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

Family Violence Death Review Committee

He tao huata e taea te karo

Fifth Report Data:
January 2009 to December 2015

'Our daughter Helen is a statistic in these pages. Understanding why, has saved others.'
David White

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

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

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FOREWORD

The Health Quality & Safety Commission (the Commission) welcomes the *Fifth Report Data: January 2009 to December 2015* from the Family Violence Death Review Committee (the Committee). This companion report presents data on family violence deaths in Aotearoa New Zealand during 2009–15 and contextualises the thinking about family violence discussed in the Committee's *Fifth Report.*

This report emphasises the Committee's call to shift how the sector thinks about and responds to family violence. Preventing deaths from family violence requires an integrated family violence system in which agencies, organisations and practitioners are oriented to work together with families and whānau to provide safe, effective and culturally responsive support.

The over-representation of Māori among family violence deceased and offenders, as well as those from the most deprived neighbourhoods, illustrates that family violence is not distributed equally. For Māori, multiple intersecting disadvantages, both contemporary and historical, continue to contribute to the violence within whānau seen today. For those experiencing family violence and living in the most deprived neighbourhoods, including many Māori whānau, the health sector's continued focus on improving equity in the quality and safety of services for all populations is paramount.

The Commission commends the Committee's contribution to the family violence sector work. This report, together with the *Fifth Report,* provide critical analysis and direction for guiding system reform and preventing deaths from family violence. These reports are important for informing the integrated system focus of the Ministerial Group on Family Violence and Sexual Violence.

Family violence causes harm that can traverse generations. This report reminds us that there are many child survivors of family violence who have lost a sibling and/or a parent, and some of these children were present when their family member was killed. To prevent intergenerational patterns of harm, we hope the conceptual shifts and approaches summarised in this report continue to inform the work of practitioners and organisations working to address and ultimately prevent family violence. It is through collective responsibility and action across the workforce and our communities that we can address the complexities of family violence, and enable safety and wellbeing for families and whānau.

Professor Alan Merry ONZM FRSNZ
Chair, Health Quality & Safety Commission

June 2017

CHAIR'S INTRODUCTION

This companion report documents the devastation of family violence – the lives lost and the enduring burden of harm afflicted upon the living. These lives and deaths are a testament to why we must transform our ways of addressing family violence and violence within whānau. History shows we cannot be effective in preventing violence through a series of system tweaks; we must be prepared to make some transformational leaps.

We know the people in this report lived in communities, they all accessed health care services and their children went to schools. To be preventative we need to consider new configurations of services and ways of responding to family violence and violence within whānau. Every day, many people are working with people experiencing or perpetrating violence. There are multiple opportunities to wrap support around child and adult victims, their families and whānau, as well as to work with fathers, men and their communities in ways that respectfully challenge them to take responsibility for their behaviour and to be the parent their family and whānau needs. We need a workforce capability lift, so we can maximise these opportunities for change. Kaupapa Māori approaches are an essential part of this reorientation.

The size of the social problem means this work cannot remain the role of the few – New Zealand Police, Oranga Tamariki and family violence non-government organisations – it must become the responsibility of the many. What is required is whole-of-family and -whānau, whole-of-organisation and whole-of-system responsiveness. The challenge is large, but so is our collective workforce.

The Committee commends Minister Adams and Minister Tolley for their leadership of the Ministerial Group on Family Violence and Sexual Violence, demonstrated on 7 June 2017 with the launch of the *Family Violence, Sexual Violence and Violence within Whānau: Workforce Capability Framework June 2017* (the Framework). The Framework sets out a vision and expectation of excellence – a workforce capable of responding safely and respectfully to family violence, sexual violence and violence in whānau.

As Interim Chair of the Committee, I wish to recognise the exceptional leadership and dedication of the previous Chair, Professor Julia Tolmie. She has worked tirelessly to ensure the Committee's learning from reviewing deaths positively influences reform in the sector. It is a privilege to have the role of kaitiakitanga of the Committee and to work with such inspiring people. I would also like to acknowledge the many practitioners who continue to respond with compassion and empathy to all those affected by family violence and violence within whānau.

To all the family and whānau members whose loved ones are detailed in this report: we know family violence is preventable. Now is a critical time in Aotearoa New Zealand to forge our collective commitment to the changes needed in our society – changes that will enable prevention to become a reality for this generation of mokopuna and for generations to come.

Dr Jacqueline Short
Chair, Family Violence Death Review Committee

June 2017

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Fifth Report Data: January 2009 to December 2015 is a companion piece to the Committee's *Fifth Report*.[1] It presents data analysed for three main types of family violence deaths in Aotearoa New Zealand during 2009–15:

- intimate partner violence (IPV)
- child abuse and neglect (CAN)
- intrafamilial violence (IFV).

The histories of harm detailed in this report are a stark and unacceptable reminder to us all of the human cost of family violence and violence within whānau. These numbers represent the lives of mothers, daughters, sisters, aunties, fathers, sons, brothers, uncles, nephews, nieces, children and grandchildren. This report makes visible their experiences of violence.

The report reinforces the *Fifth Report's* call for transformational change in Aotearoa New Zealand. New and reclaimed perspectives and actions are essential if we are to stop family violence and violence within whānau. These are preventable patterns of harm.

Key findings:

- There were 194 family violence deaths over seven years, with IPV deaths making up almost half of these deaths. In 98 percent of IPV death events where there was a recorded history of abuse, women were the primary victim, abused by their male partner.
- In these IPV deaths, the weapons used, level of premeditation and planning, escalating threat and use of overkill (excessive violence) differed for male and female offenders. These patterns were different depending on the role (predominant aggressor or primary victim) the offenders had in the abuse history of the relationship.
- Many CAN deaths (80 percent) involved children under five years of age. Two-thirds (66 percent) of child deaths occurred in fatal physical abuse and/or grossly negligent treatment death events.
- Of the 37 IFV death events,[2] 92 percent (34 death events) involved offenders and/or deceased who were known to statutory services for family violence (CAN, IPV and IFV), sexual offending and/or violence against non-family members.
- Across all types of family violence deaths analysed, Māori deceased and offenders lived in the most deprived neighbourhoods, while non-Māori deceased and offenders lived in neighbourhoods from across all levels of deprivation. Māori are over-represented as deceased and offenders in all family violence deaths.

Understanding and responding to family violence

IPV is a gendered pattern of harm

Data on the 92 IPV deaths during 2009–15 shows men were three-quarters of offenders and women were two-thirds of those who were killed. When the abuse histories in the relationships were examined, gendered patterns of harm were even more defined. Among the men who were offenders or deceased in the death events, many had been the predominant aggressor in the abuse history. Ninety-eight percent of IPV death events with a recorded history of abuse (81 death events) involved men who had abused their female partners.

1 Family Violence Death Review Committee, *Fifth Report: January 2014 to December 2015,* Wellington, Health Quality & Safety Commission, 2016.

2 Excluded are the seven aberrational mental health death events and the one uncertain IFV death event.

The circumstances of IPV death events also reveal very different patterns for male predominant aggressors who kill compared with female primary victims who kill. Male predominant aggressor offenders showed premeditation and planning, and harmed multiple people in the death event. A significant proportion of these killings also involved overkill – where the violence used was far beyond what was necessary to cause death. Female primary victim offenders were often responding to a situation of escalating threat, using a weapon readily at hand that they picked up in response to that situation. They were dealing with men who were capable of seriously hurting them and, in many instances, had already started to physically abuse them. These killings have strong defensive features and are not frequent.

To ensure victims' safety we must improve our responses to abusive men

It is commonly (mis)understood that victims are at liberty to separate from abusive partners. In reality separation is very difficult because abusive partners' behaviours are intended to undermine victims' abilities to escape and be self-determining. Victims resist their partner's violence but this does not stop the violence.

Data on female primary victims shows that separation alone does not secure their safety and, therefore, cannot be seen as the solution to stopping their partner's violence. Sixty-seven percent of the female primary victims were killed, or their new/ex-male partners were killed, by male predominant aggressors in the time leading up to or following separation. As outlined in the *Fifth Report,* the safety and wellbeing of victims is dependent on a systemic response to the abusive partner's violence.

Data presented in this report challenges us to do better to ensure victims' safety and improve our responses to abusive men. To prevent family violence re-occurring, we need to work with men and their communities in ways that respectfully challenge them to take genuine responsibility for their behaviour and to be the parent their family and whānau needs. Without ongoing, culturally responsive support to sustain behaviour changes, including trauma responses (for their own histories of abuse), and escalating consequences for continued abuse, a partner/parent will often take his pattern of abusive behaviour into subsequent relationships. His trajectory of violence towards new partners, children, step-children and other family and whānau members may be fatal.

To be preventative we have to respond to CAN and IPV together

Sixty-six percent of all CAN deaths (37 deaths) occurred in fatal physical abuse and/or grossly negligent treatment death events. Ninety-two percent of these (34 deaths) were caused by direct physical assaults. Most of these children were beaten to death by men – step-fathers, fathers and male caregivers. Seventy seven percent of the male offenders of fatal physical abuse and/or grossly negligent treatment deaths (20 offenders) were known to the police for abusing the mother of the deceased child/female partner and/or a prior female partner(s).

In total, 117 children and young people were present at IPV and CAN death events. For some children one parent killed their other parent. Effectively these children lost both parents: one to the homicide and the other to the prison system. The death(s), often of a parent or sibling, were likely to be just one of a succession of traumatic experiences for these children that started prior to the fatal event, and will continue long after the event without effective intervention.

To be preventative we have to recognise there are multiple victims whose safety and wellbeing need to be addressed. In February 2017, the Committee published a *Position Brief*[3] summarising the six reasons why we cannot be effective in responding to IPV or CAN unless we address both together:

1. Intergenerational violence requires an intergenerational response.
2. The decision to abuse a child's parent is a harmful, unsafe parenting decision.
3. 'Failure-to-protect' approaches fail to respond to both child and adult victims' safety needs.
4. Protecting children means acting protectively towards adult victims.

3 See Appendix 6.

5. To prevent family violence, we must work with the people using violence.
6. Victims' safety is a collective responsibility; it cannot be achieved by individuals or individual agencies alone.

These six reasons provide the direction for new organisational responses that acknowledge the entangled nature of IPV and CAN. They also shift the focus from assessing the protectiveness of adult victims to assessing the level of risk and danger that a partner's/parent's abusive behaviour poses to both child and adult victims. This shift is essential if we are to protect vulnerable infants, their siblings and their mothers.

Intergenerational violence requires an intergenerational response

The IFV deaths show histories of intergenerational harm (victimisation and/or perpetration) for offenders and deceased, many of whom were also experiencing high levels of structural inequities. A number of themes have emerged from the analysis of the circumstances surrounding IFV death events, including:

- family violence histories
- family violence histories *and* mental health histories
- social gatherings where large amounts of alcohol were consumed
- family inheritance/property disputes or financial exploitation.

The themes require further development. In the future the Committee intends to focus on IFV deaths to gain a better understanding of the relationships between intergenerational histories of harm, structural inequities and the circumstances preceding IFV death events.

Kaupapa Māori responses to preventing violence are essential

All violence has a whakapapa (a genealogy). To understand the over-representation of Māori as deceased and offenders in all family violence deaths, the historical and contemporary consequences of colonisation must be acknowledged. For Māori, the impacts were and are destructive and pervasive. Violence against Māori wāhine (women) and mokopuna (children and grandchildren) is not part of traditional Māori culture. Rather, the violence within whānau seen today reflects the patriarchal norms of the colonising culture as well as trauma from the widespread fragmentation of Māori social structures that were enforced during and after colonisation.

Family violence deaths in these seven years show how multiple forms of oppression based on race, gender and class (colonial, structural, institutional and interpersonal) intersect and shape how violence is experienced by people, their families and whānau. Those living with the most harmful levels of family violence are also often experiencing multiple forms of disadvantage and discrimination.

A socioeconomic gradient is visible for all family violence deaths during 2009–15 and this is particularly pronounced for Māori whānau. The distributions of Māori deceased and offenders are skewed towards high deprivation levels, with much larger proportions residing in the most deprived neighbourhoods compared with non-Māori deceased and offenders.

Preventing violence within whānau is complex. It involves reclaiming mātauranga Māori bodies of knowledge, strengthening cultural identity and restoring connections to renew the protectiveness that cultural traditions offer.[4] It also requires a long-term commitment from government and mainstream services to address structural inequities and institutional racism – forms of violence that have contributed to the current levels of violence within whānau.

4 D. Wilson., 'Transforming the normalisation and intergenerational whānau (family) violence', *Journal of Indigenous Wellbeing, Te Mauri – Pimatisiwin,* vol. 1, no. 2, 2016, pp. 32–42.

Conclusion

There are many more people affected by family violence deaths than are captured in this report. The legacies of violence and trauma often 'reverberate across generations', with 'devastating harm' to individual and collective identity and wellbeing.[5] In this generation we must lay the foundations to prevent further spiralling of violence. There is unprecedented will to make this a reality. Now is the time to act.

Key statistics:

In the seven years from 2009 to 2015 in Aotearoa New Zealand:

There were 194 family violence deaths and 188 family violence death events

- 91 deceased (**48 percent**) and 87 offenders (**49 percent**) lived in the most deprived neighbourhoods (quintile 5).[6]
- **77 percent** of Māori deceased and **68 percent** of Māori offenders lived in areas with the highest levels of deprivation, compared with **29 percent** of non-Māori deceased and **36 percent** of non-Māori offenders.[6]

There were 91 intimate partner violence (IPV) death events

Of the 92 deceased and 92 offenders in IPV death events:

- **68 percent** (63 deceased) were women and 32 percent (29 deceased) were men
- **76 percent** (70 offenders) were men and 24 percent (22 offenders) were women.

Of the **83** IPV death events where there was a recorded history of abuse:[7]

- **99 percent** (82 death events) involved women who were the primary victim (in the history of the relationship they were abused by their partner)
- **98 percent** (81 death events) involved men who were the predominant aggressor (in the history of the relationship they had abused their female partner)
- in 16 IPV death events (**19 percent**) the offender was also the primary victim of abuse. All of these were females
- **67 percent** of the female primary victims were killed, or their new/ex-male partners were killed, by male predominant aggressors in the time leading up to or following separation.

There were 92 IPV deaths

- **52 percent** (48 deaths) were overkill deaths.
- **92 percent** (44 deaths) of all overkill deaths were committed by male predominant aggressors.
- Māori were **three times** more likely to be deceased and offenders in IPV deaths than non-Māori.

5 Dignity Conference 2015: Response-Based Practice in Action.

6 Denominators only include those whose residential addresses were known.

7 Known and suspected predominant aggressors are combined. Known and suspected primary victims are combined.

There were 56 child abuse and neglect (CAN) deaths

- **80 percent** (45 deaths) involved children aged under 5 years.
- **66 percent** (37 deaths) occurred in fatal physical abuse and/or grossly negligent treatment death events. Of these 37 deaths:
  - **92 percent** (34 deaths) were caused by direct physical assault
  - **74 percent** of the 35 known offenders (26 offenders) were males
  - **77 percent** of the 26 male offenders (20 offenders) were known to the police for abusing the mother of the deceased child/female partner and/or a prior female partner(s).
- Māori children aged 0–4 years were **four times** more likely to be killed by CAN than non-Māori children aged 0–4 years.

Children present at IPV and CAN death events

- **A total of 117 children and young people** were present at IPV and CAN death events.

There were 45 intrafamilial violence (IFV) death events

- **92 percent** of the 37 IFV death events (excluding seven aberrational and one uncertain death events) involved offenders and deceased with known statutory histories of family violence, sexual violence or violence against non-family members.
- **79 percent** of offenders (38 offenders) were males and **19 percent** (9 offenders) were females.
- Māori were **four times** more likely to be deceased and **five times** more likely to be offenders in IFV deaths than non-Māori.

CHAPTER 1: INTRODUCTION

Fifth Report Data: January 2009 to December 2015 of the Family Violence Death Review Committee (the Committee) summarises data on family violence deaths in Aotearoa New Zealand from 2009 to 2015. The report is intended as a companion piece to the Committee's *Fifth Report*[8] and references relevant sections throughout. Additional tables showing rates of family violence deaths (by ethnicity, age and gender) are presented in Appendix 1.

This chapter presents an outline of the structure of the report together with background information on the Committee, its review process and the methods of quantitative analysis. For a full glossary of the terms used throughout this report, refer to Appendix 2.

The final sections of this chapter present key figures on all family violence deaths in Aotearoa New Zealand. This is followed by a discussion of the sociohistorical context and structural inequities that contribute to the over-representation of Māori whānau in all family violence death events. Readers should use these contextual factors as a lens through which they interpret the findings presented in this report.

1.1 Overview of this report

Chapters 2 to 4 present data on three types of family violence deaths: intimate partner violence (IPV), child abuse and neglect (CAN) and intrafamilial violence (IFV). Each chapter concludes with the criminal justice outcomes for the offenders in the death events followed by an analysis of the children harmed, where relevant.

Chapter 2 presents data on IPV death events, looking at the roles the offenders and deceased had in the abuse history throughout the relationship. Data is presented and discussed in relation to key concepts relevant to IPV deaths, such as separation, entrapment and overkill. This chapter also examines patterns of harm visible before, during and after the IPV death events, looking at how these patterns vary by gender for offenders and deceased, depending on their roles in the abuse history.

Chapter 3 shows data on CAN death events and introduces the Committee's method of classifying CAN by the underlying cause of death. Because of the entangled nature of CAN and IPV, the IPV police histories of the CAN offenders are also examined.

Chapter 4 summarises data on IFV death events. An analysis of the known histories of family violence and sexual violence among the IFV deceased and offenders is also presented.

Throughout the report, the Committee has included case examples to help illustrate the points discussed. These are de-identified composite cases based on a combination of details taken from death events included in the Committee's data set.

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 Amendment Act 2010, and the Committee is now one of four mortality review committees hosted by the Commission.

The overarching goal of the Committee is to contribute to the prevention of family violence and family violence deaths.[9] The Committee's functions are to 'review and report to the [Commission] 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 …'.

8 FVDRC, *Fifth Report,* Wellington, Health Quality & Safety Commission, 2016.

9 The Committee's terms of reference are available at: www.hqsc.govt.nz/assets/FVDRC/FVDRC-terms-of-reference-Oct-2015.pdf.

Members of the Committee are family violence experts from a wide range of disciplines across the social sector. They are selected on the basis of their potential to contribute to the mix of skills of the Committee and the background experiences that they bring to the table.[10]

1.2.2 Definition of a family violence death

The Committee's terms of reference were modified in 2015, and the definition of a family violence death was updated to include a requirement that the death be an episode of family violence and/or that there be an identifiable history of family violence.

The purpose of this change was to exclude death events where the death itself was not an act of abuse or the culmination of a history of abuse; for example, where one of the parties accidentally killed a family member in the absence of any history of violence.

The Committee's revised definition of a family violence death is (with revisions shown in bold text):

> The unnatural death of a person (adult or child) where the suspected perpetrator(s) is a family or extended family member,[11] caregiver,[12] intimate partner, previous partner of the victim, or previous partner of the victim's current partner, **and where the death was an episode of family violence and/or there is an identifiable history of family violence.**

The following deaths are specifically excluded from the definition of a family violence death: the death of non-family member bystanders or interveners in a family violence episode; suicides; assisted suicides; and deaths from chronic illness associated with family violence.

1.2.3 The family violence death review process

The Committee has developed a 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 regional review.

A standard set of 'tier one' information on all family violence homicides – collected from New Zealand Police and other agencies – is used for quantitative analysis of family violence deaths. From the data, the Committee can determine how many deaths are taking place in each family violence category, the demographics of the deceased and offenders (of the death event), and the services with which they have been involved. This information is useful for 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 IPV offenders are predominant aggressors or primary victims in the abuse history during the relationship. Tier one information, however, does not provide enough detail about what is happening or how the system responds to family violence, and it is this, more detailed level of information that is needed to 'develop strategic plans and methodologies' designed 'to reduce family violence morbidity and mortality'.[13]

A subset of deaths is therefore chosen for the more intensive regional review process. The regional reviews are in-depth case studies.[14] These involve examining rich 'tier two' qualitative information and narratives in case files from a range of services, with the purpose of seeing how the family violence system responded to those involved in the death events. Regional reviews are conducted by regional review panels, which include representatives from the key agencies involved in the family violence response along with family violence and cultural experts.

10 See Appendix 3 for a list of past and current members.

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

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

13 Refer to the Committee's terms of reference, available at: www.hqsc.govt.nz/assets/FVDRC/FVDRC-terms-of-reference-Oct-2015.pdf.

14 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. 301–316.

Definitions

Tier one: A standard set of data collected from a number of national agencies that is used for quantitative analysis of patterns and general trends in family violence deaths in Aotearoa New Zealand.

Tier two: The qualitative information gathered for in-depth regional reviews on a subset of family violence deaths.

Methods

Data sources

Data on family violence deaths from 2009 to 2015 were extracted from the FVDRC Data Collection, which is housed at the Health Quality & Safety Commission offices in Wellington. The FVDRC Data Collection is developed by compiling data on each family violence death event from New Zealand Police; Coronial Services; Ministry of Justice; Child, Youth and Family (now known as Ministry for Vulnerable Children, Oranga Tamariki); and the Ministry of Health.

Numerator ethnicity data was obtained from National Health Index (NHI) data sourced from the Ministry of Health. Where NHI ethnicity data was unknown, police ethnicity data has been used. This occurred for 3 deceased. Where a regional review had found 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, the ethnicity used for analysis was prioritised according to the following hierarchy: Māori > Pacific peoples > Asian > NZ European/Other.

Denominator data for rates by ethnicity, age and gender are projections from Statistics New Zealand. Totals vary slightly due to variations in assumptions about population growth. Rates have then been estimated per 100,000 people per year. Because this report includes data from 2009–15, the total population used to estimate rates and presented in the tables is from 2009–15. Within each chapter, the age range of the 'total population' used to estimate rates was based on the actual age ranges observed in the frequency counts for each type of family violence. The age ranges of the total population used for each type of family violence were: 15 years or over for IPV; 19 years or under for CAN deceased; and the whole population for CAN offenders and IFV.

Socioeconomic status

Socioeconomic status has been measured using New Zealand deprivation quintiles. The New Zealand Index of Deprivation 2013 (NZDep2013) is an area-based measure of socioeconomic deprivation using variables from the Census of Population and Dwellings 2013. The NZDep2013 scores, in this report, were assigned according to place of residence of deceased and offenders, using meshblock unit and presented as quintiles from least deprived (quintile 1) to most deprived (quintile 5). Quintiles categorise the population into five groups of equal size (each group being 20 percent of the population) based on deprivation.

Methods (cont)

Offender inclusion criteria

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. Offenders include:

- 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.

Occasionally, offenders also include 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. Such a person will be included as an offender 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

All percentages presented throughout the report have been rounded to the nearest whole number. In some instances, percentages may not sum to 100 exactly because of rounding. Rates have been rounded to two decimal places.

Statistical significance

Statistical significance tests can be used to test hypotheses about whether estimated rates differ between groups. When testing for differences between groups, obtaining a *p*-value less than 0.05 indicates there is less than a 5 percent likelihood the observed difference is due to chance alone; and is indicative that a real difference exists. In this report, because of small numbers, statistical significance tests were not undertaken to compare rates. Ninety-five percent confidence intervals can be used to gauge the likelihood that the estimated rates being compared are significantly different from each other.

Confidence intervals

Ninety-five percent confidence intervals (95% CIs) for rates have been computed using the Exact method.

The 95% CI represents the degree of uncertainty or error 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 (the sum of individual units of time that persons in the study population were exposed or at risk to the conditions of interest) in the denominator population. The CI represents the limits within which the 'true' rate is most likely to lie.

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. In this report, when the CIs for rates do not overlap, the text will refer to the magnitude of likely difference between the rates being compared (eg, 'rates were X times more likely in group A compared with group B'). However, readers are urged to interpret these comparisons with caution as they are based on small numbers and hence are associated with a reasonable degree of error (as such, all estimates of the magnitude of difference have been rounded to the nearest whole number). Refer to Appendix 1 for all tables showing the estimated age-, gender- and ethnic-specific rates together with the associated error.

1.3 Family violence deaths from 2009 to 2015

1.3.1 Homicides and related offences and family violence deaths, 2009–15

There were 194 family violence deaths in Aotearoa New Zealand during 2009–15 (Table 1). This equates to an average of 28 family violence deaths per year.

Family violence deaths are a subset of all homicides and related offences. Over the seven years during 2009-15, family violence deaths accounted for 40 percent of all homicides and related offences. The proportion of homicide and related offences deaths that were family violence deaths ranged between 31 percent and 47 percent during this period.

Table 1: Homicides and related offences and family violence deaths, New Zealand, 2009–15

HOMICIDES AND RELATED OFFENCES	2009	2010	2011	2012	2013	2014	2015	TOTAL
Family violence deaths*	44	28	24	26	24	20	28	194
All other homicides and related offences	49	48	38	38	38	44	37	292
Total of all homicide and related offences†	**93**	**76**	**62**	**64**	**62**	**64**	**65**	**486**
Excluded cases (Family violence deaths that were not homicides or related offences) n=19								
Offender suicides (as part of a family violence death)	**5**	**4**	**4**	**2**	**1**	**3**	**0**	

* Family violence deaths are homicides that fall within the Committee's terms of reference (see www.hqsc.govt.nz/assets/FVDRC/FVDRC-terms-of-reference-Oct-2015.pdf). These are a subset of 'homicide and related offences'. Source: FVDRC Data Collection.

† These numbers include recorded homicide statistics on murder, manslaughter and infanticide offences. Statistics for 2015 homicides are not yet stable because some of the investigations are still continuing. Statistics presented in this report may differ slightly from those included in previous Committee reports because of these updates. Source: *Police Statistics on Homicide Victims, 2007–2014,* Wellington, Police National Headquarters, 2017, www.police.govt.nz/about-us/publication/police-statistics-homicide-victims-new-zealand-2007-2014.

1.3.2 Family violence deaths, 2009–15

Family violence death events

A family violence death event can involve one or more deceased people and/or more than one offender.[15] In New Zealand during 2009–15 there was a total of 188[16] family violence death events; this included:

- 91 IPV death events
- 52 CAN death events
- 45 IFV death events.

In New Zealand during 2009–15 there were four suspicious and two suspected IPV death events. Suspicious death events are those where there is an identifiable history of family violence between the deceased and the suspected offender and the circumstances of the death event give rise to significant suspicion that what occurred was not accidental or self-inflicted. In these death events coroners may have ruled the cause of death to be undetermined, stated the presented evidence is incongruous with what transpired, ordered further investigation, or noted that a new inquiry may be opened in the future.

15 In this report the term 'offender' refers to the person who killed another in the death event. It is acknowledged that differs to how the Ministry of Justice (MOJ) uses the term 'offender'. The MOJ uses the term offender to describe someone who has been convicted of a crime.

16 The Committee recognises that there are more deaths that are not counted in the total number of family violence deaths. The range of reasons for undercounted family violence deaths include, for example: neonaticide deaths, which can be difficult to identify as homicide deaths; IPV deaths where it was not known that the offender and victim were in a relationship (eg, same-sex relationships); homicides that have been classified as suicides or accidents; missing persons; and unsolved homicides.

The police may have also charged a suspected offender but they were cleared by the court.

In suspected death events there is an identifiable history of family violence between the deceased and the suspected offender and the police commenced, but were unable to proceed with, a family violence homicide investigation (for reasons such as key witnesses not providing witness statements). In these death events the police have referred the case to the coroner. These six death events are not included in the 91 IPV death events but may be reported on in the future.

Family violence deaths

In the 188 death events there were 194 family violence deaths (Table 2). Almost one-half (47 percent) of the family violence deaths were IPV deaths.

Table 2: Family violence deceased by type, New Zealand, 2009–15

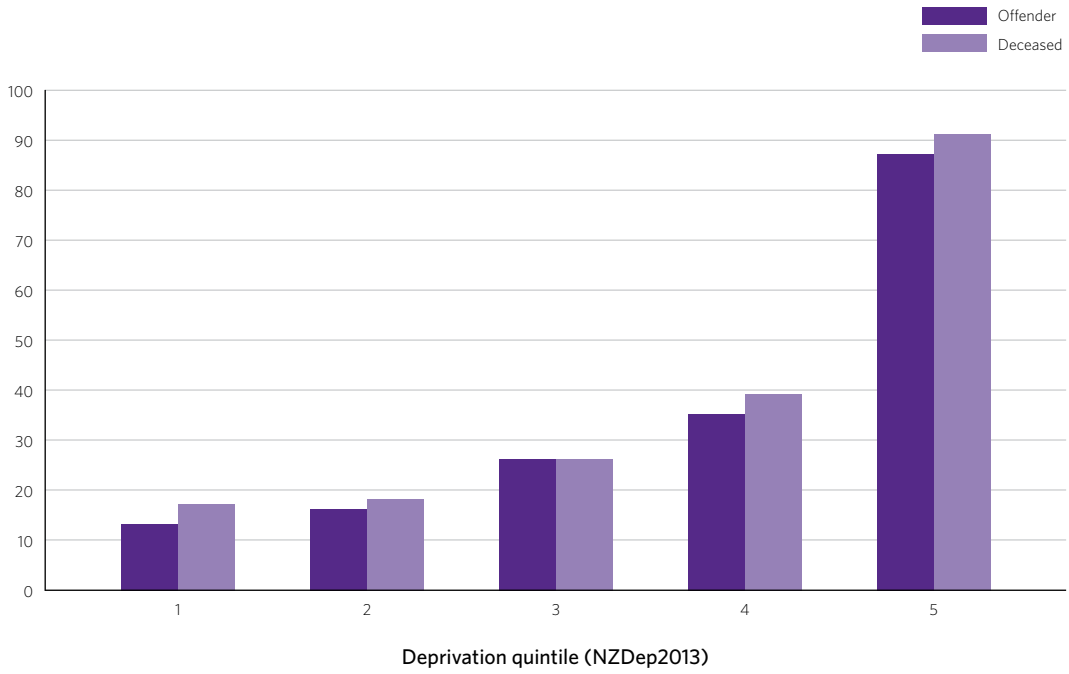
FAMILY VIOLENCE TYPE	Family violence deceased n=194	
	n	%
Intimate partner violence (IPV)	92	47
Child abuse and neglect (CAN)	56	29
Intrafamilial violence (IFV)	46	24

Family violence deaths by socioeconomic status

Socioeconomic deprivation quintiles were available for 191 deceased and 177 offenders in the family violence death events from 2009–15.

The distributions of the quintiles for those offenders and deceased whose residential addresses were known are skewed towards areas of high socioeconomic deprivation (Figure 1). There were 91 deceased (48 percent) and 87 offenders (49 percent) who lived in the most deprived neighbourhoods (quintile 5).

