioeconomic status of IPV deceased

Figure 12: Deprivation decile (NZDep2006) of deceased in IPV deaths, New Zealand, 2009–12



IPV = intimate partner violence.

2.5 CAN deaths from 2009 to 2012

There were 37 CAN deaths in Aotearoa New Zealand from 2009 to 2012 (Figure 2 and Table 2).

2.5.1 Association between death type and relationship of the deceased and offender

Table 12: Associations between death type and relationship of offender to deceased in CAN deaths, New Zealand, 2009–12

DEATH TYPE	Number of CAN death events n=34	Number of CAN child deaths associated with death events n=37	Offender role n=34				
			Mother n=13	Father n=7	Step-father n=9	Female caregiver n=3	Unknown n=2
Fatal inflicted injury	19	19	1	4	9	3	2
Filicide and parental suicide*	8	11	5	3			
Neonaticide	4	4	4				
Fatal neglectful supervision	3	3	3				

CAN = child abuse and neglect.

* Includes one filicide and suspected attempted suicide.

Fatal inflicted injury

There were 19 children who died by assault. Twelve died because of a head injury, five died of blunt force trauma to the abdomen or chest causing rupture or laceration of an internal organ, one died with both abdominal and head injuries and one was strangled. The people responsible for the assaults were:

- a step-father in nine cases
- a biological parent in five cases (four fathers and one mother)
- another female carer in three cases (a grandmother, an aunt and an informal caregiver).

In two remaining cases, the offender has not been identified but the injuries are thought to be inflicted rather than accidental.

Fourteen of the deceased children (74 percent) were Māori, three were Pacific peoples (16 percent) and two were other ethnicities.

Five (26 percent) of these deaths occurred in the context of gang involvement.

Filicide with parental suicide

There were eight cases of filicide with parental suicide from 2009 to 2012 (this includes one filicide with a suspected attempted suicide). Five cases involved the death of just one child whilst three resulted in the death of two children. In one case, the mother was also pregnant when she committed suicide. The deceased children ranged in age from 3 months to 13 years. All the parents involved were biological parents: three fathers and five mothers. Five were New Zealand European, one was Māori and two were recent immigrants to Aotearoa New Zealand.

Neonaticide

There were four cases of neonaticide, all involving biological mothers who killed newborns either actively or by neglect.

Fatal neglectful supervision

Three child deaths were thought to relate to neglectful parental supervision. Two infants died while unsupervised in the bath. A further child died of poisoning due to neglect.

2.5.2 Association between death type and age of the deceased

The first five years of life were the most vulnerable time for children with 12 (32 percent) of all CAN deaths occurring before the age of one and 29 (78 percent) before the age of five.

Table 13: Associations between death type and age of deceased in CAN deaths, New Zealand, 2009–12

DEATH TYPES	Number of CAN deaths n=37	Age of deceased at death n=37				
		≤1 month n=4	1–12 months n=8	1–4 years n=17	5–9 years n=4	10–17 years n=4
Fatal inflicted injury	19	–	6	11	1	1
Filicide and parental suicide	12	–	1	5	2	3
Neonaticide	4	4	–	–	–	–
Fatal neglectful supervision	3	–	1	1	1	–

CAN = child abuse and neglect.

2.5.3 Known history of CAN for deceased and offenders

CAN fatal inflicted injury deaths with a police reported history of IPV

In 8 (47 percent) of the 17 fatal inflicted injury deaths (where the offender was known), the father/step-father, or the male partner of the female caregiver was known to the police for abusing the mother of the child or the female caregiver. Three of the step-father offenders were known to the police for abusing three or more intimate partners. (See section 3.1.3 for further discussion on how IPV and CAN are entangled forms of abuse.)

Table 14: IPV police history of offenders in CAN fatal inflicted injury deaths, New Zealand, 2009–12

FATAL INFLICTED INJURY OFFENDERS	Police IPV recorded history in current CAN death event relationship			Police recorded IPV history in previous relationships				
	No	Yes		No	Yes			
Death events n=17	No records	PV	PA	No records	PV One abusive partner	PV Multiple abusive partners (two or more)	PA Abused one previous partner	PA Abused multiple partners (three or more)
Offenders – step-fathers and fathers								
Step-father offenders n=9	6		3	5			1	3 [#]
Offender's female partner/ Mother of child n=9	6	3		5	2	2		
Father offender n=4	1		3	3			1	
Male offender's female partner/Mother of child n=4	1	3		2	2			
Offenders – female caregiver and mother								
Female caregiver and mother offenders n=4	2	2		2	2			
Female offender's male partner n=4	2		2	3			1	
Excluded death events and people								
Unknown n=2								

IPV = intimate partner violence.

CAN = child abuse and neglect.

Grey highlight identifies serial IPV offending.

Histories of intergenerational abuse and harmful patterns of relating were evident in the fatal inflicted injury deaths. For example, of the nine step-children fatally assaulted by their step-father:⁷⁹

- Seven step-fathers were known to family and friends to be abusing their intimate partner, the mother of the deceased child. In three cases, family members and friends contacted the police, CYF or a GP about the IPV.
- For eight step-children, family or practitioners had child protection concerns before the death. In five of these cases these concerns were reported to CYF.
- Six step-children's siblings had been notified to CYF due to child protection concerns before the death event.
- Four step-fathers were known or suspected to have abused previous children. In all cases prior reports had been made to the police or CYF.
- Four step-fathers had a police recorded history of abusing previous intimate partners. For three, this was against three or more intimate partners.
- Four step-fathers were known to CYF as having experienced multiple forms of CAN as children.

⁷⁹ This analysis has been undertaken on the police family violence death review reports plus agencies' records from the regional reviews.

CAN deceased known to Child, Youth and Family

Forty-six percent of children killed in CAN deaths had a CYF history.

Table 15: CYF record of deceased in CAN deaths, New Zealand, 2009–12

DECEASED	CAN deaths n=37	
	n	%
Yes	17	46
No	20	54

CAN = child abuse and neglect.

2.5.4 Outcomes for offenders of CAN deaths

Of the 34 offenders, 7 (20 percent) committed suicide at the time of the death and could not be prosecuted. Of the 27 remaining offenders:

- 9 (26 percent) were found guilty of murder and sentenced
- 10 (29 percent) were found guilty of manslaughter plus other charges
- for two of the deaths, the suspected offender is still being processed by the courts and a final outcome is pending
- for six deaths, the person responsible for the killing has not yet been charged but for each case the offender was most likely a family member and so has been included as such in this report.

Table 16: Outcomes for offenders in CAN deaths, New Zealand, 2009–12

OUTCOMES		CAN deaths n=34	
		n	%
Legal outcome	Murder	9	26
	Manslaughter/Other charges	10	29
	Acquitted	0	0
Suicide		7	21
Unresolved/Outcome pending		2	6
Unknown		6	18

CAN = child abuse and neglect.

2.5.5 Children impacted by family violence

Child survivors of IPV and CAN deaths

In 54⁸⁰ (86 percent) of the IPV death events, there were children or step-children from the current or previous relationships. In total, 164 children or step-children lost a parent (Table 17). Some lost two parents (in the case of the eight IPV murder-suicides). In addition, there were 34 CAN death events involving 37 deaths. In 28⁸¹ (82 percent) of these CAN death events, the deceased child/ren had siblings or half-siblings. In total, 52 children lost a sibling or half-sibling. In addition there were 21 children of the offenders who were not siblings or half-siblings of the child/ren who died (Table 17).

80 In six cases, there were no known children or step-children involved and in the remaining three cases it is unknown whether there were children involved.

81 In four cases, there were no known siblings or half-siblings and in two cases it is unknown whether there were siblings or half-siblings involved.

In the four years from 2009 to 2012, there were 240 child survivors (either children, step-children, siblings, half-siblings or step-siblings) from the 82 IPV and CAN death events with children involved. This total includes the three half-siblings born after CAN death events, where the mother of the deceased child was pregnant at the time of the death.

Table 17: Child survivors of IPV and CAN death events, New Zealand, 2009–12

AGE	Total number of survivors n=237*	Child survivors of IPV n=164			Child survivors of CAN n=73	
		Children of the relationship n=60	Children from previous relationships† n=104	Siblings of deceased child/ren n=18	Half-siblings of deceased child/ren‡ n=34	Other children of the offender§ n=21
Children – under 17 years of age		48	40	18	34	21
Young people – 17 to 24 years of age		9	39	–	–	–
Adult children – 25 years+		3	25	–	–	–

IPV = intimate partner violence.

CAN = child abuse and neglect.

* In three cases, the mother of the deceased child was pregnant at the time of the death and three half-siblings were born after the death event. This brings the total to 240 surviving children.

† This includes other children of the offender who are not siblings or half-siblings of the deceased child.

‡ From mother's/father's current or previous partnerships.

§ Not siblings or half-siblings. These include children from previous relationships.

Children normally resident in the household of IPV and CAN deaths

There were 54 children and 11 young people who were normally resident in the household with one or both of the deceased and the offender in the IPV cases. There were 45 children and 1 young person who were normally resident in the household with the child/ren who were killed (Table 18). These 111 children and young people were likely exposed to at least some, and often many, of the repeated episodes of family violence that preceded the fatal event.

Table 18: Children normally resident in the household of IPV and CAN death events, New Zealand, 2009–12

AGE	Total number of children normally resident n=111	Children normally resident in household of IPV death events n=65	Children normally resident in household of CAN death events n=46
Children – under 17 years of age	99	54	45
Young people – 17 to 24 years of age	12	11	1
Adult children – 25 years+	–	–	–

IPV = intimate partner violence.

CAN = child abuse and neglect.

Children present at the IPV and CAN deaths

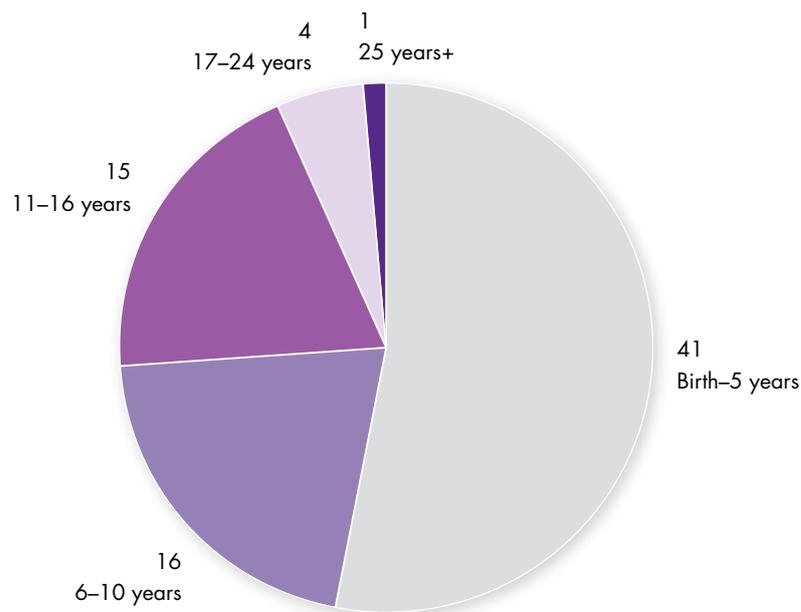
In 22 of the 63 IPV death events, there were 40 children present.⁸² In addition, in 21 of the CAN death events there were 37 children who were present at the death event or who found the deceased (Table 19). Forty-one (53 percent) of these 77 children were under five years of age (Figure 13).

Table 19: Children present at IPV and CAN death events, New Zealand, 2009–12

AGE	Total number of children present n=77	Children present at IPV death events n=40	Children present at CAN death events n=37
Children – under 17 years of age	73	36	36
Young people – 17 to 24 years of age	3	3	1
Adult children – 25 years+	1	1	–

IPV = intimate partner violence.
CAN = child abuse and neglect.

Figure 13: Age of children present at IPV and CAN death events, New Zealand, 2009–12



IPV = intimate partner violence.
CAN = child abuse and neglect.

2.5.6 Ethnicity, age, gender and socioeconomic status of CAN deceased and offenders

Gender of CAN deceased and offenders

Female children made up 62 percent of the deceased in the CAN deaths and 38 percent were male children. These children were equally likely to be killed by females as by males. As discussed in section 2.5.1, male offenders were more likely to kill children by fatal inflicted injury (76 percent of all fatal inflicted injury deaths, where the offender is known,⁸³ had male offenders) whereas female offenders were more likely to kill children by neonaticide, filicide and parental suicide or fatal neglectful supervision (80 percent of all these death types had female offenders).

⁸² Only two of these deaths involved children being present when a step-parent was killed. In two other events, the children or siblings present were related to the offender, not the deceased.

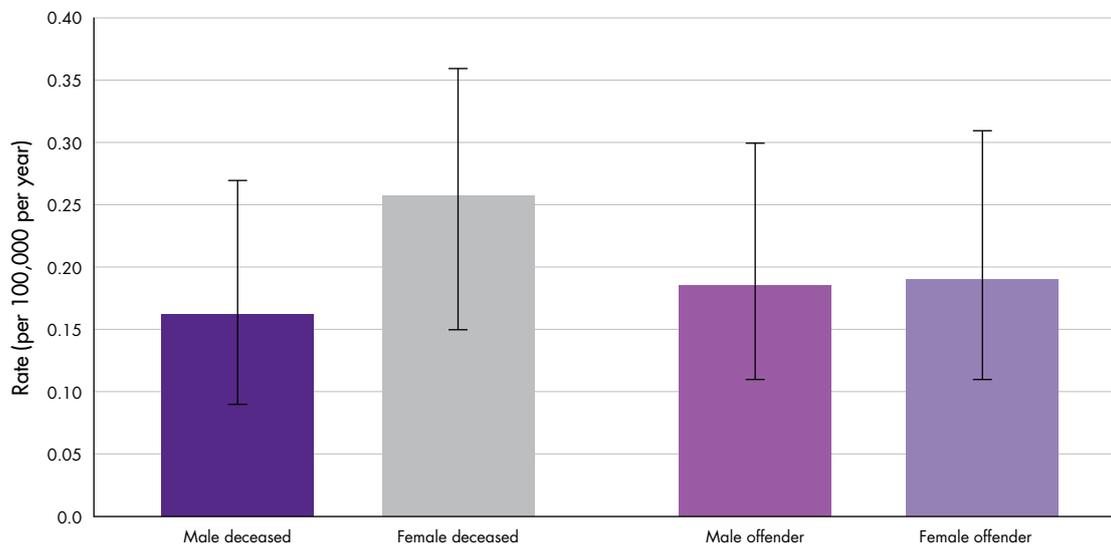
⁸³ In 2 of the 19 fatal inflicted injury deaths the offender is not known.

Table 20: Gender of deceased and offenders in CAN deaths, New Zealand, 2009–12

GENDER	Total New Zealand population 2009–12 n=17,522,000		CAN deceased n=37			CAN offender n=34		
	n	%	n	%	rate	n	%	rate
Male	8,607,100	49.12	14	38	0.16	16	47	0.19
Female	8,915,100	50.88	23	62	0.24	17	50	0.19
Unknown						1	3	

CAN = child abuse and neglect.

Figure 14: Gender-specific rates (per 100,000 people per year) for deceased and offenders in CAN deaths (with 95% CIs), New Zealand, 2009–12



CAN = child abuse and neglect.

Ethnicity of CAN deceased and offenders

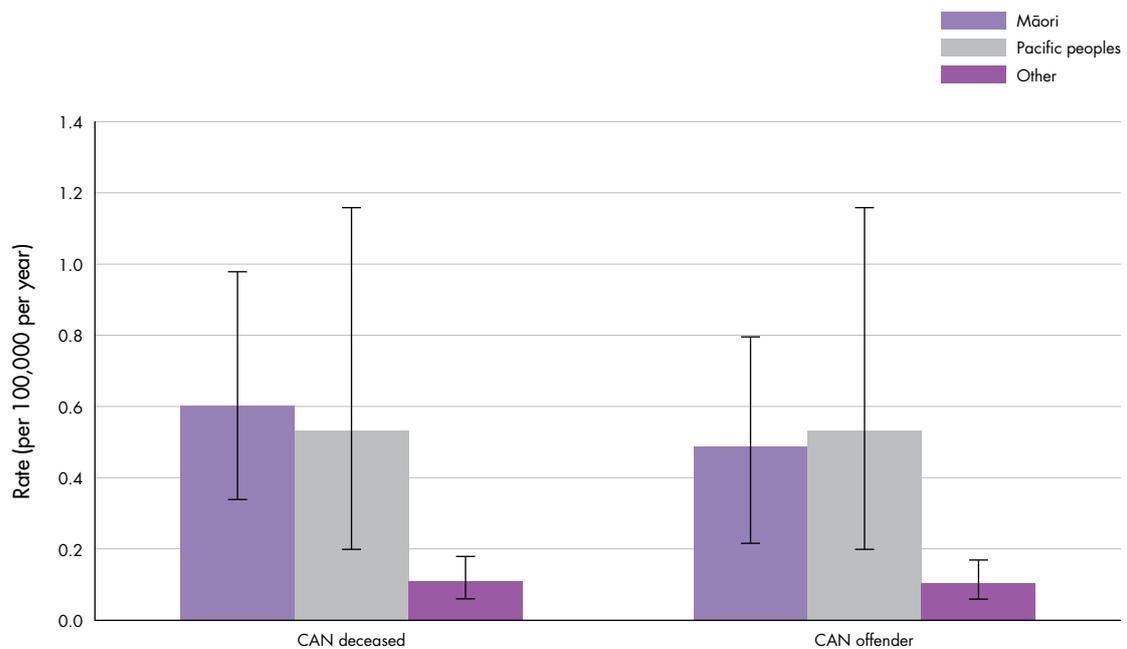
There are significant differences in the ethnicity of the deceased and offenders (Table 21 and Figure 15) in CAN deaths. Māori children were 5.5 times more likely, and Pacific children were 4.8 times more likely to die from CAN than children of other ethnicities. Similarly, Māori adults were 4.9 times more likely and Pacific adults were 5.3 times more likely to be responsible for CAN deaths than adults of other ethnicities.

Table 21: Ethnic-specific rates (per 100,000 people per year) for deceased and offenders in CAN deaths, New Zealand, 2009–12

PRIORITISED ETHNICITY	Total New Zealand population 2009–12 n=17,522,000		CAN deceased n=37			CAN offender n=34		
	n	%	n	%	rate	n	%	rate
Māori	2,659,700	15.18	16	43	0.60	13	38	0.49
Pacific peoples	1,128,100	6.44	6	16	0.53	6	18	0.53
Other	13,734,200	78.38	15	41	0.11	14	41	0.10
Unknown						1	3	

CAN = child abuse and neglect.

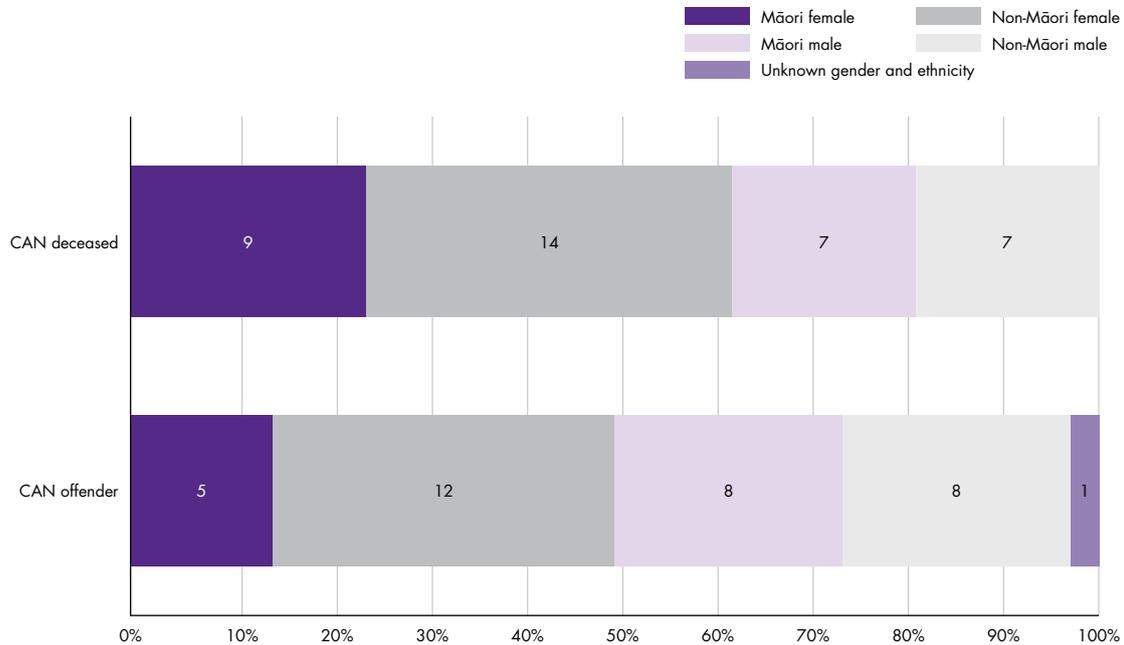
Figure 15: Ethnic-specific rates (per 100,000 people per year) for deceased and offenders in CAN deaths (with 95% CIs), New Zealand, 2009–12



CAN = child abuse and neglect.

Association between gender and ethnicity of CAN deaths

Figure 16: Gender and ethnicity of deceased and offenders in CAN deaths, New Zealand, 2009–12



CAN = child abuse and neglect.

Age of CAN deceased and offenders

In CAN deaths, most (78 percent) of the deceased were aged under five years of age. Children killed were most often killed by adults aged 20–29 years (Table 22).

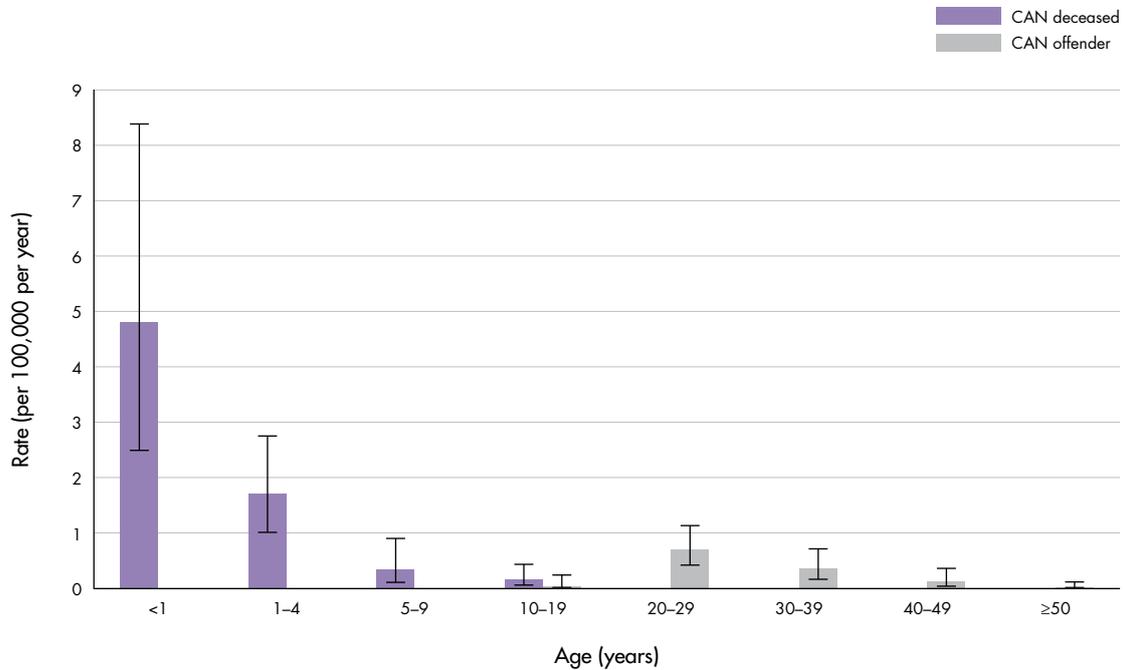
Table 22: Ethnic-specific rates (per 100,000 people per year) for deceased and offenders in CAN deaths, New Zealand, 2009–12

AGE	Total New Zealand population 2009–12 n=17,522,000		CAN deceased n=37			CAN offender n=34		
	n	%	n	%	rate	n	%	rate
<1 year	250,220	1.43	12	32	4.80			
1–4 years	992,600	5.66	17	46	1.71			
5–9 years	1,153,740	6.58	4	11	0.35			
10–19 years	2,450,360	13.98	4	11	0.16	1	3	0.04
20–29 years	2,439,990	13.93				17	50	0.70
30–39 years	2,264,920	12.93				8	24	0.35
40–49 years	2,525,760	14.41				3	9	0.12
≥50 years	5,444,480	31.07				1	3	0.02
Unknown						4	12	

CAN = child abuse and neglect.

Children under one year of age die at an approximately three-fold higher rate of CAN compared to those aged 1–4 years and a 14-fold higher rate than among children aged 5–9 years (Figure 17).

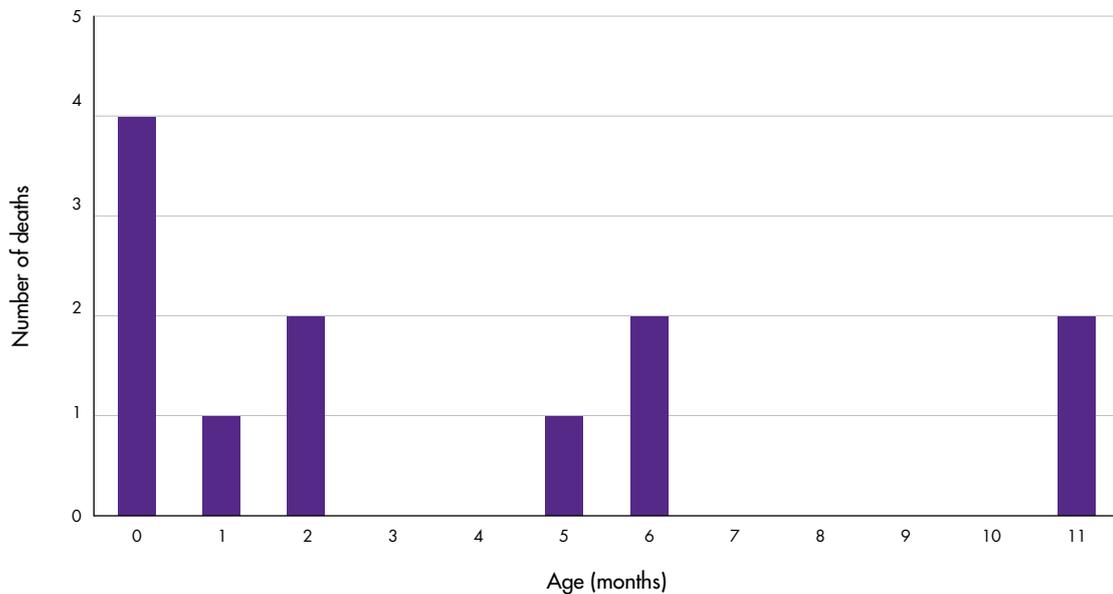
Figure 17: Age-specific rates (per 100,000 people per year) for deceased and offenders in CAN deaths (with 95% CIs), New Zealand, 2009–12



CAN = child abuse and neglect.

Figure 18 illustrates the age in months of deceased children under one year of age in Aotearoa New Zealand from 2009 to 2012. Although numbers are small, more children were killed in the first month of life than in any other month of life. All four deaths in the first month of life were neonaticides.

Figure 18: Age at death (in months) of children killed in the first year of life in CAN deaths, New Zealand, 2009–12

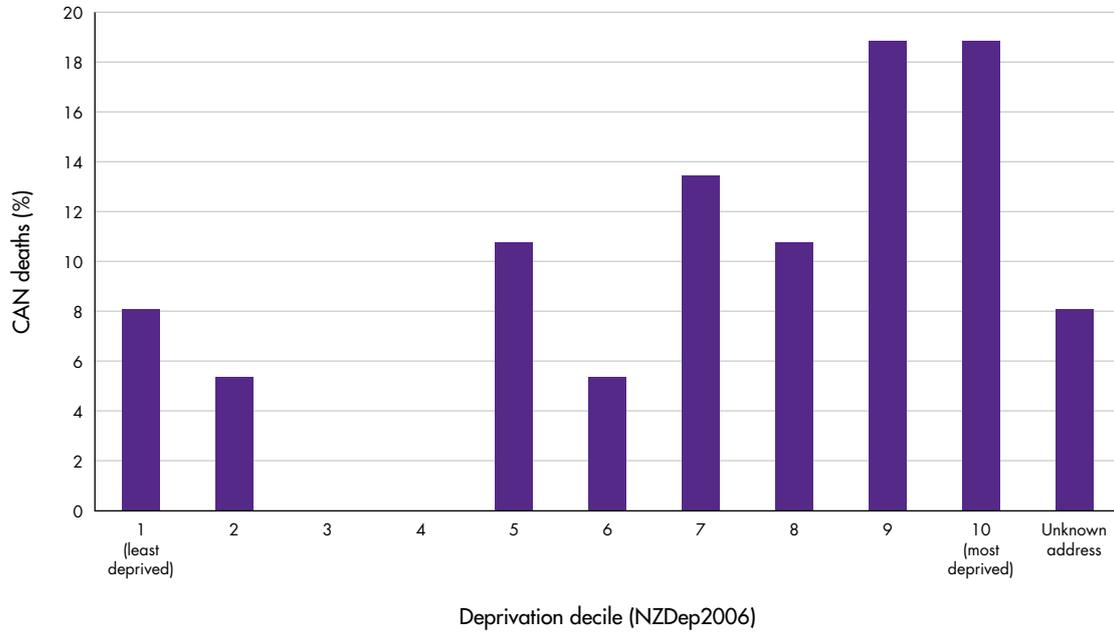


CAN = child abuse and neglect.

Socioeconomic status of CAN deceased

All CAN deaths in decile 1 and 2 were either filicide and parental suicides or neonaticides. Fourteen (74 percent) of the 19 inflicted injury deaths occurred in deciles 8–10.

Figure 19: Deprivation decile (NZDep2006) of deceased in CAN deaths, New Zealand, 2009–12



CAN = child abuse and neglect.

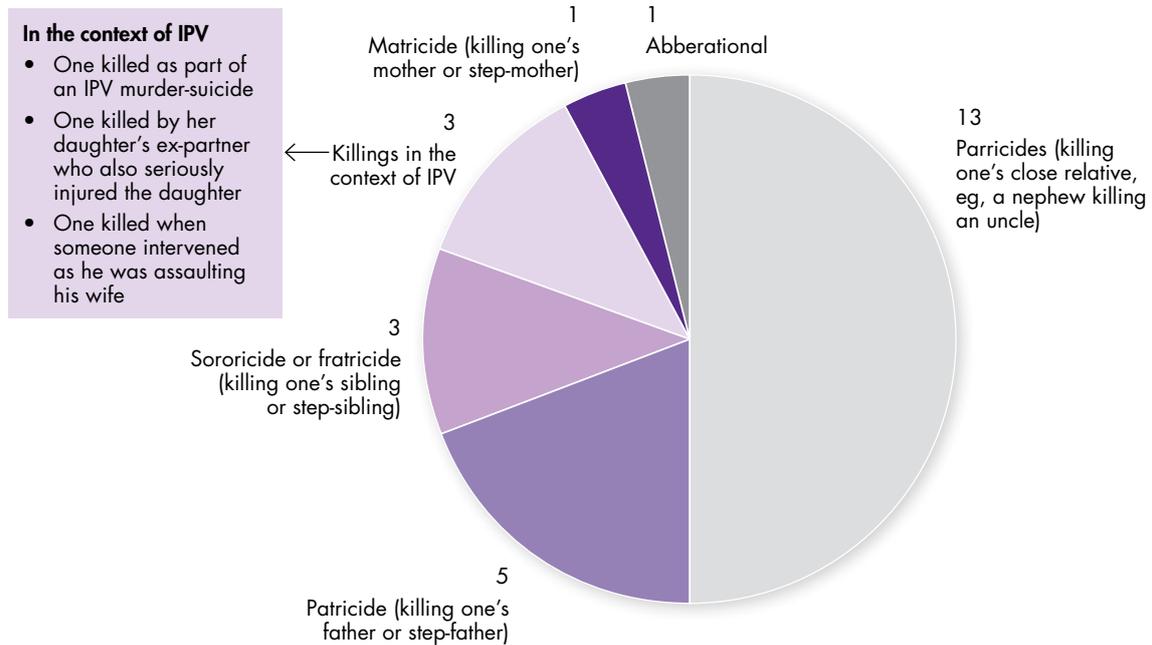
2.6 IFV deaths from 2009 to 2012

There were 26 IFV deaths in Aotearoa New Zealand from 2009 to 2012 (Figure 20 and Table 2). The victims and offenders were related (uncles and nephews, brothers, sisters, cousins or parents who were killed by adult children) but the death was neither an IPV or CAN death.

2.6.1 Death type and relationship between offender and deceased

In 13 (50 percent) of the IFV deaths the offender killed another close relative, such as a nephew killing an uncle. In five cases, the deceased was the father or step-father of the offender. In one case, the deceased was the mother and in three cases the brother/step-brother or sister/step-sister. Three of the IFV deaths were committed in the context of IPV (Figure 20).

Figure 20: Death type in IFV deaths, New Zealand, 2009–12



IFV = intrafamilial violence.
 IPV = intimate partner violence.

2.6.2 Known history of family and sexual violence among IFV deceased and offenders

Known family violence history

Section 2.5.3 notes that 47 percent of the offenders of fatal inflicted injury CAN deaths were known to police as IPV offenders. The IFV deaths also show entanglement between multiple forms of abuse occurring within some families. In 16 (62 percent) of the IFV deaths the family or extended family was known to statutory services⁸⁴ as having family violence histories⁸⁵ (Table 23).

Table 23: Known to statutory services as having family violence in the immediate or extended family in IFV deaths, New Zealand, 2009–12

KNOWN TO STATUTORY SERVICES AS HAVING FAMILY VIOLENCE IN THE IMMEDIATE OR EXTENDED FAMILY	IFV deaths n=26	
	n	%
Yes	16	62
No*	9	35
Unknown†	1	4

IFV = intrafamilial violence.