Figure 1: Deprivation quintile (NZDep2013) of deceased and offenders in family violence deaths (n=191 deceased; 177 offenders),* New Zealand, 2009–15

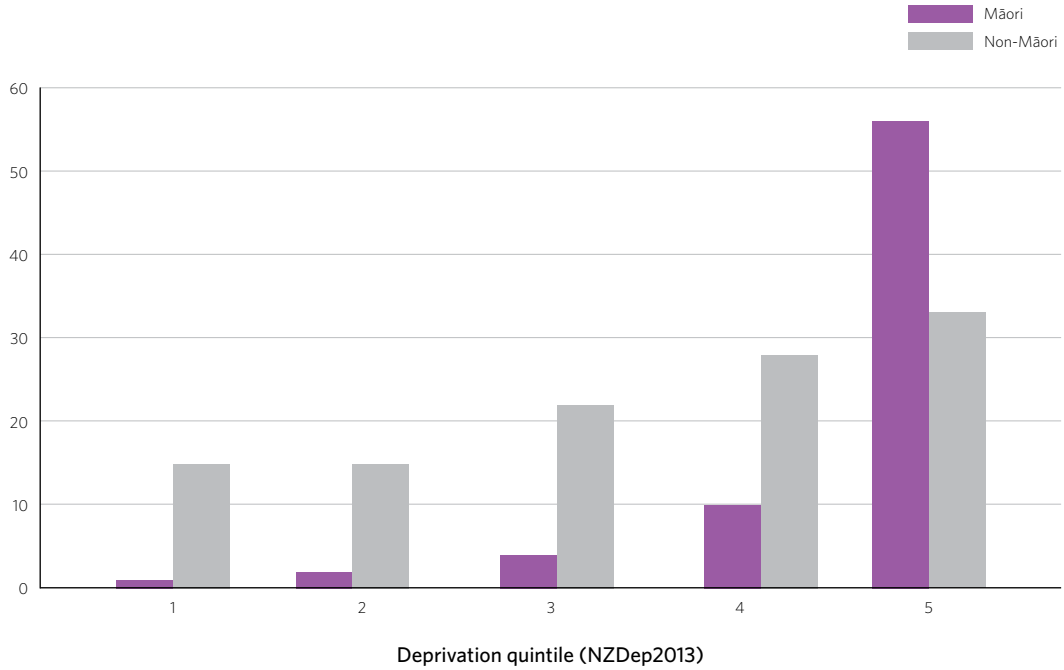


* The deprivation quintiles were unknown for three deceased and 18 offenders.

Family violence deaths by socioeconomic status and ethnicity

Figures 2 and 3 illustrate that levels of deprivation among Māori and non-Māori deceased and offenders (whose residential addresses and ethnicities were known) are distributed differently. Of those whose residential addresses and ethnicities were known, larger proportions of Māori deceased (77 percent) and offenders (68 percent) lived in areas with the highest levels of deprivation compared with non-Māori deceased (29 percent) and offenders (36 percent). The differences in distributions of offenders and deceased by ethnicity may reflect differences in the total Māori and non-Māori populations (higher proportions of Māori live in areas with higher NZDep2013 scores compared with non-Māori).[17]

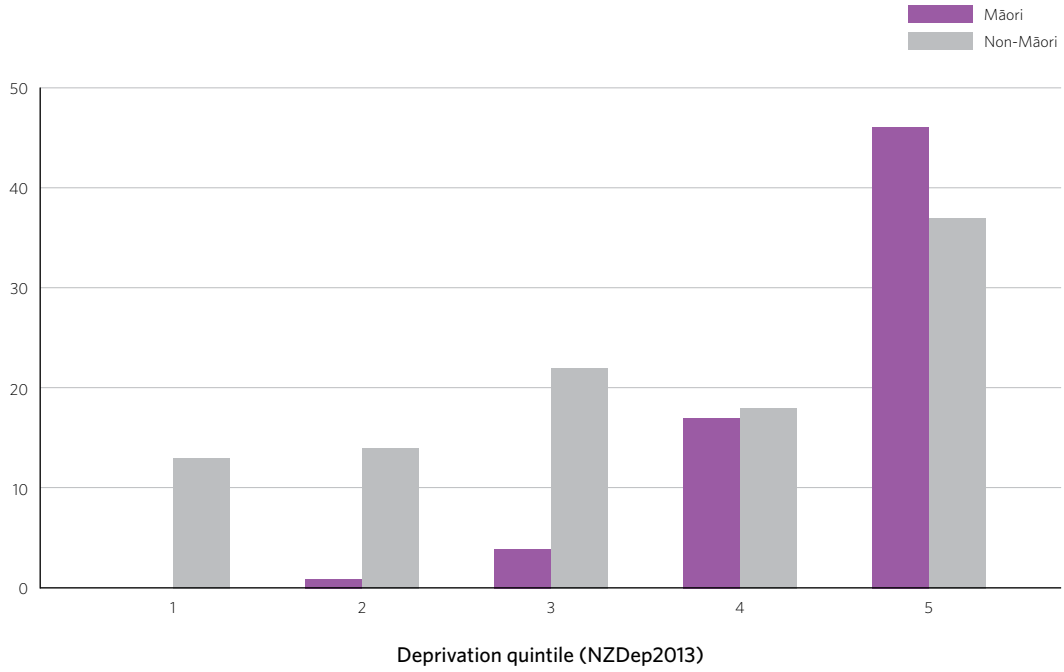
Figure 2: Deprivation quintile (NZDep2013) and ethnicity of deceased in family violence deaths (n=186),* New Zealand, 2009–15



* There were 194 deceased in total. The deprivation quintiles were unknown for three deceased and the ethnicities were unknown for five deceased.

17 See Figure 4, p. 12, Ministry of Health, *Tatau Kahukura: Māori Health Chartbook, 2015 (3rd edition),* Wellington, Ministry of Health, 2015: http://www.health.govt.nz/publication/tatau-kahukura-maori-health-chart-book-2015-3rd-edition.

Figure 3: Deprivation quintile (NZDep2013) and ethnicity of offenders in family violence deaths (n=172),* New Zealand, 2009–15



* There were 195 offenders in total. The deprivation quintiles were unknown for nine offenders and the ethnicities were unknown for five offenders. Both the deprivation quintile and ethnicities were unknown for nine offenders.

1.4 The whakapapa of violence within whānau

This section summarises current perspectives on violence within whānau. It describes the emergence of such violence and highlights the complex and contributing roles of historical and present-day challenges faced by Māori communities in Aotearoa New Zealand. The complex mix of sociohistorical and contemporary factors are argued by Māori scholars and thought-leaders to account for the over-representation of Māori in family violence.[18] We encourage readers to consider and apply these perspectives when interpreting the findings presented in this report.

Traditional roles within whānau, hapū and iwi

In its *Third Annual Report,*[19] the Committee noted, prior to Aotearoa New Zealand being settled and later colonised, it has been well documented that Māori held wāhine (women) and mokopuna (children and grandchildren) within their whānau (extended family networks) and hapū (sub-tribes) in high esteem.

> 'Their love and attachment to their children was very great; and that not merely to their own immediate offspring. They very commonly adopted children; indeed no man having a large family was ever allowed to bring them all up himself – uncles, aunts and cousins claimed and took them, often whether the parents were willing or not. They certainly took every physical care of them; and as they rarely chastised (for many reasons), of course, petted and spoiled them... The father, or uncle, often carried or nursed his infant on his back for hours at a time, and might often be seen quietly to work with the little one there snugly ensconced.'[20]

18 T. Dobbs and M. Eruera, *Kaupapa Māori wellbeing framework: The basis for whānau violence prevention and intervention,* Auckland, New Zealand Family Violence Clearinghouse, Issues Paper 6, 2014, https://nzfvc.org.nz/issues-papers-6; T. Kruger et al., *Transforming whānau violence – A conceptual framework. An updated version of the report from the former Second Māori Taskforce on Whānau Violence,* Wellington, Te Puni Kōkiri, 2004.

19 Family Violence Death Review Committee, *Third Annual Report: December 2011- December 2012,* Wellington, Health Quality & Safety Commission, 2013, pp. 21–26.

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

Mātauranga Māori (Māori knowledge and worldviews) contained within pūrākau (stories, myths and legends), waiata (songs), karakia (ritual chants or prayers), mōteatea (traditional laments or chants) and oriorio (lullabys) evidence the traditional Māori values and practices that guided and promoted respectful relationships within whānau and hapū. Collectively, these demonstrate how the whole whānau (comprising grandparents, aunties, uncles and cousins) placed the care and protection of mokopuna at the centre of their lives, as well as wahine, who were valued as bearers of the future generations[21] (one of their many roles within whānau, hapū and iwi (tribe)).

Raising children was a collective responsibility placed on all those within a whānau and hapū. Māori believed mokopuna were gifts from Atua (spiritual deity) and Tūpuna (ancestors) through their whakapapa (genealogy). This meant mokopuna were tapu (sacred, special, protected) and specific rules applied to their care.[22] Violence or harm towards children was a breaking of that tapu.[23]

The sacredness of mokopuna and the central role of women as bearers of future generations meant that any episodes of violence against children and women were understood as acts of violence and transgressions against the entire iwi.[24] Such violations were not tolerated and were addressed swiftly and publicly.[25] Because of this understanding, and the public way acts of violence were dealt with, violence in whānau was a rare occurrence.

> 'Pere also points out that assault on a woman, be it sexual or otherwise, was regarded as extremely serious and could result in death or, almost as bad, in being declared "dead" by the community and ignored from then on. Instances of abuse against women and children were regarded as whānau concerns and action would inevitably be taken against the perpetrator.'[26]

1.4.1 Understanding the sociohistorical context of violence within whānau

The emergence of violence within whānau

Today Māori are over-represented in multiple forms of family violence as victims and perpetrators,[27] including sexual violence, intimate partner violence[28] and child abuse and neglect.[29] Māori children are also more likely than non-Māori children to come into contact with Child, Youth and Family (CYF) for care and protection, or be referred to CYF for youth justice reasons.[30]

21 D. Wilson., 'Transforming the normalisation and intergenerational whānau (family) violence', 2016.

22 Pitama, Ririnui and Mikaere describe four principles related to the care and upbringing of Māori children:

- the significance of whakapapa
- children belong to whānau, hapū and iwi
- rights and responsibilities for raising children are shared
- children have rights and responsibilities to their whānau.

D. Pitama, G. Ririnui and A. Mikaere., *Guardianship, Custody and Access: Māori Perspectives and Experiences,* Ministry of Justice and Department for Courts, Wellington, 2002, p. 93.

23 M. Eruera and L. Ruwhiu., '"Eeny, meeny, miny, moe" catch hegemony by the toe: Validating cultural protective constructs for indigenous children in Aotearoa', Paper presented at the Third International Indigenous Social Work Conference, Darwin, NT, Australia, September, 2015.

24 T. Kruger et al., *Transforming whānau violence,* 2004; For a discussion on how traditional wrongs were seen collectively as the responsibility of the perpetrator's wider kin (and retribution or compensation was corrected at the level of the victim's kin) see: J.J Williams, 'Harkness Henry Lecture. Lex Aotearoa: An heroic attempt to map the Māori dimension in modern New Zealand Law', *Waikato Law Review. Taumauri,* vol. 21, 2013, pp. 1-34.

25 *Ibid.*

26 A. Mikare., 'Maori women: Caught in the contradictions of a colonised reality', *Waikato Law Review,* vol. 2, 1994/7, available at: www.waikato.ac.nz/law/research/waikato_law_review/pubs/volume_2_1994/7.

27 T. Dobbs and M. Eruera, *Kaupapa Māori wellbeing framework,* 2014; K. Aiomanu et al., *Supporting whānau to be safe, cohesive, resilient and nurturing,* joint presentation: Te Puni Kōkiri with Te Whakaruruhau O Te Waikato Women's Refuge, Ending Domestic and Family Violence Summit, Wellington, 2016.

28 J. Fanslow et al., 'Juxtaposing beliefs and reality: prevalence rates of intimate partner violence and attitudes towards violence reported by New Zealand women', *Violence Against Women,* vol. 16, no. 7, 2010, pp. 821-831.

29 J. Mardani, *Preventing child neglect in New Zealand: A public health assessment of the evidence, current approach, and best practice guidance,* Wellington, Office of the Children's Commissioner, 2010, http://www.occ.org.nz/assets/Uploads/Reports/Child-abuse-and-neglect/Preventing-child-neglect.pdf.

30 R. Templeton et al., *Research using administrative data to support the work of the Expert Panel on Modernising Child, Youth and Family,* Wellington, The Treasury, 2016, http://www.treasury.govt.nz/publications/research-policy/ap/2016/16-03/ap16-03.pdf.

These unacceptable levels of violence within whānau are rooted in the marginalisation of Māori and societal changes enforced during the colonisation of Aotearoa.[31] For Māori, colonisation resulted in multiple losses: the disconnection from their ancestral lands, the erosion of te reo (Māori language) and the fragmentation of Māori social structures. These losses undermined the ability of Māori to continue transmitting their tikanga (cultural customs and practices) and mātauranga Māori to successive generations.[32]

If we are to understand and respond effectively to violence that occurs within whānau, we must acknowledge structural issues such as the ongoing impact of colonisation. The term 'violence within whānau' encompasses all forms of violence that occur against and within Māori whānau.[33 34] Violence within whānau is conceptually broader than family violence because it considers the impact of multiple forms of oppression and violence contributing to Māori societal marginalisation, not just the acts of violence inflicted by whānau members.[35] Understanding the social, political and historical contexts impacting Māori, and the difference between violence within whānau and family violence, is critical in terms of any prevention and intervention practices, policies and legislation.

Definition:

Violence within whānau: All forms of violence that occur against and within Māori whānau, including the violence of colonisation, institutional racism and interpersonal violence. The causes of violence occurring within whānau are acknowledged as a complex mix of both historical and contemporary factors.

The impact of colonisation on Māori in Aotearoa

The disconnection of Māori from their culture had a significant impact on the nature of the relationships among whānau, hapū and iwi (tribes). As the new colonial ways of life imposed on Māori were increasingly adhered to, the gender and social roles within, and between, whānau members shifted in several ways, which contributed to increased violence within whānau.[36 37] One significant change was the shift in gender status and roles between wāhine, mokopuna and tāne (men).

The shifts in Māori gender roles resulted largely from the Victorian patriarchal cultural norms that rendered women as chattels of men. Wāhine traditionally had complementary social standings with tāne – their relationships were reciprocal, mutually beneficial and reliant on each other. However, Victorian gender ideology taught in the Native Schools and the teachings of the settling missionaries imposed patriarchal gender roles on Māori.[38] As a result wāhine were forced to be submissive to men and tāne were positioned as being authoritative leaders over women.[39] These shifting gender

31 T. Dobbs and M. Eruera, *Kaupapa Māori wellbeing framework,* 2014; T. Kruger et al., *Transforming whānau violence,* 2004; Te Puni Kōkiri (TPK), *Arotake Tūkino Whānau: Literature review on family violence,* Wellington, TPK, 2010, http://thehub.superu.govt.nz/publication/arotake-t%C5%ABkino-wh%C4%81nau-literature-review-family-violence-pdf.

32 The Confidential Listening and Assistance Service (the service) was established in 2008 as an independent agency to help people who had suffered abuse and neglect in state care before 1992. From 2008, until the closure of the service on 30 June 2015, the service met with more than 1100 New Zealanders. Thirty-seven percent of the people who spoke with the service were Māori. The panel gained the impression from their stories that Māori males were more likely to be treated harshly and put into care, especially state institutions, and more readily for minor reasons such as truancy. A common theme from the people's histories shared was Māori children were often placed with Pākehā foster families. In these contexts, iwi, hapū and whānau connections were often disregarded without thought or recognition. Māori children had their ties to their whakapapa and whānau cut. Confidential Listening and Assistance Service, *Some memories never fade: Final Report of the Confidential Listening and Assistance Service,* New Zealand, 2015.

33 T. Dobbs and M. Eruera, *Kaupapa Māori wellbeing framework,* 2014.

34 TPK, *Arotake Tūkino Whānau: Literature review on family violence,* 2010.

35 T. Kruger et al., *Transforming whānau violence*, 2004; K. Aiomanu et al., *Supporting whānau to be safe, cohesive, resilient and nurturing,* 2016.

36 *Ibid.*

37 L. Pihama et al., *'Te Rito' Action are 13 literature review: Family violence prevention for Māori research report,* Auckland, Auckland Uniservices, 2003, https://nzfvc.org.nz/sites/nzfvc.org.nz/files/Te%20Rito%20Action%20Area%2013%20Literature%20Review%20(2003)%20(.pdf.

38 A. Mikarere, 'Māori women: Caught in the contradictions of a colonised reality', 1994/7; T. Dobbs and M. Eruera, *Kaupapa Māori wellbeing framework,* 2014.

39 T. Dobbs and M. Eruera, *Kaupapa Māori wellbeing framework,* 2014; T. Kruger et al., *Transforming whānau violence,* 2004; TPK, *Arotake Tūkino Whānau,* 2010.

roles within whānau were further compounded by the fragmentation of wider Māori social support structures. Western ideologies of the 'nuclear family' were reinforced by the missionaries and in the Native Schools to be the pinnacle of cultural sophistication. Over time, this meant the loss of traditional collective support and protection for wāhine and mokopuna.[40]

The increasing confiscation of Māori lands and urbanisation policies weakened social structures and diminished the collective support offered by hapū and iwi. This led to many Māori leaving their ancestral homelands and moving to urban centres in search of work to support their families. Many Māori and their descendants became disconnected from their cultures and their tūrangawaewae (place to stand where Māori feel empowered and connected to their whakapapa). Thus, the impact of colonisation was pervasive and devastating to Māori both structurally and spiritually. Because of this, colonisation itself may also be considered an act of violence against Māori whānau.[41]

Historical trauma, intergenerational harm and the normalisation of violence

The experiences of Māori as a result of colonisation are similar to those of colonised indigenous populations in other countries, such as Canada, Australia and the United States of America. There is a growing body of international literature on trauma theory[42] articulating the mechanism by which colonisation has resulted in ongoing harm among indigenous populations. In the literature, 'historical trauma' is seen as being the collective wounding of people as a result of large-scale cataclysmic events targeting entire populations. This trauma is experienced both collectively and personally by each member of that population; if unresolved, it is then transmitted through generations to the descendants of those who experienced the events.

Māori scholars are increasingly applying historical trauma theory to frame our understanding of the inequities in Māori health seen today.[43] [44] [45] These theorists recognise that:

1. the trauma experienced by Māori during the time of colonisation of Aotearoa has been passed on to successive generations
2. the impact of the social change imposed on Māori during colonisation is ongoing.

As Reid and Robson[46] emphasise:

> 'Central to colonisation is creating a "new history". In this "new history" indigenous knowledge and beliefs are relabelled as myths legends and superstition... Unless we recognise colonisation as a deliberate and continuous process it is easy to assume that colonising events are accidental, inevitable and over. We must never assume that colonisation is something confined to our past.'

40 *Ibid.*

41 TPK, *Arotake Tūkino Whānau,* 2010.

42 K. 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. 179-189. doi:10.1017/S1742058X1100018X

M. Brave Heart., 'The return to the sacred path: Healing the historical trauma and historical unresolved grief response among the Lakota through a psychoeducational group intervention', *Smith College Studies in Social Work,* vol. 68, no. 3, 1998, pp. 287-305. doi:10.1080/00377319809517532

43 L. Pihama et al., 'Positioning historical trauma theory within Aotearoa New Zealand', *Alternative,* vol. 10, no. 3, 2013, pp. 248-262.

44 L. Pihama et al., 'Māori cultural definitions of sexual violence', *Sexual Abuse in Australia and New Zealand,* vol. 7, no. 1, 2016, pp. 43-51.

45 R.D.W Karena, 'Takitoru: From parallel to partnership. A ritual engagement based on Te Tiriti o Waitangi for implementing safe cultural practice in Māori counselling and social science', *MAI Journal,* vol. 1, no. 1, 2012, pp. 62-75.

46 P. Reid and B. Robson, 'Understanding health inequities', in B. Robson & R. Harris (eds.), *Hauora Māori Standards of Health IV,* Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, 2007, p. 4.

As with the intergenerational transmission of trauma, violence within whānau is also transmitted across generations.[47] The Committee's death reviews demonstrate this intergenerational transmission. Those who directly or indirectly experience violence as children are more likely to become victims and perpetrators as adults. Over time, violence within whānau has become 'normalised' and (mis) interpreted as being a part of Māori culture.[48]

1.4.2 Contemporary issues that impact violence within whānau

Structural inequities and multiple intersecting disadvantages experienced by Māori

The ongoing harm of colonisation is visible in the realities of many Māori whānau today. Māori experience higher levels of unemployment, lower levels of education attainment and income,[49] inequities across numerous health outcomes,[50] poorer housing conditions,[51] and less access to transport and communication technologies relative to non-Māori non-Pacific populations.

In this report, Figures 2 and 3 illustrate the entangled nature of violence within whānau and structural inequities for Māori. The figures show the distributions of Māori deceased and offenders in family violence death events during 2009–15 are skewed towards high deprivation levels, with much larger proportions residing in the most deprived neighbourhoods compared with non-Māori deceased and offenders.

Barriers to help-seeking and accessing culturally appropriate support

Structural inequities compound the intergenerational harm of violence within whānau[52] and, as discussed in the Committee's *Fifth Report,*[53] increase the level of entrapment (individual and collective) experienced by victims of violence.

47 In 2007, Te Atawhai o Te Ao undertook a project with Māori Vietnam War veterans who were seeking greater recognition by the Government of the trauma they suffered. Very few veterans received therapeutic treatment for post-traumatic stress disorder (PTSD). McDonald et al states Māori Vietnam War veterans reported higher levels of PTSD compared with their non-Māori counterparts. These higher levels were associated with higher levels of combat exposure due to rank and combat role – racism permeated the battlefield. The impact of combat exposure on Māori whānau was disproportionate to the rest of the New Zealand population. Te Ara notes that 35 percent of the New Zealand forces serving in the Vietnam War were Māori. At that time Māori comprised only 8 percent of the total population (Smith's research estimated 67 percent of the armed forces in Vietnam were Māori). Research by Te Atawhai o Te Ao highlights that, although 3000 Māori served in Vietnam, an estimated 20,000 wives and mokopuna were impacted by the veterans' combat and toxin exposure.

Smith identified three trauma pathways experienced by Māori veterans. These were trauma deriving from:

- disconnection of whakapapa (destruction of genealogical connectedness)
- disconnection to tūrangawaewae (being pushed or pulled away from a place of belonging)
- loss of te reo Māori me ona tikanga (dispossession of Māori language and culture).

Many Māori veterans spoke about the lack of Māori process to clear themselves from the trauma of war. They needed to be protected before going to war and to be cleansed afterwards. Most veterans lived outside their own iwi area even though their whānau wanted them to return. Many veterans said they actively avoided their whānau as they did not want to share or talk about their war experiences. They did not want to burden their whānau with the impact of such horrors or for the recollections of war to become part of the collective memory of their whānau. They were protecting their whānau by not sharing these memories. Te Atawhai o Te Ao is a kaupapa Māori research institute based in Whanganui http://www.teatawhai.Māori.nz/; C. MacDonald et al., 'Race, combat, and PTSD in a community sample of New Zealand Vietnam War veterans', *Trauma Stress,* vol. 10, no. 1, 1997, pp. 117–124; http://www.teara.govt.nz/en/nga-pakanga-ki-tawahi-Māori-and-overseas-wars/page-6; C. Smith., 'When Trauma Takes You Away from Home: Experiences of Māori Vietnam Veterans', in M. Kepa (ed), Home: here to stay, New Zealand, Huia Publishers, 2015; Te Atawhai o Te Ao, *Ka Rongo Te Pakanga Nei: Māori Vietnam Veterans and Whānau Perspectives on the Impacts of Involuntary Chemical Exposure and the Broader Effects of the War,* New Zealand, Independent Māori Institute for Environment and Health, 2011.

48 D. Wilson, 'Transforming the normalisation and intergenerational whānau (family) violence', 2016; Kruger et al., *Transforming whanau violence,* 2004.

49 Ministry of Social Development, *The Social Report 2016 – Te pūrongo orange tangata,* Wellington, MSD, 2016: http://socialreport.msd.govt.nz/index.html.

50 Ministry of Health, *Tatau Kahukura: Māori Health Chartbook, 2015 (3rd edition),* Wellington, Ministry of Health, 2015: http://www.health.govt.nz/publication/tatau-kahukura-maori-health-chart-book-2015-3rd-edition.

51 Statistics New Zealand, *Perceptions of housing quality in 2014/14,* Wellington, Stats NZ: http://www.stats.govt.nz/browse_for_stats/people_and_communities/housing/perceptions-housing-quality-2014-15.aspx.

52 T. Dobbs, *Te Ao Kohatu: A literature review of Indigenous theoretical and practice frameworks for mokopuna and whānau well-being,* Wellington, Ministry of Social Development, Office of the Chief Social Worker, 2015, https://practice.mvcot.govt.nz/documents/policy/working-with-m-ori/literature-review-dobbs-2015.pdf.

53 FVDRC, *Fifth Report,* 2016, section 3.2, pp. 53–60.

Māori whānau (victims and perpetrators) can experience numerous barriers when seeking help and support from services. The barriers include structural and economic ones that limit their access to services (eg, lack of transport and of essential services in some communities), and also the cultural barriers, racial biases and stereotyping that Māori encounter when seeking help.[54] When marginalised and disadvantaged people experience discrimination and victim-blaming, they are less likely to trust that, when seeking help on subsequent occasions, they will receive respectful and effective help.

1.4.3 Preventing violence within whānau

The structural inequities Māori whānau experience persist, in part, because of institutional racism at the level of governance and policy-making in the public sector.[55] This is seen in the marginalisation of Māori perspectives, decision-making and leadership in developing solutions to their health and wellbeing issues.[56]

Western paradigms of violence prevention are ill-equipped to prevent violence within whānau. The intersecting layers of disadvantage among Māori and the overlapping health and wellbeing issues (eg, violence, co-occurrence of substance use, mental health issues and poverty) require culturally informed solutions, responsive to the unique histories and requirements of each person, their whānau, hapū and iwi.

Violence against wāhine Māori and mokopuna is not part of traditional Māori culture, and is a significant threat to whānau ora. For Māori, preventing violence within whānau involves (re)establishing collective pathways that enable their transformation and healing from trauma and violence. This involves reclaiming mātauranga Māori bodies of knowledge, strengthening cultural identity, and restoring connections to renew the protectiveness that cultural traditions offer.[57]

54 C.A Houkamau, 'What you see can't hurt you. How do stereotyping, implicit bias and stereotype threat affect Māori health?' *MAI Journal,* vol. 5, no. 2, 2016, pp. 124-136.

55 'Institutional racism' is the differential access to material resources and power determined by race which involves privileging one population group while disadvantaging or discriminating against another (see H. Came and M. Humphries, 'Mopping up institutional racism', *Journal of Corporate Citizenship,* vol. 54, 2014, pp. 95-108).

56 H. Came, 'Sites of institutional racism in public health policy', *Social Science and Medicine,* vol. 106, 2014, pp. 214-220.

57 D. Wilson, 'Transforming the normalisation and intergenerational whānau (family) violence', 2016.

CHAPTER 2: INTIMATE PARTNER VIOLENCE (IPV)

Key statistics

In the seven years from 2009 to 2015 in Aotearoa New Zealand:[58]

There were 91 intimate partner violence (IPV) death events

Of the 92 deceased and 92 offenders in IPV death events:

- **68 percent** (63 deceased) were women and 32 percent (29 deceased) were men
- **76 percent** (70 offenders) were men and 24 percent (22 offenders) were women.

There were 83 IPV death events where there was a recorded history of abuse

- **99 percent** of these (82 death events) involved women who were the primary victim (in the history of the relationship they were abused by their partner).
- **98 percent** of these (81 death events) involved men who were the predominant aggressor (in the history of the relationship they had abused their female partner).
- **78 percent** involved offenders who were male predominant aggressors and **2 percent** involved offenders who were female predominant aggressors.
- In 16 IPV death events (**19 percent**) the offender was also the primary victim of abuse. All of these were females.

Separation

- **67 percent** of the female primary victims were killed, or their new/ex-male partners were killed, by the predominant aggressors in the time leading up to or following separation.

Structural inequities

- **44 percent** of the female primary victims resided in the most deprived neighbourhoods.
- **77 percent** of the Māori female primary victims resided in the most deprived neighbourhoods, compared to **30 percent** of the non-Māori female primary victims.

Overkill

- There were 48 overkill deaths (**52 percent** of all IPV deaths).
- **92 percent** of all overkill deaths were committed by male predominant aggressors.
- In **70 percent** of the IPV death events where there was overkill, the primary victim was either planning to separate or had separated from the male predominant aggressors.

Criminal justice outcomes

- Of the 67 predominant aggressors who killed primary victims, **66 percent** were convicted of murder, **10 percent** were convicted of manslaughter and **3 percent** were acquitted.
- Of the 16 primary victims who killed their predominant aggressors, **19 percent** were convicted of murder, **50 percent** were convicted of manslaughter and **19 percent** were acquitted.

Children present at IPV death events

- In **92 percent** of all IPV death events, there were children or step-children from the current or previous relationships.
- Sixty-five children and young people were present at an IPV death event, of which **78 percent** were children under 17 years old.

58 Known and suspected predominant aggressors are combined. Known and suspected primary victims are combined.

2.1 Introduction: concepts and classification systems

Intimate partner violence (IPV) is an overarching term that refers to a wide range of coercive and controlling behavioural patterns used within an intimate relationship.[59] In its *Fifth Report,*[60] the Committee discussed the importance of thinking differently about IPV, describing how, over time, our understanding has shifted away from viewing IPV as domestic disputes between couples or discrete incidents of physical violence. Contemporary ways of understanding IPV consider the **patterns of harmful behaviour** that are **used by the abusive person** in the intimate relationship.

This revised mode of thinking places episodes of IPV within the context of the history of abuse and takes into account the cumulative impact that abuse has over an extended period of time leading up to a death event. Considering the patterns of an abusive person's harmful behaviour is central to improving how organisations respond, both individually and collectively, to prevent IPV deaths.

IPV death events are located within patterns of harm

An IPV death event is the immediate set of circumstances surrounding an IPV death. IPV death events involve the deceased (the person(s) killed) and the offender (the person(s) who did the killing). Analysing IPV death events solely by examining the roles of the offenders and deceased is a simplified approach to understanding the deaths.

In its *Fourth Annual Report*,[61] the Committee emphasised the importance of using information from multiple sources to identify the patterns of abuse, and the need to carefully analyse each person's behaviour as well as the context, meaning and intent of recorded episodes of abuse, over the history of the relationship leading up to the death event.

The Committee analyses IPV death events according to the roles that the deceased and offender have within intimate relationships (prior and current). This is achieved by considering who has shown patterns of violent behaviour that involve using coercion and control in the relationship. Coercive behaviours involve using force or threats to intimidate or hurt victims. Examples of coercive behaviours include (but are not limited to): violent assaults, beatings, using weapons to inflict injury, making intimidating threats, violence directed at children, stalking and destroying property of the victim. Controlling behaviours involve isolating the victim and increasing their dependence on their abusive partner. Examples of controlling behaviours include (but are not limited to): isolating or restricting the victim's contact with family and whānau, friends and assistance, depriving the victim of food and money, and controlling how they dress.

Definitions

Death event: The immediate set of circumstances surrounding a death – this generally involves an offender who has killed the deceased. There may be more than one offender or deceased involved in a single death event when, for example, previous or new partners are involved.

Deceased: The person(s) killed in the death event. In IPV death events the deceased may be the primary victim or the predominant aggressor in the abuse history.

Offender: The person(s) who killed another in the death event. In IPV death events the offender may be a predominant aggressor or a primary victim in the abuse history.

59 This includes coercive and controlling behavioural patterns used in current and previous intimate relationships (and both live-in and dating relationships), in recognition of the fact that all intimate partners with whom an abusive person is in a relationship will be at risk from their behaviour.

60 FVDRC, *Fifth Report,* 2016, pp. 34–60.

61 FVDRC, *Fourth Annual Report,* 2014, section 3.1.2, pp. 74–76.

Roles in the abuse history

The Committee's classification system[62] identifies two main roles in the abuse history – the predominant aggressor and the primary victim. Where there is clear evidence that one partner has used coercive and controlling behaviours towards the other,[63] the predominant aggressor is the partner who has exercised coercive and controlling behaviours and the primary victim is the partner who has experienced them. In some IPV death events the roles of the predominant aggressor and the primary victim are more difficult to discern; for example, in some intimate relationships both partners may have used forms of violence. In these instances, using the Committee's classification system is fundamental to guiding assessment of the overall patterns of violence between the partners.

Definitions

Abuse history: The ongoing patterns of coercive and controlling behaviours used throughout the intimate relationship, including after the relationship ceases.

Predominant aggressor: The person who is the principal aggressor and has exercised coercive control against their intimate partner.

Primary victim: The person who has experienced ongoing coercive and controlling behaviours from their intimate partner.

Not all IPV death events falling under the Committee's scope are easily classified into predominant aggressor and primary victim categories. In some cases, the recorded evidence on the history of the abuse in the relationship is insufficient to make such a classification; however, there may be a recorded history of abusive behaviours in previous relationships, or the nature of the death event itself may raise suspicion that a history of abuse preceded the death event. Partners with these case typologies are classified as 'suspected predominant aggressor/suspected primary victim'.

In other cases, the IPV death event has not yet been reviewed or the full range of agency records could not be accessed, meaning the Committee is unable to state with certainty that there has or has not been a history of abuse. These IPV death events are classified as 'uncertain'.

Some IPV death events fall within the Committee's terms of reference but there are no evident patterns of coercive or controlling behaviours. Instead, these deaths appear to have had different patterns. Examples are offenders who kill the deceased for material gain, and offenders who have mental health issues and have not shown any previous coercive or controlling behaviours towards the deceased. These deaths are classified as 'aberrational'.

Putting it all together: analysing IPV death events and considering roles in the abuse history

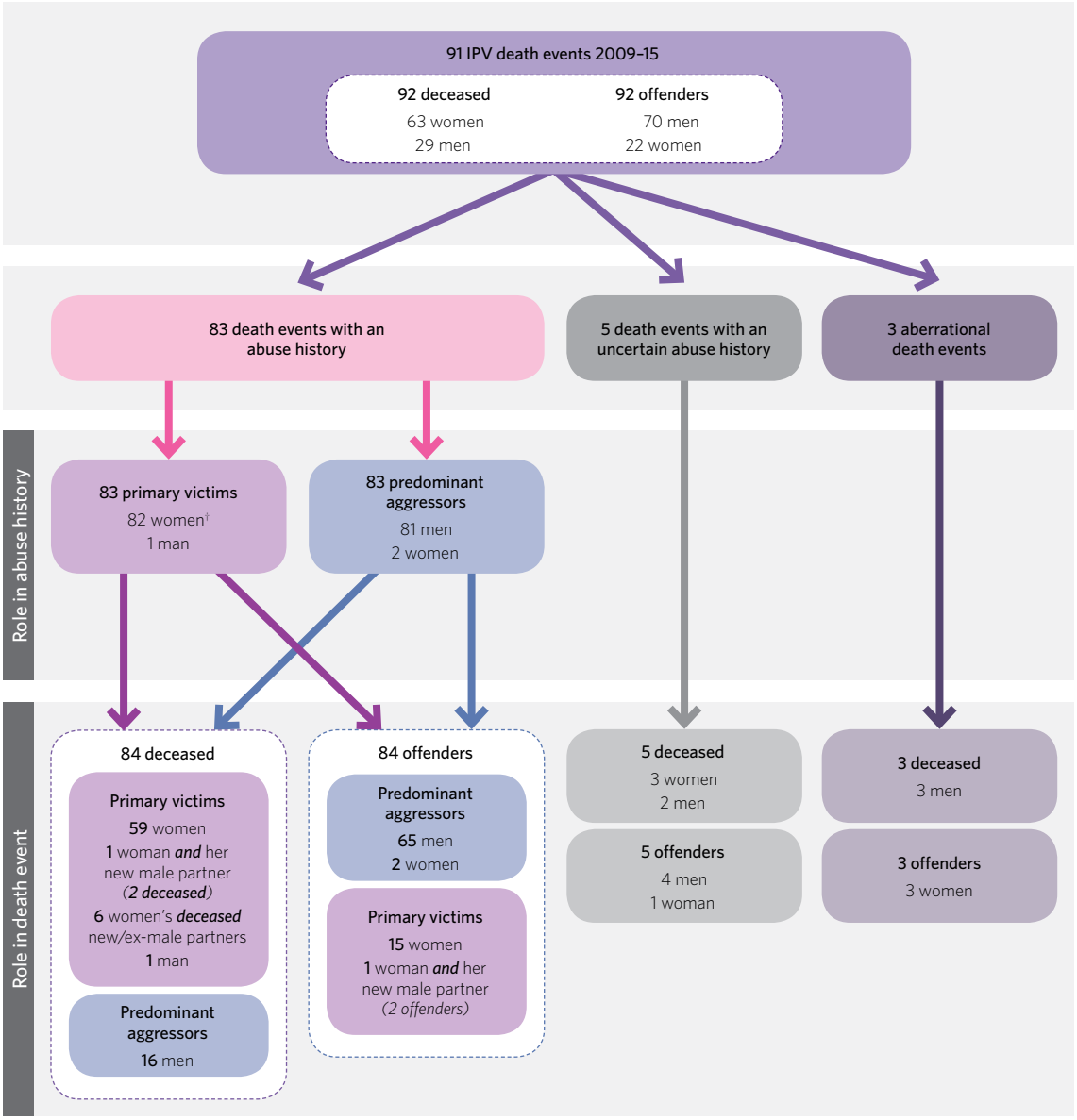
Considering the roles of the deceased and offender in a relationship with an abuse history introduces some complexity to the analysis of IPV death events – this is because the partner who kills may have been either the abuser (predominant aggressor) or the abused (primary victim) over the duration of the relationship. It should be noted here that the nature of the IPV death events are very different when the primary victim is also the offender, as discussed in more detail in section 2.3.4.

The resultant four possible combinations of predominant aggressor/primary victim and offender/deceased are illustrated in Figure 4. This figure presents the total numbers of IPV death events in New Zealand from 2009–15.

62 The Committee's predominant aggressor and primary victim classification criteria for IPV deaths are shown in Appendix 4.

63 New Zealand Police now includes these terms in its family violence training for staff.

Figure 4: Classification of IPV death events in New Zealand, 2009–15*



IPV = intimate partner violence.

* Numbers include known predominant aggressors combined with suspected predominant aggressors and known primary victims combined with suspected primary victims.

† Of these 82 female primary victims, 60 were deceased female primary victims in the death event and 16 were the offending primary victims in the death event. The remaining six female primary victims were neither the offender or the deceased in the death event – they are still alive because the six new/ex-male partners of these female primary victims were killed by six male predominant aggressor offenders.

2.2 Patterns in IPV death events when analysed in the context of the abuse history

2.2.1 Roles in abuse history and IPV death events

Gendered patterns in IPV death events

As shown in Figure 4, when looking at deceased and offenders:

- of the 92 killed in the IPV death events, 68 percent (63 deceased) were women and 32 percent (29 deceased) were men
- of the 92 offenders responsible for the IPV deaths, 76 percent (70 offenders) were men and 24 percent (22 offenders) were women.

Gendered patterns of harm in the abuse history and IPV death events

When the offenders and deceased are analysed by their respective roles in the prior abuse history, a gendered pattern of harm is even more evident. Table 3 presents the figures for the offenders who killed in the IPV death event, categorised by their role (or suspected role) in the abuse history. This shows that, of the 83 IPV death events[64] where information about the abuse history was available in New Zealand during 2009–15:

- the majority (78 percent; 65 IPV death events) involved male predominant or suspected predominant aggressors who killed female primary victims and/or their new male partner. There were only two IPV death events (2 percent) where the offenders were female predominant aggressors
- no offenders who killed in the IPV death events were male primary victims. By contrast, in 16 IPV death events (19 percent) the offenders were female primary victims
- there were 60 deceased females, all of whom were primary or suspected primary victims. Almost all of these deceased women (98 percent; 59 deaths) were killed by a male predominant or suspected predominant aggressor. The one other deceased female primary victim was killed by a female predominant aggressor
- there were 23 deceased males, only one of whom was a primary victim killed by a female predominant aggressor. Six (26 percent) of the deceased men were the new or ex-male partners of a female primary victim and were killed by a male predominant aggressor.

These findings suggest that, in most instances, the death event is a continuation of the patterns of abuse that were occurring in the relationship.

64 Excluded from these 83 death events are the five uncertain and three aberrational death events.

Table 3: Roles of offenders in IPV death events by abuse history, New Zealand, 2009–15

Role of offender in the abuse history and role of offender in the death event*	IPV death events with an abuse history n=83	
	n	%
MALE PA		
Male PA kills female PV	45	54
Male suspected PA kills female suspected PV	13	16
Male PA kills female PV's new or ex-male partner	6†	7
Male PA kills female PV and her new male partner	1‡	1
TOTAL MALE PAs	**65**	**78**
FEMALE PA		
Female PA kills female PV	1	1
Female PA kills male PV	1	1
TOTAL FEMALE PAs	**2**	**2**
FEMALE PV		
Female PV kills male PA	12	14
Female suspected PV kills suspected male PA	3	4
Female PV and her new male partner kill male PA	1#	1
TOTAL FEMALE PVs	**16**	**19**
TOTAL IPV DEATH EVENTS	**83**	**~100**

IPV = intimate partner violence.

PA = predominant aggressor.

PV = primary victim.

* The total number of IPV death events excludes the five uncertain and three aberrational death events.

† The six female primary victims involved in these six IPV death events are not deceased (their new or ex-male partners are the deceased in these cases). Of these six female primary victims, two of them had new/ex-male partners who were also abusive (one was an ex-partner and one was a new partner).

‡ This IPV death event involves two deceased (the female primary victim and her new male partner).

This IPV death event involves two offenders (the female primary victim and her new male partner).

Note: Percentages of total IPV death events with an abuse history have been rounded to the nearest whole number.

Histories of IPV sourced from police records

Many of the predominant aggressors and primary victims in the IPV death events were already known to the police as IPV victims and perpetrators.

Table 4 presents information on the police-recorded IPV histories for the 83 death events in New Zealand during 2009–15. This includes information on the IPV history between the offenders and deceased involved in the death event, and the IPV history in their previous intimate relationships with other partners.

Primary victims

Of the female primary or suspected primary victims:

- 40 (49 percent) were known to police as IPV victims in the death event relationship
- 25 (30 percent) were known to police as IPV victims in their previous relationship(s)
- 11 (13 percent) were known to police as having been abused both in their death event relationship and in their previous relationship(s).

Predominant aggressors

Of the male predominant or suspected predominant aggressors:

- 40 (49 percent) were known to police for abusing their current partner in the death event relationship
- 28 (35 percent) were known to police for abusing a partner in their previous relationship(s)
- 10 (12 percent) had a known history of abusing their current and previous partner(s).

Overall, 27 of the female primary or suspected primary victims (33 percent) and 25 of the male predominant or suspected predominant aggressors (31 percent) were unknown to police – meaning that there were no police records of IPV in either the death event relationship or in any previous relationship(s) for these people (data not shown in Table 4).

Table 4: Police-recorded IPV history of deceased and offenders involved in IPV death events, New Zealand, 2009–15*

DECEASED/OFFENDERS	Police-recorded IPV history in death event relationship			Police-recorded IPV history in previous relationships				
Death events n=83 People n=166	No	Yes		No	Yes			
	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 (two or more)
PVs/suspected PVs								
Female n=82	42	40		57	17	8	1	
Male n=1		1†						
PAs/suspected PAs								
Female n=2	1	1†		2				
Male n=81	41		40	53			19	9
Excluded death events and people n=8								

IPV = intimate partner violence.

PA = predominant aggressor.

PV = primary victim.

* This table is restricted to recorded IPV abuse histories; however, it should be noted that the abuse histories of many of the offenders and deceased extend beyond the intimate relationships captured here and include other forms of violence (eg, child abuse and IFV).

† Both were listed as complaints with respect to a 'domestic dispute'. The female PA had called police as he was at her property.

Note: Some of the PVs and suspected PVs with no police-recorded history of IPV in the death event relationship or previous relationships had presented to the front desk at a police station but this help-seeking approach was not recorded in the Police National Intelligence System Application (for a range of reasons); these people were, therefore, not formally captured in police records.

Key statistics[65]

- **78 percent** of all IPV death events with a known history of abuse involved offenders who were male predominant aggressors and **2 percent** involved offenders who were female aggressors.
- All IPV death events where the offender was also the primary victim of abuse were committed by females. These made up **19 percent** of all IPV death events.
- There were police records on the IPV death event relationship for almost one-half (**49 percent**) of all female primary victims.
- Of the 81 male predominant aggressors, **35 percent** were known to police for abusing a partner in their previous intimate relationship(s).
- In total, 68 male predominant aggressors (**84 percent**) were known to police for abusing a partner in either their current or their previous intimate relationship(s).

65 These figures include confirmed and suspected predominant aggressors and primary victims. Percentages may not add up to 100 due to rounding to the nearest whole number.

2.2.2 Separation

Traditional approaches to understanding the circumstances leading up to IPV death events have focused on whether the primary victim has separated from the predominant aggressor. Separation is often thought of as the means by which primary victims can keep themselves and their children safe. Such approaches ignore the impact that the predominant aggressor's ongoing coercive and controlling behaviours have on the primary victim's behaviour.

(Mis)understanding separation

Separation needs to be understood from the perspective of the primary victim. This requires understanding how abusive behaviours constrain the options available to the victim. Acknowledging the impact of the predominant aggressor's ongoing coercive and controlling behaviours on the victim's options means that separation **cannot** be seen as **a simple choice-based activity.**

Viewing separation from the perspective of the primary victim also means understanding that physical separation from the abuser does not necessarily mean separation from the abuse. In fact, the predominant aggressor's coercive and controlling actions often continue after victims have physically separated from them, for example, in the form of persistent stalking or threatening phone calls.[66] Separation may also not mean safety for women who occupy dangerous social positions in which there is no place of safety (eg, women in relationships with gang members). For these women, separation from their abusive partner can make them vulnerable to abuse and exploitation from others within their community. For many women, separation should **not** be seen as **the solution** to IPV.

In other words, separation is frequently misunderstood as being a decision to leave the abusive partner that is:

- a choice made by the victim
- an effective means of terminating the abuse and achieving safety.

This oversimplified misunderstanding of separation means that:

- responsibility for achieving safety is shifted largely onto the primary victim
- the safety of the children is seen as being the responsibility of the primary victim (most often the mother)
- the actions of the predominant aggressor are rendered invisible
- practitioners' and agencies' responsibility for **maintaining** victim safety is minimised.

Understanding the constrained nature of the victim's choices

It is commonly (mis)understood that victims in intimate relationships with an abusive partner are at liberty to leave the situation. This is rarely the case because the predominant aggressor's abusive behaviours purposefully undermine the primary victim's ability to be self-determining, and because practitioners and services have traditionally structured their responses to victim help-seeking on a (mis)understanding of separation. In its *Fifth Report,*[67] the Committee pointed out that IPV is a form of social entrapment because it inhibits a victim's ability to resist or escape from the abuse.

Entrapment has three main dimensions, all of which constrain the choices available to victims in a relationship with an abusive partner. These dimensions limit the victim's choices at the individual level, service level and wider societal or structural level (refer to section 2.2.3 for a detailed discussion on entrapment).

Understanding how entrapment constrains a victim's ability to separate has flow-on implications for how services and the system respond to victims. As the Committee discussed in its *Fifth Report,*[68]

66 P. Ornstein and J. Rickne, 'When does intimate partner violence continue after separation?' *Violence Against Women,* vol. 19, no. 5, 2013, pp. 617–633.

67 FVDRC, *Fifth Report,* 2016, section 3.1.2, pp. 37–47.

68 FVDRC, *Fifth Report,* 2016, sections 2.3.2, p. 32 and 3.1.2, pp. 38–39.

many family violence and statutory services use an empowerment model to guide their practice; the underlying philosophy is to empower victims of IPV by helping them devise a set of actions **they** need to take to achieve safety. The result is that the victim is made responsible for guaranteeing their own safety and yet they are likely to be living in a high-risk situation with a very controlling and coercive partner. In this sense, victim empowerment approaches construct the problem around the victim when, in fact, **the problem lies in the predominant aggressor's patterns of abusive behaviour**. Relying too heavily on empowering the victim, without taking adequate steps to prevent abusive partners from continuing to exercise their coercion and control tactics, is ineffectual. These issues are illustrated below in Case example 1.

It is vital that systems are set up to respond to the victim's help-seeking by focusing on **what agencies need to do to enable the victim's safety, not what the individual victim needs to do**. This means shifting the system response towards collectively addressing and supporting the victim's safety needs across multiple facets of their life.

Case example 1

- **Margaret separated from Stephen, her partner of 10 years, because of his ongoing violence and abuse** towards her and their three daughters. At the same time, she applied for and was granted a protection order. She hoped this might help keep them safe as she did not want to move away from her children's friends and their local support network. She also knew that if she tried to move away, he would continue looking for them.
- **Statutory services thought she was a protective mother who could keep her children safe.** This was because she had separated from Stephen and obtained a protection order.
- **Margaret and her daughters now lived in a house without him, but lived in fear of him.** She saved up and paid to have all the locks changed. She worried that despite her best efforts, Stephen would try under false pretences to get a key from her new property manager.
- **Margaret often suspected Stephen was following them.** She sold her old red car and bought a common silver car on Trade Me. However, Stephen knew their daily routines and so it was not long before he knew which car she was now driving.
- **Her friends reported seeing him parked in the public carpark near where she worked.** Stephen was wary of being arrested by the police again, so he was careful to be close enough to intimidate her while still remaining at arm's length from the law.
- **There was no separation for Margaret and her children from his ongoing surveillance.** He was always watching and waiting.

Key points

- Physical separation from an abusive partner does **not** separate victims from their abusive behaviours.
- Post-separation, abusive partners find ways to sabotage victims' acts of resistance and continue their pattern of coercive and controlling behaviours.
- For victims to be safe, actions must be taken to curtail and challenge their (ex-)partners' abusive behaviours.

Separation does not mean safety

A common misunderstanding is that victims of IPV will achieve safety when they separate from their abusive partner – the word 'separation' implies a safe distance from the predominant aggressor's behaviour. However, in reality true separation is difficult to achieve because the abusive partner's coercive and controlling behaviour often continues, regardless of any physical distance that separation has created. For example, the predominant aggressors may stalk and continually threaten their former partner (and their children). Dobash and Dobash, in their national study on *Murder in Britain,*[69] observe a similar phenomenon among the men who killed their female intimate partners:

> Failure to accept the end of a relationship was common. Men simply would not 'allow' it to end and might go to great lengths to ensure that it continued, including persistent phoning, uninvited visits to her home, stalking, and threats of violence, murder and suicide.[70]

Separation from the abuse can only be achieved if agencies are effective in curtailing the predominant aggressor's continued use of violence, surveillance and intimidation post-separation.

Definition

Separation: Actions taken by primary victims to create physical distance between themselves and the predominant aggressor. Geographical distance does not separate primary victims from a predominant aggressor's coercive and controlling behaviours.

Many primary victims have attempted to separate, often repeatedly. Predominant aggressors may respond to a primary victim's attempts to separate with continued abuse intended to limit the victim's ability to be self-determining.

Table 5 shows the separation status of the female primary victims in New Zealand IPV deaths during 2009–15. Two-thirds (67 percent; 44 women) of the female primary victims were killed, or their new/ex-male partners were killed, by the predominant aggressors in the time leading up to or following separation.[71] This table also illustrates that of the female primary victims who were killed, more were separated from their abusive partners at the time of death than not separated (33 deceased female primary victims were separated; 22 deceased female primary victims were not separated).[72] The data demonstrates that separation from a predominant aggressor does not mean separation from the abuse or violence. In the absence of effective responses from agencies that specifically address the predominant aggressor's ability to continue coercing and controlling the victim, it is very dangerous for victims to separate or remain separated.

Table 5 also shows that most of the female primary victims who killed their predominant aggressor were not separated from their partner (15 of the 16 female primary victim offenders were not separated, although 2 were planning separation). Primary victims who kill mainly do so within the 'relationship'. As highlighted in the next section, these women frequently experience extreme levels of entrapment.

69 *Murder in Britain* was a national study in which homicide data on 106 men in prison for murdering their female intimate partners (current, separated and ex-partners) were analysed, together with data gathered from interviews and case files. Case files for each offender convicted of murder were extensive. They contained numerous independent reports and interviews with details of the murder and the personal background of the offenders. The reports were sourced from police, forensic scientists, solicitors, judges, psychiatrists, medical officers, social workers, probation officers and prison staff (see R.E. Dobash et al., 'Not an ordinary killer – Just an ordinary guy. When men murder an intimate woman partner', *Violence Against Women,* vol. 10, no. 6, 2004, pp. 577–605).

70 R.E Dobash and R.P Dobash, *When Men Murder Women,* Oxford University Press, 2015, p. 43.

71 Eleven women were planning to separate and 33 women had separated.

72 This finding is supported by evidence from a large multisite case control study in the United States. In this 11-city study, women who had a highly controlling partners that had separated after living together had a nine-fold increased rate of being killed. J. 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. 1089–1097.

Table 5: Separation status for female primary victims who were deceased and offenders in IPV deaths, New Zealand, 2009–15

Separation status (n=82)*		Female PV deceased†	Female PV offender
No separation	No separation	16	9
	Attempting but unable	1	1
	History of separating and resuming relationship	5	3
Planning separation	In 3 months prior	4	1
	Imminently	7	1
Separated	In week prior	11	0
	In 3 months prior	13	0
	Over 3 months prior	9	1
Totals		**66**	**16**

IPV = intimate partner violence.

PA = predominant aggressor.

PV = primary victim.

* The three deaths considered aberrational and five deaths where the role of the deceased in the abuse history was uncertain are excluded from this table.

† This column includes the separation status for six female primary victims whose new/ex-male partners were killed.

Note: The one male primary victim killed by a female predominant aggressor is not included in this table as the police records on the separation history show that the female predominant aggressor had made attempts but was unable to separate from him.

2.2.3 Entrapment

Entrapment refers to the manner in which IPV inhibits a victim's ability to resist, or escape from, the abuse. It may be experienced individually or collectively. Entrapment and separation are closely related concepts because entrapped victims of abuse experience constrained choices across numerous facets of their lives.

IPV is a form of 'social entrapment' with three dimensions:[73]

1. the social isolation, fear and coercion created in the victim's life by the abusive (ex-)partner's violence
2. the indifference of powerful institutions to the victim's suffering
3. the ways in which coercive control (and the indifference of powerful institutions) can be aggravated by the structural inequities of gender, class and racism.

To fully understand each victim's situation, it is necessary to consider: their previous attempts to seek help and the responses they received; the broader structural constraints faced by their families, whānau and communities; and the ongoing patterns of coercion and control they experience from their partner. What this means is that each victim of IPV should receive a response from the family violence system that is based on a realistic appraisal of their needs and is tailored to their particular circumstances, because no victim's experience of abuse will be the same as any other's.

Dimension 1: the social isolation, fear and coercion created in the victim's life by the abusive (ex-)partner's violence

This dimension of entrapment requires us to examine how the actions of the predominant aggressor systematically operate to socially isolate, frighten and control the victim. Victims resist their partners' controlling and coercive behaviours, but their resistance does not stop the abuse because their partners

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

continually anticipate and undermine their acts of resistance. The very nature of coercive and controlling behaviour impedes a victim's ability to be autonomous in their life and narrows the range of available options for support. Table 6 provides examples from the death reviews of coercion and control tactics of predominant aggressors.

Table 6: Coercion and control tactics used by predominant aggressors analysed in police death reviews, New Zealand, 2009–15

Coercion tactics	
Violence	• Threatened to kill her and her children if she left him and strangled her to unconsciousness so she knew that he meant it • Held her hostage for extended periods of time or in remote areas in order to perpetrate extreme and terrifying attacks on her • Repeatedly raped her
Intimidation	• Kept one child with him when she left the house so she had to return • Tracked her down when she left and reinstated the relationship by moving into her home • Responded with extreme jealousy every time she went out, which meant she was scared to acknowledge people in the street and found it safer not to leave the house • Put a gun in her mouth and threatened to discharge it • Threatened to harm vulnerable family members, or her children if she attempted to leave or failed to comply with his demands • Used recording devices to monitor her conversations or activities • Checked her cellphone • Threatened to leave her with nothing if she left the relationship • Required her to do humiliating or degrading things and then threatened to disclose these to people
Control tactics	
Isolation	• Destroyed phones so she could not seek help • Destroyed her relationship with her friends and monitored all her community connections • Used his elevated status in the community to ensure no one would be likely to believe her if she shared what was happening • Repeatedly called her at work and was rude to her work colleagues • Assaulted or threatened to kill family, whānau and friends who attempted to intervene to protect her (including pointing guns at them)
Deprivation, exploitation and micro-regulation of everyday life	• Opposed her undertaking further study to improve her employability and damaged her electronic devices so she struggled to meet her study requirements • Required her to get permission to use bank accounts, limited her finances or monitored her spending • Took her benefit money and spent it on alcohol for himself, leaving her with little money to buy food for her children • Controlled her access to vehicles • Required her to comply with his trivial demands (eg, specifying how he liked his food prepared, timing her on the school run, making her get him alcohol and cigarettes on a daily basis) • Provided her with detailed lists of how she could improve herself in order to be a better partner

Dimension 2: The indifference of powerful institutions to the victim's suffering

Many of the victims killed in the IPV death events had previously sought help from a range of organisations and service providers within the family violence system. As mentioned in section 2.2.2, agencies often respond by seeking to empower the victims to physically separate themselves and their children from the abusive partner. These responses tend to offer victims a limited range of options: seek refuge, get a protection order and call the police. Such responses can be ineffective or result in escalated abuse from the predominant aggressor. In its *Fifth Report,*[74] the Committee discussed the need for an integrated safety system that reconfigures the current family violence workforce across a tiered continuum of safety responses in order to effectively respond to victims' help-seeking. The figure in Appendix 5 summarises this integrated safety system.

Tier one data, gathered from police family violence death review reports, shows that a number of primary victims actively sought help for IPV prior to the death event. In New Zealand during 2009–15, just over one-half (52 percent) of the 82 female primary victims had contact with the police on at least one occasion (Table 7). Twenty-eight of the female primary victims (34 percent) had between one and five contacts with the police throughout the intimate relationship, and 15 (18 percent) had contacted the police six or more times.

In addition to contacting police, many primary victims had previously contacted other agencies about IPV. For example, of the 43 female primary victims who had contact with the police, 18 were recorded in the police family violence death review reports as making disclosures to a range of services.[75] Of the 39 female primary victims who did not contact the police, six were recorded in the police family violence death review reports as making disclosures to other services.[76]

Tier two data is based on a complete set of agency records, gathered during the in-depth regional review process. These show that not all of primary victims' attempts to seek help are captured in the police homicide reports on which the tier one data is based. For example, regional death reviews conducted by the Committee have shown that some contacts and disclosures to police are not recorded by the officer concerned for multiple reasons.[77] This suggests that the police family violence death review reports are likely to undercount the number of times that primary victims have contacted the police or other agencies.

74 FVDRC, *Fifth Report,* 2016, Chapter 4: Acting differently – moving towards an integrated family violence system, pp. 61–90.

75 This includes family violence and sexual violence services (tauiwi and Māori), relationship counselling services, family lawyers, the Family Court, Child, Youth and Family, Housing NZ, Work and Income, general practitioners and district health board providers.

76 This includes Work and Income, divorce and immigration lawyers, general practitioners and district health board providers.

77 Often police front-counter staff tried to provide advice and information in response to primary victims' help-seeking approaches. However, these staff may not have had family violence training, which could have equipped them with the appropriate skills and knowledge to ask further questions about the primary victims' experiences, potentially resulting in a formal police safety response.

Table 7: Female primary victims' contact with police* concerning the behaviour of the predominant aggressor,† New Zealand, 2009–15

Female PVs n=82	Contacts with police								
	None	1 time	2–5 times	6–10 times	11–15 times	16–20 times	21–30 times	31–40 times	41–50 times
Female deceased n=61	30	11‡	13	7					
Female PVs of deceased new/ ex-male partners n=5	3	1	1						
Female offenders n=16	6	2		5	2				1
Total	**39**	**14**	**14**	**12**	**2**				**1**

PV = primary victim.

* In most cases it was the primary victim who called the police once or multiple times. For two primary victims, a district health board provider contacted police. In some instances, family members, friends or colleagues contacted the police after disclosures were made by the primary victim. These contacts with the police are likely to be an undercount, as sometimes primary victims or people on their behalf contact the police and these contacts may not be recorded on the New Zealand Police National Intelligence Application (NIA) for a number of reasons.

† Numbers include known predominant aggressors combined with suspected predominant aggressors and known primary victims combined with suspected primary victims.

‡ This includes three primary victims and one family member who reported IPV to police front counters. These disclosures were not recorded on the NIA.

Note: The one male primary victim killed by a female predominant aggressor is not included in this table because he had no prior contact with the police about the female predominant aggressor's behaviour. In this case, the police records show the female predominant aggressor had contacted the police for assistance.

Dimension 3: The ways in which coercive control (and the indifference of powerful institutions) can be aggravated by the structural inequities of gender, class and racism

Entrapment also has a structural dimension that compounds the level of entrapment experienced by individuals. Structural inequities, such as gender inequity, poverty, social marginalisation, disability and the legacy of colonisation, can profoundly impact people's experience of abuse, as well as their access to services and the quality of help they receive. These inequities, together with historical and intergenerational trauma, affect already vulnerable victims by creating precarious life circumstances and limiting their resources. As such, this dimension of entrapment can realistically close off options that might be available to others living more privileged lives.

Many of the primary victims involved in the IPV death events during 2009–15 were experiencing more than one form of structural inequity. Extreme socioeconomic disadvantage was particularly prevalent among primary victims, with greater numbers being resident in neighbourhoods with high levels of deprivation (see Figure 5).

Understanding how structural inequities impact Māori women

Māori whānau experience a significant burden of the structural inequities faced by victims of IPV. For Māori whānau and communities, it is important to recognise the pervasive impact that colonisation has on their wellbeing. The disconnection of Māori from their ancestral lands, language and culture, and the urbanisation and displacement of Māori from their tūrangawaewae (place to stand where Māori feel empowered and connected to their whakapapa) continue to impact the wellbeing of Māori in today's society. As discussed by contemporary Māori theorists,[78] [79] the oppressive actions that

78 L. Pihama, et al., 'Positioning historical trauma theory within Aotearoa New Zealand', 2014.

79 D. Waretini-Karena, 'Takitoru: From parallel to partnership – a ritual of engagement based on Te Tiriti o Waitangi for implementing safe cultural practice in Māori counselling and social science,' 2012.

took place during colonisation impeded Māori people's ability to continue passing on their tikanga (cultural protocols), reo (language) and mātauranga Māori (Māori knowledge and worldviews). This led to widespread and unresolved trauma that, as with many other colonised indigenous communities throughout the world, culminated in the multiple mental and physical health disparities experienced by Māori whānau, hapū and iwi today.