* One of these deaths occurred in the context of a major mental health episode and the offender was found not guilty due to insanity.

† Only limited information was available in this case.

84 This includes the police and CYF.

85 IPV, CAN or IFV.

In the 16 IFV cases with histories known to statutory agencies:

- Three involved child offenders (under 17 years) and adult deceased.
 - These three children had been exposed to long histories of their mother being abused by their father and/or one or more step-fathers, as well as being physically abused by these men. The deceased were all female relatives/family members.
- Thirteen involved adult offenders and deceased.
 - Eight of the 13 offenders, all men, were known to the police for abusing their current and/or previous female intimate partners. Most of these men were known for using violence over many years. One had four protection orders against him, another was known as an extreme high-risk IPV offender.
 - Four of the 13 deceased, all men, were known to the police as having abused their female intimate partners.
 - One deceased was abused by her ex-male partner, and she had been abused by and had abused her adult child.

(See section 3.1.3 for further discussion on entangled forms of abuse.)

Known sexual violence history

Sexual offending was a known feature in 4 (25 percent) of the 16 deaths with histories known to statutory agencies:

- Three adults (two offenders and one deceased) were known to the police for sexual offending against children/and or adults.
- One deceased was known to statutory services for being sexually abused as a child by a family member and a sexual assault from another family member was part of the death event.

In one further case, the offender was sexually abusive to the adult deceased, but was not known to the police for sexual offending.

2.6.3 Association between IFV deaths and alcohol abuse

In 8 (31 percent) of the 26 IFV deaths, the fatal assault occurred in the context of a social gathering of people, who had generally been drinking alcohol for an extended period of time – during the day and into the evening. Many of these families were known to have substance abuse issues.

2.6.4 Outcomes for offenders of IFV deaths

Of the 27 offenders:

- 8 (30 percent) were found guilty of murder and sentenced
- 7 (26 percent) were found guilty of manslaughter plus other charges
- 2 suspected offenders are still being processed by the courts and a final outcome is pending
- 4 were acquitted (by reason of insanity or self-defence), but are still understood to have been responsible for the killing
- in three cases the person responsible for the killing has not yet been charged but for each case the offender was most likely a family member and so has been included as such in this report.

Table 24: Outcomes for offenders in IFV deaths, New Zealand, 2009–12

OUTCOMES		IFV offenders*	
		n	%
Legal outcome	Murder	8	30
	Manslaughter/Other charges	7	26
	Acquitted	4	15
Suicide		0	0
Unresolved/Outcome pending		2	7
Other		3	11
Unknown		3	11

IFV = intrafamilial violence.

* There were 27 IFV offenders in the 26 IFV death events.

2.6.5 Ethnicity, age, gender and socioeconomic status of IFV deceased and offenders

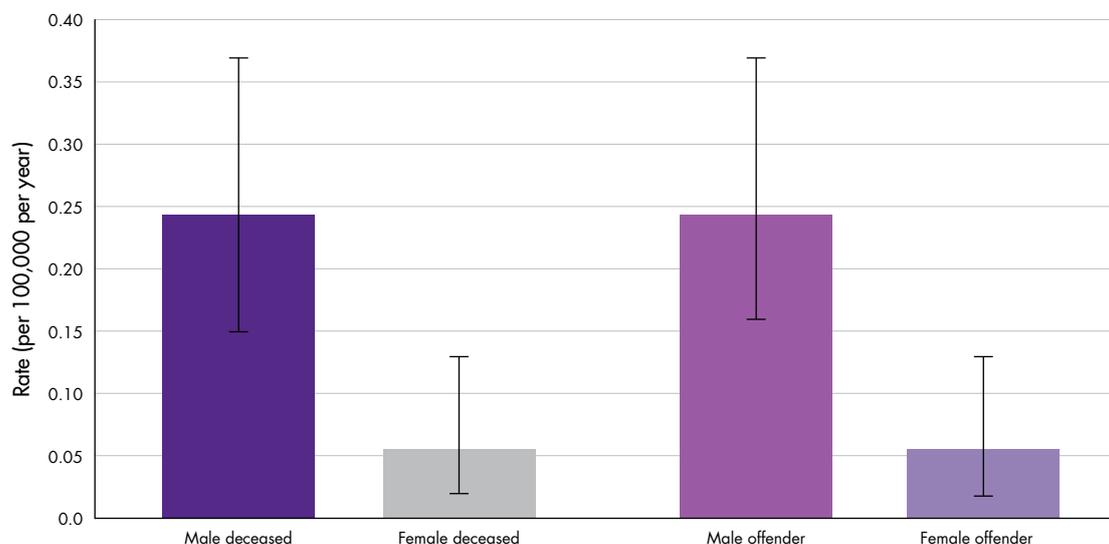
Men were more often the offenders and the deceased in IFV deaths (78 percent and 81 percent, respectively). In the majority (69 percent) of IFV cases both the offender and deceased were male. In two cases both the offender and the deceased were female. Six cases involved men and women as offenders and deceased. Men were four times more likely to be killed and six times more likely to be the offender in IFV deaths than women (Table 25 and Figure 21).

Table 25: Gender of deceased and offenders in IFV deaths, New Zealand, 2009–12

GENDER	Total New Zealand population 2009–12 n=17,522,000		IFV deceased n=26			IFV offender n=27		
	n	%	n	%	rate	n	%	rate
Male	8,607,100	49.12	21	81	0.23	21	78	0.24
Female	8,915,000	50.88	5	19	0.06	5	19	0.04
Unknown						1	4	

IFV = intrafamilial violence.

Figure 21: Gender-specific rates (per 100,000 people per year) for deceased and offenders in IFV deaths (with 95% CIs), New Zealand, 2009–12



IFV = intrafamilial violence.

Ethnicity of IFV deceased and offenders

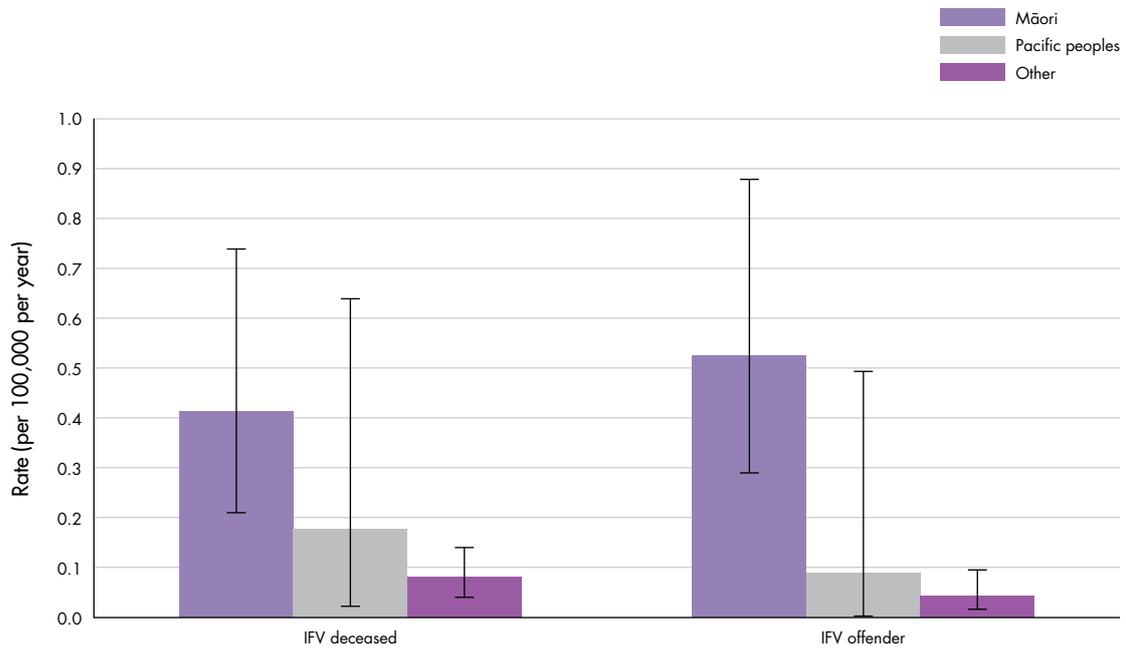
Māori made up 52 percent of IFV offenders and 42 percent of IFV deceased (Table 26). Māori were 13.2 times more often offenders and 5.1 times more often deceased than people of non-Māori, non-Pacific ethnicity. The CIs for Pacific peoples were wide because the proportion of Pacific peoples in the whole population is relatively small and so it is not possible to say whether rates among Pacific peoples vary from Māori or from other ethnicities (Figure 22).

Table 26: Ethnic-specific rates (per 100,000 people per year) for IFV deaths, New Zealand, 2009–12

PRIORITISED ETHNICITY	Total New Zealand population 2009–12 n=17,522,000		IFV deceased n=26			IFV offender n=27		
	n	%	n	%	rate	n	%	rate
Māori	2,659,700	15.18	11	42	0.41	14	52	0.53
Pacific peoples	1,128,100	6.44	2	8	0.18	1	4	0.09
Other	13,734,200	78.38	11	42	0.08	6	22	0.04
Unknown			2	8		6	22	

IFV = intrafamilial violence.

Figure 22: Ethnic-specific rates (per 100,000 people per year) for deceased and offenders in IFV deaths (with 95% CIs), New Zealand, 2009–12

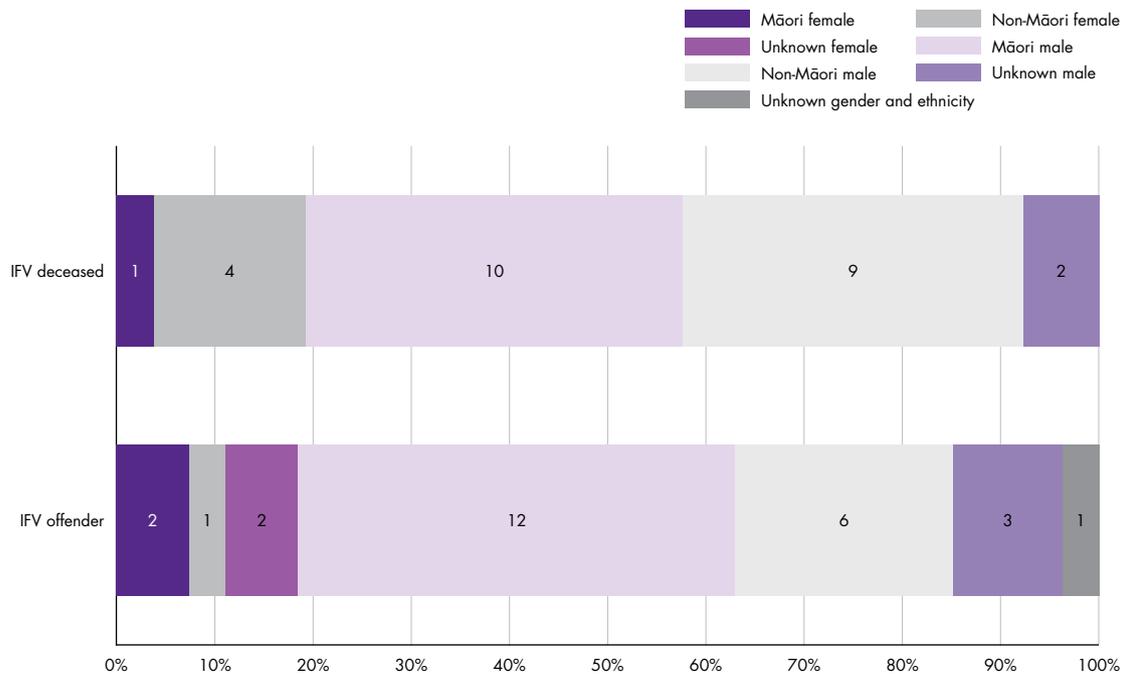


IFV = intrafamilial violence.

Association between gender and ethnicity of IFV deaths

Māori males were most often the deceased and the offenders of IFV deaths (Figure 23).

Figure 23: Gender and ethnicity of deceased and offender in IFV deaths, New Zealand, 2009–12



IFV = intrafamilial violence.

Age of IFV deceased and offenders

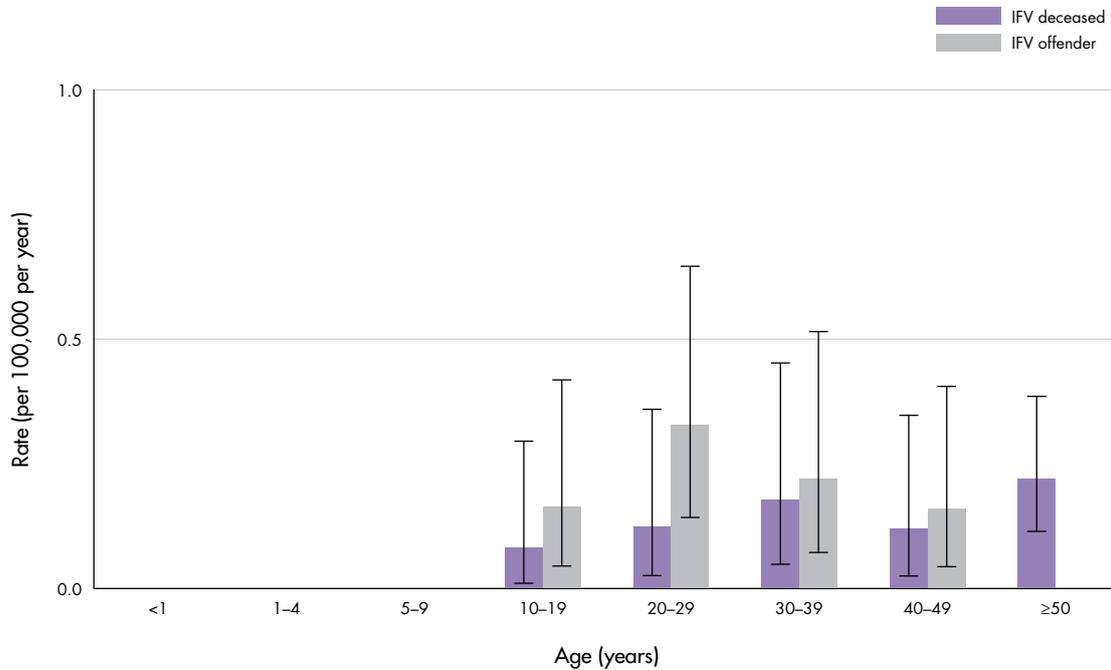
Forty-six percent of IFV deceased were aged 50 years or over, while none of the offenders (where the age is known) were in that age group. In contrast, 35 percent of the deceased and 64 percent of the offenders were aged 40 years or younger (Table 27).

Table 27: Age-specific rates (per 100,000 people per year) for deceased and offenders in IFV deaths, New Zealand, 2009–12

AGE	Total New Zealand population 2009–12 n=17,522,000		IFV deceased n=26			IFV offender n=27		
	n	%	n	%	rate	n	%	rate
<10 years	2,396,560	13.68	–			–		
10–19 years	2,450,360	13.98	2	8	0.08	4	15	0.16
20–29 years	2,439,990	13.93	3	12	0.12	8	30	0.33
30–39 years	2,264,920	12.93	4	15	0.18	5	19	0.22
40–49 years	2,525,760	14.41	3	12	0.12	4	15	0.16
≥50 years	5,444,480	31.07	12	46	0.22	0	0	0.00
Unknown			2	8		6	22	

IFV = intrafamilial violence.

Figure 24: Age-specific rates (per 100,000 people per year) for deceased and offenders in IFV deaths, New Zealand, 2009–12

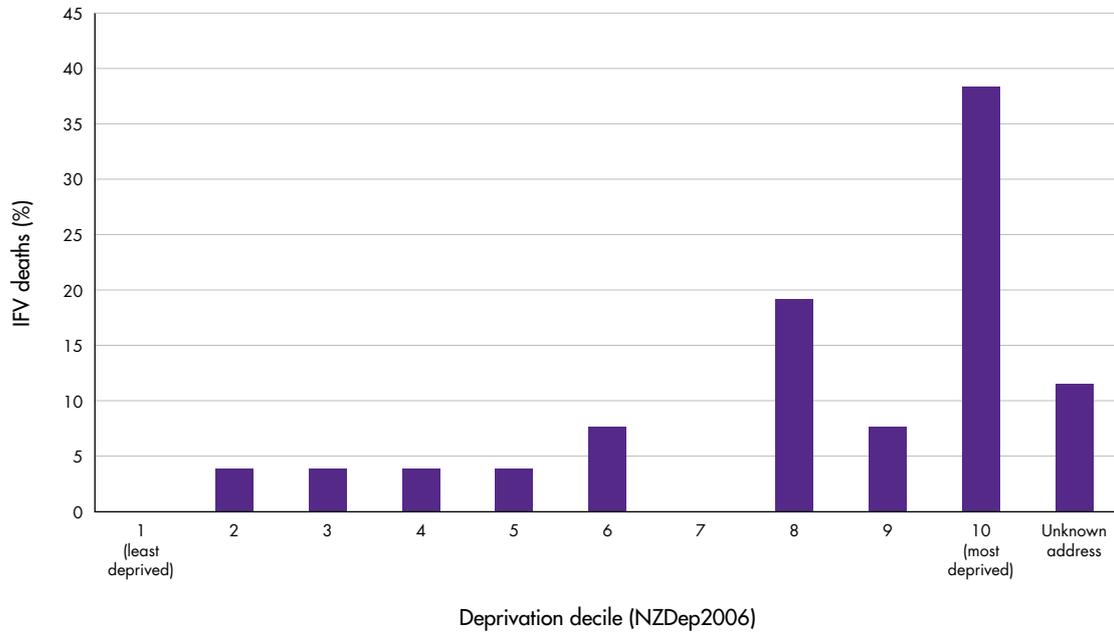


IFV = intrafamilial violence.

Socioeconomic status of IFV deceased

Figure 25 shows that 38 percent of IFV deceased lived in the most deprived residential areas (decile 10). This is higher than the average for all family violence deaths. Figure 3 shows that 25 percent of all IPV, CAN and IFV deaths (where the address of the deceased was known) were in decile 10 areas.

Figure 25: Deprivation decile (NZDep2006) of deceased in IFV deaths, New Zealand, 2009–12



IFV = intrafamilial violence.

Chapter 3: Reconceptualising family violence

There are multiple, complex and interacting factors that contribute to the occurrence of a family violence death. One of these is the manner in which family violence is conceptualised within professional practice across a range of key disciplines and in the practice structures and systems within and between organisations.

This chapter is broken into three sections outlining the key areas where the family violence workforce⁸⁶ needs to think differently about family violence to practice more effectively. Throughout these sections, examples are provided from the regional reviews where thinking differently about family violence would result in more effective responses to cases involving family violence. The sections are:

3.1 Conceptualising the issue

- Family violence is more than physical assaults.
- A primary victim and predominant aggressor analysis is essential.
- IPV and CAN are entangled forms of abuse.
- Family violence is never just a 'domestic'.
- Family violence is a cumulative pattern of harm.

3.2 Comprehending the impact and responding accordingly

- The impact of abuse is cumulative.
- Family violence is a complex form of entrapment.
- Lethality risk factors are key predictors of IPV homicide.
- A multi-agency system response is more effective than an 'empowerment' approach.

3.3 Being better informed about different forms of violence

- Family violence in the context of gang involvement.
- Forced marriage and 'honour'-based violence.

Professional education and training should be informed by the conceptual shift that is required to reframe family violence. This conceptual shift also needs to inform policy development, assessment frameworks and processes within and between organisations. These matters are explored in detail in Chapter 6.

3.1 Conceptualising the issue

3.1.1 Family violence is more than physical assaults

IPV is still often understood as physical assaults that occur within an intimate relationship. This means that some practitioners and members of the public are not attuned to the danger posed by possessive and controlling partners. The tendency to focus on the acts of physical assault overlooks the broader dynamics often involved in family violence cases – what might be thought of as the overall architecture of the abuse. For example, Stark⁸⁷ suggests that, at least in some of the most blatant cases of IPV, coercive control – rather than physical force – is a defining feature of the abuse.⁸⁸

⁸⁶ See glossary of terms for the definition of the family violence workforce when used in this report.

⁸⁷ E. Stark, *Coercive Control: How Men Entrap Women in Personal Life*, New York, Oxford University Press, 2007.

⁸⁸ Stark says that coercive control captures three aspects of women's experience that are not present in the violence model: firstly, that it is ongoing rather than episodic and resulting harm is cumulative; second, that it is multi-faceted; and third, that it involves rational and instrumental behaviour. Stark considers IPV to be less about the physical assaults than what he describes as 'the cumulative deprivations of a woman's personhood'. In other words, IPV is a crime against self-determination – the deprivation of rights and resources that are critical to personhood and citizenship, such as liberty, autonomy and connectedness to others. To appreciate the harms of IPV, there is a need to focus not only on what the abusive partner has done to the victim, but on what the victim has been prevented from doing for themselves.

Stark argues that coercive control operates through the use of a range of abusive strategies that are tailored to the 'unique psychology of the target' by someone who knows her intimately. These strategies are designed to control the victim even when she is not in the presence of the abusive (ex-) partner. These behaviours and tactics are often not immediately discernible to others and require practitioners to identify and explore the patterns and meaning of behaviours, rather than simply focusing on the incidents of physical abuse.

Defining coercive control

To explain the nature of 'coercive control', Stark separates the tactical dynamics of 'coercion' and 'control'. Coercion involves the use of force or threats to intimidate or hurt victims and instil fear. Whereas control tactics are designed to isolate and foster dependence on the abusive partner and their lifestyle. Together these abusive tactics undermine a victim's ability for independent decision-making and inhibit resistance and escape.

Examples of coercive controlling behaviours in the regional reviews include abusive partners:

- smashing multiple phones so that their partners were uncontactable or unable to contact others
- constantly monitoring their partner's phone and giving their own phone number to agencies so that all calls from practitioners went through them
- keeping at least one child with them every time their partner left the house so that she could not seek help and would return
- controlling access to friends and relatives
- being 'obsessed' about their (ex-) partner's new relationships (real or imagined)
- stalking the ex-partner after separation, covertly following them and even breaking into therapeutic residential support services
- killing or abusing family pets and animals
- threatening to hurt or kill their partner, a child, other relatives or themselves, if their partner left them.

Coercion tactics:

- Violence – assaults, severe beatings, attempted strangulation, sexual violence, use of weapons and objects to inflict injury or death.*
- Intimidation – threats, jealous surveillance,† stalking, shaming, degradation and destruction of property. This can include violence directed at children and pets/animals.

Control tactics:

- Isolation – from family, whānau, friends and networks of support.
- Deprivation, exploitation and micro-regulation of everyday life – limiting access to survival resources (such as food and money) or controlling how women dress.

* Johnson reported that men using coercive control assaulted women six times more often on average than men who used physical violence alone. M. Johnson, *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence*, Boston, Northeastern University Press, 2008.

† Regan et al have further defined the concept of jealousy to jealous surveillance. They believe that this concept gives a stronger sense of the actions abusive partners take to 'police' the acceptable boundaries of behaviour. L. Regan et al., *'If Only We'd Known': An Exploratory Study of Seven Intimate Partner Homicides in Englishire. Final Report to the Englishire Domestic Violence Homicide Review Group*, Child and Woman Abuse Studies Unit, London Metropolitan University, 2007.

For many adult victims in the regional reviews, the control their abusive (ex-) partner exercised over them had considerably constrained their lives. Often, even after separation, it restricted who they associated with, what activities they embarked on, what opinions they expressed, what issues they disclosed to different agencies and where they were able to live. It severely constrained the victim's ability to access support (either formal or informal) and seek safety for themselves and their children.

Within this coercive and controlling context, many women are hypervigilant in order to manage their and their children's safety. Thus, apparent rejections of help or a lack of response to service enquiries may be an attempt to maintain their personal safety and that of their children. It is, therefore, important for services to be alert to the signs of coercive control and to routinely ask about IPV and CAN as part of their core assessments.

For safe practice to happen: It is critical that practitioners consider the range of coercive controlling behaviours that may be occurring in an intimate relationship.

'If I can't have you, no-one will'

Potentially lethal or highly dangerous men are a small proportion of all men who abuse their intimate partners and children. Some of these men have a reported history of using high levels of physical violence; others may have no history of reported violence but exhibit intense controlling behaviours such as acute jealousy, stalking and severe control of their (ex-) partners. Highly intrusive control and/or extreme jealousy are indicators of serious risk even in the absence of physically violent behaviour.⁸⁹

The tendency to view family violence only in terms of physical assaults can also result in the minimisation of serious abuse of children. For children, the exposure to family violence, even when the child is not a direct target, is itself an extremely serious form of abuse.⁹⁰ Referring to the children as 'witnesses' to the abuse indicates a failure to recognise that these children are not passive witnesses but victims of the abuse. This issue is discussed further in Chapter 4.

Broadhurst et al⁹¹ note that with respect to child abuse:

'The cases that are most likely to catch the attention of the frontline practitioner are those that present the clearest evidence of harm. Research on biases in human reasoning finds that recall is stronger for very vivid or emotive material, such as visible injuries to children. Clearly, it is important to give priority to serious injuries; however, the practitioner must remain sensitive to less obvious signs and symptoms of harm to children and young people.'

There were children in the regional reviews who from infancy had been exposed to the physical, sexual and psychological abuse of their mother by their father and, at times, other family members. Some of these children also directly witnessed the homicide in which their mother was killed. In these cases, it appeared as though 'minor' physical abuse the child had experienced was sometimes responded to with greater concern by practitioners than these far more traumatic experiences – which were likely to have long-term consequences. In a number of instances these children received little by way of support or recovery after their parent's death.

89 The manual *Accountability and Connection with Abusive Men* developed by F. Mederos and the Massachusetts Fatherhood Education Leadership Teams for the Fatherhood Initiative at the Massachusetts Department of Social Services has more information. http://www.futureswithoutviolence.org/userfiles/file/Children_and_Families/Accountability_Connection.pdf

90 A child's exposure to IPV is psychological abuse of a child under section 3(3) of the Domestic Violence Act 1995.

91 Broadhurst et al., *Ten Pitfalls and How to Avoid Them: What Research Tells Us*, London, National Society for the Prevention of Cruelty to Children, 2010.

3.1.2 A primary victim/predominant aggressor analysis is essential

One emerging theme in the regional reviews is the lack of a primary victim/predominant aggressor analysis in the social sector⁹² response to family violence in Aotearoa New Zealand. There is a need, at all levels of the multi-agency family violence system,⁹³ to determine who the predominant aggressor is so that:

- primary victims are identified and reassured that it is safe to contact services and can be effectively supported when in danger
- repeat victimisation of primary victims and their children is prevented, reducing the likelihood of further serious harm occurring
- predominant aggressors are held to account and engaged with the appropriate services.⁹⁴

It is equally important that police prosecutors, defence counsel and judges utilise a primary victim/predominant aggressor analysis when assessing the abuse history that precedes and contextualises a family violence homicide. This is discussed in more detail in Chapter 5.

In the US, a predominant aggressor is defined as the party who is the most significant or principal aggressor in the relationship.⁹⁵ They may not be the first party to initiate violence on any particular occasion. Determining who the predominant aggressor is necessitates understanding the dynamics of IPV and considering the context, intent and meaning of the violence. Investigation guidance for the US Police⁹⁶ suggests that consideration be given to:

- offensive and defensive injuries
- the seriousness of injuries received by each party
- threats made by a party against the other, a family member or a pet
- whether a party acted in self-defence or in the defence of another
- the height and weight of the parties
- which party has the potential to seriously injure the other party
- any history of IPV between the parties
- prior convictions for assault
- orders for protection that have been filed by a party
- whether a party has a fearful demeanour
- whether a party has a controlling demeanour
- witness statements.

New Zealand Police officers would need to undertake a similar investigative process in order to identify and then arrest the predominant aggressor. During the course of the investigation frontline police officers could consult with specialist police family violence staff to determine if a charge against the other person is warranted (as not all arrest and charging decisions need to be made at the same time).

It was clear from the regional reviews that some abused women retaliate and resist coercive control by using violence themselves. This can include engaging in violence to try and establish a semblance of parity in the relationship, violent self-defence, violent retaliation and violent resistance. Primary victims may also use violence when they sense another attack from the predominant aggressor is about to occur.⁹⁷

92 See glossary of terms for the definition of the social sector when used in this report.

93 See glossary of terms for the definition of the multi-agency family violence system when used in this report.

94 This is particularly relevant to the Family Violence Interagency Response System (FVIARS), frontline police officers and those agencies providing domestic violence stopping violence programmes for offenders and safety programmes for victims.

95 For information about predominant aggressor research and policies, see www.stopvaw.org/determining_the_predominant_aggressor

96 For an example of a police IPV form that includes a predominant aggressor analysis, see the Duluth Police pocket card available at www.endvawnow.org/en/articles/437-determining-the-predominant-aggressor.html.

97 Women do use violence, but we need to think differently about their use of violence. Many women in abusive relationships are using what Pence has coined 'mosquito violence' against 'major violence', demonstrating the need for predominant aggressor policies and understandings within services. A small proportion of women are using coercive controlling violence against their male or female intimate partners. E. Pence, *Why Gender & Context Matter*, plenary speech given at the 15th Annual Batterers Intervention Services Coalition of Michigan National Conference: When She Hits Him: Why Gender & Context Matter, 4 November, 2010.

Whilst the majority of those who commit a family violence homicide are the predominant aggressor in a prior pattern of family violence in the relationship, this is not always the case. In a small subset of cases the person who committed the homicide was the primary victim and the deceased was the predominant aggressor in the history of abuse between the couple. As noted in Chapter 2, of the 63 IPV deaths from 2009 to 2012, a female primary victim killed a male predominant aggressor in nine of these cases and in one further case a female suspected primary victim killed a male suspected predominant aggressor. There were no cases where a male primary victim killed a female predominant aggressor. In 40 cases, a (suspected) male predominant aggressor killed a (suspected) female primary victim. Only two of the 63 deaths involved a female predominant aggressor who killed a primary victim (one man and one woman).⁹⁸

There are similarities in the evidence emerging from the regional reviews. Three of the regional reviews conducted in 2012 and 2013 involved women who killed their partners but each review found extensive evidence that, in their relationship with the deceased, they were the primary victim of repeated IPV before the death event.⁹⁹

The regional reviews have found that irrespective of whether the primary victims ended up committing the family violence homicide or were the deceased, they had similar patterns of:

- sustained histories of resistance and help seeking in the face of such violence
- difficulties experienced in negotiating safety
- significant detrimental effects from the violence they were experiencing.

Indeed, in some instances where the primary victim eventually retaliated and killed the predominant aggressor, individuals from agencies had predicted that the case could progress to a lethal homicide but had incorrectly assumed that the primary victim would be the one who was killed.

To identify the predominant aggressor, information from multiple sources needs to be reviewed and assessed within the broader context of coercive control. Whilst identifying the predominant aggressor is not an easy task, if it is not done then abusive (ex-) partners can successfully manipulate the system, primary victims will not be protected and they may not contact support services the next time violence occurs. For example, a victim dealing with a highly dangerous and potentially lethal (ex-) partner who contacts the police for help and is informed that both she and her (ex-) partner will be arrested because they have both used physical force is not only provided with no assistance on that particular occasion but is discouraged from reaching out for help again.

It is equally important to consider this type of analysis in relation to children. Children exposed to family violence will experience disruption of the normal pathways for development of emotional regulation and may react with a range of behavioural problems. These children may be perceived as being aggressive, naughty or even bad when in reality they are also primary victims of the abuse occurring within the home. They are acting out the effects of their (often multiple) traumatic experiences.

98 In six of the 63 deaths, it is uncertain who the primary victim or predominant aggressor was due to the limited information available. For deaths in which a regional review has not been completed, the Committee will not have access to the full range of agency records for the families in question. As such there are cases in which the Committee is unable to say whether there is a history of abuse on the basis of the information that exists. These cases are classified as 'uncertain', meaning that more information about the history between the couple would be necessary before it could be determined whether an abuse history is present or absent and whether one party is the predominant aggressor in that history.

99 Such cases have long been documented as occurring in all comparable jurisdictions. For Australia, see:

(i) R. Bradfield, 'Understanding the battered woman who kills her violent partner: The admissibility of expert evidence in Australia', *Psychiatry, Psychology and Law*, vol. 9, issue 2, 2002, p. 177.

(ii) J. Stubbs and J. Tolmie, 'Race, gender and the battered woman syndrome: An Australian case study', *Canadian Journal of Women and the Law*, vol. 9, issue 1, 1995, p. 122.

For Canada, see:

(i) *R v Lavallee* [1990] 1 SCR 852

(ii) *R v Mallot* [1998] 1 SCR 123.

For England, see *R v Ahluwalia* [1992] 4 All ER 889.

For America, see E. Schnieder, *Battered Women and Feminist Lawmaking*, Yale, Yale University Press, 2000, pp. 112–47.

For New Zealand, see N. Seuffert, 'Battered women and self-defence', *New Zealand Universities Law Review*, vol. 17, 1997, p. 292.

For safe practice to happen: Some useful questions for practitioners to help identify the predominant aggressor.¹⁰⁰

- Who is fearful of whom?
- Who in the relationship poses the most danger to the other?
- Who is seeking to stop the violence?
- Who is seeking to avoid punishment?
- Who is at most risk of future harm?
- Who has motive to lie or retaliate?
- Whose story makes the most sense?
- Do the injuries and evidence corroborate the statement?
- Is there evidence of consciousness of guilt?
- Is there a history of domestic violence, as the perpetrator or the victim?

3.1.3 IPV and CAN are entangled forms of abuse

It is well known that exposure to IPV is a form of child abuse and that there is a high rate of co-occurrence between IPV and the physical abuse of children.¹⁰¹ Many children affected by family violence are living with what Edleson et al¹⁰² have described as the 'double whammy' – the co-occurrence of being exposed to family violence in relation to other family members and being a direct victim of child maltreatment. Children are also injured in the 'crossfire' of a violent assault or attack against the adult primary victim and can be used as 'weapons' by abusive (ex-) partners in the context of IPV (see section 4.1.3).

Regan¹⁰³ explains that it is important for practitioners to further comprehend that IPV and CAN are not necessarily separate co-existing forms of violence. Rather, there are particular aspects of the abuser's behaviour that defy categorisation as either CAN or IPV. Regan says that part of what needs to be understood is 'a double level of intentionality: that an act directed towards one individual is at the same time intended to affect another or others in order to keep and/or increase control over both'. Examples would include:

- hitting/threatening a woman in front of her child/ren
- humiliating a woman in front of her child/ren
- killing a mother in front of her child/ren.

100 G.B. Strack, 'She Hit Me, Too,' *Identifying the Primary Aggressor: A Prosecutor's Perspective*, San Diego, National Centre on Domestic and Sexual Violence, n.d. at www.ncdsv.org/images/she_hit_me.pdf

101 The co-occurrence of child physical abuse and IPV is estimated internationally to range between 30 and 66 percent depending upon the study.

M. Hester et al., *Making an Impact: Children and Domestic Violence: A Reader*, London, Jessica Kingsley Publishers, 2007; J.L. Edleson, 'The overlap between child maltreatment and woman battering', *Violence Against Women*, vol. 5, no. 2, 1999; 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; M. Hester, *Mothering Through Domestic Violence*, London, Jessica Kingsley Publishers, 2007; C. Murphy et al., *Understanding Connections and Relationships: Child Maltreatment, Intimate Partner Violence and Parenting*, Auckland, New Zealand Family Violence Clearinghouse, 2013.

Murphy et al note that specific information on the co-occurrence of child maltreatment and IPV is not available for New Zealand; however, almost two-thirds of notifications to CYF are reported to have some family violence component. This figure corresponds with the estimated 50–66 percent of Australian statutory child protection cases involving IPV.

C. Humphreys, *Domestic Violence and Child Protection: Challenging Directions for Practice*, Issues Paper 13, Australian Domestic and Family Violence Clearinghouse, 2007.

102 J.L. Edleson et al., 'How children are involved in domestic violence: Results from a four-city telephone survey', *Journal of Interpersonal Violence*, vol. 18, no. 1, 2003, pp. 18–32.

103 L. Regan, *Children and Domestic Violence: Its Impacts and Links with Woman Abuse*, speech at the Impact of Domestic Violence on Children Conference, London, October 2001.

Or the reverse:

- hitting/threatening a child in front of their mother
- humiliating a child in front of their mother
- killing a child, in retaliation for the mother leaving the abusive relationship.

The regional reviews have found instances of women being threatened and assaulted by their abusive (ex-) partners whilst holding a young child and pregnant women being strangled or assaulted. Are these examples of IPV, or are they instances of CAN and just who is the primary victim – the woman, the child or unborn baby, or both? Regan says this behaviour only makes sense if you understand family violence (IPV and CAN) as a pattern of coercive control and that actions directed at one individual are not necessarily designed to impact only on that individual.

Often agencies have a specific focus on one family member; this directs their practice and affects how practitioners engage (or do not engage) with adults and children, and how information is gathered and interpreted. In Chapter 7 (section 1) of the *Third Annual Report*,¹⁰⁴ the Committee encouraged agencies to systematically incorporate both forms of abuse within their assessment frameworks.

For safe practice to happen: Organisations working with people experiencing family violence need to ensure that their assessment frameworks specifically address the ‘double intentionality’ of family violence (IPV and CAN).

Though reported incidents of abuse may initially appear to be directed towards a child or an adult victim, practitioners should always consider how abusive behaviour is frequently intended to impact on more than the targeted individual.

Engagement and assessment processes need to consider:

- the likelihood of multiple forms of abuse occurring within the immediate and wider family/relationship
- the effect and impact of these forms of abuse on adult and child victims, their relationship, and their coping and help-seeking behaviours
- how risk and needs assessments and safety planning processes encompass adult and child victims.

3.1.4 Family violence is never just a ‘domestic’

The regional reviews found instances where the word ‘domestics’ or the phrase, ‘it’s just a domestic’, were used by family members and friends to describe serious and eventually fatal IPV (some agencies still use the term ‘a verbal’ to describe ongoing emotional abuse). This normalisation and minimisation of the violence impacted on family and whānau members’ perceptions of how serious the situation was and the need for intervention. The regional reviews saw situations where couples were left alone to sort out their ‘domestics’.

The use of the word ‘domestics’ minimises the serious impact of the abuse by relegating it to the domain of ‘household affairs’. For this reason there has been a definite push within statutory services to ensure that practitioners do not refer to family violence as ‘just a domestic’. There is also a strong need to ensure that families, whānau and the wider community no longer use this term to refer to family violence.

In Aotearoa New Zealand, the social marketing campaign ‘It’s not OK’ has made a start on shifting attitudes away from tolerance of family violence. However, the reviews demonstrate that these attitudes are so deep-rooted that setting them aside is not easy.

¹⁰⁴ FVDR, *Third Annual Report*, 2013.

3.1.5 Family violence is a cumulative pattern of harm

Family violence is frequently understood and responded to as a series of incidents. In between these incidents it is assumed that the victim is not being abused and, in the case of an adult victim, it is assumed that there are opportunities to address the abuse or leave the relationship.¹⁰⁵ What is often not appreciated is that rather than being a one-off incident that may or may not be repeated, family violence is more likely to be a 'pattern of behaviour or a pattern of relating' within a relationship and across multiple relationships.¹⁰⁶

In the regional reviews, the Committee noted numerous instances where practitioners appeared to be overly confident about the ability of the abuser to stop using violence in intimate relationships, particularly if they had expressed shame or remorse. The Committee also found situations where agencies had assumed that, because the relationship was over between the primary victim and predominant aggressor or between the child's mother and the abuser, there was no further risk presented by the abuser and the situation was resolved. In fact, these abusers remained highly dangerous to their ex-partner,¹⁰⁷ future partners and children. The result is that where action is eventually taken it is often in respect of one incident, against one of his victims, as though it was only a minor and one-off event.

In the four regional reviews where fatal injuries had been inflicted on children, all the abusive step-fathers had police recorded histories of alleged abuse inflicted on multiple previous intimate partners and/or physical abuse against children. In nine of the total 17 regional reviews¹⁰⁸ (involving both adult and child victims) the predominant aggressor had a police recorded history of abusing two or more intimate partners. Five of these men had a police recorded history of abusing three or more intimate partners. Of the eight cases where the predominant aggressor did not have a police recorded history, two primary victims had a police recorded history for being abused by three or more partners.

In one regional review, the offender had a history of non-fatal strangulations against multiple former partners and a step-child – a number of these assaults were known to agencies. Known non-fatal strangulation assaults were not responded to appropriately because it was thought that relationship separation meant the danger was over or they were prosecuted as a minor assault.

In one regional review, the offender had been convicted for assault and threats to kill against his most recent partner; he was on a community sentence when he killed this partner. He was separated from her at the time of the death and she had reported his ongoing stalking of her to the police. She had a protection order against him, and there were multiple protection orders in favour of former partners, as well as multiple police reports of threats to kill and stalking behaviours against two former partners. His history of using potentially lethal violence was missed as a significant risk factor by many (but not all) of the practitioners from multiple agencies working with the victim and with him.

When it is appreciated that one may be working with a person who has a harmful pattern of relating, the need to think preventatively – rather than simply responding to an individual victim and an individual reported episode of abuse – becomes clear. It should be assumed that an abusive person will continue their past pattern of behaviour in the absence of sustained intervention and support to address their behaviour (attending a stopping violence programme on its own is insufficient support to enable such a change). It should also be assumed that they will take their pattern of relating into subsequent intimate relationships with new partners, children and step-children – and, saliently, that their trajectory of violence may escalate. For vulnerable infants, this can be fatal.

¹⁰⁵ Examples of this can be found on the public record in legal judgements eg *R v Witika* [1993] 2 NZLR 424.

¹⁰⁶ On 8 March 2014 the UK Home Office rolled out the Domestic Violence Disclosure Scheme – Clare's Law. This scheme allows the police to disclose information about a partner's previous history of domestic violence or violent acts. Clare's Law is an important information option for victims, but does not replace the need for agencies to be proactive and prevention-focused when they are aware that a person has a harmful pattern of relating.

¹⁰⁷ Campbell's research on femicide has shown that where the male partner is extremely controlling, separation is a very dangerous time, especially the period immediately after separation. In the Campbell et al research on risks for intimate partner homicide, women who had a violent partner, who was constantly jealous, were nine times more likely to be killed than other abused women. 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 explains the findings by identifying highly controlling male partners as presenting the most danger in this situation. 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.

¹⁰⁸ Three of the 17 regional reviews were of refugee or new migrants so there was not a New Zealand Police recorded history against multiple partners and/or children.

For safe practice to happen: Organisations need to work towards developing their electronic case management systems so that practitioners are assisted to identify cumulative patterns of harm within and across relationships, families and whānau.

Practitioners' risk assessments and risk management plans need to take into account these cumulative patterns of harm and consider the risks posed to potential future victims, as well as past and current victims.

Considerations when there are concerns about possible CAN:

- Do these parents and/or step-parents have histories of being abused as children?
- Are there similarities in their children's/step-children's experiences?
- How may their childhood experiences impact on their parenting ability?

Considerations for identifying and responding to repeat victimisation or perpetration:

- Has this victim been abused by previous intimate partners?
- What is the impact of repeat/chronic victimisation on their coping ability?
- Does this abuser have a history of abusing previous intimate partners and/or children?
- Does this abuser have multiple protection orders against them?
- What risks are posed by their repeated use of violence against multiple victims?

3.2 Comprehending the impact and responding accordingly

3.2.1 The impact of abuse is cumulative

Family violence as a pattern of behaviour should also be understood as having corresponding 'cumulative' and 'compounding' effects on adult and child victims.¹⁰⁹ Chronic and repeat victimisation¹¹⁰ takes longer to recover from, produces more post-traumatic stress disorder symptomatology and results in victims' coping methods being less effective. Another consequence of chronic or repeat victimisation can be the erosion of the resources and social supports available to primary victims, which in turn increases their vulnerability.¹¹¹

In the regional reviews, a number of primary victims and predominant aggressors (although not all) had experienced multiple forms of abuse as children. Primary victims had also often been abused in prior relationships. They carried the effects of the trauma into their most recent relationship.

The cumulative and compounding effect of the abuse also frequently resulted in a raft of secondary issues. These included physical and mental health issues, histories of self-medicating with drugs and alcohol, suicide attempts and the inability to hold down employment. IPV victims often had difficulty in parenting their children, which – in some cases – resulted in them terminating pregnancies because they could not face bringing another child into 'a nightmare situation' or their children being physically removed from them because they were unable to keep them safe.

109 It has been said that surviving ongoing trauma has a neurological effect. CAN has been linked to a variety of changes in brain structure and function, and stress-responsive neurobiological systems. Epidemiological studies have documented the impact of childhood abuse on health and emotional wellbeing. R.F. Anda et al., 'The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology', *European Archives of Psychiatry and Clinical Neuroscience*, vol. 256, no. 3, 2006, pp174–86.

110 Chronic – sustained abuse over time by one abusive partner. Repeat – experiencing abuse from multiple abusive partners over time. R. Matlow and A. DePrince, 'The influence of victimization history on PTSD symptom expression in women exposed to intimate partner violence', *Psychological Trauma: Theory, Research, Practice and Policy*, 12 March 2012, doi: 10.1037/a0027655. This research used a sample of 236 ethnically diverse women recruited following exposure to police reported IPV.

111 Repeat abusers are often/appear experienced at identifying and targeting vulnerable women.

At different times individual women had expressed high levels of distress, stress, agitation, fear/terror, depression, frustration and anger at being continually hurt and being unable to prevent the abuse from occurring. Some women lived with the reality that they would ultimately be killed.

3.2.2 Family violence is a complex form of entrapment

Contrary to the common assumption, it is very difficult for a victim of IPV to safely leave the relationship. However, the regional reviews have found many victims of IPV do leave their relationships – sometimes repeatedly.

There was evidence of many primary victims going to considerable lengths to try to protect themselves and their children. They had taken actions, such as:

- temporarily relocating into refuges
- moving out of the family home into alternative accommodation
- attempting to keep their new location secret from the abusive (ex-) partner
- retaliating with physical violence themselves
- taking out protection orders
- making disclosures to family, friends, employers, landlords and neighbours
- changing their car so that they could not be easily identified in public
- going to couple counselling
- contacting the police and involving other agencies to get help
- disengaging from such agencies in order to manage and placate the abusive (ex-) partner in times of escalating danger.

The reviews provide evidence of the difficulties women experienced in leaving a violent relationship, in particular the difficulty they have in securing non-association with the abusive (ex-) partner and therefore safety for themselves or their children once they have left. Indeed, as noted in Chapter 2, 50 percent (31 out of 63) of the IPV deaths took place in the context of a planned or actual separation. Some primary victims may not want to separate from their abusive partner (who might also be the father of their children); however, they all want the violence to stop and they continue to take action in an attempt to negotiate safety in their situation.

Ptacek¹¹² refers to IPV as a form of ‘social entrapment’ that has three dimensions.

- First, the social isolation, fear and coercion that the abusive (ex-) partner’s violence creates in the victim’s life.
- Second, the ‘indifference of powerful institutions’ to the victim’s suffering.
- Third, ‘the ways that men’s coercive control can be aggravated by structural inequalities of gender, class and racism’.

Family violence is marked by structural inequities (structural relationships of power, domination and privilege). Poverty, social exclusion,¹¹³ disability, heterosexism, gender inequality and the legacy left behind by colonisation also impact on people’s experiences of abuse and the resources available to them in responding to that abuse. The difficulties victims of family violence face in keeping themselves safe can be particularly extreme for some Māori women. Many are dealing with serious levels of victimisation and social entrapment, extreme economic deprivation and high levels of historical and intergenerational trauma affecting, not just themselves, but their whānau and support networks as well.

112 J. Ptacek, *Battered Women in the Courtroom: The Power of Judicial Responses*, Boston, Northeastern University Press, 1999, p.10.

113 Māori children are twice as likely as European/pākehā children to grow up in poor households. Cram states that the colonisation of Aotearoa New Zealand and how Māori became excluded in their own land provide ways of understanding Māori poverty. She draws on the concepts of ‘social exclusion’ and ‘social inclusion’ as ways of analysing the barriers to, and facilitators of, Māori living a ‘good life’. Cram quotes the work of Ruth Levitas, who describes social exclusion as a multi-faceted problem in which understandings of poverty need to ‘go beyond low income and address the multiple dimensions of deprivation’. Social exclusion is both a cause and an outcome of poverty. Cram states that for indigenous peoples, social exclusion is both the intention and the result of colonisation. F. Cram, ‘Poverty’, in McIntosh, T. and Mulholland, M. (eds.), *Māori and Social Issues*, Wellington, Huia Publishers, 2011.

These issues can be particularly intense when there is gang involvement, as these primary victims may also be dealing with a coercive social framework that extends beyond their abusive partner. Practitioners working with such victims need to understand that exiting the relationship is not simple and that attempts may increase the risk to them and their children.

People who have lived lives of extreme brutalisation and victimisation cannot be expected to easily establish positive support networks. They need:

- help to develop new skills to integrate into a healthier community than the one they have known
- support to establish new networks and friends, and build trust and confidence to talk with people with whom they have not engaged before
- to make sense of what has happened to them and a language to help them communicate and understand their feelings and emotions. This is necessary so they can begin to peel back the layers of trauma that many have experienced over a lifetime.

Family violence can be an individual, structural and collective form of entrapment. The over-representation of Māori in family violence deaths is of significant concern and the reviews have revealed patterns of normalisation of violence. Kruger et al¹¹⁴ describe the normalisation of violence within whānau as a legacy of colonisation and institutional racism that has become an 'imposter tikanga' – that is, the acceptance of using violence as a way of whānau members interacting. Indigenous researchers highlight the need to understand family violence within the historical and contemporary contexts of colonisation and the unresolved trauma that manifests in abusive and violent behaviours that becomes a 'learning environment'¹¹⁵ for the next generation. Atkinson et al¹¹⁶ reference the work of the New South Wales Aboriginal Child Sexual Assault Taskforce in 2006 and note the transgenerational transfer of trauma as a determinant of physical and sexual violence. Previous research by Atkinson and Atkinson¹¹⁷ commented that 'violent behaviours become the norm in families where there have been cumulative intergenerational impacts of trauma on trauma, expressing themselves in present generations as violence on self and others'.

The Mauri Ora framework, developed by Kruger et al¹¹⁸ describes three fundamental tasks to be carried out when analysing and approaching violence as:

- dispelling the illusion (at the collective and individual levels) that whānau violence is normal and acceptable
- removing opportunities for whānau violence to be perpetrated through education for the empowerment and liberation of whānau, hapū and iwi
- teaching transformative practices based on Māori cultural imperatives that provide alternatives to violence.

114 T. Kruger et al., *Transforming Whānau Violence – A Conceptual Framework. A Report from the Former Second Māori Taskforce on Whānau Violence*, 2004.

115 E. Duran and B. Duran, *Native American Postcolonial Psychology*, 1995.

116 J. Atkinson et al., 'Trauma, transgenerational transfer and effects on community wellbeing', in Purdie, N., Dudgeon, P. and Walker, R. (eds.), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, Canberra, Department of Health and Ageing, 2010, pp. 135-44.

117 C. Atkinson and J. Atkinson, 'Talking about perpetrator programs', in Thompson, R. (ed.), *Working in Indigenous Perpetrator Programs: Proceedings of a Forum*, Adelaide, Ministerial Council for Aboriginal and Torres Strait Islander Affairs, 1999.

118 T. Kruger et al., *Transforming Whānau Violence*, 2004.

3.2.3 Lethality risk factors are key predictors of IPV homicide

It is clear from all the regional reviews that IPV lethality risk factors were often either not recognised or not adequately responded to by practitioners, agencies and multi-agency initiatives.¹¹⁹

Some IPV victims actively sought help from multiple agencies shortly before their death and were very clearly disclosing the threats made upon their life. The failure to recognise the risk and respond appropriately meant opportunities to prevent the death were missed. The inadequate response to lethality risk indicators is exacerbated by many family violence agencies assessing risks in different ways and few agencies undertaking lethality assessments. For example, the New Zealand Police ODARA¹²⁰ system measures the risk of re-assault, not the risk of lethality.

In Chapter 5, the Committee discusses strangulation as another lethality risk factor for family violence homicide, which appears to be frequently overlooked or misunderstood. It is important that all specialist family violence agencies undertake lethality assessment against a consistent framework. In Chapter 6, the need for a national service accreditation framework and practice standards is discussed in more detail. Safety and risk assessment (including lethality assessment) should be key components of organisational practice standards.

Victims who are fearful for their lives do disclose to informal sources of support (family, whānau, friends, work colleagues and neighbours) about their fears. Regan et al¹²¹ in their research on a specific cluster of IPV homicides found that friends and informal supports are often aware of controlling behaviours but do not perceive coercive controlling behaviours either as IPV or as potentially dangerous. This same finding has emerged in the regional reviews. Frequently members of personal networks were aware of the abuse, and victims had told people they were terrified of being killed. It appears that personal networks are often ill-informed, especially about lethality, and unclear about what to do. Informal networks of support are often in a position to facilitate help-seeking, but to provide protection they must be able to name behaviours as abuse and understand their potential lethality.

For safe practice to happen: It is important that all specialist family violence agencies do a lethality assessment against a consistent framework. The main indicators of lethality are:

- the presence of an extremely controlling and possessive (ex-) partner in the context of an actual or imminent separation (initiated by the victim)
- threats to kill
- threats with a weapon
- the victim believing the abusive partner is capable of killing her
- suicidal perpetrators in the context of an actual or imminent separation
- strangulation (often referred to by victims as 'choking')
- forced sex.

For a full lethality assessment, refer to the Danger Assessment instrument.¹²²

119 See also FVDR, *Third Annual Report*, 2013.

120 Ontario Domestic Assault Risk Assessment.

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

122 The Danger Assessment instrument is designed to assess how likely it is someone will be killed or nearly killed in a case of IPV. See www.dangerassessment.org/uploads/pdf/DAEnglish2010.pdf

3.2.4 A multi-agency systemic response is more effective than an 'empowerment' approach

The empowerment framework, utilised by many family violence services, aims to respect women's agency. It is a powerful discourse that influences service providers' and statutory agencies' understanding of how to work alongside women experiencing abuse. The regional reviews highlight the difficulties and risks when expecting an IPV victim facing lethal violence to quickly or safely move from a situation of entrapment to one of empowerment.

It is important to put the concept of empowerment within victims' complex and sometimes chaotic lives, as structural inequities constrain and shape the lives of victims, albeit in different ways. The concept of 'empowerment' is problematic when working with victims facing lethal violence, who also frequently face severe structural disadvantages. This is because it makes it appear as though an individual's inability to keep themselves or their children safe is a result of their decisions and choices. It renders invisible the systemic barriers that impede those choices (such as lack of stable housing and access to money, poverty, racism, sexism and the legacy left behind by colonisation).¹²³

In the regional reviews, it was evident that frequently the well-intentioned focus of the FVIARS meetings was on empowering the victim to make their own choices, which in effect resulted in a list of actions the victim would take to make herself and her children safe (such as go into refuge, separate from her abusive partner or get a protection order). This individualist approach to safety planning had the unintended and dangerous consequence of placing the responsibility to stem the abusive partner's violence and initiate safety plans solely on the victim – someone who was extremely vulnerable, with limited resources and social supports, and in a state of considerable trauma.

In the regional reviews, it sometimes appeared as though the abusive (ex-) partners disappeared from the frame and there was little system accountability put in place to curtail their ability to use violence or to enable opportunities for potential long-term behaviour challenge and change. Furthermore, as noted in the Committee's *Third Annual Report*,¹²⁴ if men are involved with stopping violence services, these services are frequently not involved with multi-agency case management processes.

The Committee reviewed a death in which the victim's partner had repeatedly threatened to kill her. She knew that he was capable of killing her and she had fought for her life over a long time, taking multiple actions in an attempt to negotiate safety in the situation. These included proactively seeking help from the police (multiple times), her workplace, a family violence support service for access to refuge, a family lawyer, the Family Court, neighbours, strangers and relatives. However, the lack of a systemic response to the violence she was experiencing meant she was not 'empowered', or able to negotiate her safety, despite being given information on protection orders and refuge accommodation at different points in time.

The over-reliance on protection orders and refuge provision for women at risk of lethal violence is evidence of the weakness of the current multi-agency family violence response system for high-risk cases. A protection order is a reactive form of protection requiring further abuse to be reported for a breach to be considered by the police and courts. Similarly, refuge is a temporary measure and many women, for a multitude of reasons, may only stay there briefly or they may not even be able to access a refuge. The option of going into a refuge and applying for a protection order can only ever be part of a safety plan; these measures should not be the safety plan.

The research by Perez et al¹²⁵ demonstrates that for women experiencing the most severe violence, interventions that focus on violence cessation and long-term safety are likely to initially be more important than either resource acquisition or empowerment alone. Victims need the violence to stop and to experience an extended period of safety before they are in a position to make empowered choices.

123 B. Fredericks, 'Which way that empowerment? Aboriginal women's narratives of empowerment', *AlterNative*, vol. 4, no. 2, 2008, p. 9.

124 FVDR, *Third Annual Report*, 2013.

125 S. Perez et al., 'The attenuating effect of empowerment on IPV-related PTSD symptoms in battered women living in domestic violence shelters', *Violence Against Women*, vol. 18, no. 1, 102–117, 2012, doi: 10.1177/1077801212437348.

It is clear to the Committee that an effective response to high-risk victims must be a multi-agency process. In its *Third Annual Report*¹²⁶ the Committee found that the danger, complexity and urgency in high-risk family violence cases is often not adequately recognised and addressed by the current FVIARS processes and it recommended the development of a multi-agency case management process for these cases.

For such a process to be effective, first there needs to be a shift from focusing solely on the actions of the individuals involved – which makes victims' safety their own responsibility – to a proactive systemic response, in which services and the community become responsible for the victim's safety. Services need to wrap around the victim and try multiple ways of engaging and staying involved (in the short and long term). Secondly, multi-agency responses need to shift from containing the victim (ie, by providing her with temporary accommodation, a protection order and a list of things she can do to keep herself safe) to containing, challenging and changing the abuser's use of violence.¹²⁷

The Victorian government in Australia has modelled moving from 'a service system' that previously put responsibility on the victim to take action, to an 'integrated system response' that emphasises the safety of women and their children, and the accountability of the abuser.¹²⁸

For safe practice to happen: Where lethality risk factors are evident practitioners at multi-agency meetings¹²⁹ need to be proactive and initiate multi-agency safety plans that aim to prevent lethal violence occurring and that specify what agency (individual and collective) actions can be undertaken to keep victims safe and to contain the offenders' use of violence.

Referring a victim to an agency or a service undertaking a home visit are 'outputs' not 'safety outcomes'.

Multi-agency safety plans need to include:

- concurrent planning, such as what will occur if a service is unable to engage a victim or offender
- when the plan will be reviewed and updated, as relationships involving family violence may be characterised by separations, reconciliations, rapid escalations and shifts in risk
- how agencies will integrate their responses to support the victim, children, family members and the abuser (for example, trying to contact a victim when it is confirmed their partner is attending a probation appointment or stopping violence programme session).

The social sector¹³⁰ in Aotearoa New Zealand needs to develop a similar integrated system response for those at risk of lethal violence.

126 FVDR, *Third Annual Report*, 2013.

127 R.L. Snyder, 'A raised hand: Can a new approach curb domestic homicide?', *Annals of Prevention*, The New Yorker, 22 July 2013.

128 Office of Women's Policy, Department of Planning and Community Development, *A Right to Safety and Justice: Strategic Framework to Guide Continuing Family Violence Reform in Victoria 2010–2020*, 2010.

129 FVDR, *Third Annual Report*, 2013, p. 53.

130 See glossary of terms for the definition of the social sector when used in this report.

Promising international practice: In 2005, the Jeanne Geiger Crises Center in Amesbury (US) set up a multi-agency domestic violence high-risk team.¹³¹ Although there had been an average of one family violence death a year prior to 2005 in Amesbury, there have been no IPV deaths since. The center recognised that while the previous focus on providing victims with shelter might immediately save lives, it was a strategy in which ‘the burden of change fell on the victim, not the perpetrator’. They shifted from this approach to using evidence-based predictive tools to determine dangerousness followed by a series of strategies (on the part of a number of agencies) focused on containing the perpetrator ‘so the victim doesn’t have to be contained’. One way they do this is to use GPS. If an offender enters certain ‘exclusion zones’ – ranging in size from a few blocks to an entire township – an alert is sent to the local police and an arrest warrant is issued.

3.3 Being better informed about different forms of violence

3.3.1 Family violence in the context of gang involvement

Practitioners need to understand that gangs are frequently environments where the members have collectively compounded and exacerbated society’s traditional assumptions about women’s roles and justifications for violence against women.¹³² The research review by Ulloa et al¹³³ on IPV in the context of gangs identifies that there is a heightened risk of experiencing IPV for women involved with gangs.

Ulloa et al also highlight the trauma histories present for many gang members and gang-involved women. People who have experienced abuse in childhood, lived amidst violent and, frequently, deprived communities, and who have previous histories of abuse, are at risk of gang association.

Furthermore, Salter’s¹³⁴ research on multi-perpetrator domestic violence (MDV) evidences two groups that are particularly vulnerable to MDV, the first being girls and women partnered to members of gangs and the second being girls and women in some ethnic minority communities. An example of MDV is how male collectives within gangs may use rape to settle gang scores. The result is that violence and abuse against women and children within gang cultures is often more frequent and extreme. For a woman and her children living with a gang-affiliated man, their ability to leave the relationship is greatly curtailed. Fear of gang retaliatory violence and intimidation are very real barriers.

Five of the nine inflicted injury child deaths involving step-fathers occurred in the context of gang involvement. These step-fathers were gang members, prospects or associates, and/or some of their family were gang members and they had been raised in gang environments.

Five of the 10¹³⁵ female IPV primary victims who killed their abusive male partner were gang involved. Four of these men were either gang members or associates. The fifth had been raised as a child in a gang environment. A further four deaths of IPV primary victims occurred within a gang context.

The Committee sees an urgent need for the family violence workforce to have specific training in how to engage and respond effectively to family violence in a gang context. For example, there is a risk that gang culture is seen as Māori culture, when this is not the case. Addressing family violence in a gang context requires responses that are based in different programmes, approaches, pathways and support networks. The Committee would welcome the opportunity to participate in a workshop with the Social Sector Forum,¹³⁶ the Māori Reference Group and relevant agencies to consider how to interrupt the multiple forms of violence occurring in the lives of some gang women, children and men.

131 R.L. Snyder, ‘A Raised Hand’, 2013.

132 G. Dennehy and G. Newbold, *The Girls in the Gang*, New Zealand, Reed Publishing, 2001.

133 E.C. Ulloa et al., ‘Inter-partner violence in the context of gangs: A review’, *Aggression and Violent Behavior*, vol. 17, no. 5, 2001, pp. 397–404.

134 M. Salter, ‘Multi-perpetrator domestic violence’, *Trauma Violence Abuse*, April 2014, doi:10.1177/1524838013511542.

135 This number includes one suspected primary victim who killed a suspected predominant aggressor.

136 The Social Sector Forum initiatives link to or work together with other key pieces of work happening across government including the Family Violence Taskforce – refer www.msd.govt.nz/about-msd-and-our-work/publications-resources/corporate/statement-of-intent/2013/cross-agency-leadership.html

3.3.2 Forced marriage and 'honour'-based violence

The rapidly increasing diversity of Aotearoa New Zealand's population makes it particularly important for practitioners to understand a range of cultural contexts. Forced marriage and 'honour'-based violence are forms of violence against women, about which there is little information in Aotearoa New Zealand. There is evidence in the regional reviews of the need for responsible raising of awareness and guidance for practitioners about such forms of family violence.¹³⁷ Hannana Siddiqui from the Southall Black Sisters warns that there are dangers when raising awareness about 'honour'-based violence, as the result can be 'exoticism of the issue and racism when dealing with victims and minority communities'.¹³⁸ The purpose of highlighting 'honour'-based violence and forced marriage in this report is not to exoticise these forms of violence or to stereotype certain communities, but rather to draw attention to the need for practitioners to have a more nuanced understanding of violence against women, family violence and the intersection of gender, cultural norms and violence.

The distinction between arranged and forced marriage

Arranged marriage, like forced marriage, has existed for centuries in many cultures.¹³⁹ Forced marriages involve an element of coercion, which includes physical and/or mental duress, and is a form of family violence. The New Zealand Office of Ethnic Affairs describes forced marriage as:

'...one where "...marriage is conducted without the valid consent of both parties where duress is a factor". Duress may include physical, psychological, financial, sexual and emotional pressure. Duress may occur during the arrangement of a forced marriage and continue once it has taken place.'¹⁴⁰

The UK Home Office's *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*¹⁴¹ describe the 'consequences of forced marriage', as including being subjected to repeated rape (sometimes until the victim becomes pregnant), ongoing domestic abuse and, in some cases, suffering violence and abuse from the extended family.

Siddiqui¹⁴² states that there is sometimes a problem in drawing the line between forced marriage and arranged marriage:

'The fear is that by criticising the cultural practice of arranged marriage, racist assumptions are made about Asian communities. So commentators and politicians have been at pains to separate arranged marriage – as a respectable cultural practice – from forced marriage, which is abusive and unacceptable. However, the line between arranged marriage and forced marriage is a fine one. A forced marriage, as opposed to an arranged marriage, is one where there is no free and valid consent given by one or both parties. Many women feel in practice, there is little difference between the two. The desire to please parents, who exert emotional pressure, is itself experienced as coercion.'

A young woman may experience pressure to please her parents and the burden of life circumstances in her country of origin may make the marriage the best option available for a better life for her and her family. Education around the concept of 'forced marriage' as a form of family violence is required in Aotearoa New Zealand. If practitioners are not able to consider the possibility that a marriage may have been entered into in an environment of coercion, then many agencies may, firstly, fail to recognise the possible signs that a marriage may have been forced; and, secondly, may fail to comprehend the level of abuse that is occurring on a daily basis within that marriage.

137 H. Siddiqui, 'There is no "honour" in domestic violence, only shame! Women's struggles against 'honour' crimes in the UK', in *'Honour' Crimes, Paradigms, and Violence against Women*, 2005.

138 H. Siddiqui, 'There is no "honour" in domestic violence, only shame!', 2005. p. 277.

139 H. Siddiqui, "'It was written in her kismet": forced marriage', in Gupta, R. (ed.), *From Homebreakers to Jailbreakers: Southall Black Sisters*, London, Zen Books, 2003.

140 See ethnicalffairs.govt.nz/story/family-violence-new-zealand-what-it-and-what-government-doing-about-it#forced

141 E. Stobart, *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*, Foreign and Commonwealth Office Home Office, 2009, p. 12. Available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/35530/forced-marriage-guidelines09.pdf

142 H. Siddiqui, "'It was written in her kismet": forced marriage', 2003, p. 69.

'Honour'-based violence

Sen¹⁴³ states that crimes of 'honour' have a number of characteristics that mark them out from other forms of violence against women. Honour crimes are not solely about individual men controlling the lives of individual women; rather they are about community norms, social policing and collective decisions. The honour code means that women must follow rules that are set at the discretion of male relatives and which are interpreted according to what each male family member considers acceptable. Breaking the rules is seen as destroying the good name of the family and is deserving of punishment at the discretion of male relatives. Women in such circumstances may not be free to leave their husbands. It may be their responsibility to make the marriage work regardless of the ongoing emotional and physical costs to themselves and their children.