Understanding the ongoing impact of colonisation requires understanding the intergenerational nature of historical trauma, and how this trauma was passed down to the descendants of those who experienced the injustices first hand.[80] In the context of IPV, the shift in the traditional roles of Māori women and children that accompanied the trauma and disconnection of Māori from their culture is significant. Traditionally Māori women and children were valued, nurtured and protected members of Māori society who had status. However, gender roles changed dramatically in the post-colonial era as Māori were forced to assimilate to non-Māori ways of life. Over time, Māori men adopted a more dominant role and the status of Māori women became aligned with patriarchal Western cultures, as subordinate to Māori men.[81]

This fragmentation of Māori social structures and relationships within whānau accounts for why Māori are over-represented in family violence death events. Data reviewed for this report, for example, show Māori were three times more likely than non-Māori to be the offenders and deceased in IPV deaths. A broader discussion of the impact of colonisation for Māori whānau is presented in section 1.4. It is imperative that a sociohistorical Māori lens is applied throughout the family violence sector if we are to appropriately address family violence issues for Māori whānau and the wider Māori community.

Structural inequities among Māori female primary victims during 2009–15

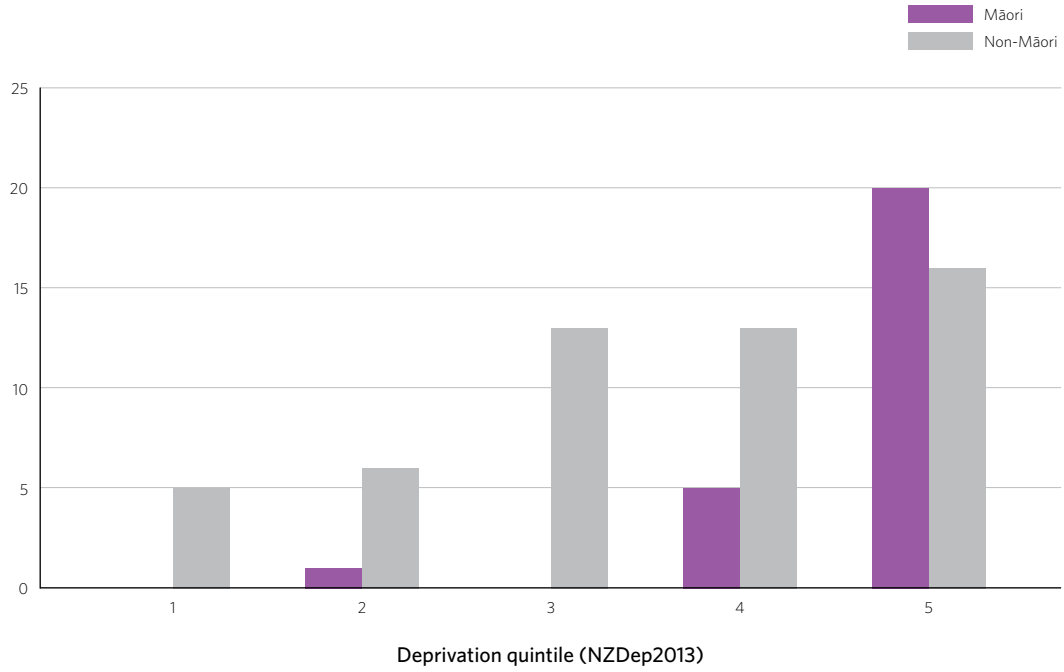
Figure 5 shows the numbers of female primary victims (deceased and offenders) involved in the IPV death events in New Zealand during 2009–15, together with their ethnicity and level of socioeconomic deprivation. This figure demonstrates that a socioeconomic gradient exists across all female primary victims: as the level of deprivation increases, the number of women involved in IPV death events who were victims of abuse also increases. Forty four percent (36 women) of female primary victims resided in the most deprived neighborhoods. Figure 5 also demonstrates that this socioeconomic gradient is steeper among Māori female primary victims (ie, the distribution for Māori female primary victims is skewed towards high levels of deprivation). Greater proportions of Māori female primary victims (77 percent) resided in the highest deprivation quintile, compared with non-Māori (30 percent). These differences in the distribution of deprivation for Māori and non-Māori female primary victims may reflect differences in the distribution of deprivation in the total Māori and non-Māori populations.[82]

80 K.L. Walters, et al., 'Bodies don't just tell stories, they tell histories: Embodiment of historical trauma among American Indians and Alaska Natives', 2011; M. Y. H. Brave Heart, 'Gender differences in the historical trauma response among the Lakota', *Journal of Health & Social Policy,* vol. 10, no. 4, 1999, pp. 1–21; M. Y. H. Brave Heart and L. M. DeBruyn, 'The American Indian holocaust: Healing historical unresolved grief', *American Indian and Alaska Native Mental Health Research Journal,* vol. 8, no. 2, 1998, pp. 56–78.

81 T. Dobbs and M. Eruera, *Kaupapa Māori Wellbeing Framework,* 2014.

82 Larger proportions of Māori live in areas with higher NZDep2013 scores. See Figure 4, p. 12, Ministry of Health, *Tatau Kahukura: Māori Health Chartbook, 2015 (3rd edition),* Wellington, Ministry of Health, 2015: http://www.health.govt.nz/publication/tatau-kahukura-maori-health-chart-book-2015-3rd-edition.

Figure 5: Number of female primary victims (n=79)* in IPV death events by ethnicity and deprivation quintile (NZDep2013), New Zealand, 2009–15



IPV = intimate partner violence.

* The ethnicities of three primary victims were unknown.

Understanding the impact of multiple and intersecting structural inequities

It was noted in the Committee's *Fifth Report*[83] that people often sit at the intersection of multiple hierarchies of disadvantage; these hierarchies all interact, producing unique experiences for those who sit at different positions. This means that multiple forms of oppression based on race, class and gender shape primary victims' experiences of IPV; together, these can profoundly impact their ability to seek and secure help, and their consequent levels of entrapment. Māori women, for example, are more likely to experience socioeconomic disadvantage and racial discrimination, and to be primary victims of IPV than non-Māori women; in addition, the experience for one Māori woman will be different from another's depending on other aspects of the woman's life that are unique to her.

The manner in which social identities and social disadvantages operate in a person's life is complex and, for those with multiple overlapping disadvantages, accessing the appropriate support for family violence is far more difficult. For Māori women, in particular, the confluence of sociohistorical, racial, structural and political contexts creates significant marginalisation that accounts for why these women continue to have their needs unmet.

Case example 2 below illustrates the intersecting structural and social inequities that female primary victims in relationships with gang members may experience and how these influence their level of entrapment. Women in relationships with gang-affiliated partners face collective levels of violence from multiple male predominant aggressors.[84] Many are highly vulnerable due to multiple experiences of abuse and sexual violence, which may have started in childhood.

83 FVDRC, *Fifth Report,* 2016, section 3.1.3, pp. 48–49.

84 Of the 82 female primary victims, 13 were either living with patched/retired gang members (8), or had a prior partner who was a patched gang member (1), or they and/or the predominant aggressor had grown up in gang-affiliated families with patched gang members (4). Nine of these 13 female primary victims were offenders in the death event. In one of the five uncertain death events the male offender was a gang prospect.

Case example 2

Kiri lived with a patched gang member. They met in a pub when she was a teenager. He approached her and made his interest known. She was not in a position to refuse him.

They had been together 12 years; about the same amount of time she had being trying to escape him. They had two children and she was currently pregnant.

His gang mates never stopped him from assaulting her. Many of them lived nearby and would often congregate at Kiri and her partner's property. Her partner used them to track her down if he was unable to do so himself.

Sometimes Kiri called the police, if she could, but she worried about the repercussions. There was always more violence from him afterwards, but she mostly feared losing her children. As a child, Kiri had been abused while growing up in state care.

Kiri lived in a neighbourhood that many people avoided going to. Most of her family were not in a position to offer support or refuge; they were struggling with too many issues of their own. She was close to one of her sisters, but her sister was terrified of Kiri's partner and his mates.

She had no access to money and nowhere to go.

Key points

- Separation from an abusive partner is not a choice-based decision.
- Primary victims may be unable to separate from a predominant aggressor.
- Separation is impeded by the predominant aggressor's coercive and controlling behaviours, the inequities primary victims and their families and whānau are experiencing, and the quality of the safety and accountability responses by agencies to the primary victim and the predominant aggressor.

2.3 Patterns of harm visible in IPV death events

When IPV death events are analysed, it becomes apparent that male and female offenders kill against different backgrounds, in different circumstances and in different ways. Their respective roles in the abuse history, the escalation in circumstances leading up to the death event, the level of premeditation evidenced, the weapons used and the manner in which they are used all show broadly different patterns.

2.3.1 Male predominant aggressor offenders – patterns of harm before the IPV death event

Behaviours prior to the IPV death event – escalation in response to victim resistance

In the time leading up to an IPV death event, predominant aggressors who kill their (ex-)intimate partner often escalate their use of coercive and controlling behaviour. Escalating levels of abusive behaviour may include excessive surveillance[85] of the victim, such as: stalking or repeatedly phoning the victim; keeping the victim confined to the home; threatening to kill the victim or their children; checking phones and impeding the victim's ability to seek help; taking the victim to remote locations; humiliating or degrading the victim; and removing the victim's access to finances or transport. Table 8 summarises the actions of offending predominant aggressors in the time leading up to and including the IPV death event.

85 Examples of 'surveillance' behaviours used by male predominant aggressors in the reviews include: repeatedly phoning the primary victim's home to see if she is there, checking the victim's text messages, constantly texting the victim, recording the victim's phone calls without her knowledge, repeatedly driving past the victim's property, watching the victim's property, engineering opportunities to have contact with her, keeping her confined to the home without access to transport, going to her place of study/work, and repeatedly going to the victim's home (uninvited).

Table 8 shows that, in New Zealand during 2009–15, 36 of the offending male predominant aggressors (55 percent) either believed the female primary victims had committed infidelity or discovered the women had a new male partner.[86] This table also shows that the majority of primary victims (44 female primary victims; 67 percent) who were killed, or whose new/ex-male partners were killed,[87] had either planned separation or were separated at the time of the IPV death event.

Overall, Table 8 illustrates the association between the predominant aggressors' patterns of escalating abuse and two different types of (perceived or real) acts of resistance made by primary victims:

1. the primary victim's attempts to separate
2. beliefs about the primary victim's infidelity and new male partners; a theme that was apparent regardless of the separation status of the relationship.

Acts of resistance can be dangerous to the victim and in all of these cases resulted in homicide.

Case example 3 below illustrates how a predominant aggressor responds to a primary victim's attempt to resist his coercive and controlling behaviour and separate from him.

Case example 3

Timothy always suspected his wife Patricia was unfaithful to him. He used to drive past her work after she finished for the day to see what she was doing. He expected her to catch the bus home immediately without talking to anyone.

Over the years he had dealt with her interfering family members. He was a keen hunter and his guns had come in handy for reminding them of the accidents that could happen if they did not mind their own business.

Patricia knew, as he had told her many times, that if she ever tried to leave him, he would hunt her down and kill her. A while back, she had left with the children. He found where they were living and moved into their home. Patricia and Timothy's relationship resumed.

Timothy regularly checked her mobile phone to see who she was talking to and what she was up to. He was sure she was f***king around on him and planning to leave him again.

He got a gun, three large knives and some rope and set everything up for when she got home.

Key points

- Men who kill their female partners usually display possessive, obsessive and jealous behaviour.
- Many men make plans in advance about how they intend to kill their female partners.
- There are high levels of premeditation and excessive use of violence in IPV death events where male predominant assessors kill.

86 Men who kill their female partners usually display possessive, obsessive and jealous behaviour. This is also reflected in international patterns in IPV homicide (see 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, 2003).

87 Six of the 66 female primary victims were not killed (their new/ex-male partners were killed). Refer to Figure 4 in section 2.1.

Table 8: Actions of the offending predominant aggressors surrounding the time of IPV death event by separation status of the primary victims,* New Zealand, 2009–15

SEPARATION STATUS OF PRIMARY VICTIMS	ACTIONS OF PREDOMINANT AGGRESSORS†	
	On the day/days preceding the death event	Actions taken to prepare for the death event (eg, procuring weapons)
Not separated (n=23) • *1 woman had a protection order* • *1 woman had a trespass order*	• 8 men believed the PV had committed infidelity or discovered she had a new male partner • 1 man pursued the PV as she was attempting to leave him and he forcibly took her back to the house • *1 female PA was unable to get the male PV to leave her house*	• 3 men had obtained or purchased the means to kill
Planning separation (n=11) • *1 woman had a protection order*	• 6 men discovered the PV was planning to leave him • 2 men physically assaulted and/or threatened to kill the PV and then pursued her • 4 men believed the PV had committed infidelity or discovered she had a new male partner • 3 men had the PV under a form of surveillance§	• 5 men obtained a gun • 3 men purchased, hid or took weapons with them
Separated (n=33) • *10 women had protection orders* • *3 women had trespass orders*	• 10 men were informed or discovered the PV was definitely leaving him • 6 men became aware of the PV's intention to have no further contact with him# • 4 men were informed of legal constraints◊ put in place because of their use of violence • 16 men had the PV under a form of surveillance • 14 men believed the PV had committed infidelity or discovered she had a new male partner	• 22 men obtained or purchased a weapon(s) • 3 men went to the PV's house and used physical violence and/or a weapon from her property • 3 men told friends, family or work colleagues they were going to kill the PV

IPV = intimate partner violence.

PV = primary victim.

PA = predominant aggressor.

* There were 67 IPV death events where predominant aggressors were the offenders (predominant aggressors: 65 men and 2 women; primary victims: 66 women and 1 man). The information presented in this table will be an undercount, as some actions may have not been recorded in the police family violence death review reports.

† Known and suspected predominant aggressors combined; known and suspected primary victims combined.

‡ Weapons include: guns; knives, scissors, a box cutter; a crowbar, a broken garden implement, axes, a drill, iron bars, a mallet; ties, constraints, lengths of rope, electrical cord, masking tape; baseball bats and chair legs.

§ 'Surveillance' encompasses the male PA: repeatedly phoning her home to see if she is there, checking her text messages, constantly texting her, recording her phone calls without her knowledge, repeatedly driving past her property, watching her property, engineering opportunities to have contact with her, keeping her confined to the home without access to transport, going to her place of study/work, and repeatedly going to her home (uninvited).

This includes his text messages being returned unread, sale of the matrimonial property, being told by friends or her that she no longer wants anything to do with him, her moving to another part of the city, her leaving the country, and her 'un-friending' him on Facebook.

◊ Legal constraints include: protection order implications where they were the respondent, matrimonial property splits, or child custody issues.

Actions taken to locate the PV prior to the death event	Unlawful contact with the PV immediately before the death event	Actions during the death event: overkill, murder suicide and harm to others
• 15 men killed the PV at the house they both resided at: 10 of these men used weapons‡ from around the house; 5 men used physical violence • 4 men went to the PV's house of residence; 2 of these took her to a remote location • *1 female PA used a weapon from around the house*	• 2 men breached a protection order or a trespass order	• 13 death events involved overkill • In 3 death events a male PA attempted or completed suicide • *1 female PA used overkill, one did not*
• 4 PVs were killed in a remote location or a public place	• 2 men breached a protection order or bail conditions due to IPV charges	• 6 death events involved overkill • In 4 death events a male PA attempted or completed suicide; in 2 of these events he killed or seriously harmed another family member
• 22 men went (with weapons) uninvited to where the PV was • 14 men forced entry into the PV's house or where she was staying	• 14 men breached a protection order, a trespass order or bail conditions	• 24 death events involved overkill • In 8 death events he attempted or completed suicide; in 2 of these events he attempted to or killed another person as well as the PV • In 1 death event he planned suicide but was prevented from attempting • In 2 other death events he seriously harmed a person who tried to stop him killing the primary victim • In 1 other death event, he killed another person as well as the PV

Behaviours prior to the death event – planning and premeditated actions

Table 8 shows that a significant proportion of the male predominant aggressors who killed in New Zealand (2009–15) prepared for the IPV death event, suggesting a level of premeditation in these killings. Examples of their preparation include obtaining or purchasing a weapon in advance of the killing, cancelling work on the day of the killing, or informing others of their intention to kill the primary victim. These actions were more frequent among those men who either had separated from their partner or knew that their partners were planning separation.

A degree of premeditation was also evident in the elaborate measures that male predominant aggressors took to identify and travel to the planned homicide location. Some of the predominant aggressors stalked the primary victim in advance to monitor her movements, forced entry into the victim's house and took the victim to remote locations. Others disguised themselves or their mode of transport to surprise the victim or avoid being detected afterwards. These killings took place despite the fact that some female primary victims had protection orders, trespass orders, or bail conditions (Table 8).

2.3.2 Male predominant aggressor offenders – patterns of harm during the IPV death event (overkill)

Developing a definition of overkill in New Zealand

'Overkill' is 'the use of violence far beyond what would be necessary to cause death'.[88] This definition encompasses the excessive use of one form of violence (eg, multiple stabbings or a severe and prolonged beating) and/or multiple forms of violence (eg, strangulation, sexual violence and stabbing). In cases involving overkill the offender has not simply used violence in order to kill the victim; it is as if they are obliterating or desecrating the person in the act of killing them.

The Committee has taken a normative approach to defining overkill. This means that, rather than simply counting the number of injuries and designating a specific threshold number of injuries (and locations) that, if met, would equate to overkill, the Committee includes a set of factors in its definition of overkill. Relevant factors to consider when determining whether this definition is met include:

- the number of injuries inflicted
- whether two or more of the injuries were fatal
- the duration and ferocity of the attack
- whether violence was directed at multiple parts of the body (including vulnerable parts, such as the head, neck and chest)
- whether the attacker continued to exert potential lethal violence on the victim even after they presumably had become aware that possible lethal wounds had already been inflicted.

After extensive discussion the Committee decided not to classify deaths by arson alone as overkill, unless there were additional forms of injury such that the violence could be understood as 'far beyond what would be necessary to cause death'. Overall, the Committee resolved that, although arson is an exceptionally violent way of causing death and could be considered a form of torture, it is not an excessive use of violence far beyond what is necessary to cause death.

Definition

Overkill: The use of violence far beyond what would be necessary to cause death. Overkill encompasses the excessive use of one form of violence – such as multiple stabbings or severe prolonged beating – and/or the use of multiple forms of violence (eg, strangulation, sexual violence and stabbing).

88 FVDRC, *Fourth Annual Report*, 2014, p. 14.

Excessive violence used in deaths with overkill

Table 9 illustrates the use of excessive use of violence in the 48 overkill IPV deaths in New Zealand during 2009–15. There were 18 overkill deaths (38 percent) where two or more forms of violence were used by the offender.

Table 9: Forms of violence used in overkill IPV deaths (n=48), New Zealand, 2009–15

One form of violence was used in 29 (60 percent) of the deaths
• Sixteen of these deaths involved the deceased being stabbed in multiple parts of their body (five deceased were stabbed 4–7 times, six deceased were stabbed 8–17 times, and five deceased were stabbed 26–50+ times). • Six deaths involved the deceased being seriously assaulted multiple times with a weapon all over the body and/or to the head.* • Four deaths involved the deceased receiving multiple injuries (including fractures and/or broken bones) caused by being beaten, punched, kicked and stomped to death. • Three deaths involved the deceased being shot multiple times (4–7+ gunshots).
Two forms of violence were used in 13 (27 percent) of the deaths
• Five of these deaths involved the deceased being seriously assaulted over their body including the head (up to 26 injuries) and being stabbed (3–18 times). • Four deaths involved the deceased being assaulted with a weapon and experiencing another form of violence.† • Two deaths involved the deceased being stabbed and either shot or set on fire. • In one case the deceased was assaulted with a weapon and experienced an act of strangulation. • In one case the deceased was stabbed (30+ times) and experienced another form of violence.
Three forms of violence were used in five (10 percent) of the deaths
• Three of these deaths involved the deceased being assaulted, stabbed and experiencing another form of violence. • Two deaths involved the deceased being assaulted (with/or without a weapon), stabbed and an act of strangulation.
Four forms of violence were used in one death
• The deceased was stabbed, strangled, set on fire and experienced another form of violence.

IPV = intimate partner violence.

* Weapons used in the different cases included an iron bar, baseball bats, a crow bar, a rock, a hammer, a garden tool, axes, a car, a piece of wood, and chair legs.

† Another form of violence includes being bound/restrained, body mutilation and/or degradation, being sexually assaulted, or being present during the torture of another person.

Understanding overkill in relation to IPV

Table 10 and Figure 6 show the method of killing used by offenders and their role in the abuse history for all IPV deaths. They show that in New Zealand during 2009–15:

- there were 48 overkill deaths in total, making up just over one-half (52 percent) of the 92 IPV deaths
- most of the overkill deaths (92 percent; 44 deaths) were committed by male predominant or suspected predominant aggressors[89]
- there were only two females who used overkill; one of these was a female predominant aggressor and the other was a female primary victim (although she was not the primary offender)

89 Two overkill deaths were classified as uncertain because there was not enough available information on the abuse history within the intimate relationship to state with certainty that there had or had not been a history of abuse.

- most of the offending female primary or suspected primary victims killed the male predominant aggressor by stabbing one or, at the most, two times (12 deaths; 13 percent of all IPV deaths). For a more detailed discussion on the patterns seen in IPV death events where the offenders were female primary victims, refer to section 2.3.4.

In deaths involving overkill, the predominant aggressor was almost always the offender. The use of excessive brutalisation could be interpreted as an extension of the prior pattern of coercion and control in the relationship.

Table 10: Method of killing by abuse history and gender in IPV deaths, New Zealand, 2009–15

Role of offender in death event*	Method of killing for each death						
	Shot	Stabbed (one or two times)	Assault/ assault with a weapon‡	Set on fire	Stran-gulation	Other#	Overkill
MALE PA/suspected PA							
Kills female PV	8	1	3	2	5	1	38
Kills female PV's new/ex-male partner		1			1		4
Kills female PV *and* her new male partner§							1 1
FEMALE PA							
Kills female PV							1
Kills male PV			1				
FEMALE PV/suspected PV							
Kills male PA	1	12†	1		1		
Kills male PA with new male partner							1∞
ABERRATIONAL CASES		2				1	
UNCERTAIN CASES	1	1	1				2

IPV = intimate partner violence.

PV = primary victim.

PA = predominant aggressor.

* Known and suspected predominant aggressors combined; known and suspected primary victims combined.

† There were two of the IPV deaths that involved two stab wounds.

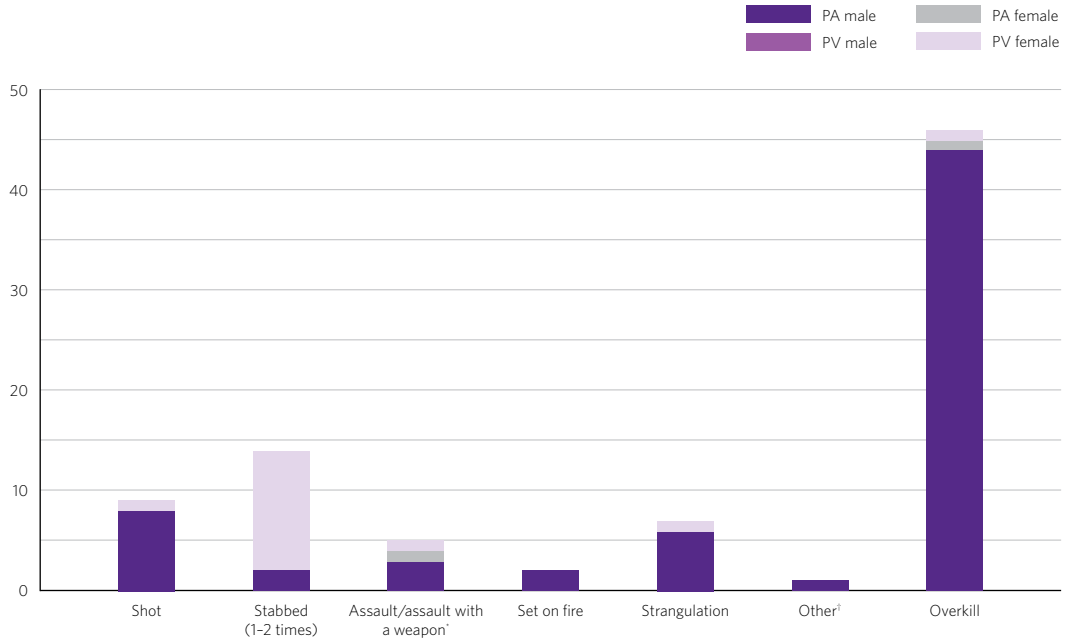
‡ A weapon other than a gun or a knife.

§ There are 92 IPV death events in total because this IPV death event involves two deceased (the female primary victim and her new male partner).

This includes deaths from other methods, such as forced drowning or poisoning.

∞ This primary victim's co-offender inflicted the injuries in this death.

Figure 6: Method of killing by abuse history and gender in IPV deaths, New Zealand, 2009–15



IPV = intimate partner violence.

PV = primary victim.

PA = predominant aggressor.

Known and suspected predominant aggressors combined; known and suspected primary victims combined.

* Weapons include: iron bars, baseball bats, crow bars, rocks, tools, cars, wood, and chair legs.

† Other forms of violence include: being bound/restrained, body mutilation and/or degradation, being sexually assaulted, or being present during the torture of another person.

2.3.3 When an offender harms multiple people

Figure 7 shows male predominant aggressors who kill their (ex-)intimate partners often harm multiple people, whereas when female primary victims or predominant aggressors kill, fewer people are harmed. Suicide or attempted suicide is also more frequent among offending male predominant aggressors. For some of these suicides or suicide attempts, the premeditated nature of the killing was also evident as pre-written suicide notes were found.

Children are sometimes present at the IPV death events; these may be the children of the predominant aggressor and/or primary victim, or they may be other children such as neighbours or relatives. Their presence is mentioned to provide a complete picture of harm to others (section 2.5 discusses in greater detail the children present at or affected by IPV death events).

Figure 7 shows the following findings for the 83 IPV death events where there was a suspected or known history of abuse in the relationship in New Zealand during 2009–15.

Harm of multiple people

- Male predominant or suspected predominant aggressors killed only the primary victims in 46 (55 percent) of the IPV death events.
- The two offending female predominant aggressors killed only the primary victims (one male and one female).
- All 16 offending female primary or suspected primary victims killed only the 16 male predominant aggressors within the death event.

- In five IPV death events, the male predominant or suspected aggressors killed family members along with the primary victims.
- In three IPV death events, the male predominant or suspected aggressors killed non-family members along with the primary victims.

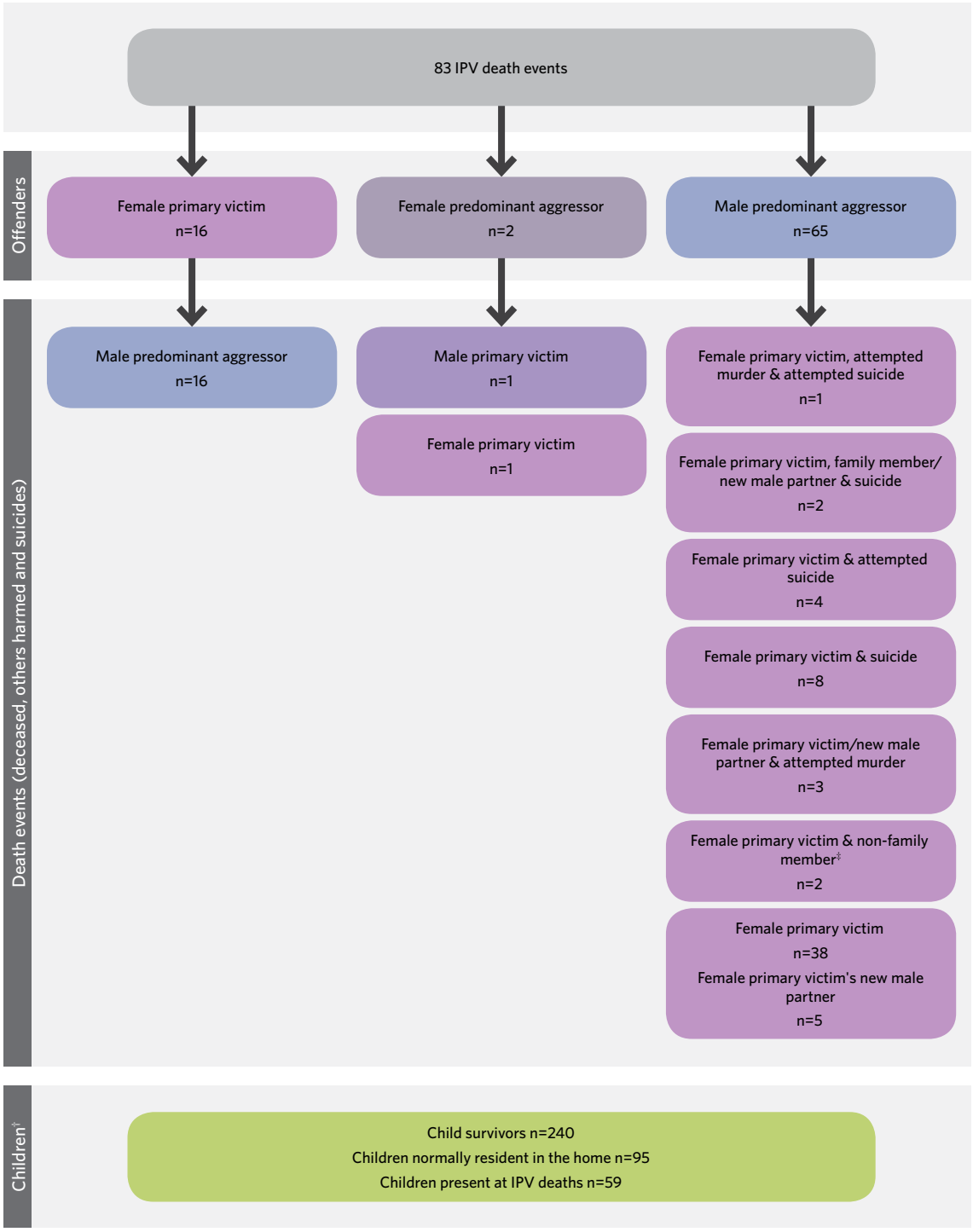
IPV murder–suicides and attempted murder–suicides

- In 15 of the 83 IPV death events (18 percent) a male predominant or suspected aggressor completed suicide or attempted suicide after killing the female primary victim.
- None of the female offenders committed or attempted suicide.
- Nine of the offending male predominant or suspected predominant aggressors completed suicide after killing the female primary victim.
- In four IPV death events the male predominant or suspected predominant aggressors killed the primary victim and a family member and either committed or attempted suicide.

Children present

- In total, 59 children were present at the IPV death events.

Figure 7: Harm associated with IPV death events by offender, deceased and abuse history,* New Zealand, 2009–15



IPV = intimate partner violence.