The London Safeguarding Children procedures¹⁴⁴ recommend that professionals should respond in a similar way to cases of honour-based violence as with IPV and forced marriage (such as facilitating disclosure, developing safety plans, ensuring the woman's/child's safety – by according them confidentiality in relation to the rest of the family – and completing risk assessments). Furthermore, practitioners are warned not to assume that perpetrators of honour-based violence (men and women)¹⁴⁵ will not kill their closest relatives and/or others for what might seem a trivial transgression. The perception or rumour of immoral behaviour may be sufficient to kill, including:

- leaving a spouse or seeking divorce
- having a sexual relationship outside of marriage.

3.4 Conclusion

Family violence work is complex and challenging because the families and whānau with whom practitioners frequently work may have overlapping issues, such as poverty, marginalisation, family violence, substance addiction and mental health issues. Practitioners need to be supported in comprehending family violence in a manner that acknowledges the complex lives and difficult decisions many people affected by family violence are faced with on a daily basis. The conceptual shifts outlined in this chapter should provide the foundation for a more effective response by the family violence system to those who are trapped in 'dangerous social positions' and 'dangerous intimate relationships'.¹⁴⁶

3.5 Recommendations

The Committee recommends that:

1. The Campaign for Action on Family Violence deepens and extends its focus to encourage safe and effective interventions by friends, family, whānau, neighbours and workmates by:
 - addressing the normalising and minimising of family violence and the use of the phrase, 'it's just a domestic'
 - educating the public about coercive control and jealous surveillance as key forms of abuse within IPV
 - defining the behaviours that can be considered coercive control and jealous surveillance
 - educating friends and whānau about the potential for danger when women are separating from extremely controlling and possessive men, especially when threats to kill have been made
 - emphasising the importance of taking action and contacting the police and family violence services for help.

143 P. Sen, "'Crimes of honour', value and meaning', in Welchman L. and Hossain S. (eds.), *'Honour' Crimes, Paradigms, and Violence against Women*, London, Zen Books, 2005.

144 See www.londoncp.co.uk/consultation/forced_marriage_ch.html#recognition

145 In some families, it is not uncommon for mother-in-laws to perpetuate violence on their daughter-in-laws (it is likely that these mother-in-laws may have experienced similar abuse from their respective mother-in-laws).

146 B. Richie, 'A Black feminist reflection on the antiviolence movement', *Signs*, vol. 25, no. 2, 2000, pp. 1133–7.

2. The Ontario Domestic Abuse Risk Assessment tool has greatly improved New Zealand Police's ability to identify and respond to chronic victimisation¹⁴⁷ within a relationship. The following practice changes are suggested to further strengthen the police family violence situational response and harm prevention agenda, especially with respect to people perpetrating abuse or being re-victimised¹⁴⁸ across multiple relationships.¹⁴⁹

With respect to offenders, New Zealand Police National Headquarters considers:

- how it identifies and manages family violence offenders who are recorded on the National Intelligence Application (NIA) system as having abused multiple partners and/or step-/children, because this is an indication of an established pattern of offending
- improving officers' risk management decision-making and prevention capabilities; the Committee's suggestions include:
 - developing a graded flagging¹⁵⁰ system on the NIA for flagging family violence (CAN and IPV) offenders who have abused multiple victims,¹⁵¹ including offenders who have multiple protection orders against them¹⁵²
 - developing an attempted IPV homicide alert on the NIA with specified criteria, which would be generated when someone has attempted to kill or seriously harm an (ex-) partner
 - supplementing and adapting the current suite of police risk assessment tools so that IPV lethality assessments and repeat offending histories contribute to the risk analyses of (ex-) partners and step-/children
 - proactively managing identified repeat offenders through a multi-agency high-risk case management¹⁵³ and safety planning process
 - identifying harmful patterns of relating in bail applications and risk management analyses for court.

With respect to victims, New Zealand Police National Headquarters considers:

- how the concepts of the primary victim and the predominant aggressor are addressed in current police IPV policy, training and operation practice tools:
 - the level of understanding of these concepts by frontline officers
- building on the NIA's Victimisation History Scorecard to systematically flag chronic IPV victimisation by the same offender and re-victimisation by multiple offenders, without any time limitation¹⁵⁴
- how identified repeat victims and their children are proactively supported by a multi-agency high-risk case management¹⁵⁵ and safety planning process
- how identified patterns of victimisation inform bail applications and safety planning analyses for court
- including education on the following in police family violence training:
 - cumulative patterns of harm
 - the impact that chronic trauma and re-victimisation has on abuse survivors
 - the need to consider these forms of trauma when deciding what forms of safety planning and support are offered.

With respect to children, New Zealand Police National Headquarters:

- ensures that the police family violence policy explicitly states that where a child is named on a protection order (or where the police become aware that a child is protected by that order), a copy of this order must be attached to the child's record
- develops a consistent process to implement this policy change.

147 Chronic victimisation – repeated victimisation by the same abusive partner.

148 Re-victimisation – multiple victimisations by different abusive partners.

149 The report from Her Majesty's Inspectorate of Constabulary (HMIC) in the UK *Everyone's Business: Improving the Police Response to Domestic Abuse* released in March 2014 addresses many of the matters raised in this report and contained in the recommendations for New Zealand Police, in particular the need for a systematic approach to targeting repeat or prolific perpetrators of domestic abuse (see pp. 106–7). Available at www.hmic.gov.uk/publication/improving-the-police-response-to-domestic-abuse/

150 Graded response to repeat offending – severity, duration and number of victims.

151 Not time limited, such as in the last 12 months, but rather a length of time that corresponds with their family violence offending.

152 The Committee recognises that this system change may be resource intensive, so an interim intelligence profile could be developed that identifies this type of repeat offender.

153 The multi-agency high-risk case management process referred to is not a police specific process, but the proposed high-risk case management process recommended in the Committee's *Third Annual Report*.

154 Not time limited, such as in the last 12 months, but rather a length of time that corresponds with their family violence victimisation.

155 See footnote 153.

Chapter 4: Fatal family violence – looking through the lens of childhood

The Committee reviews both adult and child family violence deaths. It is important to look at the relationship between these two types of deaths (as has been discussed in Chapter 3) but it is also important to consider children in isolation and the effects on them as both victims and survivors of fatal family violence.

4.1 Child victims

The Committee has reported on 37 CAN deaths over the period from 2009 to 2012. Most children were killed by a caregiver:

- for 15 (41 percent), this was their mother
- for 8 (22 percent), this was their father
- for 9 (24 percent), it was their step-father or their mother's ex-partner
- for 3 (8 percent), it was a female caregiver
- for 2 deaths the offender in the fatal assault was unknown but must have been a family member.

Ten children were killed by seven parents who also committed suicide. Male and female adults were equally likely to be responsible for CAN deaths, but the type of death varied with the gender of the offender (see Table 12, Chapter 2).

4.1.1 Inflicted fatal injury

Nineteen of the 37 CAN deaths were caused by inflicted fatal injury – making it the most common reason for CAN deaths. In nine of these 19 deaths, the offender was a step-father. In five cases, a biological parent killed the child, in three cases it was a female carer¹⁵⁶ and in two cases it was unknown. Most of these 19 children died because of head injuries but in six (32 percent) cases there were significant chest or abdominal injuries that either contributed to (in one case) or resulted in the death. This is a higher proportion than reported in some overseas studies.^{157 158 159}

With respect to inflicted fatal injury CAN deaths, 17 (89 percent) occurred before the age of five years. For some infants, there may have been just one fatal act of violence, but for others there will have been one or more previous non-fatal episodes. For some children there was evidence of an older injury/ries at post-mortem. Information from the regional reviews indicates that some of these young children and/or their caregivers had presented previously to an agency, family member or neighbour who could have taken action. For these young children, there may be only one chance to intervene, for example, to recognise and treat maternal depression or to report an initial presentation with a relatively minor injury to a statutory agency for investigation. The next presentation may be the fatal event.

A theme that has come through some of the regional reviews where a step-child was killed, is that whānau outside the child's family home have been very concerned about the wellbeing of the child/ren in the home but have felt powerless to effect change for the child. They may take the child out of the violent environment but have no powers to protect the child if the mother, father or step-father take the child back to the original home environment. Given that Māori and Pacific families, in particular, place a high value on supporting whānau and providing help from within the wider family group to resolve issues, if a family member from these ethnic backgrounds makes a report of concern to CYF about one of their tamariki whom they consider to be at risk, this should be taken very seriously. It is likely that the situation for that child is severe and has not been able to be ameliorated by the usual supportive efforts from concerned whānau.

156 One was an informal caregiver, one an aunt and one a grandmother.

157 J. Klevens and R.T. Leeb, 'Child maltreatment fatalities in children under 5: Findings from the National Violence Death Reporting System'. *Child Abuse & Neglect*, 34(4), 2010, pp. 262–6.

158 M.S. Pollanen et al., 'Fatal child abuse-maltreatment syndrome. A retrospective study in Ontario, Canada, 1990–1995', *Forensic Science International*, vol. 126, issue 2, 2002, pp. 101–4.

159 A.H. Ross et al., 'Pattern of injury in child fatalities resulting from child abuse', *Forensic Science International*, vol. 188, issue 1, 2009, pp. 99–102.

Children killed by step-fathers

Previous New Zealand data¹⁶⁰ confirm overseas findings¹⁶¹ that children who die of fatal assault are more likely to be killed by step-fathers. As shown in Table 12, Chapter 2, in 9 (47 percent) of the 19 CAN deaths caused by inflicted injury, the offender was the child's step-father. These nine children ranged in age from 3 months to 13 years of age and CYF had been involved with the family and/or step-father in seven of these cases.

According to a New Zealand Families Commission fact sheet,¹⁶² there are no national estimates of the proportion of children living in step-families in Aotearoa New Zealand. The Families Commission states that the rates are likely to be at least as great as in Australia (7 percent) and England (9.5 percent). Based on these estimates step-fathers are significantly over-represented as CAN death offenders in that only a small percentage of all children in Aotearoa New Zealand are likely to be living with or have step-parents as compared to biological parents.

Many abusive step-fathers are possessive and extremely jealous. Children who are not the biological children of the mother's partner are a constant physical reminder to the abusive partner that 'his woman' has had sexual relationships with other men (one of the biological fathers who killed his child by fatal assault did not believe that his child was his). For some infants the fatal abusive event can occur within months of the abusive step-father moving into the home.

Studies have shown that having children of former unions elevates the risk that the step-child/ren and their mothers¹⁶³ will be assaulted and killed. Daly and Wilson¹⁶⁴ coined the phrase the 'Cinderella effect' to describe the differential (mis)treatment of step-children after they found that any and all sorts of abuse and exploitation were seen to occur at higher rates in step-relationships than in genetic parent-child relationships, and that the differences persisted when possible confounds, such as socioeconomic status, were controlled for. In 2007, Daly and Wilson¹⁶⁵ reported that studies conducted in several countries had shown that step-parents fatally abuse very young children at a per capita rate more than 100 times higher than genetic parents.

International CAN reviews also evidence that risks can emerge when new partners join a household. Brandon et al¹⁶⁶ emphasise that it is vital that practitioners assess men's role as 'caregivers'. Men who are regularly part of the family are likely to have high levels of day-to-day contact with a child.¹⁶⁷ Even if this is not the case, their presence can have a significant impact on the child's environment. It is important to know the nature of the man's relationship with the child (father, mother's boyfriend, lodger), but also to consider in what ways this new male might pose a risk to the child's safety or conversely act as a protective presence. The regional reviews found instances where assessments and support plans tended to focus on the mother's problems in caring for their children and pay less or little attention to the men present in the household. Assessments need to consider the man's own experiences of being parented, any past history of perpetrating CAN or IPV and the risks he may pose to children who are part of a household. The Committee saw instances where, for example, a man was known to have used violence against several of his previous intimate partners – who were also the mothers of his children – but his pattern of behaviour was not considered a risk in parenting his children or step-children.

160 M. Duncanson et al., *Death and serious injury from assault of children aged under 5 years in Aotearoa New Zealand: A review of international literature and recent findings*, Wellington, Office of the Children's Commissioner, 2009.

161 K.R.E. Cavanagh and R.P. Dobash, 'The murder of children by fathers in the context of child abuse', *Child Abuse & Neglect*, 31, pp. 731–46, 2007.

162 See www.familiescommission.org.nz/publications/briefs-and-statistics/fact-sheet-01-%E2%80%93-new-zealand-families-today

163 Having a child living in the home who is not the perpetrator's child more than doubles the risk of femicide in the context of IPV. J.C. Campbell et al., 'Risk factors for femicide in abusive relationships', 2003, pp. 1089–97.

164 M. Daly and M. Wilson, *The Truth about Cinderella*, London, Weidenfeld & Nicolson, 1998.

165 M. Daly and M. Wilson, 'Is the "Cinderella effect" controversial? A case study of evolution-minded research and critiques thereof', in Crawford C. and Krebs D. (eds.), *Foundations of Evolutionary Psychology*, Mahwah NJ, Erlbaum, 2007.

166 M. Brandon et al., *Understanding Serious Case Reviews and Their Impact: A Biennial Analysis of Serious Case Reviews 2005–07*, University of East Anglia, 2009.

167 Ibid.

Children killed by biological parents

All five children who died from injuries inflicted from a biological parent were young, ranging in age from four weeks up to three years. Two of the children were one of a multiple birth. Overseas data suggest that premature birth, having a disabled co-twin, delay of growth or development and parental disfavour are factors in fatal maltreatment when only one twin is maltreated.¹⁶⁸

Four of the five children who died were killed by their biological father. Three of these biological fathers also had a police history of perpetrating IPV against the mother of the deceased child. One child was killed by injuries inflicted by the biological mother, who had a police history as a primary victim of IPV from her current partner.

4.1.3 Filicide with parental suicide

There have been eight cases of filicide with parental suicide from 2009 to 2012 (this includes one filicide with a suspected attempted suicide). All the parents involved were biological parents, three fathers and five mothers. Consistent with some literature reports,¹⁶⁹ father filicide-suicides seemed to be more impulsive and relate to adult custody and relationship issues, whereas mother filicide-suicides appeared to relate more to mental health disorders. In two of the cases involving fathers, the filicide-suicide took place in the aftermath of a separation and the death of the child/ren was articulated by the father as a means of hurting his ex-partner, who was the mother of the children.

The Committee urges those working with parents under stress be aware of the risk of filicide-suicide by fathers involved with acrimonious parental separation situations and mothers with mental health disorders (see section 3.1.3).

4.1.4 Fatal neglectful supervision

Experience of IPV can be overwhelming for mothers and have adverse effects on their parenting, including the active supervision of young children. Two child deaths clearly fell into this category. Both infants died while unsupervised in the bath. Both mothers had histories of abuse – as children and within their current relationship with the father of the child. In a further case, a child was poisoned. It is difficult to determine from the records available whether this was a deliberate or neglectful act.

The Committee has also considered some deaths of young infants found dead in bed with parents known to be under the influence of alcohol. In some cases these parents have been charged in relation to the death of the child. The Committee has decided that these deaths are best considered with other sudden unexpected deaths in infancy (SUDI) as reviewed by the Child and Youth Mortality Review Committee (CYMRC) and Perinatal and Maternal Mortality Review Committee (PMMRC). Therefore these infants have not been included in the Committee's dataset.

4.1.5 Neonaticide

There were four cases of neonaticide, all involving biological mothers who killed newborns either actively or by neglect. More detailed information was available for just three of the mothers. All were vulnerable because of a variety of adverse previous experiences.

168 S. Ooki, 'Characteristics of fatal child maltreatment associated with multiple births in Japan', *Twin Research and Human Genetics*, vol. 16, 2013, pp. 743–50.

169 A. Kauppi et al., 'Maternal and paternal filicides: A retrospective review of filicides in Finland', *Journal Am Acad Psychiatry Law*, vol. 38, no. 2, 2010, pp. 229–38.

4.2 Child survivors of fatal family violence

A particularly vulnerable, but often neglected, group of survivors of fatal family violence events are the children and siblings of the deceased. These children experience the combined effects of the trauma of loss, coupled with the trauma of being exposed to, and/or the subject of, previous violence within the home. Loss of a parent and loss of a sibling leads to a similar emotional and behavioural response although some gender differences are demonstrated – boys reportedly being more affected by the death of a parent and girls being more affected by the death of a sibling, especially a sister.¹⁷⁰ The regional reviews have repeatedly found that although the needs of the surviving children for a place of safety may be addressed in the aftermath of the death event, a full assessment of their ongoing care needs is usually neither considered nor undertaken.

4.2.1 Children affected by IPV

Regional reviews provide evidence that the risks to children affected¹⁷¹ by potentially lethal IPV can be underestimated and hence not addressed. As noted in Chapter 3, there is often a proactive response to any reported instances of child physical abuse, but exposure to repeated IPV is not recognised and responded to in the same manner. For example, many practitioners associate protection orders with adult victims and are not aware that children can also be afforded protection as ‘protected people’,¹⁷² and that this protection can remain in place until the child is 17 years of age, even if the applicant for a protection order dies. This is a vital protection for children who may still be at risk from the respondent from issues including ongoing exposure to the abuse of a respondent’s new intimate partners, unsafe parenting and gender role modelling.

Exposing children to IPV is legally psychological abuse¹⁷³ of the child. Exposure to caregivers with drug, alcohol and mental health problems is another form of emotional abuse for children. These are often co-morbidities with IPV. Exposure to IPV alone therefore indicates that the child is experiencing at least one type of abuse. There is also a high risk of a co-occurrence of physical abuse, sexual abuse and neglect.

There were 164 child survivors of the 63 IPV deaths.¹⁷⁴ These were children of the death event relationship or previous partnerships (88 children, 48 young people and 28 adult children). All these ‘children’ have been impacted by exposure to IPV and the death event. Most would have been exposed to IPV either in their parent’s prior relationship and/or in the death event relationship. They have all lost a parent. In the eight IPV murder-suicides, they lost two parents.

Research has shown that the ‘developmental stage’ at which children ‘witness’ and experience abuse is relevant to the impact it has on them. Humphreys¹⁷⁵ literature review highlighted that pre-school children living with IPV tended to be the group who showed the most behavioural disturbance. The ‘LONGSCAN’ longitudinal studies in the US suggest that children under eight years find exposure to violence towards their primary caregiver more traumatic than older children. Psychological tests indicated exposure to IPV against their primary caregiver was more disturbing than the effects of direct physical maltreatment.

170 J.W. Worden et al., ‘Comparing parent loss with sibling loss’, *Death Studies*, vol. 23, 1999, pp. 1–15.

171 Humphreys uses the terminology ‘children affected by domestic violence’ to overcome the problematic divisions sometimes made between ‘children witnessing DV’, ‘children exposed to DV’, ‘children directly abused in the context of DV’, ‘children living with DV’ and ‘children drawn into DV’. ‘Children affected by DV’, she states, covers all these overlapping groups, including those where healing from trauma and disruption in the aftermath of DV is an issue. Humphreys states that the distinction between children ‘witnessing’ IPV and being directly abused may be a false one and it should not be the principal criterion for understanding the severity of the impact of the abuse on children and their need for safety and protection. C. Humphreys, *Domestic Violence and Child Protection*, 2007, p. 1.

172 Children living with the applicant are automatically covered by the protection order. Children covered by a protection order will continue to be protected as long as they continue to live with the applicant and the order remains in force, even after the children have turned 17. By contrast, if the children stop living with the applicant, they will no longer be covered by the order, even if they are under 17. Once a child is no longer covered by a protection order, it is advisable to apply to the court to vary the order so that the children can be covered as a ‘specified person’.

173 See section 3(3) of the Domestic Violence Act 1995. This states ‘a person psychologically abuses a child if that person – (a) causes or allows the child to see or hear the physical, sexual, or psychological abuse of a person with whom the child has a domestic relationship; or (b) puts the child, or allows the child to be put, at real risk of seeing or hearing that abuse occurring.’

174 In six deaths, there were no children of either the primary victim or predominant aggressor. In a further three deaths, it is unknown if there are children.

175 C. Humphreys, *Domestic Violence and Child Protection*, 2007; D. Runyan, ‘Listening to children from the LONGSCAN studies on child abuse and neglect: Comparing child self-report and adult report of both exposures and outcomes’ conference paper, *XVI the ISPCAN International Congress on Child Abuse and Neglect*, York, 3–6 September, 2006.

All children are likely to have been exposed to at least some, and often many, of the repeated episodes of IPV that preceded the fatal event. Older children are more likely to have experienced other episodes of abuse. Interviews with abused children who have survived attempted filicide revealed five key themes: 'many bad things have happened to me, this was not the first time I was abused by my parent, I am concerned about my parent, I am alive thanks to my siblings, it is hard to remember exactly what happened'.¹⁷⁸ For many children this life is the only one they have experienced. They may not initially realise that their experiences are not the norm for their peers.

In 22 of the 63 IPV deaths that occurred from 2009 to 2012, 40 children (36 children,¹⁷⁶ 3 young people and 1 adult child) were present at the death event and saw or heard their parent killed,¹⁷⁷ and/or found their dead parent(s), and/or saw their dead parent(s) being attended to by emergency services.

With the death of the adult, the child/ren will have lost a biological parent or a step-parent with whom they have had a significant, although often conflicted, relationship. Their other parent or caregiver may be charged with the offence and so may also be lost to them by being sent to prison. Without either of their usual caregivers available or deemed fit to care for them, the child/ren of the family may end up in further unstable or temporary care environments. Evidence from the regional reviews conducted to date suggests that because the child/ren are now considered safe from the violence that preceded the death, thought is often not given to addressing their current and future mental and physical health needs.

When participants in the Christchurch Health and Development Study¹⁷⁸ were asked at age 18 about exposure to IPV during childhood, 38–39 percent reported experience of at least one type of verbal or physical violence between parents, with equal rates reported as perpetrated by mothers and fathers. Violence initiated by fathers was associated with an increased risk of conduct disorder, anxiety disorder and property offending. Exposure to violence initiated by mothers was associated with an increased risk of alcohol abuse or dependence. While violence perpetrated by mothers is not without its negative effects, exposure to violence by fathers appears to have more pervasive developmental effects on children. Exposure to more severe IPV was associated with a corresponding significant increase in the childhood risk of sexual abuse and regular use of physical punishment by a caregiver.

4.2.2 Children as offspring of the deceased

The children described in this report have experienced fatal family violence and often uxoricide – the murder of a parent by the other parent. The literature available in regard to outcomes for surviving children is not extensive and also not consistent as children, young people and even adult survivors may be studied at various stages and ages after their initial experience. Steeves and Parker¹⁷⁹ reported on the experiences of 47 adults who experienced uxoricide in childhood or young adulthood (up to age 21). In 41 cases, the mother was killed and in six cases the father. The child 'witnessed' the homicide in 48 percent of cases.

Children with a deceased parent are likely to subsequently have a change in caregiver and home because of the events. In Steeves and Parker's study, 26 had moved to live with a member of the victim's family and 11 with a member of the offender's family. Only three were adopted by strangers. A number reported experiencing other forms of abuse by subsequent caregivers. Many reported the need to learn about the homicide as an adult as well as the need to reconnect with and forgive the offender.

176 Two of these children were siblings of the primary victim.

177 Only two of these deaths involved children being present when a step-parent was killed. In two other events the children or sibling present were related to the offender, not the deceased.

178 D. Fergusson and L. Horwood, 'Exposure to interparental violence in childhood and psychological adjustment in young adulthood', *Child Abuse & Neglect*, vol. 22, 1998, pp. 339–57.

179 R.H. Steeves and B. Parker, 'Adult perspectives on growing up following uxoricide', *Journal of Interpersonal Violence*, vol. 22, 2007, pp. 1270–84.

4.2.3 Children as siblings of the deceased

In 28 of the 34 CAN death events discussed in this report, there were a total of 52 surviving siblings or half-siblings. A number of these children were present in the family home at the time of their sibling's death. In 21 of these death events there were 37 children¹⁸⁰ who were present at the time of the death or who found the deceased. Twenty-eight of these children were siblings or half-siblings and are therefore highly likely to have had previous experience of family violence as well as experiencing the death of their sibling or half-sibling.

For children in stable family environments, the sudden death of a sibling results in a grief reaction similar to that experienced by adults.¹⁸¹ The same death can be experienced in different ways by surviving siblings.¹⁸² Population studies suggested that between 5 and 8 percent of children and young people experience death of a sibling and that this experience is associated with a reduction of years of schooling completed and other adverse adult socioeconomic outcomes.¹⁸³ Increased risk of psychotic illness in adulthood has also been reported after sudden loss of a father or sibling in early childhood, suggesting that the experience is a significant childhood stressor.¹⁸⁴

A study (in which 15 children – aged 7–18 years – were interviewed an average of five months after the murder of an older sibling by a non-family) member, found that 80 percent met criteria for mental health disorders, which had started since the homicide.¹⁸⁵ The most common of these were co-morbid depressive, post-traumatic stress disorder and anxiety disorders.

Children who have a deceased sibling because of fatal inflicted injury in the context of family violence, have a significantly more complex experience than that of children who have a sibling die because of medical illness, an accident or a non-family homicide. They may have also lost their home and parents. In a study reporting on 392 child maltreatment fatalities reviewed by the Oklahoma Child Death Review Board¹⁸⁶ from 1993 to 2003, 299 (76.3 percent) of the victims had siblings. Data on sibling removal were available for 250 of these families. In 44 percent, no children were removed, in 41.2 percent all of the children were removed and in 14.8 percent some, but not all, of the children were removed. Younger children and those exposed to physical abuse were more likely to be removed after the sibling's death than those exposed to neglect.

A number of other factors can influence a sibling's experience of grief in the aftermath of the violent death of a child. If siblings continue to live with a biological parent, they will also experience that parent's grief for the loss of the child, which may render the parent emotionally unavailable to support the surviving children. Other experiences of siblings can include survivor guilt and patterns of overprotective behaviour from their caregivers.¹⁸⁷ If they witnessed the fatal event or preceding episodes of family violence, they are likely to be evidentially interviewed by investigating authorities and therefore may be asked to take on the responsibility of providing evidence confirming one or other of their parents is liable for the crime. They may be asked to testify in a courtroom some months or years after the event. These potentially traumatising experiences are likely to exacerbate already established symptoms of post-traumatic stress disorder arising from past exposure to or direct experience of violence within the home.

180 Thirty-six children and one young person.

181 E.A. Burns et al., 'Sibling grief in reaction to sudden infant death syndrome', *Pediatrics*, vol. 78, no. 3, 1986, pp. 485–7.

182 M. Van Riper, 'Death of a sibling: five sisters, five stories', *Pediatric Nursing*, vol. 23, 1997, pp. 587–95.

183 J. Fletcher et al., 'A sibling death in the family: Common and consequential', *Demography*, vol. 50, 2013, pp. 803–26.

184 M.C. Clarke et al., 'Sudden death of father or sibling in early childhood increases risk for psychotic disorder', *Schizophrenia Research*, vol. 143, 2013, pp. 3636.

185 L.N. Freeman et al., 'Neglected victims of homicide: The needs of young siblings of murder victims', *American Journal of Orthopsychiatry*, vol. 66, 1996, pp. 337–45.

186 A. Damashek and B.L. Bonner, 'Factors related to sibling removal after a child maltreatment fatality', *Child Abuse & Neglect*, 2010, pp. 563–9.

187 E. Winder and the Committee on Psychosocial Aspects of Child and Family Health, 'Support the family after the death of a child', *Pediatrics*, vol. 130, 2012, pp. 1164–9.

4.3 Conclusion

Fatal child abuse most frequently occurs in the wider context of family violence that is often intergenerational in nature. Death of a parent or a sibling is recognised as a traumatic childhood experience for any child. When a parent or sibling is killed in a family violence homicide and the surviving child/ren have been exposed to a history of family violence, the effect is particularly traumatic.

In the context of family violence, the death is likely to be just one of a succession of traumatic experiences that have been present prior to the fatal event and are likely to continue in the aftermath of the event. These experiences place the child or young person at a greater risk of post-traumatic stress disorder and other co-morbid psychiatric disorders, as well as changes in their care situation that may place them at further risk of abuse and neglect, long-term educational failure and consequent socioeconomic disadvantage. It is important that children in this situation are assessed for these disorders and a management plan put in place.

4.4 Recommendations

3. All child survivors of a family violence homicide involving a biological parent, caregiver or sibling¹⁸⁸ should be considered vulnerable children and therefore have access to assessment and support services as outlined in the Children's Action Plan. These children should have a comprehensive assessment of their needs (health, safety, wellbeing and educational) and appropriate follow-up. The first consideration must be whether they are currently in need of care and protection. Where these children are involved with CYF and a referral for a family group conference has been made, their health and educational needs should be considered through the Gateway assessment process (whether they are entering the ongoing care of CYF or living with family/whānau) or similar assessment processes.

Vulnerable child survivors not reaching the threshold for ongoing involvement with CYF will come under the remit of the newly emerging Children's Teams,¹⁸⁹ and assessment and follow-up should be coordinated by the relevant local team. In areas where a Children's Team is not yet functioning, CYF, where involved, should ensure appropriate referrals are made.

All vulnerable children and their families/whānau should continue to receive support from the appropriate services until a clear pathway for their ongoing care is established and the children have been shown to be making good progress in their physical and mental health, and good educational progress in their new care situation.

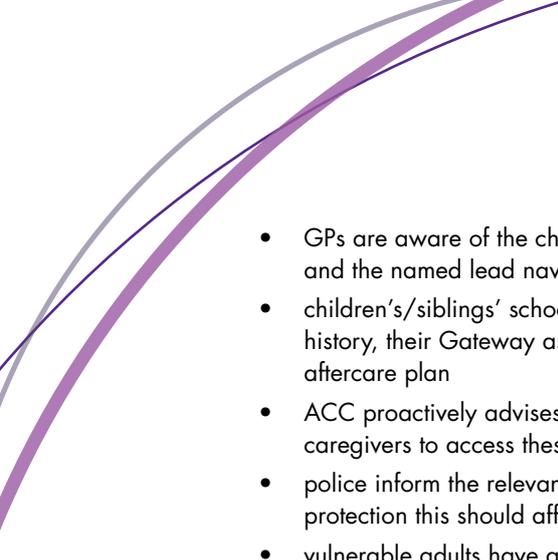
4. In the *Third Annual Report* the Committee recommended the development of a formal multi-agency aftercare process for IPV and CAN deaths.¹⁹⁰ To further this recommendation, the Committee plans to establish a working group¹⁹¹ to draft a national family violence death aftercare protocol. The protocol will be focused on clarifying the roles and responsibilities of each organisation – and the process to be followed – to ensure safe and holistic care pathways are developed for survivors of fatal family violence. This protocol will ensure that:
 - children/siblings receive culturally appropriate therapeutic services after a death and have their wellbeing needs addressed
 - a traumagram is completed to identify intergenerational patterns of trauma and harm in the extended family of the deceased and offender
 - patterns of intergenerational trauma are considered and addressed by all social sector agencies involved. Agencies will need to proactively seek and share information about safety risks posed to adults and children by ex-partners and extended family members, and plan together to mitigate further abuse

188 This includes child siblings of the offender.

189 The Gateway assessment process and involvement with the Children's Team are consent-based processes. The Gateway programme targets children and young people at risk of coming into CYF care, entering care or already in care. Participation in the programme results in an individualised and comprehensive health and education assessment for the child or young person concerned.
<http://www.cyf.govt.nz/keeping-kids-safe/ways-we-work-with-families/gateway-health-and-education-assessments.html>.

190 FVDR, *Third Annual Report*, 2013.

191 Ideally this group would involve representatives from the Department of Corrections; CYF; New Zealand Police; Ministry of Education; Ministry of Health; Ministry of Justice; Māori Reference Group; Office of the Children's Commissioner; Victim Support; Accident Compensation Corporation (ACC); Family Court and local non-governmental family violence services.

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- GPs are aware of the children's/siblings' trauma history, their Gateway assessment recommendations and the named lead navigator/agency for the aftercare plan
 - children's/siblings' schools/early education providers are aware of children's/siblings' trauma history, their Gateway assessment recommendations and the named lead navigator/agency for the aftercare plan
 - ACC proactively advises what the surviving children's entitlements are and assist them and/or their caregivers to access these
 - police inform the relevant agencies if children are protected by protection orders and explain the protection this should afford them
 - vulnerable adults have a named lead navigator/agency for their aftercare plan
 - police flag vulnerable adult victims on the NIA and ensure the police district where they may have moved to is aware that they are living there
 - parenting assessments of abusive parents (who may be involved in their children's care) involve specialist family violence service providers, who are able to undertake a risk and safety assessment of the parent.

Chapter 5: Findings from the regional reviews: Justice issues

A critical part of the multi-agency family violence system¹⁹² that responds to family violence is the justice sector. This encompasses: the legislative framework; New Zealand Police; the Department of Corrections; the courts; Ministry of Justice initiatives; CYF; judges, prosecutors, lawyers and court staff; family violence services; stopping violence programmes; and multi-agency case management processes.

Importantly, the Ministry of Justice and other agencies in the justice sector have multiple work programmes focused on improving the justice sector response to family violence. Unfortunately, this work is not aligned between organisations. In the absence of an overarching strategic framework, there is a danger that initiatives may be progressed by different organisations in an ad hoc and potentially conflicting manner. A Justice Sector Family Violence Strategy, which details the joint operational and fiscal commitment from all justice sector agencies, would ensure improved services, greater coordination and safer and more effective justice processes in family violence cases.¹⁹³

In the Committee's *Third Annual Report*¹⁹⁴ recommendations were made to improve the multi-agency (including justice) response to high-risk cases of family violence and the current provision of stopping violence programmes. The regional reviews have evidenced further emerging issues in the justice system response to family violence.

One is the timeliness of criminal court proceedings. Sentences intended to punish and rehabilitate family violence offenders are less effective the longer it is before they are imposed and implemented. Delays result in abusive (ex-) partners being less likely to change and victims being placed under increased pressure to recant. The Committee found several instances of convictions taking more than a year after a family violence episode to be entered and a sentence imposed. It remains to be seen if the Criminal Procedure Act 2011¹⁹⁵ will improve court delays in criminal matters. Consideration could be given to developing fast-track criminal justice processes for family violence related offences. This has been achieved for family violence cases in other jurisdictions.¹⁹⁶

Another issue emerging in the regional reviews is the limited consequences for breaches of protection orders (see section 3.2.4). The Independent Police Conduct Authority's report into the death of Ashlee Edwards, released on 20 December 2013,¹⁹⁷ highlights the potentially lethal consequences of not enforcing breaches of protection orders.

In Chapter 6, the Committee outlines the value of judicial education about family violence as a means of improving the justice sector response to family violence. In this chapter, the Committee focuses its discussion on two legislative reforms that would result in more effective justice sector recognition of the experience of family violence victimisation.

192 See glossary of terms for the definition of the multi-agency family violence system when used in this report.

193 *The NSW Domestic Violence Strategy: Improving the NSW Criminal Justice System's Response to Domestic Violence, 2013–2017*. Also see *A Right to Safety and Justice: Strategic Framework to Guide Continuing Family Violence Reform in Victoria 2010–2020*.

194 FVDR, *Third Annual Report*, 2013.

195 On 1 July 2013, the final stage of Criminal Procedure Act 2011 commenced, introducing the biggest overhaul of the criminal justice system in 50 years. The resulting changes are intended to simplify and streamline court processes and cut out unnecessary steps. More information on the criminal processes from 1 July 2013 is available from the 'Information for legal professionals' webpage on the Ministry of Justice's website. This includes the forms and notices for legal professionals to use, and incorporates information contained in information sheets developed by the Criminal Procedure Act Implementation project.

196 D. Cook et al., *Evaluation of Specialist Domestic Violence Courts/Fast Track Systems*, Department of Constitutional Affairs, Criminal Justice System Race Unit and Crown Protection Service, 2004.

197 Independent Police Conduct Authority, *Police Response to Complaints Made by Ashlee Edwards*, 2013.

5.1 Non-fatal strangulation – a near miss

The regional reviews have shown that non-fatal strangulation¹⁹⁸ is an important lethality risk indicator and the Committee believes it must be considered a 'red flag' for future serious abuse and fatality (see sections 3.2.3 and 6.3).

The literature suggests that victims tend to minimise incidents of strangulation when they report them. The National Center for the Prosecution of Violence Against Women (NCPVAW)¹⁹⁹ notes that often in cases involving IPV, child abuse and sexual assault, there is an allegation by the victim that 'he choked me'. What is often termed 'choking' by victims – the grabbing, suppression, squeezing or crushing of the throat – is an act of strangulation.

Because strangulation typically does not leave external evidence (if there is bruising and swelling, it often does not appear until days later and may not be visible on victims with darker complexions), strangulation is often not properly understood or investigated by agencies and tends not to be prosecuted as the serious assault it is.²⁰⁰ The Office of the City Attorney in San Diego²⁰¹ evaluated 300 alleged strangulation assault cases, submitted for misdemeanour prosecution, to identify the signs and symptoms of attempted strangulation that could be used to corroborate the victim's allegation of being 'choked' for the purposes of prosecution. The study showed that a lack of training may have caused police and prosecutors to overlook symptoms of strangulation or to rely too heavily on the visible signs of strangulation. Because most victims of strangulation had no visible injuries or their injuries were too minor to be photographed, the opportunities for higher level criminal prosecution were missed.²⁰²

The NCPVAW²⁰³ has developed a strangulation factsheet to aid the identification, investigation and prosecution of strangulation. It stresses that this form of abuse needs to be called by the correct name – strangulation. Once non-fatal strangulation has been identified, there needs to be a specific medical intervention and a thorough investigation.

Despite strangulation often being minimised in victim reports, investigations and prosecutions, it is in fact, extremely dangerous and potentially lethal. Strangulation involves the compression of the airway and the bilateral compression of the carotids that supply blood to the brain. The danger can be appreciated when it is understood that the brain needs a continuous supply of oxygen – without this brain cells quickly malfunction and die. Brain cells are not regenerative. Death and serious harm can occur imminently. Loss of consciousness can occur within 5–10 seconds and death within 4–5 minutes. There is a fine line between a non-fatal and a fatal strangulation. In Minnesota from 1989 to 2005,²⁰⁴ 13 percent of all women murdered by an intimate partner and 17 percent of all children murdered by a family member were strangled to death. In Aotearoa New Zealand from 2009 to 2012, nine (14 percent) of the 63 IPV deaths involved an act of strangulation as part of the death event. In six cases, strangulation was the cause of death, and in one case it was one of the associated causes of death. Furthermore, the study by the Office of the City Attorney in San Diego²⁰⁵ found that of 300 alleged strangulation assault cases, injuries identified in non-fatal cases were similar to injuries found in fatal IPV strangulation assaults.

198 See glossary of terms for an explanation of the terms strangulation and non-fatal strangulation as used in this report.

199 National Center for the Prosecution of Violence Against Women, 'And then he choked me', *The Voice*, vol. II, no. 1, American Prosecutors Research Institute, The Research and Development Division of NDAA, 2007.

200 The use of physical force by an intimate partner during episodes of IPV can cause traumatic brain injury as abusive partners often cause injury to a victim's head, neck (including strangulation) and face. For more information, see the Violence Against Women Net Special Collection: Traumatic Brain Injury and Domestic Violence: *Understanding the Intersection* at www.vawnet.org/special-collections/DVBrainInjury.php

201 D. Hawley et. al., 'A review of 300 attempted strangulation cases. Part III: injuries in fatal cases', *The Journal of Emergency Medicine*, vol. 21, no. 3, 2001, pp. 317–22.

202 Children were present in 41 percent of the cases (although this is thought by the researchers to be a low report); 89 percent of offenders/victims had prior domestic violence incidents; in 50 percent of the cases, police reported no visible injuries; in 35 percent the injuries were too minor to photograph, which included redness or scratch marks on the neck. Only 15 percent of the cases had photographs that could be used in evidence. There was some documentation of other non-visible injuries, such as pain when swallowing, nausea, hoarseness, shaking, loss of memory, incontinence, loss of consciousness, etc. In this study, prosecution of strangulation cases generally occurred when there was evidence of injuries from other forms of violence, independent corroboration of being strangled and a prior history of domestic violence.

203 The National Center for the Prosecution of Violence Against Women, 'And then he choked me', 2007.

204 Minnesota Coalition for Battered Women, *Special Femicide Report: Strangulation and Women and Children Murdered in Minnesota, 1989–2005*, 2005.

205 D. Hawley et.al., 'A review of 300 attempted strangulation cases', 2001, pp. 317–22.

Thomas et al²⁰⁶ state that strangulation is a unique and particularly gendered form of non-fatal IPV, affecting 10 times as many women as men. In the US, the lifetime risk of IPV strangulation in the general population is 1:100 for men and nearly 1:10 for women.²⁰⁷ Thomas et al²⁰⁸ undertook a qualitative study with 17 African American domestic violence shelter residents, to explore these women's experiences of, thoughts about and reactions to being strangled. Each woman had been strangled at least once by an intimate partner; most had survived multiple strangulation assaults. The women reported vulnerability and fear when they recognised during the strangulation assault how easy it could be for their abusive partner to kill them. They also reported experiencing intense physical pain and being convinced that death was imminent. Participants described 'going into survival mode' each time they were strangled. This indicates that they did not and could not know if their partner's intent was to kill or immobilise them. Thomas et al²⁰⁹ stated that for the participants, strangulation reinforced the many other coercive controlling behaviours they experienced on a daily basis.

'Strangulation is a way to literally silence women. We encourage theorists, practitioners and researchers to consider strangulation as a method to establish ongoing fear and control as well as a discrete act. Situating a strangulation incident within the context of coercive control highlights its unique nature and offers insight into perpetrators' motivations and the extent of victims' entrapment. Such information is necessary to improve the response of the legal and mental health systems, thereby increasing avenues to physical and mental safety for victims of IPV.'

Thomas et al²¹⁰ highlight that non-fatal strangulation differs from other forms of severe IPV, because 'few abusive behaviours are so closely linked to the possibility of dying, and few are so difficult to detect'. This combination of high harm (inability to resist and high fear of death) and low detection makes strangulation a dangerously effective method of coercive control. Non-fatal strangulation is a way an abusive partner can 'set the stage' by sending the message that he can, and perhaps will, kill the victim – her life is literally in his hands. It need not be repeated to produce compliance in the victim.

The Committee found multiple instances of non-fatal strangulation of both partners and children in the regional reviews, which were frequently downplayed in police reports and, if prosecuted, were prosecuted as a Male Assaults Female (MAF), rather than as an attempted homicide or a serious interpersonal violence offence. In part, this is because of the high standard of criminal proof and the high standard of intentionality (to kill or injure) that must be proved in respect of these more serious charges. Furthermore, because the more serious interpersonal violence offences tend to require that some degree of physical harm be caused to the victim, and non-fatal strangulation frequently does not leave an obvious physical mark on the victim, it is not readily investigated or prosecuted as one of these offences. Whilst there are specific forms of harm that are criminalised regardless of the degree of bodily injury they cause to the victim,²¹¹ non-fatal strangulation that does not render the victim unconscious²¹² does not fall into a specific type of injury that is currently criminalised.²¹³ Recognising these kinds of issues, since 2013, 37 US states have enacted laws making non-fatal strangulation a felony.

206 K. Thomas et al., "Do you know what it feels like to drown?" Strangulation as coercive control in intimate relationships', *Psychology of Women Quarterly*, 20 May 2013.

207 M.C. Black et al., National Intimate Partner and Sexual Violence Survey: 2010 Summary Report, Atlanta, GA, Centers for Disease Control and Prevention, 2011.

208 K. Thomas et al., 'Do You Know What It Feels Like to Drown?', 2013.

209 Ibid p. 11.

210 Ibid p. 9.

211 For example, 'wounding', 'maiming' and 'disfiguring', (sections 188 and 191(1), Crimes Act 1961), 'stupefying' (sections 191(1) and 197, Crimes Act 1961), 'poisoning' (section 200, Crimes Act 1961), 'acid throwing' (section 199, Crimes Act) and 'infecting with disease' (section 201, Crimes Act 1961). The inclusion of these particular forms of criminal behaviour indicates that the criminal justice system already recognises the need to single out certain specific types of physical harm.

212 Rendering the victim unconscious would amount to 'stupefying' them under sections 191(1) and 197 of the Crimes Act 1961.

213 For example, it is not a wounding under sections 188 or 191(1) because a wounding requires the breaking of the skin or a skin-like membrane.

The use of strangulation provides an insight into the mind of the abuser.

- The NCPVAW factsheet²¹⁴ on strangulation states the ‘perpetrator’s use of strangulation foreshadows an escalating use of violence and homicidal intent to the victims’.
- The research by Glass et al shows that prior non-fatal strangulation by a woman’s male partner was associated with a 700 percent increase of the likelihood he would attempt to kill her, and an 800 percent increase in the likelihood of him actually killing her.²¹⁵
- Strack and Gwinn²¹⁶ state one of the major findings from all the research undertaken on strangulation initiated by the San Diego study is, ‘most abusers do not strangle to kill – they strangle to show they “can” kill.’

These findings resonate with how strangulation features in the regional reviews. In 12 of the 17 regional reviews, reported strangulation was a feature of the abuse histories within the current relationship and/or in a previous relationship. Agency records or disclosures during the homicide inquiry suggest these 12 regional reviews involved at least 29 strangulation assaults – although, because the regional reviews are based on information derived from agency records, the actual number is likely to have been considerably higher. All 29 instances of strangulation involved a male abuser. In 27 instances, a woman was the victim. In two instances, a child was the victim.

Sixteen of the 29 strangulation assaults were reported to the police, resulting in charges with respect to acts of strangulation being laid in 11 instances. Eight of the strangulations were charged as MAF (four as solely MAF, and four as MAF accompanied by other charges resulting from the same abusive episode) and three were charged as an Assault with Intent to Injure. Convictions resulted in six cases, with MAF being the most serious conviction. In the Committee’s view, a MAF conviction for strangulation in the context of IPV, even in cases where the strangulation does not cause physical harm, downplays the impact of this form of violence on the victim by suggesting the harm she has experienced is that she has been touched without her consent.

The percentage of regional reviews that had strangulation histories (71 percent) is striking. Also striking is the gendered nature of the strangulation history recorded and the fact that in many of these cases (6 of the 12 cases in which there were strangulation histories – ie, 50 percent) the recorded history included multiple strangulations, ranging from two to nine in number. Strangulation emerges in the history of some of the abusers as a clear modus operandi in their perpetration of abuse against their intimate partners and step-children. For example, over the course of seven years, one abuser was known to the police for six reported strangulations against three victims (two adults and one child).

In 7 of the 12 regional reviews which had a recorded history of strangulation, the predominant aggressor had a reported history of non-fatal strangulation against previous partners, a child and/or their current partner before the death event.²¹⁷ In another three of these regional reviews, the predominant aggressor had a history of strangulation against a prior or current partner that was disclosed to the police homicide inquiry after the death event. In the final two cases, the primary victim in the current relationship had a police reported history of previous partners trying to strangle them.

214 The National Center for the Prosecution of Violence Against Women, ‘And then he choked me’, 2007.

215 The purpose of the study is to examine non-fatal strangulation by an intimate partner as a risk factor for major assault, or attempted or completed homicide of women. A case control design was used to describe non-fatal strangulation among complete homicides and attempted homicides (n=506) and abused controls (n=427). Interviews of proxy respondents and survivors of attempted homicides were compared with data from abused controls. Data were derived using the Danger Assessment tool. Non-fatal strangulation was reported in 10 percent of abused controls, 45 percent of attempted homicides and 43 percent of homicides. Prior non-fatal strangulation was associated with greater than six-fold odds (OR 6.70, 95% CI 3.91–11.49) of becoming an attempted homicide, and over seven-fold odds (OR 7.48, 95% CI 4.53–12.35) of becoming a completed homicide. These results show non-fatal strangulation as an important risk factor for homicide of women. N. Glass et al., ‘Non-fatal strangulation is an important risk factor for homicide of women’, *The Journal of Emergency Medicine*, vol. 35, no. 3, 2008, pp. 329–35.

216 G.B. Strack and C. Gwinn, ‘On the edge of homicide: Strangulation as a prelude’, *Criminal Justice*, vol. 26, no. 3, 2011.

217 This includes five non-fatal strangulation incidents reported to the police prior to the death:

- Two predominant aggressors were on community sentences due to being convicted for what were actually non-fatal strangulation assaults when they killed their next victims (an adult or child). In one of these cases, the predominant aggressor had previously strangled a series of adult partners and a child but had only been prosecuted for one of those events.
- One predominant aggressor was wanted for arrest for a non-fatal strangulation assault against a pregnant ex-partner when he killed his next victim (a child).
- One predominant aggressor, as part of the death event, strangled his estranged partner and had previously strangled another ex-partner who informed the police homicide inquiry she thought at the time she was going to die.
- One predominant aggressor was convicted of MAF for a non-fatal strangulation assault against a previous partner and, a year after completing his sentence for that offence, killed his next partner.

In the remaining two cases: one involved strangulation being ticked yes to as part of the (old) police family violence intervention report for another reported assault, and in the other, strangulation had been ticked yes on a family violence agency risk assessment.

Strangulation is a unique form of violence in that, even where physical injury is not caused to the victim, it exposes the victim to a high level of risk in respect of very serious harm and has a serious psychological impact. Multiple studies²¹⁸ confirm that the abuser's act of placing his hands or a ligature around a victim's neck introduces a different level of risk for lethality and brain injury than that associated with assaults such as pushing, punching, slapping or kicking (assaults which would generally result in a MAF conviction).

The deprivation of oxygen is said to be one of the most terrifying experiences a person can endure, particularly when it takes place in the context of a harmful pattern of IPV perpetration and victimisation. The body has an automatic reaction to being denied oxygen and blood to the brain. The victim knows they are about to die if they do not change the situation immediately, which can, in turn, lead to escalation of the violence by the victim.²¹⁹

Guidelines from the Californian District Attorneys Association and Training Institute on Strangulation Prevention²²⁰ emphasise that strangulation is a unique crime which, when it occurs in the context of IPV, has more in common with sexual assault crimes than physical assault crimes. Both sexual offending and strangulation in the context of IPV:

- are gendered in their manifestation
- tend to take place in private
- do not necessarily produce obvious physical injury to the victim
- are arguably motivated not by the desire to hurt the victim but rather the need to assert dominance over her
- tend to have a profound psychological impact on her because of the experience of terror, violation and extreme vulnerability that is imposed upon her.

Strangulation in the context of IPV is usually about the abuser asserting control over the victim by both securing her immediate physical compliance and communicating his lethality and her extreme vulnerability for the purposes of future interaction.

New Zealand does not have a specific criminal offence covering non-fatal strangulation. If there was such an offence it would:

- highlight non-fatal strangulation as a 'red flag' for future harm and fatality. As non-fatal strangulation is currently often minimised by victims and practitioners it frequently represents a lost opportunity for intervention before a death. Naming it would encourage community agencies, police and health professionals to identify and respond appropriately
- remove the need to prove physical injury to the victim, or intent to injure or kill on the part of the offender, before prosecution for a serious family violence criminal offence could take place – thus facilitating a more effective criminal justice response
- highlight incidents of non-fatal strangulation on an offender's criminal record. Currently a non-fatal strangulation, if successfully prosecuted, is likely to be recorded as an assault (in other words, a non-consensual touching that did not cause harm to the victim).

Accordingly the Committee has recommended the enactment of a specific criminal offence for non-fatal strangulation.

218 See, for example N. Glass et al., 'Non-fatal strangulation is an important risk factor for homicide of women', 2008, pp. 329–35; G.B. Strack et al., 'A review of 300 attempted strangulation cases. Part I: criminal legal issues', *The Journal of Emergency Medicine*, vol. 21, no. 3, 2001, pp. 303–9.

219 Brett Johnson, Sweetwater County Attorney, from testimony at a House and Senate Judiciary Committee of the Wyoming Legislature regarding SF 132: Strangulation of a Household Member (2011).

220 Californian District Attorneys Association and Training Institute on Strangulation Prevention, 'IPV Strangulation Manual: The Investigation and Prosecution of Strangulation Cases', A publication by the Training Institute on Strangulation Prevention and the California District Attorneys Association, 2013.

Promising New Zealand practice: A Ministry of Health-contracted expert advisory group²²¹ has developed a best practice guide for people who present to a health care provider following an agency assessment identifying a strangulation event.

The group has developed:

- a clinical guideline for the assessment and management of strangulation (encompassing safety planning for high-risk victims and follow-up support from health and family violence services)
- an acute post-strangulation documentation form
- a discharge information sheet for patients and their families and friends.

The aim is to include this work within the revised Ministry of Health Family Violence Intervention Guidelines. A training package will be developed when this progresses.

The Committee commends the work of this group and supports the development of a health response to strangulation.

5.2 Primary victims who kill the predominant aggressor – legal defences to homicide charges

In Chapter 3, the Committee outlined the importance of a primary victim/predominant aggressor analysis in family violence cases (see section 3.1.2). The Committee has found that some offenders in family violence homicides were not the predominant aggressor in the relationship that led to the death event. A significant number of female offenders in family violence homicides have extensive histories of being the primary victim of family violence before the death event. In 9 of the 14 IPV homicides from 2009 to 2012 with a female offender, the offender was, in fact, the primary victim in the relationship, and in a tenth case she was the suspected primary victim.²²²

The outcomes of the criminal proceedings for these 10 primary victims were: murder in two, manslaughter in six, an acquittal on the basis of self-defence in one and one hung jury. The defence of provocation, which reduces a murder conviction to manslaughter, was abolished at the end of 2009 but continues to be available to those who are charged with homicide where the death took place before that date. Therefore it is likely that some of the manslaughter verdicts in our sample were founded on the defence of provocation.²²³ Today such cases would result in murder convictions. It is also possible that the murder convictions may have been manslaughter convictions if the death had occurred before 7 December 2009 and the abolition of the provocation defence.

Compared with similar international jurisdictions, Aotearoa New Zealand is out of step in how the criminal justice system responds to IPV primary victims when they face homicide charges for killing their abusive partners. In Appendix 1 the reasons for this are explained. Firstly, it can be attributed to the fact that the defence of self-defence has been interpreted in a restrictive manner in Aotearoa New Zealand, making it difficult to apply in cases involving primary victims. Secondly, by abolishing provocation New Zealand now has no partial defences to murder for those primary victims whose circumstances do not fit within the full defence of self-defence. These defendants will now be convicted of murder rather than manslaughter. And thirdly, Aotearoa New Zealand retains a presumption of life imprisonment for murder, which is difficult to overturn even in such cases and, when it is overturned, still results in long sentences of imprisonment. As such the violent circumstances (that offenders who were primary IPV victims were entrapped in and responding to) do not appear to be reflected in local verdicts to the same degree as they are in comparable international jurisdictions.

221 Dr Jacqueline Campbell, Dr Nancy Glass, Assoc. Prof Denise Wilson, Prof Jane Koziol-McLain, Dr Kim Yates (Clinical Director ED, Waitemata DHB), Dr Clare Healy (GP and forensic physician) and Miranda Ritchie (National Violence Intervention Programme Manager).

222 The remaining four cases involved two female predominant aggressors who killed their intimate partners, one aberrational case and one case where a woman killed the female partner of a man with whom she had had an affair.

223 The other possible basis for a manslaughter verdict might be when an unlawful and dangerous act causing death has occurred, but without any evidence of mens rea (intention or recklessness as to death) for murder.

In 2001 and 2007, the New Zealand Law Commission considered the reform of the criminal defences for victims of family violence facing homicide charges, and provocation was abolished as recently as 2009. However, the Committee considers that the current position is still unsatisfactory for such defendants.

In 2001 and 2007, the Law Commission recommended reforms in order to address the effects abolishing provocation would have for such defendants. As explained in Appendix 1, these have either not been implemented or have only partially been implemented. The reforms have meant that homicide defendants who are primary victims of family violence:

- do not have improved access to self-defence
- are no longer able to raise a partial defence and therefore will be convicted of murder if they are unsuccessful in raising self-defence in cases where they were reacting to the abuse history and the killing was not accidental
- are likely to be sentenced to a substantial period of imprisonment, even if they are successful in getting the presumption of life imprisonment overturned on a murder conviction.

Prior to its abolition, the defence of provocation was being used by predominant aggressors to justify their abuse. However, the Committee notes in Appendix 1 that, since 2007, a number of comparable international jurisdictions have started reforming their criminal defence law so that provocation, or another partial defence, is available in exceptional circumstances, such as those cases in which primary victims were retaliating against the serious and ongoing violation of their fundamental human rights when they killed, but not in the unexceptional circumstances presented by, for example, relationship breakdown. In other words, these reforms are aimed at ensuring a partial defence is available for primary victims but not predominant aggressors in family violence homicides. The Committee believes these jurisdictions provide an international precedent for Aotearoa New Zealand to take a more nuanced and less black and white approach to reforming of the criminal defences to homicide.

A punitive criminal justice response to cases where IPV primary victims have retaliated against that abuse is likely to increase rather than address family violence morbidity. This includes the impact on children of being exposed to a history of serious abuse and losing one parent to death and the other to a lengthy incarceration (see Chapter 4). The Committee therefore takes the view that the response to a family violence homicide – both in the immediate aftermath care for survivors and the criminal justice response – falls within its terms of reference.²²⁴

The defence of primary victims of family violence who are facing homicide charges is a specialist subject. Although these cases take place regularly, they are not numerous. It cannot be assumed that even the most highly experienced criminal lawyers will have professional knowledge about such situations. These cases have nonetheless generated a large body of scholarship and shifts in understanding have resulted in ongoing international reform. Effective engagement with the issues presented in such cases would be facilitated by expert assistance on the subject.

The Committee recommends that the Government considers modifying the defence of self-defence so that it is more readily accessible to primary victims of family violence who are facing homicide charges, and re-introducing a partial defence for such defendants who are responding to violence but not acting in self-defence at the time of the homicide. Caution will be needed in order to ensure that such a defence is not available for predominant aggressors of family violence. It is also suggested that the Government establishes an expert advisory group to inform its deliberations on these issues.

224 See www.hqsc.govt.nz/our-programmes/mrc/fvdc/about-us/terms-of-reference/ for the Committee's terms of reference 2011.

5.3 Recommendations

The Committee recommends that:

5. the Government considers an amendment of the Crimes Act to include non-fatal strangulation as a separate crime under part 8 of the Crimes Act 1961.
6. the Government:
 - considers modifying the test for self-defence (set out in section 48 of the Crimes Act 1961) so that it is more readily accessible to homicide defendants who are primary victims of family violence
 - considers the introduction of a partial defence that can be utilised by primary victims of family violence who are not acting in self-defence at the time they retaliate in response to the abuse that they have experienced
 - convene an advisory group of experts (on the defence of primary victims who kill the predominant aggressor) to inform its deliberations.

Chapter 6: Future priorities

The Committee concludes by highlighting a number of other findings emerging from the regional reviews that further develop themes woven throughout this report. The first is the need for professional education and training. The second is the need to develop a national family violence service accreditation framework and a set of consistent practice standards across the social sector.²²⁵ The final focus is on learning from near misses, as this could prevent family violence deaths from occurring.

6.1 Education and training

In all regional reviews, the Committee found the need to strengthen professional education and training about family violence, and for multidisciplinary education forums that promote collaborative practice. The regional reviews evidenced patterns of practitioner ‘oversights’, missed cues or the non-recognition of the need to intervene across disciplines when there were clear signs of coercive control, lethality risk factors and indicators of CAN. It is noticeable that many practitioners did not understand or appreciate the significance of key cues regarding victims’, and others’, safety. The outcome of these oversights included practitioners not acting appropriately to ensure victim safety, not communicating crucial information to the relevant people or – in some cases – taking a ‘hard to reach’ victim off the ‘books’.

The Taskforce for Action on Violence within Families (the Taskforce) recognises that this is an issue. A report was prepared by the Ministry of Health for the Taskforce²²⁶ to help define the ‘family violence workforce’. The Committee understands that the Taskforce agreed to progress two recommendations in this report (a competency framework and engaging in the qualifications review)²²⁷ but that action on these is still to occur.

The report defines the ‘family violence workforce’ as including all those who have the opportunity and responsibility to identify and respond to families experiencing family violence. This includes those working intensively with victims and family violence abusers such as social workers and Family Court practitioners, and those who are likely to encounter various forms of family violence in the course of their work, such as teachers, psychologists or those delivering parenting programmes. The Taskforce report notes that individuals come into the family violence workforce with a range of skills and education, and work within a range of professional or occupational structures. They draw a distinction between:

- the ‘regulated professional workforce’ – professions where there is a legislative expectation or requirement for accreditation or registration in order to practice, such as doctors and teachers
- the ‘unregulated workforce’ – those for whom registration or accreditation is not a legal requirement, including an important volunteer workforce.

225 See glossary of terms for the definition of the social sector when used in this report.

226 Taskforce for Action on Violence Within Families, *Training and Education for the Family Violence Workforce: Developing a National Training Framework*, 2013.

227 Build consensus across the family violence workforce around the skills and knowledge required by developing a competency framework linked to the Children’s Action Plan. This would have required working with the Children’s Action Plan project team in 2013 to develop the framework and formally engage with the current qualifications review being led by Careerforce in order to promote systematic inclusion of family violence education within qualifications below degree level.

The Institute of Medicine²²⁸ states that a major barrier to effectively engaging with those living amidst family violence is inadequate education, training and support given to practitioners to intervene effectively. This can lead to practitioners:

- reinforcing societal myths about family violence
- neglecting to understand the complicated lives of victims, with the result that victims are not identified, or are re-victimised or blamed
- interfering with victims' strategies to 'escape' violence
- not holding perpetrators accountable for their behaviours
- discriminating against victims in a manner that impacts on their access to crucial services
- having over-confidence in assessing situations when there is a lack of evidence to inform practice.

Promising New Zealand practice: The Department of Corrections' family violence training.

Training will be delivered to all probation officers and some other frontline staff and adapted for prison-based case managers. The training package involves two days of training for all frontline practitioners and a third day, aimed at developing a specialist in each team who will be available for case consultation. The training is complemented by additional information in the Corrections Practice Centre, for staff to access to support their practice into the future. The training content covers:

Day One '*Understanding Family Violence*':

Introduction and history of family violence
Acts and orders
Defining family violence
Prevalence
Family violence offender treatment
Why abuse happens
Perpetrator typology
Effects on women and children

Day Two '*Family Violence Practice Guidelines*':

Assessing and responding to risk
Why women stay in abusive relationships
Supporting victim safety through relapse prevention work with offenders
Working with external agencies (including other agencies' risk assessments)

Day Three '*Family Violence Interventions*':

Victim safety at point of disclosure
Monitoring, supervision, treatment and victim safety aspects of sentence management
Motivational interviewing techniques tailored to family violence cases
Challenging conversations and distortions safely
Practice tools available

228 Institute of Medicine (IOM), *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence*, Washington, DC, The National Academies Press, 2002, p.124.

6.1.1 Defining education and training

Successful education and training is contingent on the right content and effective education methods, which are informed by adult learning theory. A three-pronged approach that includes personal, professional and interdisciplinary components is needed.

The Institute of Medicine²²⁹ suggests three levels of education and training.

1. Basic – applies to everyone and is essential for building a system that responds to family violence.
2. Advanced – requires complex and advanced specialty knowledge and skills necessary for people to function in their role or position.
3. Leadership – necessary for those who hold family violence-specific positions.

Education promotes knowledge about family violence, ie, dynamics of family violence and IPV lethality risk factors.

Training focuses on the development of skills that can be used in practice, ie, the interpersonal skills of communicating, which include monitoring what one conveys by way of information, how one listens to another practitioner and how other practitioners' messages are interpreted.

Education and training should not be considered a single or short-term event. Little is known about whether knowledge and skills are sustained or if they reduce over time without ongoing support. Practitioners' formal learning needs to be embedded through actual practice, including mentoring and modelling by senior practitioners. Long-term investment in practitioners' ongoing knowledge and skill development is required to ensure that practitioners can think critically, deal with complexity and practise in a culturally competent and responsive way.

The Committee's observations support the need for continuing education that includes an interdisciplinary and multi-agency approach. The benefits of interdisciplinary/multi-agency training are numerous. This type of approach fosters:

- understanding of different practitioners' roles and responsibilities
- trust in each other's services
- development of skills necessary for working collaboratively.^{230 231 232}

The Committee is also cognisant that education and training is only one, albeit key, component of strengthening organisational responsiveness to family violence.²³³ For example, in addition to inadequate education and training, a number of less visible contributory factors can result in practitioners making erroneous assumptions and decisions. These include:

- workplace conditions – for example, unreasonable caseloads and a lack of managerial support
- workplace systems – for example, incident-focused case management systems and lack of policies/procedures, documentation and quality improvement activities

229 Ibid.

230 L. Colarossi and M.A. Forgey, 'Evaluation study of an interdisciplinary social work and law curriculum for domestic violence', *Journal of Social Work Education*, vol. 42, 2006, pp. 307–23.

231 J.L. Witt and J.L. Edelson, 'The Minnesota Center Against Violence and Abuse (MINCAVA): Providing research, education, and access to information on violence against women and children', *Violence Against Women*, vol. 17, 2011, pp. 1207–19.

232 D.J. Ritchie and K.K. Eby, 'Transcending boundaries: An international, interdisciplinary community partnership to address domestic violence', *Journal of Community Practice*, vol. 15, 2007, pp. 121–45.

233 P. Gillingham and C. Humphreys, 'Child protection practitioners and decision-making tools: Observations and reflections from the front line', *British Journal of Social Work*, 40, pp. 2598–616, 2010. Gillingham and Humphreys emphasise that education and training are not a panacea and other fundamental structural changes need to happen.

- team factors – for example, issues with accessing help, advice or support or poor quality practice supervision and feedback
- interagency/inter-professional team factors – for example, professional hierarchies
- organisational culture and management – for example, the influence of resource allocation and key performance indicators.

6.1.2 Overlapping workforces

The Taskforce report²³⁴ notes the need for education and training of the family violence workforce to be aligned with the sexual violence workforce and the children’s workforce²³⁵ – both of which have a significant overlap with the family violence workforce. The Committee would welcome the opportunity to work with the Social Sector Forum²³⁶ and those developing the Children’s Workforce Action Plan to provide information from the death review process to inform their work.

6.1.3 Specific professional groups

In the following sections the Committee outlines issues arising from the regional reviews that highlight the need for education and training of three professional groups – judges, GPs and mental health professionals.

Judges

Judges are a key professional group, particularly as they have the final say on sentencing decisions for family violence offenders – a matter that can significantly impact on the safety of victims. Particular issues emerging from the regional reviews include the importance of judges requesting pre-advice court (PAC) reports and considering the safety of children, particularly when a defendant is sentenced to detention at a child’s home.

PAC reports

The regional reviews have noted instances where judges have sentenced from the bench in the absence of a PAC report (previously called a pre-sentence report). This can be problematic as the criminal conviction history does not identify or include contextual information – such as which convictions were for family violence or who the victims of offences were (a stranger, an intimate partner or multiple intimate partners).

As discussed in section 3.1.5, family violence is more likely to be a pattern of behaviour or a pattern of relating than a one-off incident that may or may not be repeated. In order to make safe decisions in cases involving family violence, judges need to be aware of a defendant’s motivation for change and their family violence history against current and previous partners, children or step-children.

In addition to a PAC, the Committee suggests that – in family violence cases – an appropriate risk assessment is made available to assist the judge’s decision-making around risk management and victim safety.

Home and community detention

Abusers who are regularly part of a child’s home environment are likely to have high levels of day-to-day contact with the child/ren. Even if this is not the case, their presence can have a significant impact on the caring environment for the child/ren. Placing an abuser with a history of family violence on community detention at a child’s home can have a significant impact on that child’s life (Chapters 3 and 4 discuss the impact of family violence on children). It is vital for judges and probation officers to consider and assess an abuser’s role as a caregiver, not just as a father, step-father or relative. Where a child’s life is significantly affected by an adult’s sentence, the child’s right to safety needs to be the paramount concern and proactively addressed.