* There were 83 IPV death events with a known abuse history (the five IPV death events with an uncertain abuse history and the three aberrational IPV death events are excluded; refer to Figure 1). In this figure, known and suspected predominant aggressors are combined; and known and suspected primary victims are combined.

Note: Some deaths occurred within an IPV death event but the deceased were adult family members who were not directly part of the intimate partner relationship (eg, father to a deceased female primary victim).

† These numbers only include those children present at the IPV death event and likely undercount the overall number of children harmed. Refer to section 2.6 for further details on the children present at IPV death events.

‡ These non-family members were killed in the IPV death events but were not counted in the numbers of deceased in this chapter because they fall outside the Committee's terms of reference.

2.3.4 Female primary victim offenders – patterns of harm surrounding the IPV death event

Female primary victims who kill male predominant aggressors do so in very different circumstances, against very different backgrounds and in very different ways compared with the offenders who are male predominant aggressors. Many have survived long and ongoing histories of abuse and experience complex layers of entrapment. Female primary victims who are offenders are typically responding to a situation of escalating threat, use a weapon readily at hand that they have picked up in response to the threatening circumstances and inflict only one wound (sometimes two). These women are dealing with men who are capable of seriously hurting them and in many instances had started to physically abuse them on the occasion in which the death took place. In just under half of these deaths there is an element of accident in the fact that death occurred. These women do not demonstrate premeditated or planned behaviours prior to their offending and many of the IPV death events have strong defensive features.

Complex layers of entrapment

Many of the female primary victims who killed the predominant aggressor experienced multiple intersecting and compounding layers of entrapment. Table 5 (section 2.2.2) illustrates that a large proportion (81 percent) were not separated from their predominant aggressor when they killed him. For some of these women it is not clear that entering, let alone leaving, the relationship was a choice. For example, some women had had their marriage to their abusive partner arranged by their family or as a teenager or young adult had been 'partnered' to an adult patched gang member.

Box 1 summarises some of the layers of entrapment for the 16 offending female primary victims. Most of the female primary victim offenders experienced structural inequities; many resided in neighbourhoods with high levels of socioeconomic deprivation; and a large proportion (69 percent) were Māori women for whom the levels of entrapment are further compounded by structural inequities. Six of the female primary victim offenders (38 percent) were in relationships with gang-affiliated men. Women (with children) living with gang-affiliated partners are likely to be exposed to multiple predominant aggressors and experience multiple forms of violence, including sexual violence.[90]

Box 1: Complex layers of entrapment experienced by the female primary victims who killed their male predominant aggressor (n=16)

1. **Social isolation, fear and coercion created by the predominant aggressor:**
    - Six women were living with patched gang members; none of these women were separated.
    - Two women had previous partners who were patched gang members and their families also had numerous gang connections.
    - Fifteen women were not separated at the time of the IPV death event; two of these women were planning to separate.
2. **The indifference of powerful institutions to the victim's suffering:**
    - Ten of the women had sought help for IPV from the police.
    - One woman had contacted the police over 30 times throughout the relationship.
3. **Coercive control aggravated by the structural inequities of gender, class and racism:**
    - Twelve were Māori women; their level of entrapment is further compounded by the ongoing impact of colonisation.
    - Eleven women were from neighbourhoods in the highest deprivation quintile (NZDep quintile 5).

90 M. Salter, 'Multi-perpetrator domestic violence', *Trauma Violence Abuse,* vol. 15, no. 2, 2014, doi:10.1177/1524838013511542.

Characteristics of the IPV death events – responding to escalating risk

Table 11 summarises the circumstances of threat, location of the IPV death event, and the means and method of killing among the 16 female primary victim offenders. It shows that, among the primary victim offenders in New Zealand during 2009–15:

- 10 were responding to actual physical assault or the imminent threat of physical assault
- 14 killed their predominant aggressor inside or just outside the house
- 13 used kitchen knives or kitchen implements
- 12 killed their predominant aggressor by stabbing one or two times only; most of these deaths involved only one fatal stab wound (10 deaths)
- there was only one death event involving overkill.

There are strong defensive elements to the IPV death events shown in Table 11: most of the offending took place in the victim's home in response to imminent threat of physical harm, and the weapons used were those immediately available at hand, sourced from inside or around the home. There was no evidence of premeditation or planning in advance – none of the women prepared suicide notes or specifically purchased or obtained weapons prior to the death event. Only one death involved overkill and in that instance the female primary victim was not the primary offender in the death event.

Table 11: Circumstances of threat, location, mode, method of killing and criminal court outcomes among offending female primary victims, New Zealand, 2009–15

The day of/immediately prior to homicide		Location of death event	Means	Method of killing	n=16
Physically assaulted/ imminent threat of physical assault in the context of ongoing abuse*	8 physically assaulted† 1 fearful of imminent physical assault 1 tried to leave the house but was physically brought back	8 kitchen 2 inside house	9 kitchen knives 1 kitchen implement	9 stabbing one or two times 1 assault with kitchen implement	10
Called police after physical assault/ imminent threat of physical assault in the context of ongoing abuse	2 called/ attempted to call police for help	2 inside house	1 gun 1 kitchen knife	1 gunshot 1 stabbing one or two times	2
Responding to a final attack on their dignity after enduring years of abuse	2 were responding to years of abuse, culminating in a further threat of violence or the loss of what they most valued‡	2 inside/just outside house	2 kitchen knives	2 stabbing one or two times	2

The day of/immediately prior to homicide		Location of death event	Means	Method of killing	n=16
Responding to ongoing abuse over time, not events that day	1 responding to ongoing abuse	1 not in house	1 knife	1 overkill#	1
Responding to ongoing abuse, immediate context unknown	1 unknown	1 unknown	1 other form of violence	1 other form of violence	1

* Known primary victims combined with suspected primary victims.

† Includes non-fatal strangulation, punched in the body and face, dragged by their hair, slapped, and thrown on to household surfaces.

‡ Such as sexual violence or the loss of a child.

The female primary victim's new male partner inflicted the injuries.

2.4 Criminal justice outcomes for offenders in IPV deaths

The patterns of harm evident in the death event, as outlined in the preceding section, are reflected in the criminal justice responses to offenders who are primary victims or predominant aggressors.

For example, 66 percent of predominant aggressors who killed primary victims were convicted of murder, while only 10 percent were convicted of manslaughter and 1 percent were acquitted (Table 12 and Figure 8). Furthermore, 18 (41 percent) of the 44 male predominant aggressors who were convicted of murder were given minimum non-parole periods of 17 or more years to reflect the levels of premeditation, invasion of privacy and brutality involved in the death event. Section 104 of the Sentencing Act 2002 requires a court to impose a minimum non-parole period of 17 years or more for murder where there are particular features present, including where the murder: involved calculated or lengthy planning;[91] involved the unlawful entry into, or unlawful presence in, a dwelling place;[92] was committed with a high level of brutality, cruelty, depravity or callousness;[93] or the deceased was particularly vulnerable (Table 13).[94]

The criminal justice response to primary victims was less punitive, reflecting the different patterns evident in the death events involving primary victims as offenders. For example, 50 percent of primary victims (eight victims) were convicted of manslaughter rather than murder, while 19 percent (three victims) were completely acquitted (Table 12). Furthermore, two of the primary victim offenders who were convicted of murder had the presumption in favour of life imprisonment overturned (Table 13). This judicial decision is unusual and requires demonstration that life imprisonment would be 'manifestly unjust' in the circumstances.[95]

91 Section 104(1)(b).

92 Section 104(1)(c).

93 Section 104(1)(e).

94 Section 104(1)(g).

95 Section 102, Sentencing Act 2002.

While overall this criminal justice response is significantly ameliorated for primary victims who are offenders, it is possible to read it as a response that does not yet fully recognise the level of entrapment and the defensive aspects of many of these primary victims' actions. The New Zealand Law Commission has noted that there is a need for the jury 'to have a full understanding of the dynamics of the violent relationship including the history of violence, the defendant's prior responses to that violence and the effects of the violence on the defendant' in order to understand primary victims' use of force as reasonable in self-defence in these kinds of cases.[96] It has recommended reforms to the law on self-defence, explicit recognition that a broad range of family violence evidence should be admitted in support of self-defence and education for judges, lawyers and police on the dynamics of family violence.

Table 12: Outcomes for offenders in IPV deaths, New Zealand, 2009–15

Outcomes		Primary victim n=16		Predominant aggressor n=67		Uncertain/ aberrational offenders n=8	
		n	%	n	%	n	%
Legal outcome	Murder conviction	3*	19	44	66	3	38
	Manslaughter and/or other conviction(s)	8	50	7	10	4	50
	Other assault conviction			2	3		
	Acquitted	3	19	1	1		
Suicide				10	15	1	13
Unresolved/outcome pending		1	6	1	1		
Other†		1	6	2	3		
Unknown							

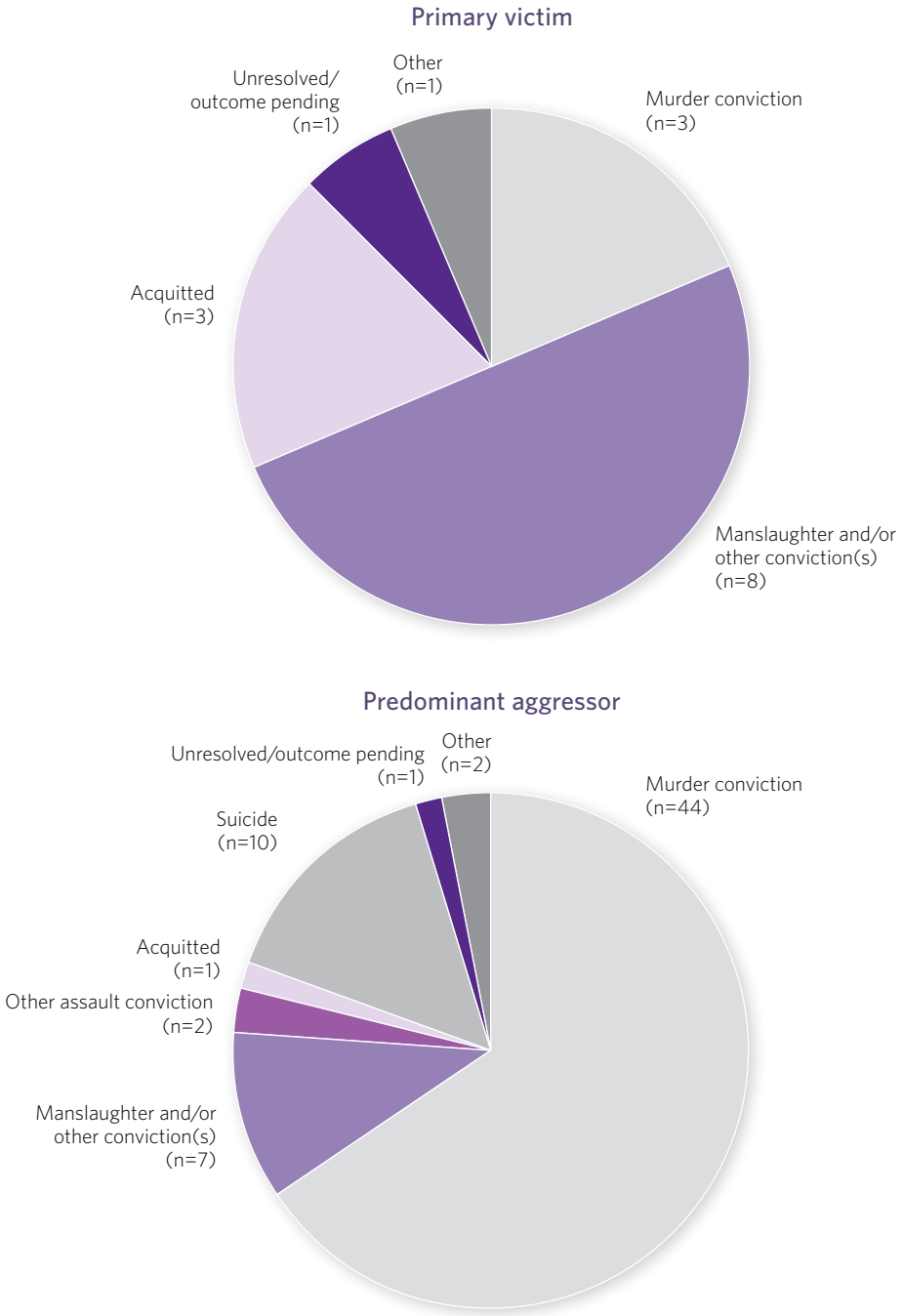
IPV = intimate partner violence.

* There were four murder charges for three female primary victims: these charges were for two female primary victims, one female primary victim and her new male partner.

† Includes people found unfit to stand trial or not guilty by reason of insanity, and those detained in secure mental health facilities as special patients.

96 New Zealand Law Commission, *Understanding Family Violence: Reforming the Law Relating to Homicide*, May 2016, 7.1.

Figure 8: Outcomes for primary victim and predominant aggressor offenders in IPV deaths, New Zealand, 2009–15



IPV = intimate partner violence.

Table 13: Murder convictions for IPV deaths, New Zealand, 2009–15

Sentencing bands in relation to murder	PA/suspected PA offenders*	PV offenders†	Uncertain/ aberrational offenders#
Less than life (presumption in favour of life must be over-turned)	0	2	
Life with a minimum non-parole of 10–17 years	26	0	2
Life with a minimum non-parole of 17+	18	2	1
Life without parole (which means the offender will never be released from prison)	0	0	
Total	**44**	**4**	**3**

IPV = intimate partner violence.

PA = predominant aggressor.

PV = primary victim.

* One female predominant aggressor, 43 male predominant aggressors/suspected predominant aggressors.

† Two female primary victims, one female primary victim and her new male partner.

\# One aberrational (a woman), two uncertain (two men).

Note: 51 murder convictions with respect to 50 IPV death events.

2.5 Children impacted by IPV death events

Children are among the many who are harmed by the IPV death events, including some children who were present at the actual IPV death event. Among these surviving children, most are family members (children or step-children from current and previous relationships) and others are relatives or neighbours not usually resident in the household where the death event took place. The harm experienced by these children is significant.

Many of the children impacted by IPV death events are likely to have been exposed to repeated episodes of family violence prior to the death event and will continue to be affected by this long afterwards in the absence of effective intervention.

2.5.1 Child survivors of IPV death events

In 84 (92 percent) of the 91 IPV death events in New Zealand during 2009–15, the adults involved had children or step-children from current or previous relationships. In these IPV death events, a total of 254 children or step-children lost a parent (Table 14). Over one-half of these children or step-children were minors aged under 17 years at the time of the death event (144 children/step-children; 57 percent).

Table 14: Child survivors of IPV death events by their relationship to those involved in the IPV death event,* New Zealand, 2009–15

AGE	Total number of survivors n=254†	Children of the relationship n=86	Children from previous relationships‡ n=168
Children – under 17 years of age	144	61	83
Young people – 17–24 years of age	62	15	47
Adult children – 25 years+	48	10	38

IPV = intimate partner violence.

* There are 84 IPV death events in total.

† One woman was pregnant.

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

2.5.2 Children present and children normally resident in the household of IPV death events

A total of 104 children and young people were normally resident in the household of one or both of the deceased and offenders in the IPV death event (Table 15). Eighty percent of these children (83 children) were under 17 years old at the time of the IPV death event.

In total, 65 children and young people were present at the IPV death event. A large proportion of those present at an IPV death event were under 17 years of age (51 children; 78 percent).

Table 15: Children normally resident in the household of IPV death events and children present at IPV death events,* New Zealand, 2009–15

AGE	Children normally resident in household of IPV death events n= 104	Children present at IPV death events n=65
Children – under 17 years of age	83	51
Young people – 17–24 years of age	21	11
Adult children – 25 years+	-	3

IPV = intimate partner violence.

* There are 84 IPV death events in total.

CHAPTER 3: CHILD ABUSE AND NEGLECT (CAN)

Key statistics

In the seven years from 2009 to 2015 in Aotearoa New Zealand:

There were 52 CAN death events

- **92 percent** of these (48 death events) involved one offender killing one child.
- In **8 percent** of these (4 death events) more than one child was killed. These were all filicides with parental suicide.
- **72 percent** were fatal physical abuse and/or grossly negligent treatment; **19 percent** were filicides with parental suicide; and **10 percent** were neonaticides.

There were 56 CAN deaths

- **66 percent** (37 deaths) of these occurred in fatal physical abuse and/or grossly negligent treatment death events; **25 percent** were filicides with parental suicide; and **9 percent** were neonaticides.

Underlying cause of death

- **92 percent** of the 37 fatal physical abuse and/or grossly negligent treatment deaths were caused by direct physical assault. Traumatic head injury was reported as the cause of death for **65 percent** of all those killed by direct physical assault.
- **71 percent** of the filicides with parental suicide were caused by indirect assault or poisoning.
- Four of the five neonaticides were due to intentional asphyxiation.

Demographics of deceased and offenders

- In **80 percent** of CAN deaths (45 deaths) the child or children killed were under five years of age.
- Over one-third (**36 percent**) of CAN deaths were child(ren) aged under one year.
- All neonaticide offenders were young mothers aged 10–19 years.
- **49 percent** of all children killed by CAN resided in the most socioeconomically deprived neighbourhoods.
- Māori children aged 0–4 years were **four times** more likely to be killed by CAN than non-Māori children. Three-quarters (**75 percent**) of Māori children and **22 percent** of non-Māori children killed by CAN resided in the most deprived neighbourhoods.[97]
- Two-thirds (**67 percent**) of offenders who killed children in fatal physical abuse and/or grossly negligent treatment death events were from the most deprived neighbourhoods.
- **74 percent** of the 35 known offenders in fatal physical abuse and/or grossly negligent treatment death events were males.

Entanglement of CAN and IPV

- **77 percent** (20 offenders) of the 26 male offenders in fatal physical abuse/grossly negligent treatment death events were known to the police for abusing the mother of deceased child/female partner and/or a prior female partner(s).

97 Denominators only include those whose residential addresses were known.

Criminal justice outcomes

- Of the 55 offenders who killed children: **20 percent** were convicted of murder, **31 percent** were convicted of manslaughter and one was acquitted. Another **18 percent** completed suicide at the time of the killing and could not be prosecuted.

Children present at CAN death events

- Of the 110 child survivors alive at the time of a CAN death event, one-third (**33 percent**) were siblings of the child or children killed and **40 percent** were half-siblings.
- **98 percent** of the 52 children and young people present at a CAN death event were aged under 17 years old.

3.1 CAN concepts and classification

Child abuse and neglect (CAN) is a broad term that includes all forms of physical and emotional ill-treatment, sexual abuse, neglect and exploitation that actually or potentially harm a child's health and development or dignity. Within this broad definition, five sub-types can be distinguished:[98]

1. physical abuse
2. sexual abuse
3. neglect
4. emotional abuse
5. exploitation.

CAN and IPV are entangled forms of family violence because children who are exposed to IPV experience ongoing physical and/or emotional harm from that exposure. Children's exposure to IPV is defined in section 3 of the Domestic Violence Act 1995 as psychological (emotional) abuse of the child and is, therefore, included in the definition of CAN.

3.1.1 CAN concepts

CAN and IPV are entangled forms of abuse

As discussed in the Committee's *Fourth Annual Report*[99] and *Fifth Report,*[100] CAN and IPV are entangled forms of abuse. Both forms of family violence often occur together in the context of IPV, as children may be present when an adult primary victim is being attacked, and may be physically harmed themselves and/or humiliated or threatened when a predominant aggressor intentionally uses them to coerce and control an adult victim. Because exposure to IPV is itself a form of emotional abuse, it is not necessary to ask whether children exposed to IPV have been abused. It is more pertinent to ask whether these children have also experienced other forms of abuse, such as physical abuse, sexual abuse, or neglect.

Understanding that CAN and IPV are entangled forms of family violence has important implications for how agencies respond to both adult and child victims. When working with a victim of CAN or IPV, engagement and assessment processes must always consider how the immediate and wider family and whānau are impacted by the abusive person's behaviour. Safe practice involves providing wrap-around supports that safeguard children and adults and their families and whānau together (not separately, in isolation of each other).

Because IPV and CAN are entangled, it is necessary to apply the understandings about IPV – the entrapment/resistance frameworks – to adult victims who are involved in a care and protection

98 World Health Organization, *Health Topics: Child Maltreatment.* URL: www.who.int/topics/child_abuse/en/.

99 FVDRC, *Fourth Annual Report,* 2014, section 3.1.3, pp. 76–77.

100 FVDRC, *Fifth Report,* 2016, section 3.2, pp. 53–60.

context.[101] It is imperative that practitioners move away from 'failure-to-protect' paradigms, which assume adult victims of IPV have the choice to stop the abuse (and protect their children from CAN) by separating from their abusive partners. Services must be aware that, in the post-separation period, adult victims of IPV and their children are particularly vulnerable to escalating abuse from the predominant aggressor, which may be fatal. Safe responses must include measures that aim to curtail the predominant aggressor's coercive and controlling behaviours.

'Failure-to-protect' paradigms undermine the protection of children because mothers, who fear being judged as an inadequate parent or losing their child(ren) to statutory and protection services, are less likely to disclose their experiences of IPV. Focusing on what adult victims of IPV are doing to keep their children safe ignores the level of risk and danger posed by the abusive partner's/parent's behaviour, and the multiple structural inequities (eg, housing and financial security) experienced by child and adult victims. The safety and wellbeing of child and adult victims can only be secured **collectively** through multi-agency and community responses.

CAN and IPV cause ongoing, cumulative and intergenerational harm

Services and systems have historically failed to recognise the ongoing and cumulative patterns of harm caused by CAN. As discussed in the Committee's *Fifth Report,*[102] children impacted by CAN and IPV are affected developmentally and socially; similarly, their attendance at school and their educational achievement can suffer as a result of the abuse. Along with the structural inequities that many of these children face, their experiences of abuse often continue to disadvantage them well into adulthood. Some of these children may experience or perpetrate family violence as adults. For child victims, the intergenerational transmission of trauma they experience can only be disrupted by preventing their exposure to the violence early in their lives.

Six reasons why IPV and CAN should be addressed together

The Committee recently published a *Position Brief* summarising the six reasons why we cannot be effective with either IPV or CAN unless both are addressed together (see Appendix 6).

1. **Intergenerational violence requires an intergenerational response:** Many children are born into families and whānau experiencing intergenerational violence. Protecting these children requires providing support to them and their families and whānau.
2. **The decision to abuse a child's parent is a harmful, unsafe parenting decision:** Abusive behaviour towards a partner who is a parent significantly impacts how that partner parents, and the functioning of the whole family and whānau.
3. **'Failure-to-protect' approaches fail to respond to both child and adult victims' safety needs:** Focusing on what adult victims are doing to keep their children safe diverts attention away from the partner/parent using violence and the risks his behaviour poses to child and adult victims.
4. **Protecting children means acting protectively towards adult victims:** Safety and wellbeing for child and adult victims can only be achieved by practitioners, communities, families and whānau working in partnership with adult victims and taking supportive actions to ensure the safety of child **and** adult victims.
5. **To prevent family violence, we must work with the people using violence:** We need to respectfully challenge men to take responsibility for their behaviour and to be the parent their family and whānau needs.
6. **Victims' safety is a collective responsibility; it cannot be achieved by individuals or individual agencies alone:** Because the lives of those affected by family violence are complex, it is necessary to develop culturally responsive and multi-layered responses with multiple family and whānau members.

101 This includes child welfare and statutory care and protection services.

102 FVDRC, *Fifth Report,* 2016, section 3.2, pp. 53–60.

Definition

CAN death event: The event at which the offending took place that resulted in a child's death. There may be more than one child killed in a single CAN death event. Multiple offenders may be involved in a single CAN death event.

3.1.2 Classification of CAN deaths and death events

Classifying CAN by death event type

The Committee classifies CAN death events into three types:

1. fatal physical abuse and/or grossly negligent treatment
2. filicide with parental suicide
3. neonaticide.

In previous reports, the Committee included 'fatal neglectful supervision' within the scope of CAN deaths. These were accidental deaths (eg, unsupervised bath drownings or poisonings) that came to the attention of the Committee because the police had prosecuted a caregiver or parent for the death. The Committee's terms of reference have subsequently been revised and the definition of a family violence death has been modified. In this report, the Committee has excluded 'fatal neglectful supervision' CAN death event types from the data set because the deaths did not occur within an episode of family violence or show an observable pattern of family violence used by the offender. The Committee acknowledges that, like many other deaths, some of these deaths may have occurred within a broader context of family violence perpetrated by someone other than the offender in the death event.

Grossly negligent treatment involves failing to provide the necessities of life, including protection from harm, and failing to provide food, shelter or medical care to meet the basic needs of a child. Because of its unique definition of a family violence death, the Committee uses the term 'grossly negligent treatment' in a different manner to how it is used in the criminal law in New Zealand. In the criminal law a single episode of neglect could be sufficient to constitute 'a major departure from the standards of care of a reasonable person'[103] and could, therefore, form the foundation for homicide charges based on an omission to provide the children with the necessities of life or protect them from harm.[104] The Committee requires widespread neglect of the child's basic needs across multiple facets of their life (eg, physical neglect, emotional neglect, medical neglect or educational neglect),[105] rather than a single episode of negligence (eg, unsupervised bath drownings). For a CAN death event to be classified as fatal grossly negligent treatment, there must be evidence of multiple forms of negligent treatment that appear to have been persistent and have resulted in the child's death. Children who die from grossly negligent treatment often experience other forms of child abuse as well (eg, emotional and physical abuse by the offender).

Fatal physical abuse and/or grossly negligent treatment death events were termed 'fatal inflicted injury' in the *Fourth Annual Report*.[106] The name of this CAN death event type was modified for this report for two reasons: (1) because children who are killed in filicide and parental suicide death events may also be killed by fatal inflicted injuries; and (2) to include grossly negligent treatment CAN death events.

The patterns of harm evident in each of the three CAN death event types differ in terms of the age of the deceased child, the relationship between the offender(s) and the deceased child, and the circumstances underlying the death of the child. These differences are outlined below.

103 Section 150A, Crimes Act 1961.

104 Sections 152 and 160(2)(b), Crimes Act 1961.

105 Neglect is distinguished from circumstances of poverty in that neglect can occur only in cases where reasonable resources are available to the family or caregiver. E.G. Krug et al., (eds.), *World Report on Violence and Health.* Geneva, World Health Organization, 2002, p. 60.

106 FVDRC, *Fourth Annual Report,* 2014, p. 53.

Fatal physical abuse and/or grossly negligent treatment

This category includes CAN death events where, in the circumstances resulting in death, the child was physically injured (with or without a weapon) and/or the child suffered grossly negligent treatment that resulted in their death but the death did not fall into the category of either filicide/suicide or neonaticide.

Filicide and parental suicide

Filicide is a form of homicide in which a parent deliberately kills their own child.[107] The term is used generically throughout the literature to refer to children of any age who were killed by their parents (or step-parents); therefore, the broad definition of filicide also includes neonaticide and infanticide[108] deaths.[109] Because neonaticide deaths are circumstantially very different to other filicide deaths, the Committee separates them out into a different death event type. Filicide and parental suicide CAN death events involve the killing of a child or children by their parent(s) (or step-parent(s)) and the completed or attempted suicide of their parent(s) (or step-parent(s)).

Neonaticide

Neonaticide is the killing of a child within the first 24 hours of life. Neonaticide typically involves the killing of newborns by young women for whom pregnancy is unwanted.[110] For these women, their pregnancy may be either concealed or denied, and often proceeds without the usual signs and symptoms of pregnancy.[111]

Neonaticide CAN death events often involve the unassisted delivery of the baby followed by killing of the newborn.[112] There is a complex interplay between external circumstances and mental health issues experienced by the mothers; these are discussed in more detail in section 3.2.2.

Definitions

Fatal physical abuse and/or grossly negligent treatment: Child death resulting from intentional physical injury and/or grossly negligent treatment by a parent or caregiver. Grossly negligent treatment refers to a persistent pattern of negligent treatment, involving multiple forms of neglect, rather than a single incident of supervisory neglect.

Filicide and parental suicide: A form of homicide in which a parent (or step-parent/other parental figure) deliberately kills a child and then attempts or completes suicide.

Neonaticide: The killing of a child who is less than 24 hours old.

107 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.

108 Infanticide commonly applies to the killing of an infant under 12 months old by their parent(s). New Zealand is unusual in that infanticide covers the killing of any child of that mother, up to the age of 10 years. Infanticide is legally defined by the Crimes Act 1961, s 178(1) , which states that: 'Where a woman causes the death of any child of hers **under the age of 10 years** in a manner that amounts to culpable homicide, and where at the time of the offence the balance of her mind was disturbed, by reason of her not having fully recovered from the effect of giving birth to that or any other child, or by reason of the effect of lactation, or by reason of any disorder consequent upon childbirth or lactation, to such an extent that she should not be held fully responsible, she is guilty of infanticide, and not of murder or manslaughter, and is liable to imprisonment for a term not exceeding 3 years'.

109 J. Stanton and A. Simpson, 'Filicide: A review', *International Journal of Law and Psychiatry,* vol. 25, 2002, pp. 1–14.

110 S. McCue et al., 'Murder by mothers: A critical analysis of the current state of knowledge and a research agenda', *American Journal of Psychiatry,* vol. 162, no. 9, pp. 1578–1587.

111 M. Brozovsky and H. Falit, 'Neonaticide: Clinical and psychodynamic considerations', *Journal of the American Academy of Child Psychiatry,* vol. 10, 1971, pp. 673–683.

112 *Ibid.*

Classifying CAN by underlying cause of death

For this data report, the Committee has further classified all CAN deaths by the underlying cause of death. This refers to the type of violence that resulted in death.[113] CAN death event types can have different underlying causes of death. For example, filicides and parental suicide deaths are commonly due to intentional asphyxiation or indirect assault or poisoning.

The Committee has classified CAN deaths into four underlying causes of death:

1. direct physical assault
2. indirect assault or poisoning
3. intentional asphyxiation
4. grossly negligent treatment.

Direct physical assault

This category includes CAN deaths due to blunt force trauma, shaking or a combination of forces. The trauma injuries are caused **by another person** directly physically assaulting the child by **hitting or shaking them.** There may be multiple forms of traumatic injury, including traumatic head, chest or abdominal injuries, spinal cord injury and other blunt force injuries.

Indirect assault or poisoning

This category includes CAN deaths due to injuries from indirect physical assault or poisoning. 'Indirect' means the death is caused not by the body of the offender but by force inflicted on the body of the victim through the medium of something else. Examples include: motor vehicle crashes, falling from a great height, and shooting. Poisoning deaths are due to the adverse effect of administered drugs, medicines and biological substances by the offender, or the intentional exposure to the toxic effects of substances (eg, car exhaust fumes).

Intentional asphyxiation

This category includes CAN deaths due to the intentional deprivation of oxygen. Examples include intentional suffocation, strangulation and drownings.

Grossly negligent treatment

This category includes CAN deaths due to multiple forms of negligent treatment and the persistent failure to provide the necessities of life that have resulted in the child's death. Examples include deaths where the child may have been exposed to chronic drug use by the offender, resulting in multiple forms of neglect such as starvation and being unresponsive to the child's emotional needs. These forms of neglect often co-occur with a history of emotional and physical abuse by the offender.

Definitions

Direct physical assault: CAN deaths due to direct physical assault from another person. This means the offender has used their body to inflict harm on the victim by hitting or shaking them.

Indirect assault or poisoning: CAN deaths due to fatal injuries that were not caused by direct physical assault (hitting or shaking) by another person. CAN poisoning deaths are due to the administering of drugs or the intentional exposure to the toxic effects of substances by the offender.

Intentional asphyxiation: CAN deaths due to the intentional deprivation of oxygen.

Grossly negligent treatment: CAN deaths due to multiple forms of negligent treatment and the persistent failure to provide the necessities of life that resulted in the child's death.

113 It should be noted that, by definition, 'underlying cause of death' differs from 'immediate cause of death'. The latter is used in post-mortem reports to describe the final injury or complication that directly resulted in death. Underlying causes of death, on the other hand, encompass the broader upstream chain of events and injuries that led to the death and these may differ from what is seen in post-mortem reports.

3.2 CAN deaths from 2009 to 2015

There were 52 CAN death events in Aotearoa New Zealand during 2009–15 (Table 16). The majority of these death events (92 percent; 48 CAN death events) involved one offender killing one child.

Multiple deceased and offenders

In four of the CAN death events, all of which were filicide and parental suicides, there were two children killed (eight children killed in four events).

In two of the CAN death events, all of which were fatal physical abuse and/or grossly negligent treatment death types, there were two or more offenders.

Table 16: CAN deaths by death event type and relationship of offender to deceased, New Zealand, 2009–15

DEATH EVENT TYPE	Number of CAN death events n=52	Number of CAN child deaths associated with death events n=56	Offender's relationship to deceased n=55					
			Mother n=14	Father n=13	Step-father n=15	Female caregiver n=6	Male caregiver n=2	Unknown n=5
Fatal physical abuse and/or grossly negligent treatment	37*	37	3	9	15	6	2	5
Filicide and parental suicide†	10‡	14	6	4	0	0	0	0
Neonaticide	5	5	5	0	0	0	0	0

CAN = child abuse and neglect.

* In two of the fatal physical abuse and/or grossly negligent treatment death events there were two or more offenders. One involved two offenders and the other involved three offenders.

† Includes two filicides with attempted suicide.

‡ Two of the filicide and parental suicide deaths involved multiple CAN deaths. In two death events two mothers killed two children and in another two death events two fathers killed two children.

3.2.1 CAN deaths by death event type and relationship between the deceased and offender

There were 56 CAN deaths in Aotearoa New Zealand during 2009–15 (Table 16). Most of the children were killed by a parent or caregiver. Among the 55 offenders:

- 14 (25 percent) were the mothers of the deceased children
- 13 (24 percent) were the fathers of the deceased children
- 15 (27 percent) were step-fathers to the deceased children
- six (11 percent) were female caregivers and two (4 percent) were male caregivers
- five (9 percent) were an unknown family member of the child.

Fatal physical abuse and/or grossly negligent treatment

There were 37 fatal physical abuse and/or grossly negligent treatment CAN deaths. These made up almost two-thirds (66 percent) of all CAN deaths during 2009–15 (Table 16).

Among the fatal physical abuse and/or grossly negligent treatment CAN deaths, the relationship of the offenders responsible for the deaths varied and included:

- a step-father in 15 death events
- one or both biological parents in 11 death events (three mothers and nine fathers). One death event involved both biological parents
- one or more caregivers in six death events (six female caregivers[114] and two male caregivers). Two death events involved multiple caregivers.

Step-father was the most common type of relationship of the offender to the deceased child in fatal physical abuse and/or grossly negligent treatment deaths. As discussed in the Committee's *Fourth Annual Report,*[115] this finding is consistent with the international literature. Case example 4 illustrates the entangled issues that need to be considered when a step-father is abusing a child and their mother.

Filicide with parental suicide

There were 10 CAN filicide and parental suicide death events, in which a total of 14 children were killed (this includes two filicides where the parent attempted suicide). CAN deaths by filicide and parental suicide made up one-quarter (25 percent) of all CAN deaths during 2009–15 (Table 16).

Six of the filicide and parental suicide death events involved the death of one child (six CAN deaths). Four of the filicide and parental suicide death events involved the deaths of two children (eight CAN deaths in total). In two of these four death events, a mother killed two children and in the other two a father killed two children.

Paternal filicide–suicides appeared to be a result of child custody and relationship issues, whereas maternal filicide–suicides appeared to result from mental health disorders, with or without experiences of IPV victimisation. This is consistent with literature about filicides.[116] In three of the cases involving fathers, the filicide–suicide took place after a parental separation where the father intentionally killed the child(ren) to 'hurt' their mother, his ex-partner.

Neonaticide

There were five neonaticide CAN death event types, all of which involved biological mothers who killed newborns. These were all concealed or denied pregnancies.

Case example 4

Peter met Kaylene through social media; they had friends in common. At the time he was staying on people's couches and needed a place to live. A few weeks later he moved into her flat.

Kaylene was a young mum, just 20 years old, who had very little family support. She appreciated having another adult around to help care for Mark, her 14-month-old son from a previous relationship. A few months later she became pregnant.

Peter told her he was good with children. As a child he often had to stay home and look after his siblings. Back then, they moved around a lot trying to escape his mother's abusive partners. He had been to countless primary schools.

Peter was jealous of Kaylene's friendships with her male neighbours. He called her the street slut and claimed their unborn baby was some 'other man's b***tard'. He started making comments about how stupid and ugly Mark was, 'just like his idiot father'.

114 This includes grandmothers, an aunt and informal female caregivers.

115 FVDRC, *Fourth Annual Report,* 2014, section 4.1.1, p. 90.

116 A. Kauppi et al., 'Maternal and paternal filicides: A retrospective review of filicides in Finland', *Journal of the American Academy of Psychiatry and Law,* vol. 38, no. 2, 2010, pp. 229–238.

Kaylene was unaware that Peter was known to the police for abusing his two ex-partners. Both women had protection orders against him. Child, Youth and Family had received a few reports of concern about one of these women's children. The child's kindergarten had reported unexplained bruises.

Peter started forcing Kaylene to leave Mark with him when she went out to get groceries. She was not allowed out with Mark. Now, Peter hardly left the flat and if he did he would tell her he could easily find her if she ran away.

Kaylene became worried Peter was harming Mark. When the Plunket nurse and other services visited, it was difficult to say anything as Peter was always there. She felt trapped and unable to get help.

Key points

- Children who are not the biological children of the mother's abusive partner are a physical reminder to him that 'his woman' has had sexual relationships with other men.
- In the context of IPV, step-children are at significant risk of being directly abused by a new male partner. For vulnerable infants, this can be fatal.

3.2.2 CAN deaths by death event type and underlying cause of death

Table 17: CAN deaths by death event type and underlying cause of death, New Zealand, 2009–15

DEATH EVENT TYPE	Number of CAN death events n=52	Number of CAN child deaths associated with death events n=56	Underlying cause of death n=55*			
			Direct physical assault n=34	Indirect assault or poisoning n=10	Intentional asphyxiation n=10	Grossly negligent treatment n=1
Fatal physical abuse and/or grossly negligent treatment	37	37	34	0	2	1
Filicide and parental suicide	10	14	0	10	4	0
Neonaticide	5	5			4	

CAN = child abuse and neglect.

* There were 56 CAN deaths in total. The underlying cause of one neonaticide death is unknown.

Fatal physical abuse and/or grossly negligent treatment

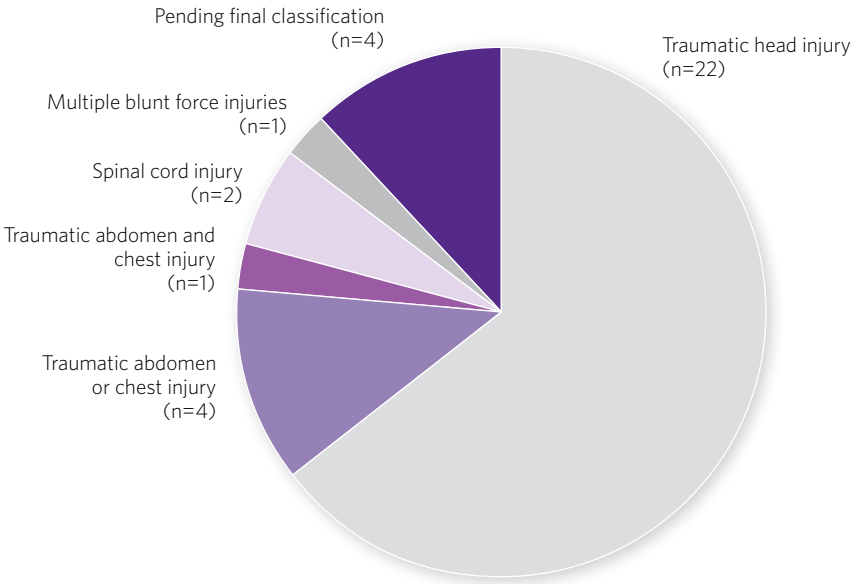
Most (92 percent) of the 37 child deaths by fatal physical abuse and/or grossly negligent treatment in New Zealand during 2009–15 were caused by direct physical assault (Table 17). There was one death due to grossly negligent treatment.

Among the 34 deaths resulting from direct physical assault, traumatic head injury was the most common immediate cause of death recorded in the post-mortem report (Figure 9). There were 22 children who died of traumatic head injury (65 percent of all those who died as a result of direct

physical assault). Two children died from more than one traumatic injury, one of whom died from multiple blunt force injuries. Other injuries included:

- traumatic abdomen or chest injury (12 percent)
- spinal cord injury (6 percent).

Figure 9: Cause of death recorded in post-mortem reports for all CAN deaths from direct physical assault (n=34), New Zealand, 2009–15



CAN = child abuse and neglect.

Note: Three of these direct physical assault deaths were likely caused by a person shaking the child. Two of these deaths were caused by spinal cord injuries and one was caused by traumatic head injury.

Filicide with parental suicide

Indirect assault or poisoning was the most common underlying cause of death among the 14 children killed by filicide with parental suicide (71 percent; 10 filicide and parental suicide CAN deaths) (Table 17). The deaths of four children were due to intentional asphyxiation.

Neonaticide

Four of the five neonaticide death events were due to intentional asphyxiation (Table 17). All of these were strangulation or suffocation deaths. In one of the neonaticide death events, the underlying cause of death was undetermined or unknown. There were no neonaticide deaths due to fatal physical abuse.

It is important to note that the circumstances underlying neonaticide deaths are quite specific and differ from the other two death event types. According to the literature, these death events typically involve offenders who are young women in their late teenage years or early 20s, living at home (or with relatives), with pregnancies that are unwanted.[117] These young women deny and/or conceal[118] their pregnancies for various reasons such as sexual assault, incest, cultural reasons or shame over an illicit relationship.[119]

117 S. Hatters Friedman et al., 'Murder by mothers: A critical analysis of the current state of knowledge and a research agenda', *American Journal of Psychiatry,* vol. 162, no. 9, 2005, pp. 1578–1587.

118 Denial of pregnancy can be understood as a powerful psychological defence mechanism that operates at an unconscious level against the guilt and/or shame associated with the circumstances of pregnancy, for example, over sexual relations that may be perceived as being unacceptable by their family, or in their cultures and communities. It is often a temporary state that may vary in depth among individuals. As such, denial differs from conscious lying about a pregnancy or concealment. Concealment of a pregnancy occurs when a woman is aware she is pregnant but actively hides the pregnancy from others; it is more akin to deception or duplicity than denial, although the reasons for both concealed and denied pregnancies may overlap. Concealment of pregnancy may be associated with IPV, given pregnancy is a time when there is a high risk that IPV will begin or escalate.

119 R.L. Sadoff, 'Mothers who kill their children', *Psychiatric Annals,* vol. 25, no. 10, 1995, pp. 601–605; C.L. Meyer and M. Oberman, *Mothers Who Kill Their Children: Understanding the Acts of Moms from Susan Smith to the 'Prom Mom'*, New York, New York University Press, 2001.

In the time leading up to a neonaticide death, these women usually deliver their child unassisted and in secret. Common methods of neonaticide include suffocation, drowning, strangulation, head trauma and exposure.[120]

Key statistics

- There were **56** CAN deaths during 2009–15.
- **66 percent** of all CAN deaths were classified as fatal physical abuse and/or grossly negligent treatment deaths.
- Step-fathers were the offenders who killed the children in **41 percent** of the fatal physical abuse and/or grossly negligent treatment CAN death events.
- **92 percent** of the fatal physical abuse and/or grossly negligent treatment deaths were caused by direct physical assault.
- **71 percent** of the children who were killed in a filicide with parental suicide death event died by indirect assault or poisoning.

3.2.3 CAN deaths by death event type and age of deceased and offenders

CAN deaths by death event type and age of deceased at death

The first five years of life were the most vulnerable time for children, with most of the CAN deaths (80 percent; 45 deaths) in New Zealand during 2009–15 involving children under five years of age (Table 18). Twenty CAN deaths (36 percent) occurred before the age of one year and 25 deaths (45 percent) between the ages of one and five years.

Most of the children (33 deaths; 90 percent) who were killed in fatal physical abuse and/or grossly negligent treatment death events died before the age of five years. The ages of children killed by filicide with parental suicide were more widely distributed and included older children: one-half (seven deceased) were aged between 5 and 17 years.

Table 18: CAN deaths by death event type and age of deceased at death, New Zealand, 2009–15

DEATH EVENT TYPE	Number of CAN deaths n=56	Age of deceased at death n=56				
		≤1 month n=5	1–12 months n=15	1–4 years n=25	5–9 years n=7	10–17 years n=4
Fatal physical abuse and/or grossly negligent treatment	37	0	14	19	2	2
Filicide and parental suicide	14	0	1	6	5	2
Neonaticide	5	5	0	0	0	0

CAN = child abuse and neglect.

CAN deaths by death event type and age of offender at death

Of all the CAN deaths in New Zealand during 2009–15, almost one-half (48 percent) involved young offenders aged under 30 years (Table 19).[121]

120 P.J. Resnick, 'Murder of the newborn: a psychiatric review of neonaticide', *American Journal of Psychiatry*, vol. 26, 1970, pp. 1414–1420.

121 For age-specific rates of CAN offenders see Table C1, Appendix 1.

The median age of offenders in fatal physical abuse and/or negligent treatment death events (20–29 years) was younger than the median age of offenders in filicide and parental suicide death events (40–49 years). All of the neonaticide death events involved offenders who were young mothers aged 10–19 years.

Table 19: CAN deaths by death event type and age of offender at death, New Zealand, 2009–15

DEATH EVENT TYPE	Number of CAN deaths n=56	Age of offender n=50*				
		10–19 years n=8	20–29 years n=19	30–39 years n=13	40–49 years n=7	50+ years n=3
Fatal physical abuse and/or grossly negligent treatment	37	3	19	8	3	2
Filicide and parental suicide	14	0	0	5	4	1
Neonaticide	5	5	0	0	0	0

CAN = child abuse and neglect.

* No age was recorded for five offenders. These were all offenders in fatal physical abuse and/or grossly negligent treatment death events.

3.2.4 IPV police history for offenders in CAN death events

Table 20 shows the history for those offenders in fatal physical abuse and/or grossly negligent treatment and filicide with parental suicide death events who were known to the police for IPV perpetration.

In the 47 CAN death events in New Zealand during 2009–15, among the offenders with a police-recorded IPV history prior to the death event:

Fatal physical abuse and/or grossly negligent treatment

- Eleven of the 26 male offenders were known for abusing either the mothers of the deceased child or their female partner. Thirteen were also known for having abused one or more previous partners.
- Twelve of the 15 step-father offenders were known to police for abusing their current female partner (or the mother of the child who was killed) and/or one or more previous partners.
- Six of the nine father offenders were known to police for abusing their current female partner or the mother of the child who was killed. Three were known for having abused one prior partner.
- Four of the nine offending mothers or female caregivers were known for being abused by their male partners in their current IPV relationship.[122] Two had been victims of abuse by a prior partner.

Filicide and parental suicide

- Two of the four father offenders were known for abusing their current female partner who was the child's mother.
- Two of the six offending mothers were known for having been victims of abuse by one or more prior partners.

122 In both of the death events involving multiple offenders, the male offender was known to the police for abusing the female co-offender.

Table 20: IPV police history of fatal physical abuse and/or grossly negligent and filicide and parental suicide offenders in CAN deaths, New Zealand, 2009–15

Death event type n=47	Offenders n=50	Police IPV recorded history in current CAN death event relationship			Police-recorded IPV history in previous relationships				
		No	Yes		No	Yes			
		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 (two or more)
Male offenders n=30									
Fatal physical abuse and/or grossly negligent treatment*	**Step-fathers** n=15	11		4	7			4	4
	Stepfathers' female partner/child's mother n=15	11	4		8	4	3		
	Fathers n=9	3		6	6			3	
	Fathers' female partner/child's mother n=8	3	5		5		3		
	Caregivers n=2			1				2	
Filicide and parental suicide	**Fathers** n=4	2		2	4				
	Fathers' female partner/child's mother n=4	2	2		4				
Female offenders n=15									
Fatal physical abuse and/or grossly negligent treatment	**Caregivers and mothers** n=9	4 1 unknown	4		6 1 unknown	2			
	Caregivers and mothers' male partners n=5	3		2	4			1	
Filicide and parental suicide	**Mothers** n=6	6‡			4	1	1		
	Mothers' male partner/child's father n=4	4			4				
Excluded death events and people									
Unknown n=5†									

CAN = child abuse and neglect.

IPV = intimate partner violence.

PA = predominant aggressor.

PV = primary victim.

* Four male offenders in the fatal physical abuse and/or grossly negligent treatment deaths had abused both current and prior partner(s).

† These were all fatal physical abuse and/or grossly negligent treatment deaths. The offender was a family member, but no prosecution has been progressed.

‡ Two mothers and their male partners were new immigrants to New Zealand. It is unlikely that they would be captured in police records.

Note: There are two reasons why male and female offenders' partner numbers do not always match: (1) Not all offenders had a current partner at the time of the death event; and (2) some offenders had partners who were co-offenders in the death event. Their IPV histories are captured only once in the offender sections of this table.

Key statistics

- **80 percent** of the CAN deaths were children under five years of age.
- Children who died by CAN were most frequently killed by young adults aged 20–29 years. Of all CAN offenders, **35 percent** were aged 20–29 years.
- All offenders in the neonaticide deaths were young mothers aged 10–19 years.
- **11 of the 26** male offenders in fatal physical abuse and/or grossly negligent treatment death events were known for abusing either the mother of the deceased child or their female partner.
- **77 percent** of the 26 male offenders in fatal physical abuse/grossly negligent treatment death events were known to the police for abusing the mother of the deceased child/female partner and/or a prior female partner(s).

3.3 Ethnicity, gender and socioeconomic status of CAN deceased and offenders

This section presents data on CAN deaths analysed by ethnicity, socioeconomic status and gender of the deceased and offenders. As discussed in section 1.5, it is important to view the findings through a lens that considers the compounding impact of multiple intersecting disadvantages. For Māori whānau this lens should also acknowledge the multiple layers of disadvantage that are associated with a history of colonisation and contemporary structural inequities.

3.3.1 Ethnicity of CAN deceased and offenders

Table 21 and Figure 10 show there were significant differences in the ethnicity of the deceased and offenders in New Zealand CAN deaths during 2009–15. Māori children were three times more likely to die from CAN than non-Māori children. Similarly, offenders of Māori ethnicity were six times more likely to be responsible for CAN deaths than those of non-Māori ethnicity. When stratified by age, the rate of CAN deceased was highest among children aged 0–4 years and, for Māori, the rate of the children killed by CAN aged 0–4 years was four times higher than the non-Māori rate (see Table C4, Appendix 1).

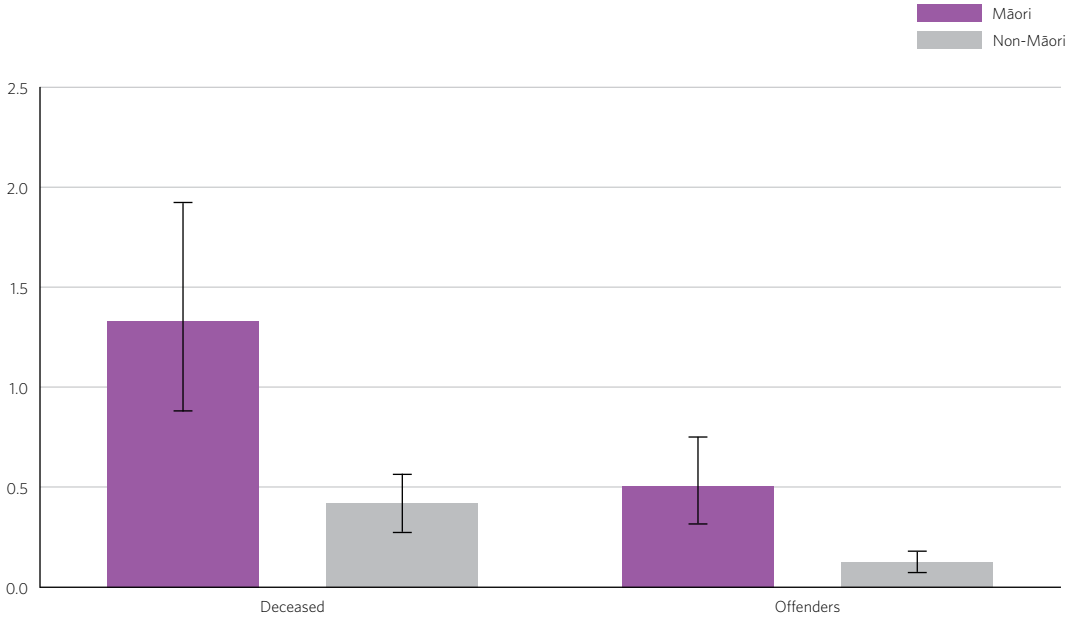
Table 21: Ethnic-specific rates (per 100,000 people per year)* for deceased and offenders in CAN deaths, New Zealand, 2009–15

PRIORITISED ETHNICITY	Total New Zealand population aged under 19 years 2009–15		CAN deceased n=56			
Deceased	n	%	n	%	rate	95% CI
Māori	2,105,140	25	28	50	1.33	0.88-1.92
Non-Māori	6,412,780	75	27	48	0.42	0.28-0.61
Unknown			1	2		
PRIORITISED ETHNICITY	Total New Zealand population 2009–15		CAN offenders n=55			
Offenders	n	%	n	%	rate	95% CI
Māori	4,787,440	16	24	44	0.50	0.32-0.75
Non-Māori	26,334,670	84	24	44	0.09	0.06-0.14
Unknown			7	13		

CAN = child abuse and neglect.

* Rates for CAN deceased were estimated per 100,000 people aged 19 years and under per year. Rates for CAN offenders were estimated per 100,000 people per year of the total population.

Figure 10: Ethnic-specific rates (per 100,000 people per year) for deceased and offenders* in CAN deaths (with 95% CIs), New Zealand, 2009–15



CAN = child abuse and neglect.

* Rates for CAN deceased were estimated per 100,000 people aged 19 years and under per year. Rates for CAN offenders were estimated per 100,000 people per year of the total population.

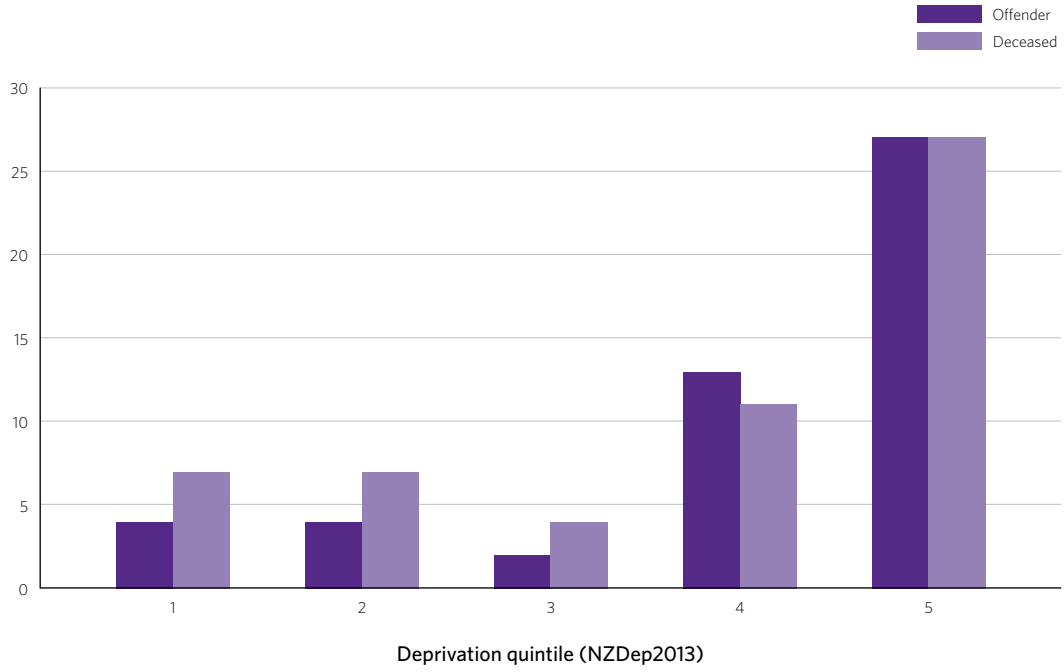
3.3.2 Gender of CAN deceased and offenders

Female children made up 43 percent of the deceased in the CAN deaths in New Zealand during 2009–15 and male children made up 57 percent. As shown in Table 16 (section 3.2), when analysed by the death event type there were some gender differences. Males were more frequently the offenders in fatal physical abuse and/or grossly negligent treatment (74 percent of the 35 known offenders).[123] Females were more frequently the offenders in neonaticide and filicide with parental suicide death events.

3.3.3 Socioeconomic status of CAN deceased and offenders

There were 55 deceased children who died by CAN and for whom socioeconomic status was known in New Zealand during 2009–15. A large proportion of these children (69 percent; 38 deaths) resided in neighbourhoods with higher levels of deprivation (quintiles 4 and 5). Almost one-half (49 percent; 27 deaths) lived in the most deprived quintile (Table 22). Figure 11 depicts the socioeconomic gradient seen in all the CAN deaths, whereby the numbers of CAN deceased and offenders increase as deprivation quintile increases.

Figure 11: Deprivation quintile (NZDep2013) of deceased and offenders in CAN deaths, New Zealand, 2009–15



CAN = child abuse and neglect.

Socioeconomic status of CAN offender by death event type

Table 22 shows that, among the offenders whose socioeconomic status was known, deprivation differed for the different types of CAN death events. A deprivation gradient was noticeable for fatal physical abuse/grossly negligent treatment death events – two-thirds (67 percent) of the offenders who killed children by fatal physical abuse/grossly negligent treatment were from the most deprived neighbourhoods (deprivation quintile 5) and no offenders were from the least deprived neighbourhoods (deprivation quintile 1). By contrast, the neonaticide and filicide with parental suicide CAN death events involved offenders from neighbourhoods that spanned the range of deprivation quintiles. Four offenders in the neonaticide and filicide with parental suicide deaths lived in the least deprived neighbourhoods.

123 There were 40 offenders in the fatal physical abuse and/or grossly negligent treatment death events. Five of the offenders were unknown.

Table 22: Deprivation quintile (NZDep2013) of deceased in CAN deaths by death event type (n=50),* New Zealand, 2009–15

Death event type	Total n=50	Deprivation quintile (NZDep2013)				
		1 (low deprivation)	2	3	4	5 (high deprivation)
Fatal physical abuse and/or grossly negligent treatment	36	0	2	1	9	24
Filicide and parental suicide	9	1	2	1	4	1
Neonaticide	5	3	0	0	0	2
TOTAL	**50**	**4**	**4**	**2**	**13**	**27**

CAN = child abuse and neglect.

* The deprivation quintiles were unknown for four fatal physical abuse and/or grossly negligent treatment deaths and one filicide with parental suicide death.

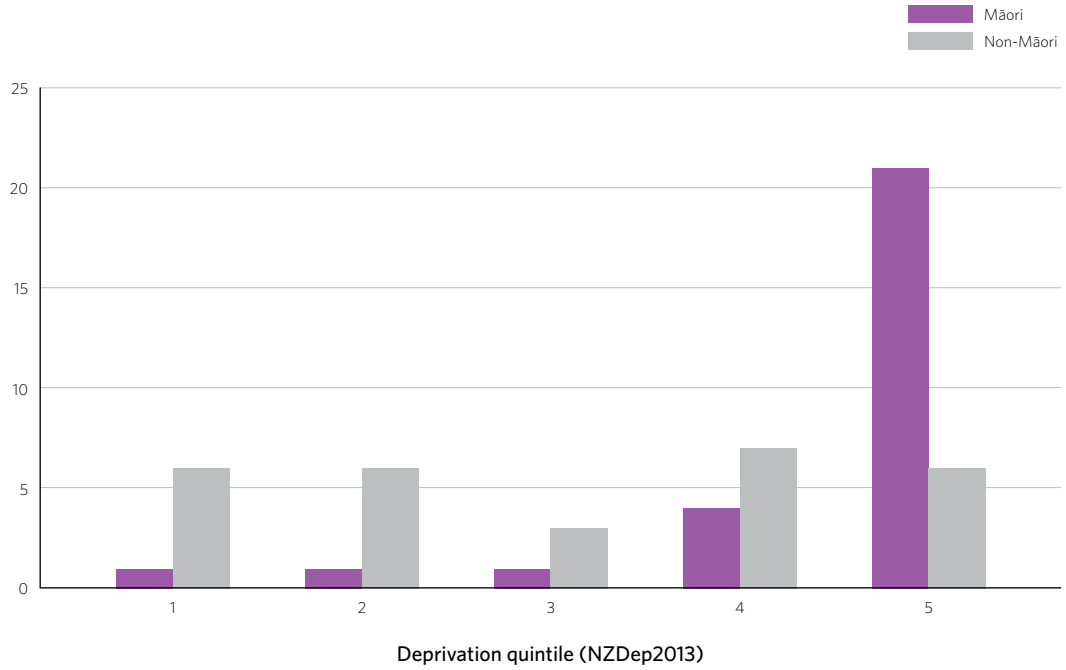
Socioeconomic status of CAN deceased and offender by ethnicity

Figures 12 and 13 show the deprivation of the deceased children and offenders in New Zealand CAN deaths during 2009–15 whose residential addresses were known. Both figures show the socioeconomic gradients for the deceased and offenders in CAN deaths were steeper for Māori compared with non-Māori. These may reflect the steeper socioeconomic gradient for the total Māori population compared with the non-Māori population.[124]

- Three-quarters (75 percent; 21 deaths) of 28 Māori children killed by CAN were from the most deprived neighbourhoods (quintile 5), whereas 22 percent (6 deaths) of the 27 non-Māori children with known addresses resided in the most deprived neighbourhoods.
- Seventeen of the 24 Māori offenders (71 percent) responsible for the CAN deaths resided in the most deprived neighbourhoods, whereas over one-quarter (30 percent; 7 offenders) of the 23 non-Māori offenders with known addresses resided in the most deprived neighbourhoods.
- The distributions of Māori deceased and offenders were skewed towards the most deprived quintile, whereas for non-Māori the deceased and offenders were more evenly distributed across the range of deprivation quintiles.
- No Māori offenders responsible for CAN deaths lived in the least deprived neighbourhood.