234 Taskforce for Action on Violence Within Families, *Training and Education for the Family Violence Workforce*, 2013. This report draws a distinction between the referring workforce (those who, when encountering instances of family violence, have a responsibility to recognise and refer cases to others) and the responding workforce (those with a responsibility for responding to families experiencing family violence, providing services for both victims and perpetrators).

235 The *Children’s Action Plan 2012* includes the development of a Children’s Workforce Action Plan.

236 The Children’s Action Plan is one of the priorities of the Social Sector Forum and the Social Sector Forum initiatives link to work together with other key pieces of work happening across government including the Family Violence Taskforce – see www.msd.govt.nz/about-msd-and-our-work/publications-resources/corporate/statement-of-intent/2013/cross-agency-leadership.html.

Placing an abuser on community detention at a child's home effectively means that the specified address will become the abuser's social hub. The question which must be asked by probation officers and judges is whether this child's home is going to be a safe place with the presence of this adult.

The new restorative justice family violence pathway response in criminal cases (established in October 2013) and the changes to stopping violence programmes being implemented by the Ministry of Justice in 2014 further highlight the critical role judges play in decisions around family violence interventions within the community context. These changes strengthen the need for a nationally consistent approach to judicial family violence education, training and protocols.

GPs

GPs provide one of the consistent services involved with a family over time, and are frequently one of the few practitioners to whom an IPV victim may disclose abuse, or a parent or caregiver may present with a child who has been abused, before a fatal assault.

The Committee plans to discuss family violence (IPV and CAN) prevention programmes with the Royal College of General Practitioners and the Ministry of Health. The Ministry has been focused on implementing the Violence Intervention Programme (VIP) within district health boards (DHBs), and – while there is some good work occurring within some primary health organisations – there needs to be a Ministry-directed and staged plan for implementing, monitoring and evaluating the VIP within primary health care. Furthermore, there needs to be further discussion as to whether GPs and other professionals working in primary health care should be undertaking routine or targeted screening. GPs also need ready access to specialist family violence practitioners from whom they can seek advice and learn which services in the community are appropriate to assist women and children identified through any screening process.

Mental health professionals

Mental health histories are important in the context of IPV and CAN. In six²³⁷ of the 17 regional reviews conducted to date, the adult family violence offender or victim had been recently involved with DHB mental health services at the time of the death. In a further four regional reviews, the family violence offender had a previous history of suicide attempts and involvement with DHB mental health services.

Findings from the regional reviews have shown that abusive men – who are socially disconnected, depressed and facing an imminent separation – were not only often suicidal, but potentially homicidal as well. Furthermore, mothers experiencing both IPV and mental health issues are at increased risk of neglecting or harming their children. 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 any children and partners must be considered.

Mental health services are emerging as services that are in a pivotal position to enhance the safety of IPV and CAN victims. Since many family violence victims²³⁸ and abusers will present to mental health services, it is important that services take a gendered and trauma-informed approach to their practice – and integrate family violence within their risk and safety assessment frameworks and care pathways.

237 One included the DHB addiction service, which was involved at the time of the death.

238 IPV is one of the strongest risk factors for suicide attempts in women. The systematic review of longitudinal studies, by Devries et al, concluded that IPV was associated with incident depressive symptoms, depressive symptoms and incident suicide attempts. Devries et al state that because IPV is an ongoing pattern of abuse, treatment strategies that fail to address a woman's experience of violence may do further harm. For example, they point out that if violence is not suspected as a potential causative factor, 'patients who have attempted suicide may be encouraged to return to partners/relatives, which could increase the risk of further violence and eventual suicide'.

Devries et al note that women who have attempted suicide and who have experienced IPV are likely to benefit from tailored interventions that address the effects of prolonged exposure to trauma in order to prevent future depression and suicidal behaviour. The PMMRC reported a strong relationship with women's prior experience of IPV and maternal mortality by suicide. For half of the women who took their own lives, a history of family violence was recorded. Gulliver and Fanslow found that women's experience of physical or sexual violence by an intimate partner is strongly associated with suicidal thoughts. Further, this study notes that among women who have ever experienced physical or sexual IPV, their risk of suicidal thinking is strongly associated with their experience of violence by a partner, experience of a miscarriage, stillbirth or abortion and/or their history of recreational drug use. Gulliver and Fanslow say that while all health care providers need to enquire routinely about IPV among their patients, providers must also be aware of, and equipped to respond to, the mental health needs of their clients. They conclude that the results of their New Zealand study indicate that there is a need for mental health services to assess for, and respond to, IPV among women presenting with suicidal ideation. K.M. Devries et al., 'Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies', *PLoS Med*, 10(5): e1001439, doi:10.1371/journal.pmed.1001439, 2013; PMMRC, *Sixth Annual Report: Reporting Mortality 2010*, Wellington, Health Quality Safety Commission, 2012; P. Gulliver and J. Fanslow, 'Exploring risk factors for suicidal ideation in a population-based sample of New Zealand women who have experienced intimate partner violence', *Australian and New Zealand Journal of Public Health*, vol. 37, 2013, pp. 527–33.

6.2 National accreditation framework and practice standards

The effectiveness of family violence education and training is inextricably linked to the quality of organisational practice frameworks within and between the numerous government, non-government and statutory agencies providing services that are accessed by people experiencing, perpetrating and exposed to violence and abuse. These services have been collectively referred to throughout this report as the multi-agency family violence system.

Currently there are no consistent national service accreditation processes or organisational practice standards (that include organisational and practitioner competencies required for safe and quality family violence service provision) pertaining to all service providers within the multi-agency family violence system.²³⁹ The regional reviews have raised many questions about the safety and quality of family violence services and have highlighted the gap in family violence service providers' quality assurance processes. The regional reviews have also found evidence of significant variability (excellent to problematic) in the quality and safety of the work being done by specialist family violence services and non-specialist family support NGO service providers contracted to deliver family violence work.²⁴⁰

6.2.1 Safety issues

Although NGO family violence providers invariably have good intentions, good intentions do not necessarily translate into safe and competent practice. The danger is that without a set of defined practice principles – which detail how an organisation will prioritise the safety of victims and their children, victims' informed choice, and offender and system accountability – practitioners will interpret what is occurring in a family on the basis of their own individual understanding (Chapter 3 explores these matters in detail). The danger is that 'you do not know what you do not know'. The following sections detail two specific examples where safety issues can arise as a result.

6.2.2 Relationship counselling, mediation and restorative justice conferences

It has been evident in regional reviews that practitioners can too readily assume that relationship counselling is a useful way of addressing the underlying issues experienced by the couple in an IPV relationship. Relationship counselling and other forms of facilitated negotiation between the parties (such as mediation and restorative justice conferences) can be premised on the assumption that victims are able to assert their own interests in joint sessions. An understanding of the coercive²⁴¹ nature of IPV should caution against too readily making such assumptions. Women who have experienced abuse are often very fearful of their partners, which will restrain their ability to participate freely. In such contexts there is a strong likelihood that a victim will negotiate for 'what she can get', rather than 'what she actually wants'. Abuse may also constrain a victim's decision about whether or not to participate in the first place if this would confer benefits for the abusive (ex-) partner (such as the avoidance of more punitive consequences). There is also the risk that the safety and wellbeing needs of children living amidst family violence may be less visible in an adult-focused process. This is particularly pertinent for pre-verbal children.

The Committee acknowledges the importance of having alternative pathways for justice, which may be more meaningful to victims and offenders, and involve community sanctions and support. However, such models in other jurisdictions have received mixed responses from the victims they aim to protect.²⁴² Any family violence restorative justice process needs to be victim centred and ensure that accredited specialist family violence organisations are involved in risk and safety planning (encompassing adults and children) before, during and after any conferencing.

239 In January 2014, Women's Aid published its *National Quality standards*. The standards form a set of accredited criteria through which dedicated specialist services addressing domestic violence perpetrated against women and children can evidence their quality. There is a formal accreditation process organisations must complete to prove they meet the standards. As there are other accreditation systems available (which cover specific aspects of service delivery), Women's Aid has worked together with Imkaan, CAADA, Respect and Rape Crisis England and Wales to establish a coordinated framework of standards for the sector. The *National Quality Standards* provide a quality benchmark for all domestic violence services that will work in tandem with other issue- or service-specific standards. See www.womensaid.org.uk/page.asp?section=0001000100350002§ionTitle=National+Service+Standards

240 The workforce with these specialist and non-specialist services is referred to in section 6.1 as the 'regulated professional workforce' and the 'unregulated workforce'.

241 For further discussion of the concept of coercive control, see section 3.1.1.

242 J. Patac and L. Frederick, *Restorative Justice and Intimate Partner Violence*, Harrisburg, PA, VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence, 2009. Available at www.vawnet.org

The Mediation and Restorative Justice Centre of Edmonton, Alberta, Canada has worked with domestic violence cases at the 'less complex' end of the continuum. Before they proceed with restorative justice work all the participants have been extensively screened individually, to ensure that the victim's participation is well informed and genuinely voluntary, and to identify abusive (ex-) partners who are not appropriate for the restorative justice process (ie, lack of empathy, not taking responsibility and their level of dangerousness). Without such screening processes dangerous practice can occur.²⁴³ Organisations need to be accountable for the interventions they are providing, and not underestimate the potential for retaliatory violence, as it is the victims who pay when we get it wrong.

6.2.3 Overestimating behaviour change

Preventative work needs to change abusers' attitudes, but ultimately this work must respectfully challenge and change their behaviour. It is easy for an abuser to say they want to change, but the actual change process is far more difficult, particularly when they have few positive social networks to support and embed this change.

Regional reviews provide evidence of multiple instances where well-intentioned practitioners formed the impression that repeat abusers, who had been before the courts multiple times, sometimes for abuse against multiple partners, would not re-offend and would be 'safe'. These impressions, in the absence of a thorough assessment, greatly influenced the safety and support mechanisms recommended, which frequently were no different from what had previously been offered or mandated.

Practitioners need to ensure they do not conflate an abuser's desire to change with their ability to make such a change. Practitioners need to ask what sort of behaviour they expect to see that will demonstrate that an abuser is becoming safer. Actions are more reliable than words.

Within the child protection literature, commentators often speak of the need for social workers to demonstrate what Lord Laming has termed 'healthy scepticism' and 'respectful uncertainty'²⁴⁴ when working with families. These concepts should be employed when working with family violence abusers as they rarely fully disclose their violence, even in the face of considerable evidence.

Some abusers are well practiced in manipulating practitioners. Practitioners need to anticipate that abusers may reframe the abuse as 'communication problems', minimise their use of coercive control and abdicate their responsibility for their abusive behaviour.

Abusers may say that they have 'learned their lesson' or 'put their past behind them' and be mild mannered and appear reasonable despite severe risk. Willingness to believe them, stemming from optimism about the abuser's goodwill and a wish to work in 'partnership', can lead to decisions that precede further violence. Healthy scepticism may be more protective than optimism, as well as more realistic.

6.2.4 Ad hoc service standards development

The multi-agency family violence system is largely reliant on NGO service providers ensuring that their service is safe. In the absence of a national framework, different agencies are developing different and potentially conflicting practice standards and/or response pathways.

243 The Committee understands that the Ministry of Justice family violence restorative justice facilitators are required to conduct individual screening, risk assessment and safety planning with all parties before, during and after conference.

244 In his 2003 inquiry report into the death of Victoria Climbié, Lord Laming came up with the phrases 'healthy scepticism' and 'respectful uncertainty'. In the Victoria Climbié case the inexperienced and poorly supervised social worker had failed to keep an open mind as to alternative explanations or to test out all the concerns raised and the explanations given. Due to this, Lord Laming proposed that the concepts of 'healthy scepticism' and 'respectful uncertainty' should form the basis of relationships between the social worker and families in such cases. House of Commons Health Committee, *The Victoria Climbié Inquiry Report. Sixth Report of Session 2002-03*. HC 570, London, TSO, 2003, pp.159, 205, 322.

For example, in 2013 the Ministry of Justice developed *Restorative Justice Standards for Family Violence Cases*.²⁴⁵ Part C of these standards states that:

'Service providers must recognise the paramountcy of victim safety; that specialist family violence knowledge skills and processes are required for restorative justice processes to be a safe and effective process; the need for specialist professional supervision. When working with family violence clients the dynamics of the offending and prior relationships require in-depth assessment and follow up. The quality of the assessment and intervention pre-conferencing will mitigate risk for all parties and largely determine the potential for safe, effective conferencing and successful outcomes.'

These principle-based standards state what individual²⁴⁶ facilitators must 'recognise', but do not detail the evidence needed to meet the standard or how the implementation of these key standards in practice will be monitored and evaluated.

The Committee believes restorative justice responses should be required to meet the same safe practice standards as the Committee recommended for stopping violence programmes in the *Third Annual Report*.²⁴⁷ Restorative justice providers therefore need to:

- provide specific services for victims that focus on victim safety and enable victims' views to be sought as part of the ongoing assessment process
- have 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
- consistently use evidence-based risk assessment tools.

In the UK, voluntary accreditation for the providers of stopping violence services is available through Respect. Respect developed their accreditation standards so that members of the public, funders, commissioning agencies and other professionals can be assured of a high-quality, safety-focused service from organisations accredited by Respect.²⁴⁸ Any organisation seeking Respect accreditation must be able to demonstrate that they are providing a service that embodies the following aims to:

1. increase the safety of victims
2. assess and manage risk
3. be part of a coordinated community response to domestic violence
4. provide services that recognise and respond to the needs of diverse communities
5. promote respectful relationships
6. work accountably
7. support social change
8. offer a competent response.

The tables below show examples of organisational competencies in the Respect standard that an organisation must meet to be considered as providing safe and competent domestic violence services.

²⁴⁵ Ministry of Justice, *Restorative Justice Standards for Family Violence Cases*, 2013. Available at: www.justice.govt.nz/publications/global-publications/t/restorative-justice-standards-for-family-violence-cases.

²⁴⁶ The development of the Restorative justice standards for family violence cases were intended to address the national accreditation of individual specialist facilitators. The purpose of the standards is to ensure that family violence clients are kept safe and to minimise any unintended risk or harm to those participating.

²⁴⁷ FVDR, *Third Annual Report*, 2013.

²⁴⁸ N. Blacklock and T. Debbonaire, *The Respect Accreditation Standard*, 2nd ed., London, Respect, July 2012.

A5 SERVICE STANDARD: The organisation has an effective case management process.

PURPOSE: To ensure that the organisation is monitoring and responding to changes in risk and the safety needs of its clients and their children

Evidence		Main aim
A5.1	The organisation undertakes regular (at least monthly) case management in which decisions are taken and previous decisions are reviewed on how best to manage risk and increase the safety of clients and their children. This is recorded and covers all clients and their children. Case management includes representation from both integrated support services (ISS) and domestic violence perpetrator programmes (DVPP). Within this process, risk assessments are revisited and revised where necessary.	Assess and manage risk
A5.2	The manager with responsibility for case management has a minimum of three years' relevant experience and adequate specialist knowledge, including of risk factors and assessment.	Competence

A6 SERVICE STANDARD: The organisation provides staff with practice management (sometimes referred to as treatment management) and clinical supervision.

PURPOSE: To ensure that the content and quality of its service to clients is as described in the model of work and to support the development of the skills, knowledge and wellbeing of its staff.

Evidence		Main aim
A6.1	Clinical supervision is provided for and used by all frontline staff.	Safety
A6.2	All staff attend practice management at least monthly, which is provided by a suitably experienced senior practitioner. The practice manager keeps notes of practice management sessions.	Competence
A6.3	Sessional staff and volunteers are provided with the same practice management and access to clinical supervision, on a pro rata basis, as staff working full time.	Competence

The Department of Attorney General and Justice, New South Wales (NSW), has developed minimum standards²⁴⁹ for men's domestic and family violence behaviour change group programmes and a practice guide²⁵⁰ to help programme providers implement the standards.

The minimum standards contain five overarching principles, each with a number of specific standards.

1. The safety of women and children must be given the highest priority.
2. Victim safety and offender accountability are best achieved through an integrated, systemic response that ensures that all relevant agencies work together.
3. Challenging domestic and family violence requires a sustained commitment to professional and evidence-based practice.
4. Perpetrators of domestic and family violence must be held accountable for their behaviour.
5. Programmes should respond to the diverse needs of the participants and partners.

²⁴⁹ Department of Attorney General and Justice, *Minimum Standards for Men's Domestic Violence Behaviour Change Programs*. See www.domesticviolence.lawlink.nsw.gov.au/domesticviolence/minimum_standards_mdvbcp.html

²⁵⁰ Department of Attorney General and Justice, *Towards Safe Families; A Practice Guide for Men's Domestic Violence Behaviour Change Programs*, 2012. See www.domesticviolence.lawlink.nsw.gov.au/domesticviolence/minimum_standards_mdvbcp/what_provide.html

The practice guide provides examples of 'acceptable, optimal and unacceptable practices related to the standards to highlight how they might be put into practice'²⁵¹ and notes that 'beyond these practices, many other issues need to be considered if programs are to achieve excellence'.²⁵² Providers must have adapted their practice and be registered as meeting the standards to receive funding or referrals from the NSW government.²⁵³

In Aotearoa New Zealand, the Ministry of Social Development has Funding Contracting Service Guidelines, which include practice guidelines as part of the funding agreements for the delivery of social services funded by the Ministry, such as family violence response coordination. The practice guidelines set the minimum standards from which services can be developed. However, these guidelines are very broad and do not assess the safety and quality of family violence services.

6.3 Prevention opportunities – learning from near misses

Currently many organisations review their involvement in a case where a homicide has occurred. But by this time things have already gone seriously wrong. The Committee recommends that organisations develop protocols to review near misses as these cases present opportunities for learning from errors and hazards before further serious harm or fatal violence takes place.

Some industries, such as aviation and health²⁵⁴ (for example, in relation to medication errors), have developed processes that actively encourage practitioners to report hazards and near misses – often for 'continuous improvement'.

Weick and Sutcliffe²⁵⁵ in their work on high-reliability organisations identify that organisations need to firstly define what a near miss is and then people need to talk about them when they occur. They suggest that organisations should err on the side of interpreting a near miss as 'a sign of danger in the guise of safety' (ie, a sign that the system is vulnerable), rather than as 'a sign of safety disguised as danger' (ie, a sign that your system's safeguards are working). Weick and Sutcliffe recommend putting discussions of near misses and their meanings on meeting agendas and proactively raising the comfort level around talking about near misses within organisations.

One of the challenges for those working in the multi-agency family violence system is the need to define 'a family violence near miss'. Near misses are framed as weaknesses in organisational systems and processes, but with family violence near misses, there may need to be a widening of the definition. A near miss may be when an adult reports that a child has been strangled by an adult or there is a suicide attempt by a pregnant woman experiencing IPV. Since the majority of family violence is not reported to services,²⁵⁶ when such reports are made they need to be understood as signals that something is very wrong. Furthermore, how services understand these presentations, respond and document their concerns and actions will influence how other practitioners make decisions about future presentations to the system. The course of action taken can either strengthen the system's response capability or hinder it.

251 Department of Attorney General and Justice, *Towards Safe Families; A Practice Guide for Men's Domestic Violence Behaviour Change Programs*, 2012. p. 9.

252 Ibid, p. 9.

253 In drafting the Restorative Justice Standards, the Committee understand that the Ministry of Justice has reviewed the accreditation frameworks introduced in the UK (Respect), NSW (Department of Attorney General and Justice) and Victoria. The Ministry intends to model the new domestic violence programme standards and practice framework on these jurisdictions. It also intends to incorporate into the programme standards minimum requirements for experience, skills and supervision of those actually facilitating the delivery of programmes.

254 J. Reason, *Managing the Risks of Organisational Accidents*, Brookfield, VT, Ashgate, 1997.

255 K. Weick and K.M. Sutcliffe, *Managing the Unexpected*, 2007.

256 J. Fanslow and E. Robinson, 'Help-Seeking Behaviors and Reasons for Help Seeking Reported by a Representative Sample of Women Victims of Intimate Partner Violence in New Zealand', *Journal Interpersonal Violence*, vol. 25, no. 5, pp. 929–51, 2010. Ministry of Justice, *The New Zealand Crime & Safety Survey: 2009: Main Findings Report*, Wellington, Ministry of Justice, 2010, p. 36 demonstrates that in 2009 the police learned about only 32 percent of assaults (p. 44) and 7 percent of sexual offences (p. 45). Victims were less likely to report offences committed against them when the perpetrator was known to them (p. 47). In P. Mayhew and J. Reilly, *The New Zealand Crime & Safety Survey: 2006*, Wellington, Ministry of Justice, 2007, it was also 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.

The Committee believes it is important that understanding and responding appropriately to near misses is included in professional education, training and in practice standards. The Committee recognises and acknowledges the dedication and commitment to violence prevention by the agencies and practitioners they are privileged to work with. As a family violence prevention initiative, the Committee plans to work with the regional review panels and member organisations to develop a family violence near miss continuous improvement tool kit. This is an opportunity to create a learning framework within each organisation and across multi-agency forums, which can strengthen the system's resilience and enable practitioners to respond better to those living amidst family violence.

6.4 Recommendations

The Committee recommends that:

7. The judiciary, with the approval and strong recommendation of the Heads of Bench, in association with the Institute of Judicial Studies, implement family violence (IPV and CAN) education and training, as well as establishing a mechanism for refresher training. This training should include child development, attachment, adverse childhood experiences, cumulative harm, dynamics and lethality risk indicators for IPV, primary victim/predominant aggressor analysis and multi-agency case management processes. Training should be available to all members of the judiciary who preside in and hear appeals from the District Court (including the Family Court and Family Violence Courts) and to coroners.
8. The Ministry of Justice, in partnership with New Zealand Police, strengthen the criminal and appellate courts' ability to respond effectively to family violence charges by facilitating the provision of comprehensive information to judges to aid safe and robust decision-making. This includes the provision of:
 - criminal conviction histories, which clearly identify family violence offending, as well as who the victim(s) are – one intimate partner or multiple, and/or related children
 - IPV risk information (regarding assault and lethality) and risk management analyses
 - information for bail applications that documents family violence offending histories and identifies harmful patterns of relating, including the number of protection orders against the defendant.

Appendix 1: A restrictive interpretation of the legal requirements for self-defence

Aotearoa New Zealand, like England, Canada and all states of Australia, has the defence of self-defence, and this is the defence that is generally agreed to be the appropriate defence to use in cases where battered defendants respond with defensive force to the violent situation they find themselves in. Self-defence, if successfully raised, will result in a complete acquittal.

While Aotearoa New Zealand has one of the more generously worded self-defence provisions,²⁵⁷ New Zealand case law has tended to interpret the law in a more conservative fashion than the interpretation taken in Australia and Canada in respect of similar, sometimes more restrictive, legislative provisions. For example, one of the obstacles to raising self-defence for primary victims who kill their predominant aggressor historically has been the need to establish that they are responding to an 'imminent' attack at the time they were seeking to defend themselves. While most women will not take a violent man on in hand-to-hand combat if they wish to survive, such a requirement effectively necessitates waiting until they must actually physically fight their abuser before the defence can be successfully raised. It appears that the only cases where there have been acquittals on the basis of self-defence in Aotearoa New Zealand are those in which the primary victim concerned was witnessed by a third party in the process of being attacked when she delivered the injury that killed her abuser. Given the frequently hidden nature of family violence and the fact that women defending themselves against a violent man frequently pre-empt an attack or try to catch the abuser off guard, these cases are rarely witnessed by an independent third party. This may account for the low number of such cases resulting in acquittals on the basis of self-defence in New Zealand, when compared with other relevant jurisdictions.²⁵⁸

The case law in Canada and Australia has relaxed the requirement of 'imminence' in cases involving primary victims who kill their predominant aggressor in recognition of this issue.²⁵⁹ These cases have allowed battered defendants to raise self-defence in circumstances where they are not just about to be attacked but where, because of the serious, recurrent and escalating nature of the violence and the level of entrapment they are experiencing in the relationship, they are not able to prevent further victimisation by more peaceful means. By way of contrast, the New Zealand Court of Appeal in *R v Wang*²⁶⁰ required 'immediacy of life-threatening violence to justify killing in self-defence or the defence of another'²⁶¹ and *Wang* remains authoritative on this point. The Law Commission's recommendation in 2001 that 'imminence' be replaced with the need for an 'inevitable' attack (involving an assessment of the likelihood of it occurring and the effectiveness of other means of dealing with it) has yet to be acted upon by the legislature.²⁶²

The partial defences to murder

Partial defences are defences that reduce a murder conviction to manslaughter where the lethal force is used in circumstances that mitigate the accused's responsibility for using violence. This results in the lesser stigma that is attached to a 'manslaughter' conviction, as well as the greater flexibility in sentencing that follows on from a conviction for manslaughter as opposed to murder.

257 Section 48 of the Crimes Act 1961 says, 'Everyone is justified in using, in the defence of himself or another, such force as, in the circumstances as he believes them to be, it is reasonable to use'.

258 E.A. Sheehy, et al., 'Defences to homicide for battered women: A comparative analysis of laws in Australia, Canada and New Zealand', *The Sydney Law Review*, vol. 34, no. 3, 2012, p. 467. We note that in 2007, the Law Commission pointed out, at p. 58, that in 2004 'the Ministry of Justice concluded that amendment to section 48 of the Crimes Act 1961 was not required to meet the needs of battered defendants, and might be undesirable in light of the fact that the section is generally regarded as working well. The Ministry reviewed recent case law, which tended to suggest that problems previously encountered were being ironed out in the courts; it thus concluded that the real problem previously was one of social awareness, rather than of law. The Ministry found that overwhelmingly stakeholders were comfortable with 'letting matters take their course'. It is not clear from the public record which cases were reviewed (*R v Wang* (1989) 4 CRNZ 674, for example, remains authoritative), or which 'stakeholders' were consulted and what basis they had for expressing such satisfaction. The expressed views are also approximately nine years old and not supported by more recent research (see Sheehy et al., 2012).

259 See, for example, *R v Lavallee* [1990] 1 SCR 852 in Canada and *R v Falls* Supreme Court of Queensland, No. 928 of 2007, 17 May 2010 (Aust).

260 (1989) 4 CRNZ 674.

261 *Ibid.*, at 683.

262 New Zealand Law Commission, *Some Criminal Defences with Particular Reference to Battered Defendants*, Wellington, NZLC Report 73, 2001, pp. 9–12.

New Zealand has no partial defences to murder. England, Canada and all but one Australian state²⁶³ have at least one partial defence that may be raised in such cases. Examples of partial defences to murder include (a) excessive self-defence, (b) killing for self-preservation in an abusive domestic relationship and (c) provocation.²⁶⁴

Excessive self-defence

Excessive self-defence is designed for situations where the defendant honestly believes it is necessary to defend themselves or another with physical force, but mistakenly uses more force than they reasonably needed.

NSW, South Australia and Western Australia have the defence of excessive self-defence. Victoria has an offence of 'defensive homicide', which applies in the same circumstances that a defence of excessive self-defence could be raised, carries the same maximum penalty as manslaughter and is an alternative to a verdict of murder.²⁶⁵ Sections 54 and 55 of the Coroners and Justice Act 2009 (Eng) make it clear that the English partial defence of loss of control is intended to cover a range of circumstances that might be encompassed by the defence of excessive self-defence.

In 2007, the New Zealand Law Commission said that the wording of self-defence in section 48 of the New Zealand Crimes Act 1961, which allows the reasonableness of the accused's defensive force to be assessed in the circumstances that the accused believes they are in, made the defence of excessive self-defence 'not necessary in New Zealand'.²⁶⁶ Unfortunately, as *Wang*²⁶⁷ makes clear, while New Zealand courts have been careful to assess the reasonableness of the accused's defensive force in light of the threat that she honestly thought that she faced at the time, they have often failed to factor her honest beliefs about the resources she had available to defuse the threat into this assessment. Some New Zealand commentators have argued that the wording of self-defence in section 48 clearly demands more emphasis than has been given in the New Zealand case law to the accused's subjective appraisal of the threat that they were under and the resources they had to deal with it – including how effective they believed contacting the police or leaving the relationship would be in removing the threat.²⁶⁸ In the absence of changes to the manner in which self-defence is operating (which would be preferable), excessive self-defence in New Zealand would still apply in situations where the accused honestly believed that they were only using the force that was necessary to defend themselves or their children, but where the court thought that they had over-reacted and could have defused the threat via other means or with less force.

Killing for self-preservation in an abusive domestic relationship

While Queensland does not have the defence of excessive self-defence, in 2010 it introduced the partial defence of 'killing for preservation in an abusive domestic relationship' in an attempt to address the difficulties experienced by some primary victims of family violence in raising self-defence.²⁶⁹ Three conditions must be satisfied.

263 Tasmania is an exception. It does not have the defence of excessive self-defence, and it abolished provocation in 2003.

264 Note that there is also the partial defence of diminished responsibility, which applies where the accused was suffering from an abnormality of mind (short of insanity) that at the time substantially impaired his or her responsibility for committing the offence. Diminished responsibility is available in England (see section 2(1) of the Homicide Act 1957) and many Australian states (see, for example, section 23A, Crimes Act 1900 (NSW)).

265 Although it is to be noted that this defence has not worked as intended and may be abolished. See Domestic Violence Resource Centre Victoria, 'Justice of judgement? The impact of Victorian homicide law reforms on responses to women who kill intimate partners', *Discussion Paper No 9*, 2013. On 6 March 2014, the Crimes Amendment (Provocation) Bill 2014 [NSW] was introduced to Parliament. This bill requires 'extreme provocation' defined as a 'serious indictable offence', and excludes non-violent sexual advances and conduct incited by the accused in order to provide an excuse to use violence against the deceased; and evidence of self-induced intoxication cannot be taken into account. The new provision omits any mention of 'an ordinary person in the position of the accused' in the current statute and replaces it with 'the conduct of the deceased could have caused an ordinary person to lose self-control'.

266 New Zealand Law Commission, *The Partial Defence of Provocation*, Wellington, NZLC Report 98, 2007, para 123.

267 (1989) 4 CRNZ 674.

268 See, for example, F. Wright, 'The circumstances as she believed them to be: A reappraisal of section 48 of the Crimes Act 1966', *Waikato Law Review*, vol. 6, 1998, p. 109.

269 Section 304B, Criminal Code Act 1899 (Qld).

1. The deceased has committed acts of serious domestic violence against the accused in the course of an abusive domestic relationship.
2. The accused believes that it is necessary for their preservation from death or grievous bodily harm to do the act or make the omission that causes the death.²⁷⁰
3. The accused has reasonable grounds for that belief having regard to the abusive domestic relationship and all the circumstances of the case.

The accused can raise this defence even though they have killed in non-confrontational circumstances, rather than in response to a specific attack that is being made on them. This defence has been criticised on the basis that it should be available as a complete rather than a partial defence.²⁷¹

Provocation

Canada²⁷² and the Australian states of Queensland,²⁷³ NSW,²⁷⁴ the Australian Capital Territory²⁷⁵ and the Northern Territory²⁷⁶ have the defence of provocation. England has replaced the provocation defence with a similar defence of 'loss of control'.²⁷⁷

Provocation is a partial defence for those who lost emotional control and responded with lethal force to extreme and 'provocative' circumstances and where this can be considered to be an 'ordinary' response to those circumstances. The defence is designed to recognise that there are some life experiences that are so traumatic and extreme even ordinary people might be pushed beyond the bounds of human endurance.

The defence of provocation is widely criticised for operating to excuse perpetrators of family violence who kill their victims in circumstances that are unexceptional; for example, where relationships break down or do not progress as one partner would wish.²⁷⁸ Some jurisdictions have, therefore, recently modified or recommended the modification of the defence of provocation in order to prevent its use in such circumstances. For example, in Queensland since 2011, provocation cannot be based on words alone or things done to end or change the nature of a relationship 'other than in circumstances of a most extreme and exceptional nature'.²⁷⁹ For proof of circumstances of an extreme and exceptional nature, regard may be had to any relevant history of violence.²⁸⁰ There was also an attempt to address such criticisms in the enactment of the English 'loss of control' defence in 2009 by disallowing the defence in response to sexual infidelity.²⁸¹

270 The defence applies even when the accused was responding 'to a particular act of domestic violence committed by the deceased that would not, if the history of acts of serious domestic violence were disregarded, warrant the response' (section 304B(5)) and even if the person claiming the defence has 'sometimes committed acts of domestic violence in the relationship' (section 304B(6)).

271 See P. Easta and A. Hopkins, 'Walking in her shoes: Battered women who kill in Victoria, Western Australia and Queensland', 35(3) *Alternative Law Journal*, vol. 132, 2010, pp. 135–6. In such circumstances, in *R v Stjernqvist* (Unreported, Cairns Circuit Court, 18 June 1996) the accused was acquitted on the basis of self-defence.

272 Section 232, Criminal Code (Can).

273 Section 302, Criminal Code Act 1899 (Qld).

274 Section 23, Crimes Act 1900 (NSW).

275 Section 13, Crimes Act 1900 (ACT).

276 Section 158, Criminal Code (NT).

277 Sections 54–56, Coroners and Justice Act 2009.

278 See, for example, W. Gorman, 'Provocation: The jealous husband defence', *Criminal Law Quarterly*, vol. 42, 1999, p. 478, and Model Criminal Code Officers Committee of the Attorneys-General, Model Criminal Code, Chapter 5, Fatal Offences Against the Person, Discussion paper 89, 1998. Victorian Law Reform Commission, Defences to Homicide: Final Report, 2004, pp. 27–30. It has also been criticised for its use in cases where the accused has responded in a homicidal rage to a homosexual advance. See New Zealand Law Commission, *The Partial Defence of Provocation*, 2007, p. 7. Undesired sexual advances are clearly another unexceptional life circumstance that does not prompt ordinary people to use physical violence.

279 Sections 304(2) and (3), Criminal Code Act 1899 (Qld), as modified by the Criminal Code and Other Legislation Amendment Act 2011.