124 Larger proportions of Māori live in areas with higher NZDep2013 scores. See Figure 4, p. 12, Ministry of Health, *Tatau Kahukura: Māori Health Chartbook, 2015 (3rd edition)*, Wellington, Ministry of Health, 2015: http://www.health.govt.nz/publication/tatau-kahukura-maori-health-chart-book-2015-3rd-edition.

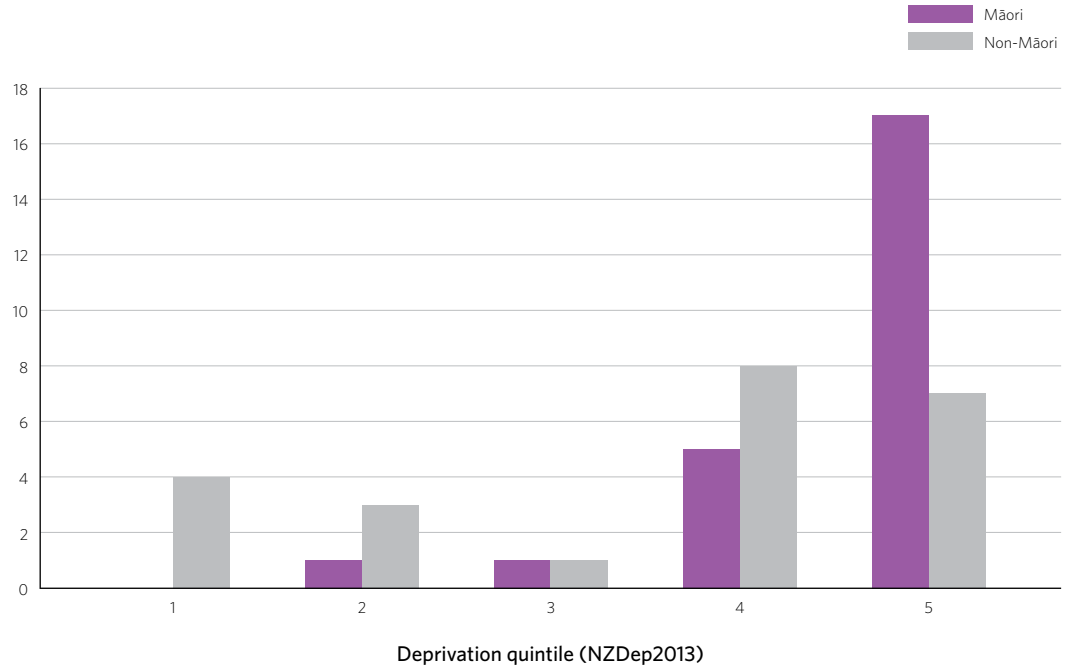
Figure 12: Deprivation quintile (NZDep2013) of deceased in CAN deaths by ethnicity (n=55),* New Zealand, 2009–15



CAN = child abuse and neglect.

* The ethnicity of one deceased child was unknown.

Figure 13: Deprivation quintile (NZDep2013) of offenders in CAN deaths by ethnicity (n=47),* New Zealand, 2009–15



CAN = child abuse and neglect.

* The ethnicity of three offenders were unknown. The deprivation quintile was unknown for one offender. Both the ethnicity and deprivation quintiles for four other offenders were unknown.

Key statistics

- Māori children aged 0–4 years were **four times** more likely to be killed by CAN than non-Māori children.
- **74 percent** of the known offenders responsible for the fatal physical abuse and/or grossly negligent treatment CAN deaths were males.
- **49 percent**[125] of the children killed by CAN resided in neighbourhoods with the highest level of deprivation.
- Three-quarters (**75 percent**) of Māori children killed by CAN resided in neighbourhoods with the highest level of deprivation; **22 percent**[125] of non-Māori children killed by CAN resided in neighbourhoods with the highest level of deprivation.

3.4 Criminal justice outcomes for offenders in CAN deaths

Of the 55 CAN offenders in New Zealand CAN deaths during 2009–15 (Table 23):

- 11 (20 percent of all CAN offenders) were convicted for murder
- 17 (31 percent) were found guilty of manslaughter with other charges
- one was acquitted
- one was unfit to stand trial
- 10 (18 percent) completed suicide as part of the death event or after the event
- the cases for 11 suspected offenders (20 percent) are unresolved; for five suspected offenders, no charges[126] have been laid, while the remaining six suspected offenders are still being processed by the courts and a final outcome is pending
- for two offenders, no charges were progressed
- for two offenders, their outcomes are unknown.

Table 23: Outcomes for offenders in CAN deaths, New Zealand, 2009–15

Outcomes		CAN offenders n=55	
		n	%
Legal outcome	Murder conviction	11	20
	Manslaughter and/or other conviction(s)	17	31
	Acquitted	1	2
Unfit to stand trial		1	2
Suicide		10*	18
Unresolved/outcome pending†		11	20
Unknown/no charges progressed		4‡	7

CAN = child abuse and neglect.

* Eight offender suicides were part of the death event, and two offenders completed suicide after being charged with the death of a child.

† These are all fatal physical abuse and/or grossly negligent treatment deaths events.

‡ For two offenders the outcome is unknown, for two offenders, charges were not progressed. These are all with respect to neonaticide death events.

125 Denominators only include numbers of children with known NZDep2013 information.

126 They are included in the data set because they are most likely a family member.

3.5 Child survivors impacted by CAN death events

3.5.1 Child survivors of CAN death events

In total there were 114 child survivors from the 52 CAN death events in New Zealand during 2009–15. Four of these survivors were half-siblings born after a death event to a mother who was pregnant at the time of her deceased child's death (Table 24). Most (93 percent; 106 children) of the 114 child survivors were minors under 17 years of age at the time of the death event.

Of the 110 children who were alive at the time of the CAN death event (ie, excluding the four children who were *in utero*), 36 (33 percent) were siblings of the child(ren) who were killed and 44 (40 percent) were half-siblings. There were also 30 other surviving children who were neither siblings nor half-siblings to the child(ren) killed, some of whom were children from previous relationships of one of the parents (in other words, step-siblings).

Table 24: Child survivors of CAN death events, New Zealand, 2009–15

Age	Total number of child survivors of CAN n=110*	Siblings of deceased child/ren n=36	Half-siblings of deceased child/ren† n=44	Other children of the offender‡ n=30
Children – under 17 years of age	106	36	40	30
Young people – 17–24 years of age	1	–	1	–
Adult children – 25 years+	3	–	3	–

CAN = child abuse and neglect.

* In four cases, the mother of the deceased child was pregnant at the time of the death and four half-siblings were born after the death event. This brings the total to 114 surviving children.

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

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

3.5.2 Children normally resident in the household and children present at CAN death events

There were 58 children and 1 young person who were normally resident in the household of the child(ren) who were killed in New Zealand CAN death events during 2009–15 (Table 25). There were 52 children in total present at the time of a CAN death event, almost all (98 percent) of whom were minors aged under 17 years. As illustrated in Case example 5, these children were likely to have been exposed to multiple and repeated episodes of family violence that preceded the fatal event.

Table 25: Children normally resident in the household of CAN death events, New Zealand, 2009–15

Age	Children normally resident in household of CAN death events n=59	Children present at CAN death events n=52
Children – under 17 years of age	58	51
Young people – 17–24 years of age	1	1
Adult children – 25 years+	–	–

CAN = child abuse and neglect.

Age of children present at CAN death events

Most (94 percent; 49 children) of the 52 children present at the CAN death events during 2009–15 were aged 10 years or younger (Table 26). A large proportion (69 percent; 36 children) of the children present at a death event were aged five years or younger.

Table 26: Age of children present at CAN death events, New Zealand, 2009–15

Age		n=52
Children – under 17 years of age	0–5 years	36
	6–10 years	13
	11–16 years	2
Young people – 17–24 years of age		1
Adult children – 25 years+		0

CAN = child abuse and neglect.

Case example 5

Hemi was 3 years old and his sister Blossom was 15 months old. Hemi loved being a big brother and making Blossom laugh and smile. They were very close.

They lived with their mother, Kylie, and her new boyfriend Michael. When Kylie worked shifts at a local business, Michael looked after Hemi and Blossom.

In recent weeks, Kylie noticed that Hemi's behaviour towards Michael had changed; he did not seem to want to be alone with him. Kylie was not sure why. She knew he missed his father, who he saw infrequently. Hemi and Blossom were protected people on Kylie's protection order. Their biological father was the respondent.

One night, Kylie was called to cover a shift for a sick colleague. She left food prepared for Hemi's and Blossom's dinner. She got home late and went to check on her children before going to bed.

She found Blossom unresponsive in her cot and immediately rang an ambulance. That evening, Hemi and Blossom had been at home alone with Michael – Hemi had seen and heard things.

After Blossom's death, Hemi's daycare noticed changes in his behaviour. Hemi talked about Blossom crying, being 'hurt by the bad man' and not liking that. Hemi could no longer bear the sound of sirens. He got upset if one of the other children played with the toy ambulance.

After Blossom's death Hemi was removed from his mother's care. He was placed with a Child, Youth and Family (CYF) caregiver while the investigation into Blossom's death progressed.

Hemi's CYF caregiver reported that he had nightmares.

Key points

- The death of a sibling is a traumatic experience for any child.
- The death of a sibling in a child abuse homicide is likely to be just one of a succession of traumatic experiences for surviving children that were present prior to the fatal event. These are likely to continue long after the event.

CHAPTER 4: INTRAFAMILIAL VIOLENCE (IFV)

Key statistics

In the seven years from 2009 to 2015 in Aotearoa New Zealand:[127]

There were 45 IFV death events

- **93 percent** of these (42 death events) involved one offender killing one family member.
- **40 percent** were parricides; **22 percent** were patricides and **18 percent** were matricides.

Known histories of family and sexual violence

- **92 percent** of the 37 IFV death events (excluding aberrational and uncertain death events) involved offenders and deceased with known histories of family violence, sexual violence or violence against non-family members.

Demographics of deceased and offenders

- **63 percent** of IFV deceased were aged 40 years or over.
- **65 percent** of IFV offenders were aged 39 years or younger. One-third (**33 percent**) of all offenders were aged 20–29 years.
- **79 percent** (38 offenders) were males and **19 percent** (9 offenders) were females.
- **55 percent** of IFV deceased and **47 percent** of IFV offenders lived in the most socioeconomically deprived neighbourhoods (NZDep2013 quintile 5).[128]
- **89 percent** of the Māori IFV deceased and **32 percent** of the non-Māori IFV deceased lived in the most deprived neighbourhoods.[129]

Criminal justice outcomes

- Of the 48 IFV offenders, **35 percent** were convicted of murder, **29 percent** were convicted of manslaughter and **13 percent** were acquitted.

4.1 IFV classification

Intrafamilial violence (IFV) is a broad term that includes all forms of abuse between family members other than IPV or abuse of children by adult family members or parents.[130] It includes the abuse/neglect of older people, violence perpetrated by a child against their parent, violence perpetrated by a parent against an adult child and violence among siblings.

Definition

IFV death event: The event at which the offending took place that resulted in the death of one or more family members (none of whom was an intimate (ex-)partner or a child). There may be more than one family member killed in a single IFV death event. There may be multiple offenders involved in a single IFV death event.

127 Denominators only include those whose residential addresses were known.

128 Denominators only include those whose residential addresses were known.

129 Denominators only include those whose residential addresses were known.

130 A child is defined as being under 17 years of age.

4.1.1 Classification of IFV death events

The Committee analyses IFV death events according to the **familial relationship** between the deceased and offender(s) and the patterns of abuse in the history of the relationship. The IFV death events are categorised into the following types:

1. filicide
2. fratricide
3. matricide
4. parricide
5. patricide
6. sororicide.

Definitions

Filicide: A parent kills their adult child (or adult step-child/non-biological child).

Fratricide: A person kills their brother (or step-brother/non-biological brother).

Matricide: A person kills their mother (or step-mother/non-biological mother).

Parricide: A family member kills a close relative.

Patricide: A person kills their father (or step-father/non-biological father).

Sororicide: A person kills their sister (or step-sister/non-biological sister).

Classifying the roles in a familial relationship with an abuse history

The Committee has devised a classification system to ascertain the patterns of abuse in the wider familial relationships, including the death event relationship. These patterns of harm are discussed in more detail in section 4.2.2.

Some cases involve IFV death events that fall within the Committee's terms of reference, because the death was an episode of family violence, but they have aberrational features as there is no identifiable history of family violence. In these IFV death events there is an identifiable mental health history (but no known acts of violence against family members outside of the mental health disorder) and the homicide is usually committed by a family member who was mentally unwell at the time. The Committee has classified these death events as 'aberrational mental health homicides'.

In some IFV death events, the death event was an episode of family violence and there was an identifiable history of both family violence and mental health issues. Where the predominant pattern is a history of family violence perpetration these death events have not been classified as aberrational mental health homicides. In other words, these are cases where someone is perpetrating family violence **and** has mental health issues.

In other cases, the IFV death event has not yet been reviewed or the full range of agency records could not be accessed, meaning the Committee is unable to state with certainty that there has or has not been an identifiable history of family violence and/or an identifiable mental health history. These IFV death events are classified as 'uncertain'.

4.2 IFV deaths from 2009 to 2015

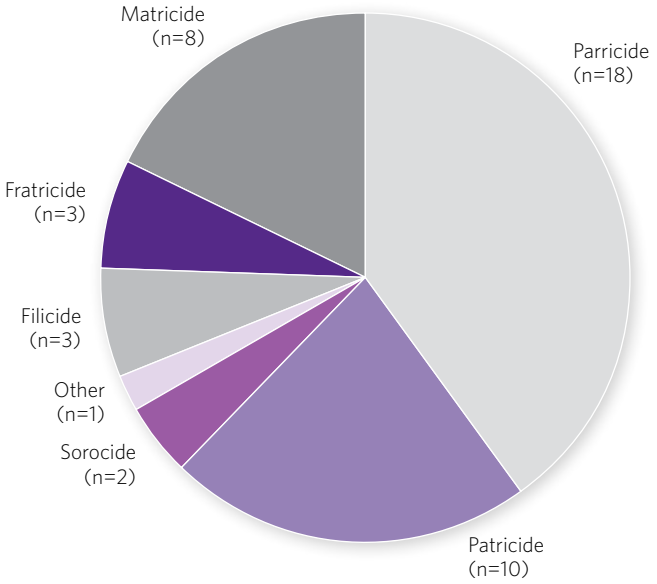
4.2.1 IFV deaths by death event type

There were 45 IFV death events in Aotearoa New Zealand during 2009–15 (Figure 14). The majority of these death events (93 percent; 42 death events) involved one offender killing one family member. In two IFV death events there were two or more offenders. In one parricide death event, one offender killed two people.

The most common types of IFV death events were parricides (40 percent of all IFV death events), patricides (22 percent) and matricides (18 percent).

Seven IFV death events were classified as aberrational mental health homicides and one as uncertain. All of these death events involved matricides (three death events) or patricides (five death events).

Figure 14: IFV deaths by death event type (n=45),* New Zealand, 2009–15



IFV = intrafamilial violence.

* There were 45 IFV death events involving 46 deceased and 48 offenders. In one parricide there were two deceased. In one parricide and one matricide there were multiple offenders.

4.2.2 Known histories of violence for IFV deceased and offenders

The IFV deaths show entanglement – with multiple forms of abuse co-occurring in some families. Of the 37 IFV death events in New Zealand during 2009–15,[131] there were 34 IFV death events (92 percent) involving offenders and/or deceased who were known to statutory services[132] for family violence (CAN, IPV and IFV), sexual offending and/or violence against non-family members. Seven of these 34 death events occurred with an IPV context (two family members were killed in an IPV death event).

IFV offenders with known histories of violence

In the 34 IFV death events with known histories of violence, there were 34 offenders who killed family members (Table 27). Among these 34 offenders:

- 12 (35 percent) were known to services when they were children as victims of child abuse.[133]

131 Excluded are the seven aberrational mental health homicides and the one uncertain IFV death.

132 This information is from the police family violence death review reports and sentencing notes, and the histories of violence known to statutory services recorded in these documents. Statutory services include New Zealand Police, the Department of Corrections, Child, Youth and Family, and district health board providers.

133 This includes children's exposure to IPV.

There were 25 male offenders

- Of these, 12 (48 percent) were known to the police for abusing one or more female partners.
- Eight had convictions and/or had been imprisoned for violence against other people.
- Sixteen (64 percent)[134] were known for one form of violence, and six were known for two or more forms of violence (data not shown).

There were five female offenders

- Three were known to services when they were children as victims of child abuse.

There were four child offenders

- Three were known to Child, Youth and Family for being abused by their father or by their mother's male partner.

IFV deceased with known histories of violence

In the 34 IFV death events with known histories of violence, there were 35 deceased killed by family members (Table 28). The following results were found among these 35 deceased.

There were 22 deceased males

- Eight were known to the police for abusing one or more female partners.

There were 12 deceased females

- Five were known to the police for being abused by a male partner.

134 Two of the 25 men were known to statutory services as victims of violence only; one male offender was not known to statutory services, but the deceased in the death event was.

Table 27: IFV offenders known to statutory services as having family violence, sexual violence and other violence histories against non-family members, New Zealand, 2009–15

IFV death events n=34		
	CAN	IPV
Male offenders 25 men* killed: • 20 male family members • 6 female family members† **n=25 death events**	5 men were known as children to Health and/or Child, Youth and Family (CYF) for child abuse concerns‡ 3 men were known to CYF or police for child abuse concerns with respect to their children 1 man was known as a child to services for anger and communication issues 1 man, as a child, was a protected person on a protection order due to exposure to IPV. His father (the deceased) was the respondent	12 men§ were known to police for abusing one or more female partners 3 of these men were respondents of protection orders 1 female co-offender was abused by a prior male partner
Female offenders 5 women killed: • 3 female family members • 2 male family members **n=5 death events**	3 women were known to have experienced child abuse; 2 were sexually abused as children by adult family members	1 woman was known to police for being abused by her male partner
Child offenders 4 children° killed: • 1 child • 3 adult female family members **n=4 death events**	3 children were known to CYF due to the risks posed by their fathers'/step-fathers' IPV perpetration and/or their physical abuse of them 1 child was known to bully other children at school	

CAN = child abuse and neglect.

IFV = intrafamilial violence.

IPV = intimate partner violence.

* One death event had three offenders: one primary male offender with two co-offenders who had supporting roles in the death event. In another death event, there was one primary male offender who had a female co-offender. In this table for these two death events, the histories of these two male primary offenders are the focus.

† In one other death event a man killed a female family member and a male family member.

‡ In this table child abuse/concerns include: sexual abuse by family members, being a protected person on a protection order, physical abuse, being removed from family members and placed in state care (including due to IPV perpetration by their mother's partner), and persistent neglect.

§ One man was known to the Australian Police for IPV perpetration.

Including the deceased of the IFV death event.

∞ Two men were charged/convicted with respect to offences against children and one man with respect to an adult.

+ Includes: assaults on police, assaults (ie, wounds with intent to injure), aggravated robbery, discharging a fire weapon and possession of offensive weapons.

ˆ Including a chainsaw and a firearm.

± These were all with respect to the deceased.

° Three were male children and one was a female child.

Offenders (n=34)		
IFV	Sexual violence offending	Other violence
4 men were known to police for assaulting and/or threatening family members;[#] 1 was recorded as a victim and a perpetrator 1 other man was exposed as a young person to IFV	3 men were charged and/or convicted of sexual offences[∞]	8 men had convictions and/or had been imprisoned for violence[+] against other people 2 other men were known to have threatened neighbours with weapons[^] 4 men were gang affiliated
2 women were known to police as victims of IFV;[*] 1 was recorded as a victim and a perpetrator		

Table 28: IFV deceased known to statutory services as having family violence, sexual violence and other violence histories against non-family members, New Zealand, 2009–15

IFV death events n=34		
	CAN	IPV
26 deceased (killed by male offenders): • 20 male family members • 6 female family members **n=25 death events**	1 woman was convicted of child abuse (against the offender)	6 men were known to police for abusing one or more female partners 3 of these men were also respondents of protection orders 3 women had been abused by their partners; 2 of these men were the offender's* father
5 deceased (killed by female offenders): • 3 female family members • 2 male family members **n=5 death events**	1 man had Child, Youth and Family (CYF) remove his child from his care due to child abuse concerns	2 men were known to police for abusing one or more female partners 2 women were known to police for being abused by their male partners; 1 was the respondent of a protection order, and was recorded as a victim and perpetrator of IPV
4 deceased (killed by child offenders): • 1 child • 3 adult female family members **n=4 death events (child offenders)**	1 woman was known as a child to CYF, as a family member had sexually abused her	

CAN = child abuse and neglect.
IFV = intrafamilial violence.
IPV = intimate partner violence.
* Offender refers to the offender in the IFV death event.
† Including the offender.
‡ This was with respect to the offender.
§ Her mother was killed in the same death event.

Key statistics

- There were **45** IFV death events (seven were aberrational and one was uncertain).
- **40 percent** of all IFV death events were parricides, **22 percent** were patricides and **18 percent** were matricides.
- Most of the 37 IFV death events (**92 percent**)[135] involved offenders and deceased with known histories of family violence, sexual violence or violence against non-family members.

135 Excluding the aberrational and uncertain death events.

Deceased (n=35)		
IFV	Sexual violence offending	Other violence
3 men were known to police for assaulting and/or having disputes with family members 2 other men were known to police as victims of assaults and/or disputes with family members[†] 2 women were known to police for being abused by their adult children; 1 was recorded as a victim and perpetrator[‡] 1 woman was a protected person on a protection order against the offender[§]	1 man had multiple convictions for sexual offending against children	2 men had convictions and/or had been imprisoned for violence against other people 2 men were gang members
1 woman was known to police, as a victim and perpetrator of IFV (from the offender)		1 man had convictions and had been imprisoned for violence against other people

4.2.3 Emerging themes in IFV death events

The Committee's analysis of the IFV death events in Aotearoa New Zealand during 2009–15 revealed a number of emerging themes. These themes were common across multiple death events and will be explored in future work as a way of classifying IFV death events by the context in which they occurred (ie, considering the details of circumstances preceding the death event and histories of those involved). Classification of IFV death events by their context aligns with how deaths events are categorised for IPV and CAN.

Four themes emerged across the IFV death events:

- family violence histories
- family violence *and* mental health histories
- social gatherings (large or small) where large amounts of alcohol were consumed
- financial inheritance/property disputes or financial exploitation.

These are discussed below (see also Table 29).

Family violence histories

These death events were part of an identifiable history of family violence. The offenders involved had a history of perpetrating family violence and the death event was a continuation of their abusive behaviour, or the offender was responding to experiencing violence from the deceased and/or the victimisation of another family member.

There were 15 IFV death events with family violence histories.

- Seven death events involved family violence histories of IPV. In these:
  - two female offenders intervened to defend family members from male predominant aggressors; the two male predominant aggressors they killed were known to police for abusing their female intimate partner
  - five male offenders[136] were known to the police for abusing intimate partner(s) and/or had convictions for violence against other people.
- Seven death events involved family violence histories of IFV; all involved men killing men. In these:
  - four offenders were known for using violence; two were known to the police for abusing intimate partner(s) and/or had convictions for violence against other people, and two were known for threatening neighbours with weapons
  - one other offender was known to services for anger and communication issues.

Family violence *and* mental health histories

These death events were part of an identifiable history of family violence (perpetration and/or victimisation), and the offender had a history of experiencing mental health issues. The offender was usually known to mental health services. In these death events both the family violence and mental health histories contributed to the circumstances preceding the death event.

There were four IFV death events with family violence *and* mental health histories, all of which were matricides. In these:

- two offenders were recorded by the police as the victim and perpetrator of IFV with the deceased
- three offenders were men, of which two were notified to CYF when they were children for child abuse concerns, and the remaining offender was known to CYF as an adult due to concerns he had abused his child.

There were also seven aberrational mental health death events, all of which were matricides or patricides.

136 One offender had two co-offenders.

Social gatherings (large or small) where large amounts of alcohol were consumed

These death events occurred at social gatherings (large or small) where the offender and deceased were present, along with family and whānau members and/or friends. The gatherings typically spanned many hours, during which time alcohol was consumed. Many offenders were known for using violence against people (family and/or non-family members). In the circumstances preceding the death event their readiness to use violence appears to have been exacerbated by their alcohol consumption, which may have compounded the severity of their violence.

There were nine IFV death events that occurred at social gatherings; all involved men killing men. In these:

- seven offenders were known for using violence; six were known to the police for abusing intimate partner(s) and/or had convictions for violence against other people, and one was known to police for IFV perpetration
- one was an offender who, as a child, was a protected person on a protection order where the deceased was the respondent
- the assault at the social gathering did not immediately kill the deceased in four of the deaths. The deceased died in the following day, days or weeks after the assault.

Family inheritance/property disputes or financial exploitation

These death events occurred in the context of ongoing disputes about who should inherit property and/or other family and whānau resources, often after the death of a family or whānau member. In some death events the offender was financially exploiting a family member or sought to gain financially from their death. These offenders had a history of financially exploiting the family member and/or other people.

There were five IFV death events involving family inheritance/property disputes or financial exploitation. In these:

- two offenders did not have recorded histories
- two offenders had been convicted for assault(s) on non-family members
- one offender had been abused as a child by a family member.

Table 29 illustrates the four emerging themes across the IFV death events (excluding the IFV death events with child offenders aged under 17 years).

Table 29: Emerging themes in IFV death events, New Zealand, 2009–15

Death event context		Death events n=41	Circumstances preceding the death event
Family violence histories	IPV	7	• 3 offenders killed the deceased and killed/attempted to kill the female primary victim • 2 offenders intervened to defend (a) family member(s) from the male predominant aggressor • In 2 death events the offenders assaulted the deceased, whom they perceived had abused his intimate partner (the offender's family member)
	CAN	1	• 1 offender was drinking with a family member, whom they assaulted as they perceived the person had not protected them from child abuse
	IFV	7	• 1 offender sexually abused the deceased and killed them a short time later • 1 offender physically abused and humiliated the deceased for years, before killing them • 1 offender initiated a campaign of intimidation intended to cause fear against the deceased and their family members • 1 offender was in financial difficulties and appeared to have a long history of emotional abuse from the deceased; he went to the deceased's property armed with a weapon • 2 deceased were known to family members for belittling or humiliating the offender; for 1 this had been occurring since childhood • 1 deceased responded to a request for help from a family member who felt threatened by the offender; the deceased was repeatedly assaulted by the offender
Family violence *and* mental health histories		4	• 3 offenders were living with their mothers and their relationships were strained; 2 had been asked to move out • 1 offender and the deceased were known to police as victims and perpetrators of IFV against each other
Social gathering (large or small) where large amounts of alcohol was consumed		9	• 4 offenders were drinking with family members and/or the deceased, and either started fighting with the deceased, or were aggressive, abusive or argumentative towards the deceased before assaulting them • 2 offenders at large social events argued with the deceased and physically assaulted them • 1 offender went to the deceased's home intoxicated, intimidated the people there, and assaulted the deceased when he did not comply with his demands • 2 deceased had been drinking with family and friends all day, were argumentative with multiple people prior to the death event, and assaulted the offender immediately before the assault, resulting in their own death
Family inheritance/ property disputes or financial exploitation		5	• 2 offenders killed the deceased over long-standing property and/or inheritance disputes; the offenders felt unfairly treated by the deceased and their family members • 2 offenders financially exploited or sought to gain financially from the deceased • 1 offender, after a day of consuming alcohol with associates and the deceased, killed the deceased over a long-standing property dispute
Aberrational mental health history: 7 death events **Uncertain history: 1 death event**			

CAN = child abuse and neglect.

IFV = intrafamilial violence.

IPV = intimate partner violence.

4.3 Age, gender, ethnicity and socioeconomic status of IFV deceased and offenders

4.3.1 Age of IFV deceased and offenders

Almost one-half (48 percent) of all the IFV deceased in New Zealand during 2009–15 were aged 50 years or over, whereas only 17 percent of offenders (eight offenders) were in this age group (Table 30). Twenty-nine (63 percent) of the IFV deceased were aged 40 years or over.

Most of the IFV offenders were younger, with 65 percent (31 offenders) being aged 39 years or younger. The highest rate of IFV offending was seen among those aged 20–29 years (33 percent of all offenders).

Of the eight offenders aged 0–19 years, four were children aged under 17 years old (data not shown).

Table 30: Age-specific rates (per 100,000 people per year) for deceased and offenders in IFV deaths (with 95% CIs), New Zealand, 2009–15

AGE	Total New Zealand population 2009–15		IFV deceased n=46				IFV offender n=48			
	n	%	n	%	rate	95% CI	n	%	rate	95% CI
0–19 years	8,576,960	27	3	7	0.03	0.01–0.10	8	17	0.09	0.04–0.18
20–29 years	4,243,670	14	6	13	0.14	0.05–0.31	16	33	0.38	0.22–0.61
30–39 years	3,926,070	13	8	17	0.20	0.09–0.40	7	15	0.18	0.07–0.37
40–49 years	4,416,180	14	7	15	0.16	0.06–0.33	8	17	0.18	0.08–0.36
≥ 50 years	10,046,050	32	22	48	0.22	0.14–0.33	8	17	0.08	0.03–0.16
Unknown							1	2		

IFV = intrafamilial violence.

4.3.2 Gender of IFV deceased and offenders

Thirty-two (70 percent) of the deceased in the IFV deaths in New Zealand during 2009–15 were males and 14 (30 percent) were females. Males were five times more likely than females to be the offenders in IFV deaths (Table 31). Of the 48 offenders who killed a family member, 79 percent (38 offenders) were males and 19 percent (9 offenders) were females.

Table 31: Gender-specific rates (per 100,000 people per year) for deceased and offenders in IFV deaths (with 95% CIs), New Zealand, 2009–15

Gender	Total New Zealand population 2009–15		IFV deceased n=46				IFV offender n=48			
	n	%	n	%	rate	95% CI	n	%	rate	95% CI
Male	15,292,150	49	32	70	0.21	0.14–0.30	38	79	0.25	0.18–0.34
Female	15,829,960	51	14	30	0.09	0.05–0.15	9	19	0.06	0.03–0.11
Unknown							1	2		

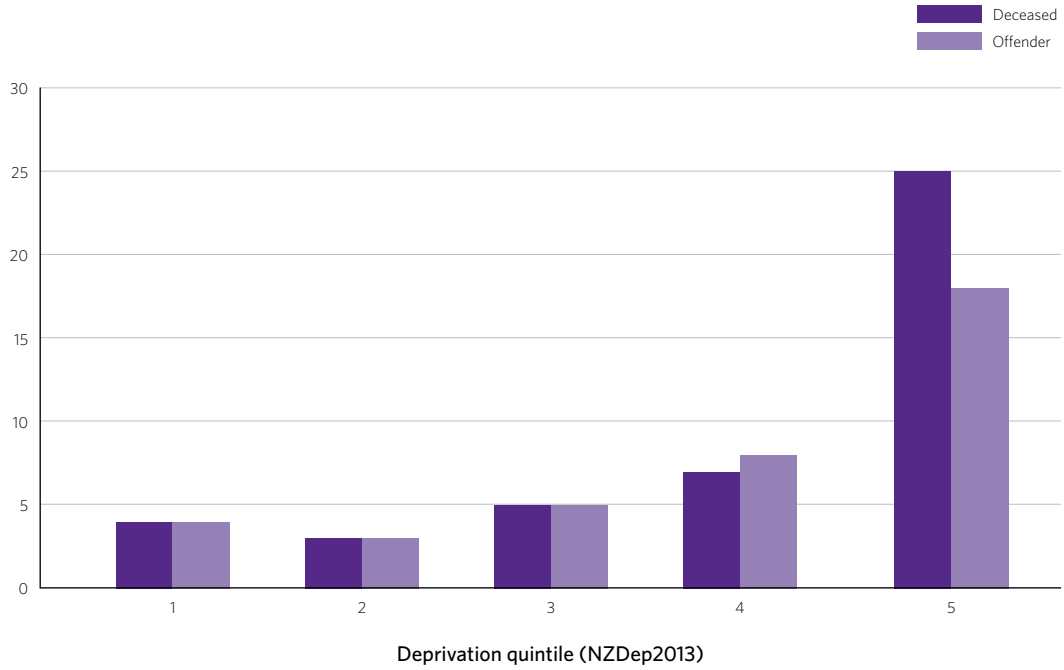
IFV = intrafamilial violence.