280 Section 304(6), Criminal Code Act 1899 (Qld).

281 Section 55(6)(c).

In April 2013, the NSW Select Committee on the Partial Defence of Provocation, after extensive public consultation on whether the defence of provocation should be abolished or amended, released a report recommending the retention and reform of the defence.²⁸² The committee was clear that the defence should not be available in response to 'circumstances which are, in fact, a normal part of human experience, such as being told that a relationship is going to end, discovering infidelity or feeling jealous or betrayed'.²⁸³ However, the committee did not recommend abolition because it 'was mindful that there are some defendants, particularly women who have been victims of long-term domestic abuse, for whom the partial defence of provocation may appropriately reflect their legal and moral responsibility in circumstances where self-defence would be difficult to establish'.²⁸⁴

Instead the committee developed a reform model that seeks to restrict provocation to circumstances where the conduct relied on is 'grossly provocative' and identifies a number of circumstances in which the defence will not be available other than in extreme and unusual circumstances, such as relationship breakdown, partner infidelity or a homosexual advance. The NSW Government has just enacted the Crimes Amendment (Provocation) Bill 2014, which reforms the defence of provocation so that it is only available in relation to 'extreme provocation' by the deceased, which must also amount to a 'serious indictable offence'.

Provocation is the only partial defence that has ever existed in New Zealand, but it was abolished in 2009 in response to *R v Weatherston* (in which provocation was unsuccessfully argued by the defendant in order to explain his lethal rage after his relationship with his girlfriend finished).²⁸⁵ While the Law Commission had recommended abolition in 2001 and 2007, this recommendation was made in the context of other recommendations that it was thought would address the impact of losing the defence of provocation on battered defendants.²⁸⁶ As we explain below, however, these additional recommendations have been either not implemented or have only partially been implemented.

In 2001, when the Law Commission recommended the abolition of provocation, it expressed the belief that self-defence was the defence more appropriately used in cases where the defendant is facing homicide charges for killing the person who has abused her.²⁸⁷ (For further discussion on women's victims' use of violence, see Chapter 3.) Accordingly, it recommended reforms to self-defence which, as noted above, have not taken place. The Law Commission also recommended replacing the then mandatory life sentence for murder with 'a sentencing discretion' so that the mitigating circumstances expressed in the partial defences could instead be addressed at sentencing. This was partially implemented in 2002 when mandatory life for murder was replaced by a strong presumption of life imprisonment.²⁸⁸

While it is correct that self-defence is a more appropriate defence in the majority of these cases, not every victim of severe IPV uses retaliatory physical violence from a position of self-protection, as opposed to reacting with anger to what has been done to her. This means that it cannot be assumed that even if self-defence is appropriately reformed and sensitively applied in such cases, that it will necessarily always be available on the facts.²⁸⁹ In one of our regional reviews, the female offender had a very strong case for provocation but was unable to argue it because it had been abolished prior to the killing. Self-defence was also not available on the facts.

282 NSW Legislative Council, Select Committee on the Partial Defence of Provocation, *The Partial Defence of Provocation*, 23, April 2013. The committee also recommended developing guidelines for the prosecution in deciding what charges to lay when there is a history of family violence, an education package on the nature and dynamics of family violence targeting the legal sector and the community more broadly and monitoring by the Law Commission of the defenses (including their suggested reforms to provocation) in five years' time.

283 *Ibid* at x.

284 *Ibid* at x.

285 See tvnz.co.nz/national-news/weatherston-jury-retires-night-2856161 and www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10586155

286 The Law Commission had recommended the abolition of provocation before, but it was not until 2001 and 2007 that it attempted to engage with the impact of abolishing this defence on primary victims of family violence who retaliate and kill their abusers.

287 New Zealand Law Commission, *The Partial Defence of Provocation*, 2007, p. 58, para [121]. See also the commentary on the Crimes (Provocation Repeal) Amendment Bill 2009, Wellington, NZ, House of Representatives, 2009, pp. 2–3.

288 Section 102, Sentencing Act 2002.

289 Sheehy et al have noted that the defences of excessive self-defence and provocation are still strongly utilised in Australia to support manslaughter convictions in response to murder charges for battered defendants who have responded to their situation using lethal violence. E.A. Sheehy et al., 'Defences to homicide for battered women', 2012. See also Judicial Commission of NSW, *Partial Defences to Murder in NSW 1990–2004*, 2006, p. 45.

A search of databases and media reports for other New Zealand homicide cases involving primary victims of domestic violence who have retaliated against the predominant aggressor revealed similar cases that had occurred prior to the defence being abolished where provocation was successful at the time, but would no longer be available if the homicide occurred today.²⁹⁰ In several cases processed through the justice system and on the public record in New Zealand, the victim was a child or step-child who killed in response to severe abuse against themselves and/or other close family members, but was not responding in self-defence at the time of the homicide.²⁹¹

In 2007, the Law Commission again recommended the abolition of provocation, but this time on the basis that the repeal of mandatory life for murder in 2002 left sentencing judges with the ability to accommodate mitigating factors, such as a history of primary victimisation, when sentencing a defendant for murder.²⁹² The Law Commission expressed the view that the defence of provocation is fundamentally flawed because it:

'puts a premium on anger – and not merely anger, but homicidally violent anger. This, to our minds, is or should be a central issue in considering whether reform is required: out of the range of possible responses to adversity, why is this the sole response that we choose to partially excuse?'²⁹³

It went on to comment that 'the most fundamental flaw in the provocation defence is also the most simple to explain: an ordinary person does not under any circumstances, homicidally lose control'.²⁹⁴

However, because New Zealand retains a strong presumption in favour of life imprisonment for murder, which has been strictly applied by the courts, the Law Commission acknowledged the 'concern that abolishing provocation would result in harsher sentences for those battered defendants (primary victims) who could not argue self-defence and were no longer able to rely on provocation'. The Commission therefore recommended that priority be given to drafting a guideline for judges addressing when it would be 'manifestly unjust' to impose a life sentence in these and other cases. This recommendation has not been implemented.²⁹⁵

The Committee posits that one of the difficulties with arriving at a position from a process of abstract reasoning and generalisation is that context, which is everything, is lost. Loss of intimate relationship, sexual jealousy and unwelcome expressions of sexual interest are all normal human experiences that may evoke intense feelings, but which most people navigate without expressing their reactions in homicide. It is easy to characterise homicidal rage in these circumstances as a dangerous expression of thwarted male entitlement or homophobia and difficult to justify giving the offender a partial defence to murder in such cases. It is, however, much harder to condemn such a reaction when the offender is a primary victim who is acting in response to more than a decade of severe physical, sexual and psychological abuse, including multiple beatings and rapes. The primary victim in an IPV relationship may have never really had a fully independent choice about being in the relationship initially, may have been unable to terminate the relationship at any point and may have been denied all opportunities for a normal life by the predominant aggressor – including fundamentals such as being able to psychologically recover from past trauma, keeping the children safe, retaining care of the children or holding down employment.

290 Provocation was successfully raised in *R v King* (HC Hamilton, 7 April 2005, CRI 2004-019-003825), *R v Suluape* [2002] 19 CRNZ 492 and *R v Wang* [1989] 4 CRNZ 674. It may also have been the basis of a manslaughter conviction in *R v Mahari* (HC Rotorua, 14 November 2007, CRI 2006-070-8179) and *R v Stone* (HC Wellington 9 December 2005, CRI 2005-078-1802). It was unsuccessfully argued in a further four cases [*R v Ranger* (CA 2 November 1988, CA 146/88), *R v Brown* (CA 11 April 1995, CA 93/94), *R v Oakes* [1995] 2 NZLR 673 and *R v Reti* [2009] NZCA 271], which might suggest that it was not appropriate on the facts of those cases or might suggest a need for reform so that the defence is better accessible to battered defendants.

291 *R v Raivarua* (HC Rotorua, 5 August 2005, CRI 2004-077-1667) and *R v Erstich* [2002] 19 CRNZ 419.

292 New Zealand Law Commission, *The Partial Defence of Provocation*, 2007.

293 *Ibid.*, p. 11.

294 *Ibid.*, p. 70.

295 *Hamidzadeh v R* [2012] NZCA 550 at para [46].

Furthermore, Evan Stark explains that repetitive abuse over an extended period must always be understood in terms of the cumulative and compounding effect it has on the victim.²⁹⁶ It cannot be expected that the response to having one's human rights (the right to be free from inhumane and degrading treatment) transgressed for more than a decade will always be overwhelming fear, as opposed to moments of violent anger. The defence of provocation does not condone that expression of anger – the defendant is still convicted of a serious criminal offence – but it does provide the defendant with some amelioration of criminal consequences in recognition of the extreme victimisation they were experiencing and the trauma they were suffering from. (See section 3.2.1 for further discussion on this matter.)

A presumption of life imprisonment for murder

New Zealand still has a presumption of life imprisonment for murder.²⁹⁷ This means that, since the abolition of provocation, a battered defendant who is unable to successfully argue self-defence will be facing life imprisonment unless they are able to overturn the presumption. When mandatory life imprisonment for murder was abolished, cases where battered defendants had killed their perpetrators were considered the archetypal cases in which such a presumption would be overturned. However, a review of New Zealand cases involving battered defendants charged with homicide from 2000 to 2010 found that of the four cases resulting in murder convictions, in only one was the presumption in favour of life imprisonment overturned.²⁹⁸ This suggests it is more difficult to overturn the presumption, and there is less flexibility in sentencing in these types of cases, than was anticipated.

Furthermore, even if the presumption is overturned, the sentence is for murder and is likely to be higher than would be expected for a manslaughter conviction.²⁹⁹ It is interesting to observe that the battered defendant in *R v Suluape*³⁰⁰ was sentenced to five years imprisonment for manslaughter after successfully raising provocation, and the defendant in *R v King*³⁰¹ in similar circumstances was sentenced to four years and three months. On the other hand, those battered defendants who have had the presumption of life overturned since the abolition of provocation have attracted sentences of 10 and 12 years in respect of their murder convictions. In *R v Wihongi*,³⁰² 12 years was imposed, while in *R v Rihia*³⁰³ the sentence of 10 years was arrived at by taking the 12 years imposed in *Wihongi* as a starting point and allowing a discount for the defendant's early guilty plea.

296 E. Stark, *Coercive Control: How Men Entrap Women in Personal Life*, New York, 2007.

297 Section 102, Sentencing Act 2002. It must be 'manifestly unjust' to impose life imprisonment before the presumption is overturned.

298 E.A. Sheehy et al., 'Defences to homicide for battered women', 2012. All four murder cases were decided after mandatory life imprisonment was replaced by a presumption in favour of life imprisonment.

299 This appears to have been accepted by the New Zealand Law Commission, *The Partial Defence of Provocation*, 2007, p. 82, and the New Zealand Court of Appeal in *Hamidzadeh v R* [2012] NZCA 550 at para [71].

300 (2002) 19 CRNZ 492. This was the one case involving a battered defendant in the Law Commission's sample of the four cases in which provocation was successful in trials that occurred in Auckland and Wellington between 2001 and 2005 inclusive. Provocation was argued in 15 out of the 87 homicide files held by Crown prosecutors in these two cities over this time period, but was only successful in four. See Appendix A, New Zealand Law Commission, *The Partial Defence of Provocation*, 2007.

301 CA71/06, 27 July 2006.

302 [2012] 1 NZLR 775.

303 [2012] NZHC 2720.

Deeper systemic and conceptual issues

The problems generated by employing an incident-based analysis of family violence are evidenced in the cases where primary victims are charged with homicide and seek to raise one of the criminal defences (see Section 3.1.5 for discussion about the risks of taking an incident-based analysis in family violence cases). For example:

- a focus on the incident comprising the killing and the immediate surrounding circumstances has a tendency to downplay the significance of the history of the abuse that has occurred and its cumulative impact
- the construction of family violence as a series of individual incidents of physical abuse in between which the victim is free to take evasive action (as opposed to a 'pattern' of behaviour reinforcing a broader architecture of abuse) constructs the victim as having numerous opportunities for escape in the past and downplays the inevitability of further violence in the future
- an assumption that all physical acts of abuse have the same meaning results in acts of defensive physical violence by the victim being read as acts of perpetration.

It is important to note that the need for a specific imminent threat that the women was responding to in order to successfully raise self-defence reduces the assessment of her actions to a very small timespan. The result is that cases that bear strong factual parallels are constructed as radically different and attract very different consequences because of what happens in a few short moments. For example, Jessica Keefe was recently acquitted of stabbing her violent partner (Sean Verma, who was also a Mongrel Mob member) to death. However, when one broadens the scope of the inquiry to a larger timeframe and examines the violence in the relationship over an extended period of time, the difficulties she had in negotiating safety and the levels of entrapment experienced – if one assessed the danger she faced in terms of the nature of the ongoing relationship that she had with the deceased – then there is very little difference between her situation and that of Rachel Rihia or Jacqueline Wihongi, both of whom experienced extreme levels of victimisation and entrapment over an extended period of time. Jacqueline was also in a relationship with a gang member. Nonetheless, as noted above, both of those women have been convicted and imprisoned for extended periods. (For further discussion about women's use of violence and entrapment, see sections 3.1.2 and 3.2.2.)

Appendix 2: Family Violence Death Review Committee 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
Fia Turner	Counsellor, Family Therapist and Clinical Supervisor	Genesis Youth Trust, and Private Practice
Paul von Dadelszen*	Family Court Judge	Family Court
Denise Wilson	Associate Professor Māori Health	Auckland University of Technology

* Paul von Dadelszen retired as a judge at the end of May 2013.

Past members

Wendy Davis (Inaugural Chair), Brenda Hynes, Patrick Kelly, George Ririnui, Barry Taylor, Alison Towns, Rob Veale and Vaoga Mary Watts.

Advisors

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

Appendix 3: Demography of deceased and offenders of all types of family violence deaths combined

Outcome for offenders from 2009 to 2012

Of the 122 offenders, 14 committed suicide at the time of the death event (Table 28) and were therefore not subject to prosecution. Forty-eight of the 108 remaining offenders (44 percent) were found guilty of murder and sentenced, while 27 (25 percent) were found guilty of manslaughter plus other charges and sentenced. For 12 of the deaths, the suspected offender is still being processed by the legal system and a final outcome is pending. In seven of the cases, the offender was acquitted (by reason of insanity or self-defence), but was still understood to have been responsible for the killing. (For more detail on justice-related issues, see Chapter 6.) For 10 deaths, the person responsible for the killing has not yet been identified and charged but for each case the offender was most likely a family member and so has been included as such in this report.

Table 28: Outcomes for offenders in family violence deaths, New Zealand, 2009–12

OUTCOMES		Offenders n=124		IPV n=63		CAN n=34		IFV n=27	
		n	%	n	%	n	%	n	%
Legal outcome	Murder	48	39	31	49	9	26	8	30
	Manslaughter/Other charges	27	22	10	16	10	29	7	26
	Acquitted	7	6	3	5	0	0	4	15
Suicide		15	12	8	13	7	21	0	0
Unresolved/Outcome pending		12	12	10	8	13	2	6	2
Other		4	3	1	2	0	0	3	11
Unknown		11	9	2	3	6	18	3	11

IPV = intimate partner violence.

CAN = child abuse and neglect.

IFV = intrafamilial violence.

Ethnicity and family violence deaths in New Zealand 2009–12

There are significant differences in the ethnicity of deceased (Table 29) and offenders (Table 30) in family violence. For all, except offenders in IPV (where the difference does not reach statistical significance), Māori predominate over 'other' or non-Māori, non-Pacific ethnicities. The CIs for Pacific peoples are wide as the proportion of Pacific peoples in the whole population is relatively small. However, for deceased and offenders in CAN, the rates for Pacific peoples are similar to Māori and are significantly higher than for non-Māori, non-Pacific ethnicities.

Table 29: Ethnic-specific rates (per 100,000 people per year) of family violence deaths by type of family violence, New Zealand, 2009–12

PRIORITISED ETHNICITY	Total New Zealand population n=17,522,000		Total family violence deaths n=126			IPV n=63			CAN n=37			IFV n=26		
	n	%	n	%	rate	n	%	rate	n	%	rate	n	%	rate
Māori	2,659,700	15.18	47	38	1.77	20	32	0.75	16	43	0.60	11	42	0.41
Pacific peoples	1,128,100	6.44	12	10	1.06	4	6	0.35	6	16	0.53	2	8	0.18
Other	13,734,200	78.38	63	51	0.46	37	59	0.27	15	41	0.11	11	42	0.08
Unknown			4	3		2	3					2	8	

IPV = intimate partner violence.

CAN = child abuse and neglect.

IFV = intrafamilial violence.

Table 30: Ethnic-specific rates (per 100,000 people per year) for offenders of family violence death by type of family violence, New Zealand, 2009–12

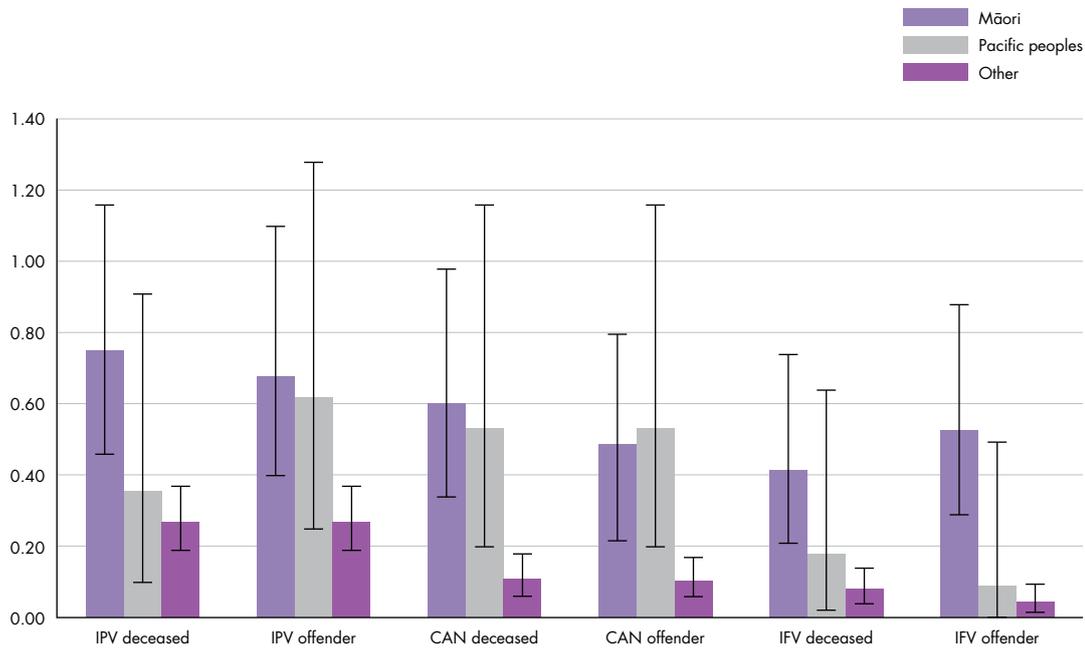
PRIORITISED ETHNICITY	Total New Zealand population n=17,522,000		Total family violence offenders n=124			IPV n=63			CAN n=34			IFV n=27		
	n	%	n	%	rate	n	%	rate	n	%	rate	n	%	rate
Māori	2,659,700	15.18	45	37	1.69	18	29	0.68	13	38	0.49	14	52	0.53
Pacific peoples	1,128,100	6.44	14	11	1.24	7	11	0.62	6	18	0.53	1	4	0.09
Other	13,734,200	78.38	57	47	0.42	37	59	0.27	14	41	0.10	6	22	0.04
Unknown			8	7		1	2		1	3		6	22	

IPV = intimate partner violence.

CAN = child abuse and neglect.

IFV = intrafamilial violence.

Figure 26: Ethnic-specific rates (per 100,000 people per year) for deceased and offenders in family violence deaths by category of death (with 95% CIs), New Zealand, 2009–12



IPV = intimate partner violence.
 CAN = child abuse and neglect.
 IFV = intrafamilial violence.

Gender and family violence deaths in New Zealand 2009–12

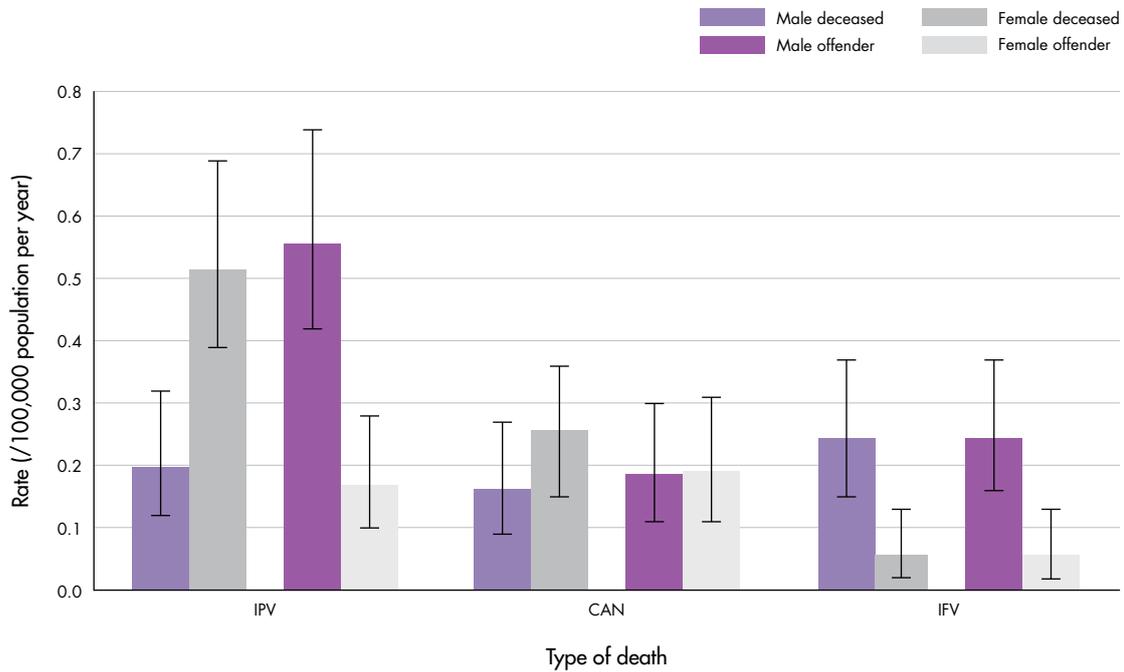
Significantly more women were killed by IPV than men (73 percent of the IPV deceased were female) and, conversely, men were more often IPV offenders than women (76 percent of IPV offenders were male). Men were more often offenders and more often the deceased in intrafamilial family violence (81 percent and 83 percent, respectively). Greater numbers of female children were likely to be CAN deceased than male children (62 percent and 38 percent, respectively). They were equally likely to be killed by females as by males but, as shown in Table 12, male offenders were more likely to kill children by inflicted injury whereas female offenders were more likely to kill children by neonaticide, filicide and parental suicide or neglectful supervision.

Table 31: Gender-specific rates (per 100,000 people per year) for deceased and offenders of family violence death by type of family violence, New Zealand, 2009–12

GENDER	Total NZ population		Total			IPV			CAN			IFV		
	n	%	n	%	rate	n	%	rate	n	%	rate	n	%	rate
Deceased	17,522,200		n=126			n=63			n=37			n=26		
Male	8,607,100	49.12	52	42	0.60	17	27	0.20	14	37.8	0.16	21	81	0.24
Female	8,915,100	50.88	74	60	0.83	46	73	0.52	23	62.2	0.26	5	19	0.06
Offender	17,522,200		n=124			n=63			n=34			n=27		
Male	8,607,100	49.12	85	70	0.99	48	76	0.56	16	47	0.19	21	78	0.24
Female	8,915,100	50.88	37	30	0.42	15	24	0.17	17	50	0.19	5	19	0.06
Unknown			2	2		0			1	3		1	4	

IPV = intimate partner violence.
 CAN = child abuse and neglect.
 IFV = intrafamilial violence.

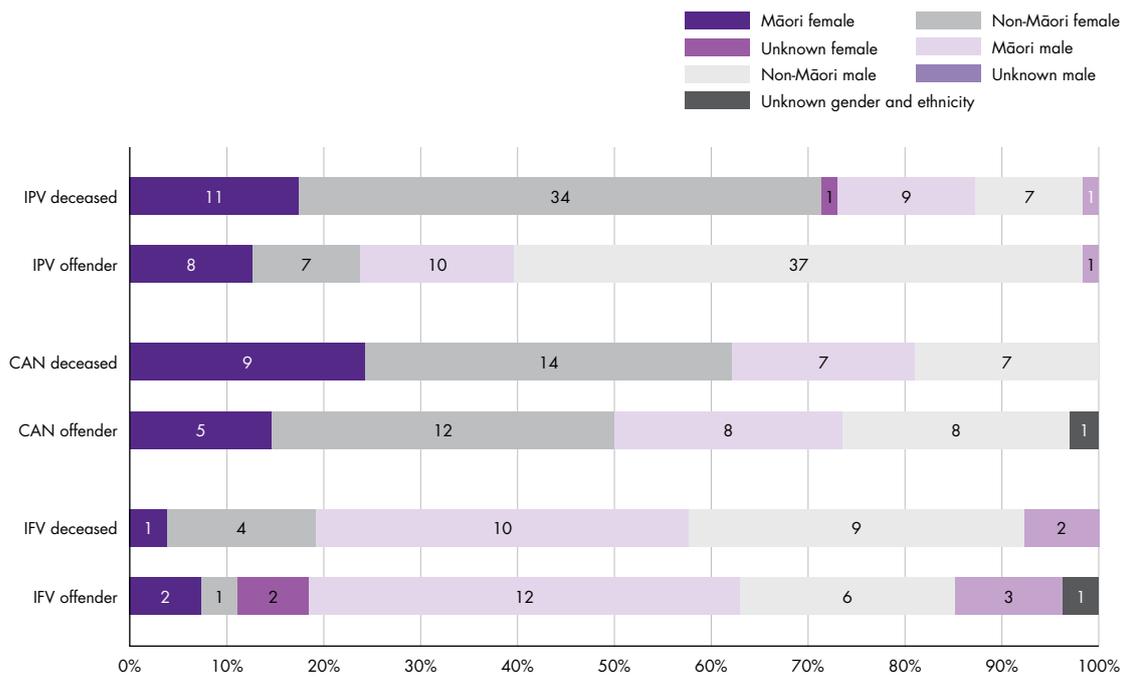
Figure 27: Gender-specific rates (per 100,000 people per year) for deceased and offenders in family violence death by type of family violence, New Zealand, 2009–12



IPV = intimate partner violence.
 CAN = child abuse and neglect.
 IFV = intrafamilial violence.

Association between gender and ethnicity of family violence deaths in New Zealand 2009–12

Figure 28: Gender and ethnicity of deceased and offender in family violence deaths by type, New Zealand, 2009–12



IPV = intimate partner violence.
 CAN = child abuse and neglect.
 IFV = intrafamilial violence.

Age and family violence deaths in New Zealand 2009–12

There were differences in age of deceased and of offenders (Table 11) in family violence deaths in New Zealand from 2009 to 2012. In IPV, most deceased were aged from 20 to 49, with significantly fewer either below or above these ages. Offenders ranged in age from 20 to 50 years of age and beyond. Children killed from CAN were most often killed by adults aged 20–29 years.

Table 32: Age-specific rates (per 100,000 people per year) for family violence deaths by type of family violence, New Zealand, 2009–12

DECEASED AGE	Total New Zealand population n=17,522,000		Total family violence deaths n=126			IPV n=63			CAN n=37			IFV n=26		
	n	%	n	%	rate	n	%	rate	n	%	rate	n	%	rate
<1 year	250,220	1.43	12	10	4.80	0			12	32	4.80	0		
1–4 years	992,600	5.66	17	14	1.71	0			17	46	1.71	0		
5–9 years	1,153,740	6.58	4	3	0.35	0			4	11	0.35	0		
10–19 years	2,450,360	13.98	7	6	0.29	1	2	0.04	4	11	0.16	2	8	0.08
20–29 years	2,439,990	13.93	18	15	0.74	15	24	0.61				3	12	0.12
30–39 years	2,264,920	12.93	18	15	0.79	14	22	0.62				4	15	0.18
40–49 years	2,525,760	14.41	24	20	0.95	21	33	0.83				3	12	0.12
≥50 years	5,444,480	31.07	21	17	0.39	9	14	0.17				12	46	0.22
Unknown			5	4		3	5					2	8	

IPV = intimate partner violence.

CAN = child abuse and neglect.

IFV = intrafamilial violence.

Table 33: Age-specific rates (per 100,000 people per year) for offenders in family violence death by type of family violence, New Zealand, 2009–12

OFFENDER AGE	Total New Zealand population n=17,522,000		Total family violence offenders n=124			IPV n=63			CAN n=34			IFV n=27		
	n	%	n	%	rate	n	%	rate	n	%	rate	n	%	rate
<1 year	250,220	1.43												
1–4 years	992,600	5.66												
5–9 years	1,153,740	6.58												
10–19 years	2,450,360	13.98	5	4	0.20				1	3	0.04	4	15	0.16
20–29 years	2,439,990	13.93	39	32	1.60	14	22	0.57	17	50	0.70	8	30	0.33
30–39 years	2,264,920	12.93	28	23	1.24	15	24	0.66	8	24	0.35	5	19	0.22
40–49 years	2,525,760	14.41	23	19	0.91	16	25	0.63	3	9	0.12	4	15	0.16
≥50 years	5,444,480	31.07	16	13	0.29	15	24	0.28	1	3	0.02	0	0	0.00
Unknown			13	11		3	5		4	12		6	22	

IPV = intimate partner violence.

CAN = child abuse and neglect.

IFV = intrafamilial violence.

Location of family violence deaths in New Zealand 2009–12

Table 34: Family violence deaths by police district, New Zealand, 2009–12

POLICE DISTRICT	Family violence deaths n=126	Population of region 2009–12 n	Rate per 100,000
Northland	6	619,415	0.97
Auckland	9	1,721,320	0.52
Waitemata	11	2,157,920	0.51
Counties Manukau	18	2,042,650	0.88
Waikato	7	1,340,560	0.52
Bay of Plenty	13	1,328,295	0.98
Eastern	14	802,650	1.74
Central	13	1,394,695	0.93
Wellington	10	1,901,530	0.53
Tasman	4	699,825	0.57
Canterbury	16	2,223,370	0.72
Southern	5	1,213,225	0.41

Appendix 4: Family Violence Death Review Committee predominant aggressor and primary victim classification criteria for intimate partner violence deaths

Background

The Family Violence Death Review Committee (the Committee) is required to ascertain what patterns of abuse were occurring in relationships prior to the death event. In order to do this, there is a need to consider the 'wider contextual framework' and look beyond the reported abuse incidents and who died in the death event. To establish whether the roles of predominant aggressor (PA) and primary victim (PV) were evident or suspected in adult intimate relationships, the Committee analyses each person's patterns of behaviours, as well as the context, meaning and intent of recorded or disclosed episodes of abuse prior to the death event. This approach involves understanding that 'abuse has different meanings in different contexts'.

The Committee has looked at the history of the relationship between intimate partners in order to determine whether one partner was using coercive controlling³⁰⁴ behaviours towards their partner in the relationship before the death event.

Coercive behaviours include:

- *violence* – pushing, slapping, assaults, severe beatings, attempted strangulation, sexual violence and use of weapons³⁰⁵ and objects to inflict injury
- *intimidation* – threats, jealous surveillance, stalking,³⁰⁶ shaming and degradation, and destruction of property. This can include violence directed at children and pets/animals.

Controlling behaviours include:

- *isolation* – from family, whānau, friends and networks of support³⁰⁷
- *deprivation, exploitation and micro-regulation of everyday life* – limiting access to survival resources such as food and money, or controlling how the victim dresses.

Classification categories for IPV deaths

PA and PV

Deaths in which there is evidence of a history of abuse in which one partner is utilising coercive and controlling behaviours towards the other are cases which the Committee has classified as involving a PA and a PV. Whilst most PVs will not have used violence themselves, as noted in this report some victims in extremely physically abusive relationships can use physical violence to resist the coercion and control that they are experiencing from their partner. If both partners have used violence in the past, it is therefore important to assess the overall pattern and meaning of the violence between the couple. Important considerations include the following:³⁰⁸

304 The definition of coercive and controlling behaviours has been taken from E. Stark, *Coercive Control. How Men Entrap Women in Personal Life*, 2007.

305 A weapon is defined as an instrument/object that when used is capable of inflicting serious injury and/or death and can include an ordinary household object if it is used to assault or threaten to assault. Note that it is important to distinguish between defensive and offensive use/threats with weapons.

306 This includes the behaviours listed in the stalking victimisation scales. There are eight stalking victimisation scales. See Section D in M.P. Thompson et al., *Measuring Intimate Partner Violence Victimization and Perpetration: A Compendium of Assessment Tools*, Atlanta, Centers for Disease Control and Prevention, 2006. Available at www.cdc.gov/ncipc/pub-res/IPV_Compendium.pdf

307 This can include threats directed at those attempting to help the victim, undermining the victim's relationships with family and friends, and isolating behaviours.

308 These indicators are taken from the determining the predominant aggressor indicators available on www.stopvaw.org/determining_the_predominant_aggressor

- Who has initiated most of the violence?
- What are the respective motivations of each party for their use of violence (to dominate and/or to resist being dominated or defend themselves or another)?
- What are the nature of any injuries sustained (offensive or defensive) and the seriousness of injuries received by each person?
- Who in the relationship has posed the greatest danger and had the potential to seriously injure the other?
- Whether one person was recorded as being fearful, whether one person was recorded as being controlling?
- Who has had their activities constrained or has been forced to do things that they do not want to do because of fear of the other?

Suspected PA and PV

In some cases, on the information which is available to the Committee, there is not enough direct evidence of a history of abuse between the couple before the death event to determine whether such a history exists. However, sometimes the nature of the killing itself and the recorded history of victimisation and perpetration in previous intimate relationships for one or both in the couple raises strong suspicions that one of the parties is a PA and one the PV in an abuse history which precedes the death event. The Committee has labelled these cases as suspected PA and suspected PV.

Uncertain deaths

For deaths in which a tier two regional review has not been completed, the Committee will not have access to the full range of agency records for the families in question. Therefore there are cases in which the Committee is unable to say whether there is a history of abuse on the basis of the information that exists. These cases will be classified as 'uncertain', meaning that more information about the history between the couple would be necessary before it could be determined whether an abuse history is present or absent and whether one party is the PA in that history.

Aberrational

Some cases have aberrational features. Whilst there may have been an intimate relationship between the offender and the deceased, the killing does not appear to be an act of family violence, for example, cases in which the offender in the death event appears to be a serial killer or where an offender has killed the deceased for material gain. The Committee has labelled these as cases as aberrational.

Mutual fighting

Mutual fighting is where physical violence is used by both partners within an egalitarian or non-abusive relationship as a means of problem-solving. Where mutual fighting occurs both partners may use violence against each other but coercive controlling behaviours will be absent and neither partner will have instilled ongoing fear in the other. We would expect mutual fighting to involve very low-level violence, such as slapping and pushing, rather than serious assaults³⁰⁹ and it would therefore be extremely rare to find cases of mutual fighting resulting in an intimate partner death event. When assessing the history between the couple, it is important to bear in mind the tendency on the part of those involved in, and responding to, family violence to minimise the nature and seriousness of family violence.

³⁰⁹ M.P. Johnson, *Types of Domestic Violence*, 2008.

Classification process

Because the classification of the deaths involves an evaluation of the facts and evidence in respect of each death event, the Committee has been careful to ensure that the process of evaluation is rigorous and involves a number of people. First, a minimum of three committee members should each individually assess the information that is available for each case to classify the case. Second, those cases for which clear agreement as to classification does not exist amongst those who have made the preliminary assessment are then discussed in full committee until a consensus is reached.

Section 1: Deaths which have direct evidence of a history of coercive controlling behaviours and an identified PA and PV

- 1.1 This classification is for those cases where there is direct evidence of an abuse history before the homicide and it is possible to discern a PA and PV in that history.
- 1.2 If there is strong evidence (from either informal and/or formal sources) of an abuse history that involves at least two coercive controlling behaviours, then the Committee can classify the case as involving a prior abuse history with a PA and a PV. If there is evidence of a history of abuse that involves one partner using only one type of coercive and controlling behaviour towards the other (for example, the use of physical force or stalking behaviours) then corroborating evidence in the form of either points 1b, 4, 5 or 6 in Table A2 would be sufficient to classify the case as involving a PA and PV. The weaker the direct evidence of abuse the greater will be the need for evidence of other corroborating factors before the case could be classified as involving actual abuse.
- 1.3 Table A1 outlines the type of information that must be assessed when considering whether or not there was an abuse history between the couple.

Point	Prior abuse history indicator in the relationship ³¹⁰	Considerations	PA or PV role indicator	Direct evidence of a PA and PV	Definite Yes/No
A	Evidence of coercive controlling behaviours from informal sources.	Informal sources include disclosures made by witnesses in police homicide statements, and disclosures to other agencies by family and friends after the death event.	The person who has a pattern of using coercive controlling behaviours is considered the PA.		
B	Agency record(s) of past coercive controlling behaviours in the intimate partner relationship (formal sources). This includes non-government and government agencies' records.	Consider who the PA is and who the PV is in the majority of the reported episodes. Consider what services the people were referred to, victim services or perpetrator services.	The PA is considered to be the person whose recorded episodes of abuse indicate that in the majority of episodes they used coercive controlling behaviours.		
C	Protection order(s) in place for this relationship. This includes temporary and final orders.	In some occasions there may be a trespass order (TO) and no protection order. A TO might be strong corroborating evidence if there is other evidence of an abuse dynamic and weak evidence if there is not.	The applicant for the protection order is considered the PV, the respondent the PA.		

³¹⁰ Relationship here encompasses the following partnerships: current partners, separated partners and ex-partners.

TABLE A1

Point	Prior abuse history indicator in the relationship ³¹⁰	Considerations	PA or PV role indicator	Direct evidence of a PA and PV	Definite Yes/No
D	Two or more lethality risk factors present prior to the death event. Lethality risk factors are those included on the Dangerousness Assessment (DA). ³¹¹	DA (excluding questions 2, 4, 8, 11 and 12): ³¹² <i>Physical violence increased in severity/frequency over past year?</i> <i>Separation after living together during the past year?</i> <i>Abuser used a weapon against you or threatened you with a lethal weapon?</i> <i>Abuser threatened to kill you?</i> <i>Abuser avoided being arrested for domestic violence?</i> <i>Abuser forced you to have sex?</i> <i>Abuser tried to choke you?</i> <i>Abuser controls most/all of your daily activities?</i> <i>Abuser is violently and constantly jealous of you?</i> <i>Victim ever been beaten by abuser while pregnant?</i> <i>Abuser ever threatened/tried to commit suicide?</i> <i>Abuser threatened to harm your children?</i> <i>Do you believe the abuser is capable of killing you?</i> <i>Abuser follows or spies on you, leaves threatening notes or messages, destroys your property or calls you when you don't want them to?</i> <i>Victim ever threatened or tried to commit suicide?</i> Some deaths may involve 'honour'-based violence. This may result in certain lethality risk factors, such as threats to kill, being made by a family member rather than the abusive partner.	Answering yes to two or more lethality risk factors listed is evidence of being a PV.		
E	Victim's/Family's/Friends fearfulness or expressed concerns about her/his partner's behaviour.	Such as she/he has made a will 'in case' anything happens to her/him or has sought protection or expressed fear.	The person who is most fearful, who people believe is at risk from their partner, is considered the PV.		

311 This is a 20-item instrument developed by Jacquelyn Campbell (PhD, RN, FAAN) which uses a weighted system to score yes/no responses to risk factors associated with intimate partner homicide. For more information, see www.dangerassessment.org/About.aspx

312 Question 2. Does he own a gun? 4. Is he unemployed? 8. Do you have a child that is not his? 11. Does he use illegal drugs? By drugs, I mean 'uppers' or amphetamines, 'meth', speed, angel dust, cocaine, 'crack', street drugs or mixtures? 12. Is he an alcoholic or problem drinker? These questions on their own would not be sufficient evidence of lethality risk. Two or more yes answers are required to the remaining 16 questions listed under point D, Considerations.

Section 2: Deaths where there is a strong suspicion that there was a history of coercive controlling behaviours involving a suspected PA and a suspected PV

- 2.1 'Indirect evidence' of an abuse history, such as the nature of the homicide event (for example, that it is pre-meditated, has the flavour of an 'execution' and is triggered by the deceased's desire to separate) and/or a clear prior history of abuse with past partners, will raise strong suspicions that there was an abuse history in the current relationship prior to the death event. However, because it is not direct evidence of that abuse history it is not considered conclusive.
- 2.2 Similar evaluative judgements to section 1 must be made when the evidence is indirect and only raises suspicions of an abuse history in which one partner is the suspected predominant aggressor (SPA) and the other the suspected primary victim (SPV).
- 2.3 When there is strong evidence supporting two of the criteria in Table A2, the Committee would classify the death as involving an SPA and SPV (this must include points 1b, 5 or 6). Where there is weak evidence supporting two of the criteria below, then we would need to seek corroborating evidence from one or more of the other categories before classifying the case as suspected and the two partners as an SPA and SPV.
- 2.4 Table A2 outlines the type of information that must be assessed when considering whether there was a suspected abuse history between the couple.

TABLE A2

No	Suspected abuse indicators	Considerations	SPA or SPV role indicator	Indirect evidence of an SPA and SPV	Suspected Yes/No
1a	SPV – no known agency history/informal information that indicates they have used a pattern of coercive controlling behaviour in: <ul style="list-style-type: none"> • previous relationships • death event relationship. 	Consider context of offences and balance of roles – who is the aggressor/victim in the majority of episodes.	The person who does not have a history/predominant pattern of using coercive controlling behaviours in relationships is considered the SPV.		
1b	AND SPA – recorded agency history/informal information of abuse episodes or pattern of coercive controlling behaviour towards (ex-) partners. SPA is mainly recorded as being the offender in current or previous relationships.	Protection order(s) against the SPA in favour of previous partners. Family violence charges against the SPA with respect to previous partners and children.	The person who had a history/predominant pattern of using coercive controlling behaviours in previous relationships is considered the SPA.		

TABLE A2

No	Suspected abuse indicators	Considerations	SPA or SPV role indicator	Indirect evidence of an SPA and SPV	Suspected Yes/No
2	Significant PV vulnerabilities.	<p>A clear power imbalance between partners. For example, a marked discrepancy in age where there is an older man and a young woman.</p> <p>Sex worker.</p> <p>Past patterns of family violence victimisation (other than victimisation mentioned in 1a). For example, a history of child abuse victimisation.</p> <p>(which impacts on reporting/help-seeking/ability to leave) – for example, gang involvement; chronic intergenerational histories of abuse; limited social supports.</p>	Indicators of previous and/or current vulnerability indicate the person is an SPV.		
3	Who was trying to end the relationship?	SPV is more likely to have a history of attempting to leave.	The person trying to leave the relationship is considered the SPV.		
4	The context of the death event suggests there were jealousy and control issues in the relationship.	<p>The killing is triggered by the SPV wanting a separation, separating or being 'unfaithful' (real or imagined).</p> <p>The new partner of the SPV is killed.</p>	The person who killed the deceased due to separation, 'infidelity' or presence of a new partner is considered the SPA.		
5	The nature and method of the killing, and nature of the injuries sustained by both parties raises strong suspicions that there were control and domination issues.	<p>There was an element of pre-meditation or flavour of 'execution' to the killing.</p> <p>Death event included strangulation.</p> <p>The killing was particularly violent (overkill in the execution of the death – eg, multiple stab wounds).</p> <p>Stalking/Intimidation was part of death event, eg, pursuing the victim in order to inflict injuries.</p> <p>Pattern of offensive or defensive injuries.</p> <p>Murder-suicide.</p>	<p>The person is considered the SPA in a death event where they killed the deceased, including one or more of the following:</p> <ul style="list-style-type: none"> • execution-type killing • overkill • strangulation • active pursuit of the deceased before death • killer committed suicide/ attempted suicide afterwards. 		

TABLE A2

No	Suspected abuse indicators	Considerations	SPA or SPV role indicator	Indirect evidence of an SPA and SPV	Suspected Yes/No
6	The nature and method of the killing, and nature of the injuries sustained by both parties raises strong suspicions that the offender was acting defensively.	<p>Use of serious physical violence from the deceased against the offender before the death event.</p> <p>Offender had tried to make the deceased leave prior to the killing or had been backed into a corner.</p> <p>Spontaneous killing – no premeditation evident and, in some cases the killing itself has an ‘accidental’ element (even if the offender has deliberately armed themselves).</p> <p>Weapon used readily available (kitchen knife).</p> <p>No overkill evident, one or two injuries.</p> <p>Defensive injuries present on offender.</p>	The person who did the killing is considered the SPV.		

References

Books, journal articles and websites

- Anda, R.F. et al., 'The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology', *European Archives of Psychiatry and Clinical Neuroscience*, vol. 256, no. 3, 2006, pp. 174–86.
- Atkinson, C. and Atkinson, J., 'Talking about perpetrator programs' in Thompson, R. (ed.), *Working in Indigenous Perpetrator Programs: Proceedings of a Forum*, Adelaide, Ministerial Council for Aboriginal and Torres Strait Islander Affairs, 1999.
- Atkinson, J., Nelson, J. and Atkinson, C., 'Trauma, transgenerational transfer and effects on community wellbeing', in Purdie, N., Dudgeon, P. and Walker, R. (eds.), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, Canberra, Department of Health and Ageing, 2010, pp. 135–44. p. 139.
- Australian Public Services Commission, *Tackling Wicked Problems: A Public Policy Perspective*, Canberra, Commonwealth of Australia, 2007.
- Black, M.C. et al., *National Intimate Partner and Sexual Violence Survey: 2010 Summary Report*, Atlanta, GA, Centers for Disease Control and Prevention, 2011.
- Blacklock, N. and Debonnaire, T., *The Respect Accreditation Standard*, 2nd ed., London, Respect, July 2012.
- Bradfield R., 'Understanding the battered woman who kills her violent partner: the admissibility of expert evidence in Australia', *Psychiatry, Psychology and Law*, vol. 9, no. 2, 2002, pp. 177–9.
- Brandon, M. et al., *Understanding Serious Case Reviews and Their Impact: A Biennial Analysis of Serious Case Reviews, 2005–07*, University of East Anglia, 2009.
- Broadhurst et al., *Ten Pitfalls and How to Avoid Them: What Research Tells Us*. London: National Society for the Prevention of Cruelty to Children, 2010.
- Burns, E.A., House, J.D. and Ankenbauer, M.R., 'Sibling grief in reaction to sudden infant death syndrome', *Pediatrics*, vol. 78, no. 3, pp. 485–7, 1986.
- Californian District Attorneys Association and Training Institute on Strangulation Prevention, *The Investigation and Prosecution of Strangulation Cases*, 2013.
- Campbell, J.C. et al., 'Assessing risk factors for intimate partner homicide', *National Institute of Justice Journal*, vol. 250, 2003.
- Campbell, J.C. 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.
- Campbell, J. and Wolf, A.D., *Guns and Domestic Violence Homicide*, Unpublished presentation reporting on findings of Multi City Intimate Partner Femicide Study, Johns Hopkins University School of Nursing, n.d.
- Campinha-Bacote, J., 'Coming to know cultural competence: An evolutionary process', *International Journal for Human Caring*, vol. 15, no. 3, 2011, pp. 42–8.
- Cavanagh, K.R.E. and Dobash, R.P., 'The murder of children by fathers in the context of child abuse', *Child Abuse and Neglect*, vol. 31, 2007, pp. 731–46.

Centre for Suicide Prevention, 'Filicide: A literature review', *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, University of Manchester, Manchester, 2009.

Chapman, J., *Systems Failure — Why Governments Must Learn to Think Differently*, 2nd edn., London, Demos, 2004.

Clarke, M.C. et al., 'Sudden death of father or sibling in early childhood increases risk for psychotic disorder', *Schizophrenia Research*, vol. 143, 2013, pp. 363–6.

Colarossi, L. and Forgey, M.A., 'Evaluation study of an interdisciplinary social work and law curriculum for domestic violence', *Journal of Social Work Education*, vol. 42, 2006, pp. 307–23.

Cook, D. et al., *Evaluation of Specialist Domestic Violence Courts/Fast Track Systems*, Department of Constitutional Affairs, Criminal Justice System Race Unit and Crown Protection Service, 2004.

Cram, F., 'Poverty', in McIntosh, T. and Mulholland, M. (eds.), *Māori and Social Issues*, Wellington, Huia Publishers, 2011.

Daly, M. and Wilson, M., 'Is the "Cinderella effect" controversial? A case study of evolution-minded research and critiques thereof', in Crawford, C. and Krebs, D. (eds.), *Foundations of Evolutionary Psychology*, Mahwah NJ, Erlbaum, 2007.

Daly, M. and Wilson, M., *The Truth about Cinderella*, London, Weidenfeld & Nicolson, 1998.

Damashek, A. and Bonner, B.L., 'Factors related to sibling removal after a child maltreatment fatality', *Child Abuse & Neglect*, vol. 34, no. 8, 2010, pp. 563–9.

Dennehy, G. and Newbold, G., *The Girls in the Gang*, New Zealand, Reed Publishing, 2001.

Department of Attorney General and Justice, *Minimum Standards for Men's Domestic Violence Behaviour Change Programs*, http://www.domesticviolence.lawlink.nsw.gov.au/domesticviolence/minimum_standards_mdvbcp.html, n.d.

Department of Attorney General and Justice, *Towards safe families: A practice guide for men's domestic violence behaviour change programs*, http://www.domesticviolence.lawlink.nsw.gov.au/domesticviolence/minimum_standards_mdvbcp/what_provide.html, 2012.

Devries, K.M. et al., 'Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies', *PLOS Medicine*, vol. 10, no. 5, e1001439, doi:10.1371/journal.pmed.1001439, 2013.

Domestic Violence Resource Centre Victoria, 'Justice of judgement? The impact of Victorian homicide law reforms on responses to women who kill intimate partners', *Discussion Paper No 9*, 2013.

Drumm, J. and Moss, C., *Domestic Violence Victimisations in the Police Auckland City*, Auckland, Shine, 2014.

Duncanson, M., Smith, D. and Davies, E., 'Death and serious injury from assault of children aged under 5 years', *Aotearoa New Zealand: a Review of International Literature and Recent Findings*. Wellington, Office of the Children's Commissioner, 2009.

Duran, E., *Healing the Soul Wound: Counselling with American Indians and Other Native Peoples*, New York, Teachers College Press, 2006.

Duran, E. and Duran, B., *Native American Postcolonial Psychology*, Albany, NY, State University of New York, 1995.

Easteal, P. and Hopkins, A., 'Walking in her shoes: Battered women who kill in Victoria, Western Australia and Queensland', *Alternative Law Journal*, vol. 35, no. 3, 2010, pp. 135–36.

Edleson, J.L., 'The overlap between child maltreatment and woman battering', *Violence Against Women*, vol. 5, no. 2, 1999.

Edleson, J.L. et al., 'How children are involved in domestic violence: Results from a four-city telephone survey', *Journal of Interpersonal Violence*, vol. 18, no. 1, 2003, pp. 18–32.

Family Violence Death Review Committee, *Third Annual Report: December 2011 to December 2012*, Wellington, Health Quality & Safety Commission, 2013.

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

Family Violence Death Review Committee, *First Annual Report to the Minister of Health*, October 2008 to September 2009, Wellington, Ministry of Health, 2009.

Fanslow, J. and Robinson, E., 'Help-seeking behaviors and reasons for help seeking reported by a representative sample of women victims of intimate partner violence in New Zealand', *Journal Interpersonal Violence*, vol. 25, no. 5, 2010, pp. 929–51.

Fergusson, D. and Horwood, L., 'Exposure to interparental violence in childhood and psychological adjustment in young adulthood', *Child Abuse & Neglect*, vol. 22, 1998, pp. 339–57.

Fletcher, J. et al., 'A sibling death in the family: Common and consequential', *Demography*, vol. 50, 2013, pp. 803–26.

Flyvbjerg, B., '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.

Fredericks, B., 'Which way that empowerment? Aboriginal women's narratives of empowerment', *AlterNative*, vol 4, no. 2, 2008, p. 9.

Freeman, L.N., Shaffer, D. and Smith, H., 'Neglected victims of homicide: The needs of young siblings of murder victims', *American Journal of Orthopsychiatry*, vol. 66, 1996, pp. 337–45.

Glass, N. et al., 'Non-fatal strangulation is an important risk factor for homicide of women', *The Journal of Emergency Medicine*, vol. 35, no. 3, 2008, pp. 329–35.

Gillingham, P. and Humphreys, C., 'Child protection practitioners and decision-making tools: observations and reflections from the front line', *British Journal of Social Work*, vol. 40, 2010, pp. 2598–616.

Gorman, W., 'Provocation: The jealous husband defence', *Criminal Law Quarterly*, vol. 42, 1999, p. 478.

Gulliver, P. and Fanslow, J., 'Exploring risk factors for suicidal ideation in a population-based sample of New Zealand women who have experienced intimate partner violence', *Australian and New Zealand Journal of Public Health*, vol. 37, pp. 527–33, 2013.

Hawley, D. et al., 'A review of 300 attempted strangulation cases. Part III: injuries in fatal cases', *The Journal of Emergency Medicine*, vol. 21, no. 3, 2001, pp. 317–22.

Her Majesty's Inspectorate of Constabulary, *Everyone's Business: Improving the Police Response to Domestic Violence*, London, <http://www.hmic.gov.uk/publication/improving-the-police-response-to-domestic-abuse/>, 2014.

Hester, M., *Mothering through Domestic Violence*, London, Jessica Kingsley Publishers, 2007.

Hester, M., Pearson, C. and Harwin, N., *Making an Impact: Children and Domestic Violence: A Reader*, London, Jessica Kingsley Publishers, 2007.

House of Commons Health Committee, *The Victoria Climbié Inquiry Report. Sixth Report of Session 2002–03*, HC 570, London, TSO, 2003, pp.159, 205, 322.

Humphreys, C., *Domestic Violence and Child Protection: Challenging Directions for Practice*, Issues Paper 13, Australian Domestic and Family Violence Clearinghouse, 2007.

Humphreys, C. and Thiara, R., *Routes to Safety: Protection Issues Facing Abused Women and Children and the Role of Outreach Services*, Bristol, Women's Aid Federation of England, 2002.

Independent Police Conduct Authority, *Police Response to Complaints Made by Ashlee Edwards*, 2013.

Institute of Medicine, *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence*, Washington, DC, The National Academies Press, 2002, p.124.

Johnson, M.P., *Types of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence*, Boston, Northeastern University Press, 2008.

Judicial Commission of NSW, *Partial Defences to Murder in NSW 1990–2004*, 2008.

Katz, C., 'The narratives of abused children who have survived attempted filicide', *Child Abuse & Neglect*, vol. 37, 2013, pp. 762–70.

Kauppi, A. et al., 'Maternal and paternal filicides: A retrospective review of filicides in Finland', *Journal of the American Academy of Psychiatry and the Law*, vol. 38, no. 2, 2010, pp. 229–38.

Klevens, J. and Leeb, R.T., 'Child maltreatment fatalities in children under 5: Findings from the National Violence Death Reporting System', *Child Abuse & Neglect*, vol. 34, no. 4, 2010, pp. 262–6.

Krug, E. et al. (eds.), *World Report on Violence and Health*, Geneva, World Health Organization, 2002.

Kruger, T. et al., *Transforming Whānau Violence – A Conceptual Framework. A Report from the Former Second Māori Taskforce on Whānau Violence*, 2004.

Martin, J. and Pritchard, R., *Learning from Tragedy: Homicide within Families in New Zealand 2002–2006*, Wellington, Ministry of Social Development, 2010.

Matlow, R. and DePrince, A., 'The influence of victimization history on PTSD symptom expression in women exposed to intimate partner violence', *Psychological Trauma: Theory, Research, Practice, and Policy*, 12 March 2012.

Mayhew, P. and Reilly, J., *The New Zealand Crime & Safety Survey: 2006*, Wellington, Ministry of Justice, 2007.

Mederos, F., *Accountability and connection with abusive men: A new child protection response to increasing family safety*, Family Violence Prevention Fund, 2004.

Ministry of Justice, *The New Zealand Crime & Safety Survey: 2009: Main Findings Report*, Wellington, Ministry of Justice, 2010.

Ministry of Justice, *Restorative Justice Standards for Family Violence Cases*, <http://www.justice.govt.nz/publications/global-publications/r/restorative-justice-standards-for-family-violence-cases>, 2013.

Minnesota Coalition for Battered Women, *Special Femicide Report: Strangulation and Women and Children Murdered in Minnesota, 1989–2005*, 2005.

Model Criminal Code Officers Committee of the Attorneys-General, *Model Criminal Code, Chapter 5, Fatal Offences Against the Person*, Discussion paper 89, 1998.

Murphy, C. et al., *Understanding Connections and Relationships: Child Maltreatment, Intimate Partner Violence and Parenting*, Auckland, New Zealand Family Violence Clearinghouse, 2013.

NSW Attorney General and Justice, *The NSW Domestic Violence Justice Strategy: Improving the NSW Criminal Justice System's Response to Domestic Violence, 2013–2017*, 2012.

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

New Zealand Government, *Children's Action Plan: Identifying, Supporting and Protecting Vulnerable Children*, 2012.

New Zealand Law Commission, *The Partial Defence of Provocation*, Wellington, NZLC Report 98, 2007.

New Zealand Law Commission, *Some Criminal Defences with Particular Reference to Battered Defendants*, Wellington, NZLC Report 73, 2001, pp. 9–12.

Office of Women's Policy, Department of Planning and Community Development, *A Right to Safety and Justice: Strategic Framework to Guide Continuing Family Violence Reform in Victoria 2010–2020*, 2010.

Ooki, S., 'Characteristics of fatal child maltreatment associated with multiple births in Japan', *Twin Research and Human Genetics*, vol. 16, 2013, pp. 743–50.

Paulin, J., *Homicide within Families in New Zealand 2002–2008*, Unpublished work commissioned by the Health Quality & Safety Commission, 2011.

Pence, E., *Why Gender & Context Matter*, plenary speech given at the 15th Annual Batters Intervention Services Coalition of Michigan National Conference: When She Hits Him: Why Gender & Context Matter, 4 November, 2010.

Perez, S. et al., 'The attenuating effect of empowerment on IPV-related PTSD symptoms in battered women living in domestic violence shelters', *Violence Against Women*, vol. 18, 2012, pp. 102–17.

PMMRC, *Sixth Annual Report: Reporting Mortality 2010*, Wellington, Health Quality & Safety Commission, 2012.

Pollanen, M.S. et al., 'Fatal child abuse-maltreatment syndrome. A retrospective study in Ontario, Canada, 1990–1995', *Forensic Science International*, vol. 126, no. 2, 2002, pp. 101–4.

Ptacek, J., *Battered Women in the Courtroom: The Power of Judicial Responses*, Northeastern University Press, Boston, 1999.

Ptacek, J. and Frederick, L., *Restorative Justice and Intimate Partner Violence*. Harrisburg, PA, VAWnet, National Resource Center on Violence Against Women, <http://www.vawnet.org>, 2009.

Reason, J., *Managing the Risks of Organisational Accidents*, Brookfield, VT, Ashgate, 1997.

Regan, L., 'Children and domestic violence: Its impacts and links with woman abuse', Presented at the *Impact of Domestic Violence on Children Conference*, London, October 2001.

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

- Richie, B., 'A Black feminist reflection on the antiviolence movement', *Signs*, vol. 25, no. 4, 2000, pp. 1133–7.
- Ritchie, D.J. and Eby, K.K., 'Transcending boundaries: An international, interdisciplinary community partnership to address domestic violence', *Journal of Community Practice*, vol. 15, 2007, pp. 121–45.
- Roehl, J. et al., *Intimate Partner Violence Risk Assessment Validation Study*, NIJ 2000WTVX0011, Final Report 28 March 2005.
- Ross, A.H., Abel, S.M. and Radisch, D., 'Pattern of injury in child fatalities resulting from child abuse', *Forensic Science International*, vol. 188, no. 1, 2009, pp. 99–102.
- Runyan, D., 'Listening to children from the LONGSCAN studies on child abuse and neglect: Comparing child self-report and adult report of both exposures and outcomes', Conference Paper, XVI the ISPCAN International Congress on Child Abuse and Neglect, York, 3–6 September 2006.
- Salter, M., 'Multi-perpetrator domestic violence', *Trauma Violence Abuse*, vol. 15, no. 2, 2014, pp. 102–12.
- Schnieder, E., *Battered Women and Feminist Lawmaking*, Yale, Yale University Press, 2000, pp. 112–47.
- Sen, P., "'Crimes of honour", value and meaning', in Welchman, L. and Hossain, S. (eds.), *'Honour' Crimes, Paradigms, and Violence against Women*, London, Zen Books, 2005.
- Seuffert, N., *Battered Women and Self-Defence*, *New Zealand Universities Law Review*, 17, 1997, pp. 292–328.
- Sheehy, E.A., Stubbs, J. and Tolmie, J., 'Defences to homicide for battered women: A comparative analysis of laws in Australia, Canada and New Zealand', *The Sydney Law Review*, vol. 34, no. 3, 2012, p. 467.
- Siddiqui, H., 'There is no "honour" in domestic violence, only shame! Women's struggles against 'honour' crimes in the UK', in *'Honour' Crimes, Paradigms, and Violence against Women*, 2005.
- Siddiqui, H., "'It was written in her kismet": forced marriage', in Gupta, R. (ed.), *From Homebreakers to Jailbreakers: Southall Black Sisters*, London, Zen Books, 2003.
- Snowden, D. and Boone, W., 'A leader's framework for decision making', *Harvard Business Review*, vol. 85, no. 11, 2007.
- Snyder, R.L., 'A raised hand; Can a new approach curb domestic homicide?', *Annals of Prevention*, The New Yorker, 22 July 2013.
- Stark, E., *Coercive Control. How Men Entrap Women in Personal Life*, New York, Oxford University Press, 2007.
- Steeves, R.H. and Parker, B., 'Adult perspectives on growing up following uxoricide', *Journal of Interpersonal Violence*, vol. 22, 2007, pp.1270–84.
- Stobart, E., *Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage*. Foreign and Commonwealth Office Home Office, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/35530/forced-marriage-guidelines09.pdf, 2009, p. 12.
- Strack, G.B., 'She Hit Me, Too,' *Identifying the Primary Aggressor: A Prosecutor's Perspective*, http://www.ncdsv.org/images/she_hit_me.pdf.
- Strack, G.B. and Gwinn, C., 'On the edge of homicide: Strangulation as a prelude', *Criminal Justice*, vol. 26, no. 3, 2011.

- Strack G.B. et al., 'A review of 300 attempted strangulation cases. Part I: criminal legal issues', *The Journal of Emergency Medicine*, vol. 21, no 3, 2001, pp. 303–9.
- Stubbs, J. and Tolmie, J., 'Race, gender and the battered woman syndrome: An Australian case study', *Canadian Journal of Women and the Law*, vol. 8, no. 1, 1995, p. 122.
- Taskforce for Action on Violence Within Families, *Training and Education for the Family Violence Workforce: Developing a National Training Framework*, 2013.
- National Center for the Prosecution of Violence Against Women, "'And then he choked me": Understanding, investigating, and prosecuting strangulation cases', *The Voice*, vol. 2, no. 1, American Prosecutors Research Institute, The Research and Development Division of NDAA, 2007.
- Thomas, K. et al., "'Do you know what it feels like to drown?" Strangulation as coercive control in intimate relationships', *Psychology of Women Quarterly*, 20 May 2013.
- Thompson, M.P. et al., *Measuring Intimate Partner Violence Victimization and Perpetration: A Compendium of Assessment Tools*, Atlanta, Centers for Disease Control and Prevention, 2006.
- Turquet, L. et al., *Progress of the World's Women: In Pursuit of Justice*, New York, UN Women, 2011.
- Ulloa, E.C., Dyson, R.B. and Wynes, D.D., 'Inter-partner violence in the context of gangs: A review', *Aggression and Violent Behavior*, vol. 17, 2012, pp. 397–404.
- Van Riper, M., 'Death of a sibling: five sisters, five stories', *Pediatric Nursing*, vol. 23, 1997, pp. 587–95.
- Victorian Law Reform Commission, *Defences to Homicide: Final Report*, 2004, pp. 27–30.
- Vincent, C.A., '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.
- Walters, K.L. 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.
- Washington State Coalition Against Domestic Violence, *2012 Domestic Violence Fatalities in Washington State*, 2013, <http://fatalityreview.files.wordpress.com/2014/01/2012-washington-dv-fatalities.pdf>, 2014, (accessed on 28 January 2014).
- Websdale, N., *Familicidal Hearts: The Emotional Styles of 211 killers*, New York, Oxford University Press, 2010.
- Weick, K. and Sutcliffe, K.M., *Managing the Unexpected: Resilient Performance in an Age of Uncertainty*, 2nd edn., San Francisco, John Wiley & Sons, Inc., 2007.
- Winder, E. and the Committee on Psychosocial Aspects of Child and Family Health, 'Support the Family after the Death of a Child', *Pediatrics*, vol. 130, 2012, pp. 1164–9.
- Witt, J.L. and Edelson, J.L., 'The Minnesota Center Against Violence and Abuse (MINCAVA): Providing research, education, and access to information on violence against women and children', *Violence Against Women*, vol. 17, 2011, pp. 1207–19.
- Worden, J.W. et al., 'Comparing parent loss with sibling loss', *Death Studies*, vol. 23, 1999, pp. 1–15.
- Wright, F., 'The circumstances as she believed them to be: A reappraisal of section 48 of the Crimes Act 1966', *Waikato Law Review*, vol. 6, 1998, p. 109.

Cases

Hamidzadeh v R [2012] 26 CRNZ 245

R v Ahluwalia [1992] 4 All ER 889 (Eng)

R v Brown CA 93/94, 11 April 1995

R v Erstich [2002] 19 CRNZ 419

R v Falls Supreme Court of Queensland, No 928 of 2007, 17 May 2010 (Aust)

R v King HC Hamilton, CR1 2004 019 003825, 7 April 2005

R v Mahari HC Rotorua, CRI 2006-070-8179, 14 November 2007

R v Mallot [1998] 1 SCR 123 (Can)

R v Lavallee [1990] 1 SCR 852 (Can)

R v Oakes [1995] 2 NZLR 673

R v Raivaru HC Rotorua, CRI 2004-077-1667, 5 August 2005

R v Ranger [1988] 4 CRNZ 6

R v Reti [2009] NZCA 271

R v Rihia [2012] NZHC 2720

R v Stjernqvist Cairns Circuit Court, 18 June 1996 (Aust)

R v Stone HC Wellington, CRI 2005-078-1802, 9 December 2005

R v Suluape [2002] 19 CRNZ 492

R v Wang [1989] 4 CRNZ 674

R v Weatherston

R v Wihongi [2012] 1 NZLR 775

Legislation

Coroners and Justice Act 2009 (Eng)

Crimes Act 1900 (NSW)

Crimes Act 1961 (NZ)

Crimes Amendment (Provocation) Bill 2014 (NSW)

Crimes Act 1900 (ACT)

Crimes (Provocation Repeal) Amendment Act 2009 (NZ)

Criminal Code 1985 (Can)

Criminal Code Act 1899 (Qld)

Criminal Code Act 1983 (NT)

Criminal Procedure Act 2011 (NZ)

Domestic Violence Act 1995 (NZ)

Domestic Violence (Programmes) Regulations 1996 (NZ)

Privacy Act 1993 (NZ)

Privacy Amendment Act 2013 (NZ)

Public Health and Disability Act 2000 (NZ)

Public Health and Disability Amendment Act 2010 (NZ)

Sentencing Act 2002 (NZ)

**Family Violence Death
Review Committee**



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