4.3.3 Socioeconomic status of IFV deceased and offenders

There were 44 IFV deceased for whom the deprivation quintile was known in New Zealand during 2009–15 (Figure 15). A large proportion of these deceased (73 percent; 32 deaths) resided in neighbourhoods with higher levels of deprivation (quintiles 4 and 5), and over one-half (57 percent; 25 deaths) lived in the most deprived quintile. There were 38 IFV offenders for whom the deprivation quintile was known. Almost one-half (47 percent) of the offenders resided in neighbourhoods with the highest level of deprivation.

Figure 15 depicts the socioeconomic gradient seen in all the IFV deaths. While the numbers of deceased and offenders increase as deprivation quintile increases, the gradient is slightly more pronounced among the IFV deceased.

Figure 15: Deprivation quintile (NZDep2013) of deceased and offenders in IFV deaths (n=44 deceased; n=38 offenders),* New Zealand, 2009–15



IFV = intrafamilial violence.

* The deprivation quintiles for two deceased and 10 offenders were unknown.

4.3.4 Ethnicity of IFV deceased and offenders

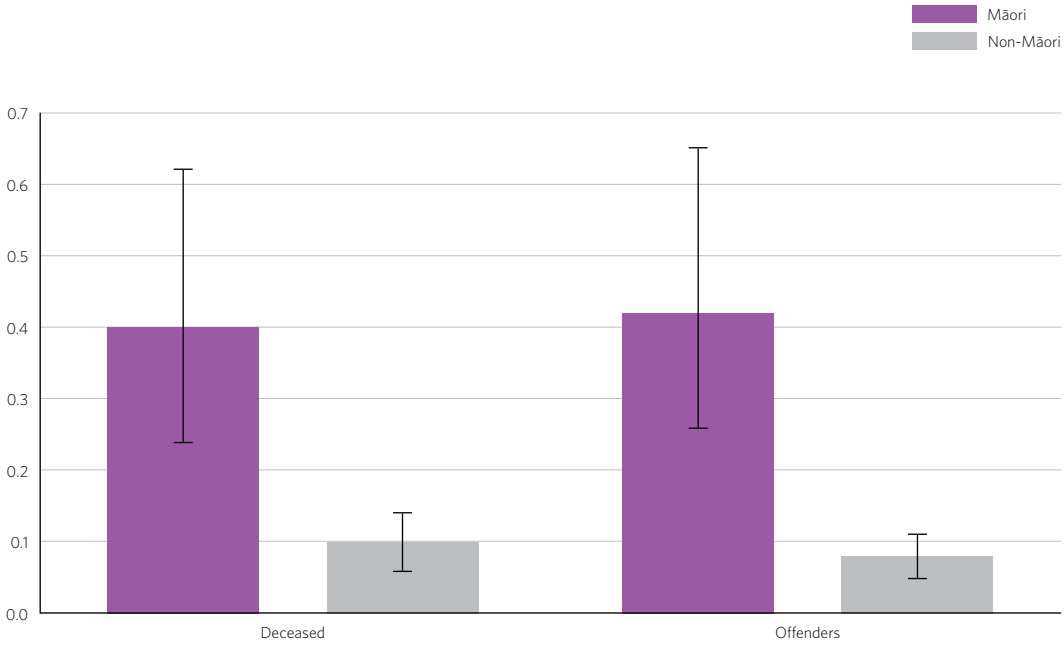
Table 32 and Figure 16 show there were significant differences in the ethnicity of the deceased and offenders in New Zealand IFV deaths during 2009–15. IFV deaths were four times more likely to occur among Māori than non-Māori. Similarly, Māori offenders were five times more likely to be responsible for IFV deaths than those of non-Māori ethnicity.

Table 32: Ethnic-specific rates (per 100,000 people per year) for deceased and offenders in IFV deaths (with 95% CIs), New Zealand, 2009–15

PRIORITISED ETHNICITY	Total New Zealand population 2009–15		IFV deceased n=46				IFV offender n=48			
	n	%	n	%	rate	95% CI	n	%	rate	95% CI
Māori	4,787,440	16	19	41	0.40	0.24–0.62	20	42	0.42	0.26–0.65
Non-Māori	26,334,670	84	26	57	0.10	0.06–0.15	23	48	0.09	0.06–0.13
Unknown			1	2			5	10		

IFV = intrafamilial violence.

Figure 16: Ethnic-specific rates (per 100,000 people per year) for deceased and offenders in IFV deaths (with 95% CIs), New Zealand, 2009–15



IFV = intrafamilial violence.

4.3.5 Socioeconomic status and ethnicity of IFV deceased and offenders

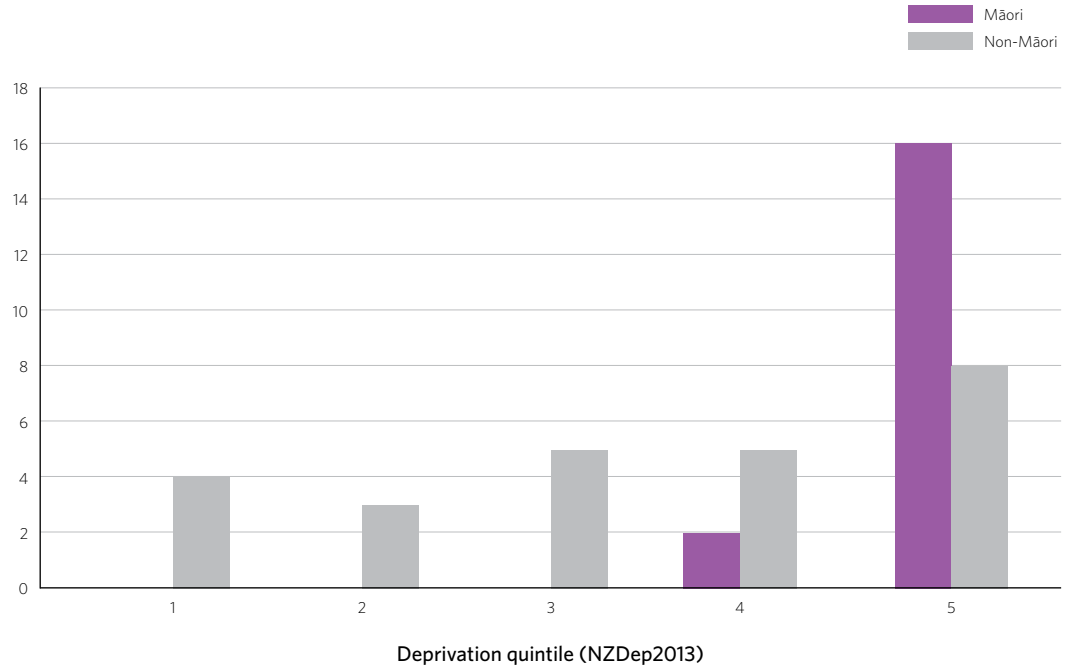
Figures 17 and 18 show the level of socioeconomic deprivation of the deceased and offenders in New Zealand IFV deaths during 2009–15. The figures show that, for both the deceased and offenders in IFV deaths, the socioeconomic gradients were steeper for Māori compared with non-Māori. In other words, socioeconomic status was more evenly distributed across the non-Māori deceased and offenders in IFV death events, but was skewed towards higher levels of deprivation for the Māori deceased and offenders. These may reflect the steeper socioeconomic gradient in the total Māori population compared with the non-Māori population.[137]

Of the deceased and offenders in IFV death events whose residential addresses were known during 2009–15:

- most of the 18 Māori deceased (89 percent; 16 deaths) lived in the most deprived neighbourhoods (quintile 5), compared with 32 percent (8 deaths) of the 25 non-Māori deceased
- 10 of the 16 Māori offenders (63 percent) lived in the most deprived neighbourhoods, compared with over one-third (36 percent; 8 offenders) of the 22 non-Māori offenders.
- No Māori offenders responsible for IFV deaths lived in the two least deprived neighbourhoods.

137 Larger proportions of Māori live in areas with higher NZDep2013 scores. See Figure 4, p. 12, Ministry of Health, *Tatau Kahukura: Māori Health Chartbook, 2015 (3rd edition),* Wellington, Ministry of Health, 2015: http://www.health.govt.nz/publication/tatau-kahukura-maori-health-chart-book-2015-3rd-edition.

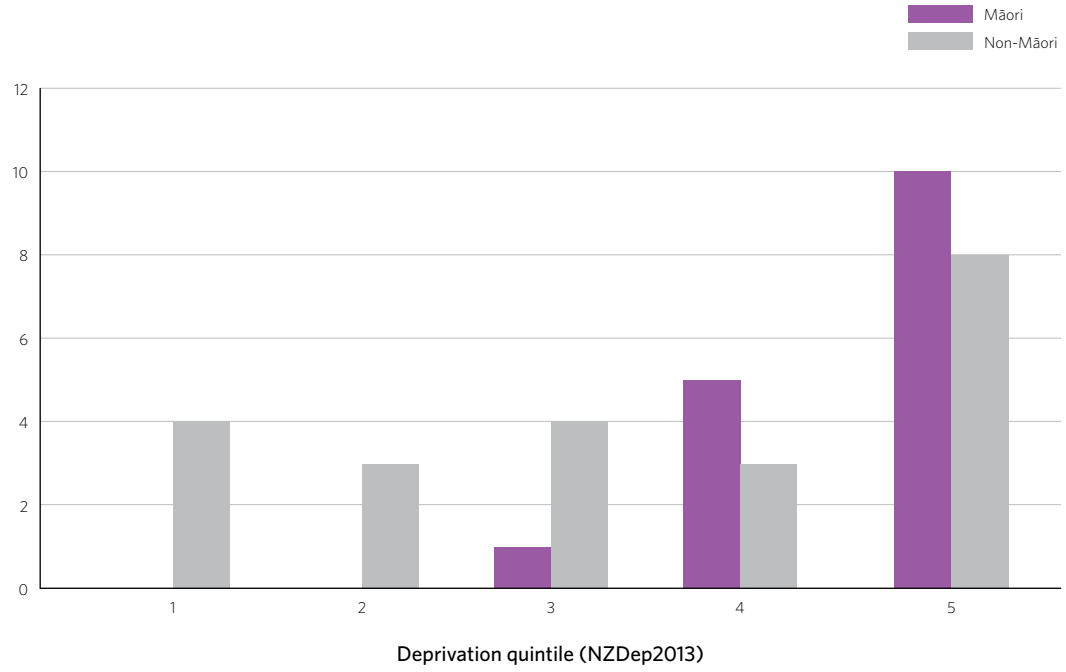
Figure 17: Deprivation quintile (NZDep2013) of deceased in IFV deaths by ethnicity (n=43),* New Zealand, 2009–15



IFV = intrafamilial violence.

* The ethnicity of one deceased was unknown. The deprivation quintiles for two deceased were unknown.

Figure 18: Deprivation quintile (NZDep2013) of offenders in IFV deaths by ethnicity (n=43),* New Zealand, 2009–15



IFV = intrafamilial violence.

* The deprivation quintiles for five offenders were unknown.

Key statistics

- **33 percent** of all IFV offenders were aged 20–29 years.
- **79 percent** of offenders responsible for IFV deaths were males. Males were **five times** more likely to be offenders in IFV deaths than females.
- **55 percent**[138] of those killed in IFV deaths resided in neighbourhoods with the highest level of socioeconomic deprivation.
- Māori were **five times** more likely to be offenders and **four times** more likely to be deceased in IFV deaths than non-Māori.
- **89 percent**[138] of Māori IFV deceased and **32 percent**[138] of non-Māori IFV deceased resided in neighbourhoods with the highest level of deprivation.

4.4 Criminal justice outcomes for offenders in IFV deaths

There were 48 offenders in New Zealand IFV deaths during 2009–15. Of these, one offender completed suicide at the time of death and could not be prosecuted (Table 33), while two offenders were unfit to stand trial.

Among the remaining 45 offenders:

- 17 (35 percent of all IFV offenders) were convicted for murder
- 14 (29 percent) were found guilty of manslaughter with other charges
- six were acquitted (13 percent)
- one is still being processed by the courts and a final outcome is pending
- one offender has not yet been charged; their outcome is unknown but they are included in the data set because they are most likely a family member.

Table 33: Outcomes for offenders in IFV deaths, New Zealand, 2009–15

Outcomes		IFV offenders n=48	Percentage
		n	%
Legal outcome	Murder conviction	17	35
	Manslaughter and/or other conviction(s)	14	29
	Acquitted	6	13
	Insanity	3	6
Unfit to stand trial		2	4
Suicide		1	2
Unresolved/outcome pending		1	2
Unknown		1	2
Discharged		1	2
Other		2	4

IFV = intrafamilial violence.

138 Denominators only include numbers with known NZDep2013 information.

APPENDIX 1: ADDITIONAL DATA TABLES

A. All family violence deaths

Table A1: Age-specific rates (per 100,000 people per year) for offenders in family violence deaths by type of family violence, New Zealand, 2009–15

OFFENDER AGE	Total New Zealand population		Total family violence offenders n=195			IPV n=92			CAN n=55			IFV n=48		
	n	%	n	%	rate	n	%	rate	n	%	rate	n	%	rate
< 1 year	428,400	1												
1–4 years	1,753,790	6												
5–9 years	2,103,340	7												
10–19 years	4,291,430	14	13	7	0.30	1	1	0.02	4	7	0.09	8	17	0.19
20–29 years	4,243,670	14	62	32	1.46	23	25	0.54	23	42	0.54	16	33	0.38
30–39 years	3,926,070	13	40	21	1.02	20	22	0.51	13	24	0.33	7	15	0.18
40–49 years	4,416,180	14	40	21	0.91	25	27	0.57	7	13	0.16	8	17	0.18
≥ 50 years	10,046,050	32	34	17	0.34	23	25	0.23	3	5	0.03	8	17	0.08
Unknown			6	3					5	9		1	2	

CAN = child abuse and neglect.

IFV = intrafamilial violence.

IPV = intimate partner violence.

B. Intimate partner violence (IPV)

Table B1: Offender abuse history and ethnicity in IPV deaths, New Zealand, 2009–15

Offender role in abuse history	Ethnicity of offender					
	Māori	Pacific peoples	Other	Unknown	Total	
	n	n	n	n	n	%
PV offender						
Female PV/suspected PV	12	0	4	0	16	17
Male PV/suspected PV	0	0	0	0	0	0
PA offender						
Female PA/suspected PA	0	0	2	0	2	2
Male PA/suspected PA (inc ex- and new PA)	16	4	44	1	65	71
Excluded						
Male new partner of PV*	0	0	1	0	1	1
Aberrational cases	0	0	3	0	3	3
Uncertain cases	1	1	2	1	5	5
TOTAL	29	5	56	2	92	~100

IPV = intimate partner violence.

PA = predominant aggressor.

PV = primary victim.

* Was an offender in death event with a primary victim offender; abuse history was between primary victim offender and predominant aggressor deceased.

Table B2: Deceased abuse history and ethnicity in IPV deaths, New Zealand, 2009–15

Deceased role in abuse history	Ethnicity of deceased					
	Māori	Pacific peoples	Other	Unknown	Total	
	n	n	n	n	n	%
PV deceased						
Female PV/suspected PV	14	2	44	0	60	65
Male PV/suspected PV	0	0	1	0	1	1
Male new partner of female PV	0	0	4	1	5	5
PA deceased						
Female PA/suspected PA	0	0	0	0	0	0
Male PA/suspected PA	13	0	5	0	18	20
Excluded						
Aberrational cases	0	0	3	0	3	3
Uncertain cases	1	1	1	2	5	5
TOTAL	**28**	**3**	**58**	**3**	**92**	**~100**

IPV = intimate partner violence.

PA = predominant aggressor.

PV = primary victim.

Table B3: Age-specific rates (per 100,000 people aged 15 years or over per year) for deceased and offenders in IPV deaths, New Zealand, 2009–15

AGE	Total New Zealand population		IPV deceased n=92				IPV offender n=92			
	n	%	n	%	rate	95% CI	n	%	rate	95% CI
< 1 year	428,400	1	0							
1–4 years	1,753,790	6	0							
5–9 years	2,103,340	7	0							
10–19 years	4,291,430	14	1	1	0.02	0.00–0.13	1	1	0.02	0.00–0.13
20–29 years	4,243,670	14	23	25	0.54	0.34–0.81	23	25	0.54	0.34–0.81
30–39 years	3,926,070	13	25	27	0.64	0.41–0.94	20	22	0.51	0.31–0.79
40–49 years	4,416,180	14	29	32	0.66	0.44–0.94	25	27	0.57	0.37–0.84
≥ 50 years	10,046,050	32	14	15	0.14	0.08–0.23	23	25	0.23	0.15–0.34
Unknown										

IPV = intimate partner violence.

Table B4: Gender-specific rates (per 100,000 people aged 15 years or over per year) for deceased and offenders in IPV deaths, New Zealand, 2009–15

	Total population aged 15 years or over 2009–15		IPV deceased n=92				IPV offender n=92			
	n	%	n	%	Rate (per 100,000 people aged ≥ 15 years)	95% CI	n	%	Rate (per 100,000 people aged ≥ 15 years)	95% CI
Male	12,050,580	49	29	32	0.24	0.16–0.35	70	76	0.58	0.45–0.73
Female	12,749,825	51	63	68	0.49	0.38–0.63	22	24	0.17	0.10–0.26

IPV = intimate partner violence.

Table B5: Ethnic-specific rates (per 100,000 people aged 15 years or over per year) for deceased and offenders in IPV deaths, New Zealand, 2009–15

	Total population aged 15 years or over 2009–15		IPV deceased n=92				IPV offender n=92			
	n	%	n	%	Rate (per 100,000 people aged ≥ 15 years)	95% CI	n	%	Rate (per 100,000 people aged ≥ 15 years)	95% CI
Māori	3,148,970	13	28	30	0.89	0.59–0.13	29	32	0.92	0.62–0.13
Pacific peoples	1,387,185	6	3	3	0.22	0.03–0.43	5	5	0.36	0.08–0.57
Other	20,264,250	82	58	63	0.29	0.24–0.40	56	61	0.28	0.21–0.36

IPV = intimate partner violence.

* There were three deceased with unknown ethnicity, and two offenders with unknown ethnicity.

Table B6: Ethnic-specific rates (per 100,000 people aged 15 years or over per year) for deceased and offenders in IPV deaths, New Zealand, 2009–15

	Total population aged 15 years or over 2009–15		IPV deceased n=92				IPV offender n=92			
	n	%	n	%	Rate (per 100,000 people aged ≥ 15 years)	95% CI	n	%	Rate (per 100,000 people aged ≥ 15 years)	95% CI
Māori	3,148,970	13	28	30	0.89	0.59–0.13	29	32	0.92	0.62–0.13
Non-Māori	21,651,435	88	61	66	0.28	0.22–0.36	61	66	0.28	0.22–0.36

IPV = intimate partner violence.

* There were three deceased with unknown ethnicity, and two offenders with unknown ethnicity.

C. Child abuse and neglect (CAN)

Table C1: Age-specific rates (per 100,000 people per year)* for deceased and offenders in CAN deaths, New Zealand, 2009–15

AGE	Total New Zealand population 2009–15		CAN deceased n=56				CAN offender n=55			
	n	%	n	%	rate	95% CI	n	%	rate	95% CI
< 1 year	428,400	1	20	36	4.67	2.85–7.21				
1–4 years	1,753,790	6	25	45	1.43	0.92–2.10				
5–9 years	2,103,340	7	6	11	0.29	0.11–0.62				
10–19 years	4,291,430	14	5	9	0.12	0.04–0.27	4	7	0.09	0.03–0.24
20–29 years	4,243,670	14					23	42	0.54	0.34–0.81
30–39 years	3,926,070	13					13	24	0.33	0.18–0.57
40–49 years	4,416,180	14					7	13	0.16	0.06–0.33
≥ 50 years	10,046,050	32					3	5	0.03	0.01–0.09
Unknown							5	9		

CAN = child abuse and neglect.

* Rates for CAN deceased were estimated per 100,000 people aged 19 years and under per year. Rates for CAN offenders were estimated per 100,000 people per year of the total population.

Table C2: Gender-specific rates (per 100,000 people per year)* for deceased and offenders in CAN deaths, New Zealand, 2009–15

Gender	Total New Zealand population aged under 19 years 2009–15		CAN deceased n=56			
Deceased	n	%	n	%	rate	95% CI
Male	4,363,790	49	29	52	0.66	0.45–0.95
Female	4,154,130	51	27	48	0.65	0.43–0.95
Gender	**Total New Zealand population 2009–15**		**CAN offender n=55**			
Offenders	n	%	n	%	rate	95% CI
Male	15,292,150	49	30	55	0.20	0.13–0.28
Female	15,829,960	51	20	36	0.13	0.07–0.20
Unknown			5	9		

CAN = child abuse and neglect.

* Rates for CAN deceased were estimated per 100,000 people aged 19 years and under per year. Rates for CAN offenders were estimated per 100,000 people per year of the total population.

Table C3: Ethnic-specific rates (per 100,000 people per year)* for deceased and offenders in CAN deaths, New Zealand, 2009–15

PRIORITISED ETHNICITY	Total New Zealand population aged under 19 years 2009–15		CAN deceased n=56			
Deceased	n	%	n	%	rate	95% CI
Māori	2,105,140	15	28	50	1.33	0.88–1.92
Pacific peoples	838,475	6	5	9	0.60	0.19–1.39
Other	5,574,305	78	22	39	0.40	0.25–0.60
Unknown			1	2		
PRIORITISED ETHNICITY	**Total New Zealand population 2009–15**		**CAN offender n=55**			
Offenders	n	%	n	%	rate	95% CI
Māori	4,787,440	15	24	44	0.50	0.59–1.29
Pacific peoples	2,031,330	7	4	7	0.20	0.12–0.84
Other	24,303,340	78	20	36	0.08	0.07–0.16
Unknown			7	13		

CAN = child abuse and neglect.

* Rates for CAN deceased were estimated per 100,000 people aged 19 years and under per year. Rates for CAN offenders were estimated per 100,000 people per year of the total population.

Table C4: Ethnic-specific rates (per 100,000 people per year)* stratified by age for deceased and offenders in CAN deaths, New Zealand, 2009–15

MĀORI										
AGE	Māori population 2009–15		CAN deceased n=29				CAN offender n=24			
	n	%	n	%	rate	95% CI	n	%	rate	95% CI
0–4 years	622,970	13	27	93	4.33	2.86–6.31				
5–9 years	535,470	11	2	7	0.37	0.05–1.35				
10–19 years	946,700	20					3	13	0.32	0.07–0.93
20–29 years	750,730	15					12	50	1.60	0.83–2.79
30–39 years	574,430	12					5	21	0.87	0.19–1.78
40–49 years	554,170	12					3	13	0.54	0.11–1.58
≥ 50 years	802,970	16					1	4	0.13	0.00–0.69
NON-MĀORI										
AGE	Non-Māori population 2009–15		CAN deceased n=26				CAN offender n=24			
	n	%	n	%	rate	95% CI	n	%	rate	95% CI
0–4 years	1,567,005	6	17	65	1.08	0.63–1.74				
5–9 years	1,548,225	6	4	15	0.26	0.07–0.66				
10–19 years	3,297,550	13	5	19	0.15	0.05–0.35	1	4	0.03	
20–29 years	3,579,720	13					10	42	0.28	0.15–0.55
30–39 years	3,402,385	13					8	33	0.24	0.10–0.46
40–49 years	3,834,140	15					4	17	0.10	0.03–0.27
≥ 50 years	9,105,645	34					1	4	0.01	0.00–0.06

CAN = child abuse and neglect.

* Rates for CAN deceased were estimated per 100,000 people aged 19 years and under per year. Rates for CAN offenders were estimated per 100,000 people per year of the total population.

Note: The ethnicities were unknown for one deceased and seven offenders.

D. Intrafamilial violence (IFV)

Table D1: Ethnic-specific rates (per 100,000 people per year) for IFV deaths, New Zealand, 2009–15

PRIORITISED ETHNICITY	Total New Zealand population 2009–15		IFV deceased n=46				IFV offender n=48			
	n	%	n	%	rate	95% CI	n	%	rate	95% CI
Māori	4,787,440	15	21	46	0.44	0.24–0.62	20	42	0.42	0.26–0.65
Pacific peoples	2,031,330	6	3	7	0.15	0.03–0.43	2	4	0.10	0.01–0.36
Other	24,303,340	23	21	46	0.09	0.06–0.14	21	44	0.09	0.05–0.13
Unknown			1	2			5	10		

IFV = intrafamilial violence.

APPENDIX 2: GLOSSARY OF TERMS

The following is an explanation of key terms used in this data report.

Terminology	
Abuse history	The ongoing patterns of coercive and controlling behaviours used throughout the intimate relationship, including after the relationship ceases.
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 result in actual or potential harm to the child's health, development or dignity. Within this broad definition, five sub-types can be distinguished: physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse and exploitation.[139] Children's exposure to intimate partner violence (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.
Child present at a death event	Being present at the death event includes a child seeing and/or hearing a person being killed, and/or finding the deceased, and/or seeing the deceased being attended to by emergency services.
Death event	The immediate set of circumstances surrounding a death – this generally involves an offender who has killed the deceased. There may be more than one offender or deceased involved in a single death event when, for example, previous or new partners are involved.
Deceased	The person(s) killed in the death event; in IPV death events this may be the primary victim or the predominant aggressor.
Deprivation	A lack of the socioeconomic resources necessary for positive health and social outcomes. The New Zealand Deprivation Index (NZDep) is commonly used to measure deprivation in neighbourhoods or geographical areas. It uses census data to calculate the degree of deprivation in geographical areas of approximately 81 people (referred to as meshblocks) using the following dimensions: access to internet at home, income derived from benefits, income, employment, qualifications, owned home, support (eg, single parent family), living space, and access to a car.[140] The NZDep shows the distribution of *relative* socioeconomic deprivation in populations by scaling deprivation into five quintiles ranging from low deprivation (quintile 1) to high deprivation (quintile 5). When deprivation is equally distributed in any given population, each NZDep quintile will contain approximately 20 percent of the population.
Direct physical assault	CAN deaths due to direct physical assault from another person. This means the offender has used their body to inflict harm on the victim by hitting or shaking them.

139 World Health Organization, *Health Topics: Child Maltreatment.* URL: www.who.int/topics/child_abuse/en/.

140 J. Atkinson, C. Salmond and P. Crampton, *NZDep2013 Index of Deprivation,* 2014. Available at: www.otago.ac.nz/wellington/otago069936.pdf.

Entrapment	The manner in which IPV inhibits a victim's resistance to, or escape from, the abuse. The use of coercive and controlling tactics (including isolation, threats and violence) by abusive partners entraps victims, preventing them from keeping themselves and their children safe (prior to or post-separation) or, in some instances, from leaving the relationship. Entrapment can also have social and structural dimensions. The quality of agencies' responses to victims' help-seeking and the inequities victims may be living with can compound their entrapment. Entrapment can be experienced individually and collectively.
Family violence	A broad range of controlling behaviours, commonly of a physical, sexual and/or psychological nature, which typically involve fear, intimidation and emotional deprivation. Family violence 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: • violence between adult partners • abuse of children by an adult • abuse of older people by a person with whom they have a relationship of trust • violence perpetrated by a child against their parent • violence among siblings.
Fatal physical abuse and/or grossly negligent treatment	Child death resulting from intentional physical injury and/or grossly negligent treatment by a parent or caregiver. Grossly negligent treatment refers to a persistent pattern of negligent treatment, involving multiple forms of neglect, rather than a single incident of supervisory neglect.
Filicide	A parent kills their child (or step-child/non-biological child).
Filicide and parental suicide	A form of homicide in which a parent (or step-parent/other parental figure) deliberately kills a child and then attempts or completes suicide.
Fratricide	A person kills their brother (or step-brother/non-biological brother).
Grossly negligent treatment	CAN deaths due to multiple forms of negligent treatment and the persistent failure to provide the necessities of life that resulted in the child's death.
Historical trauma	Trauma experienced by individuals, groups and communities because of major historical events. For example, the processes and actions associated with the colonisation of indigenous people. If unaddressed, such trauma is transmitted from generation to generation, resulting in contemporary lifetime trauma, chronic stress, physiological and epigenetic changes, discrimination, family violence and violence within whānau.[141]
Indirect assault or poisoning	CAN deaths due to fatal injuries that were not caused by direct physical assault (hitting or shaking) by another person. CAN poisoning deaths are due to the administering of drugs or the intentional exposure to the toxic effects of substances by the offender.

141 K.L. Walters et al., 'Bodies don't just tell stories, they tell histories: Embodiment of historical trauma among American Indians and Alaska Natives', 2011.

Inequity	The presence of socially unwarranted, avoidable or remediable differences among populations or groups defined socially, economically, demographically or geographically. Inequities result from unjust social structures that lead to the exclusion and marginalisation of some groups.[142]
Institutional racism	Institutional racism is a pattern of differential access to material resources and power determined by race which advantages or privileges one sector of the population while disadvantaging or discriminating against another.[143]
Institutional violence	Discriminatory systems, processes and behaviours in the delivery of resources and services by institutions responsible for providing those resources or services to people who need and qualify for them. Institutional violence contributes to inequities in access to resources and services, in quality of services and in outcomes.
Intentional asphyxiation	CAN deaths due to the intentional deprivation of oxygen.
Intergenerational abuse	A pattern of interpersonal violence, abuse and/or neglect that, if unaddressed, is experienced from one generation to the next.
Intimate partner violence (IPV)	Coercive and controlling behaviours[144] within an intimate relationship (including current and/or past live-in relationships or dating relationships). Coercion involves the use of force or threats to intimidate or hurt victims and instil fear. Control tactics are designed to isolate the victim and foster dependence on the abusive partner. Together these abusive tactics inhibit resistance and escape. Coercion tactics include: • 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 include: • isolation – restricting the victim's contact with family, whānau, friends and networks of support, monitoring their movements and restricting their access to information and assistance[145] • deprivation, exploitation and micro-regulation of everyday life – limiting access to survival resources (such as food, money and cell phones) or controlling how the victim dresses.
Intrafamilial violence (IFV)	Intrafamilial violence (IFV) is a broad term that includes all forms of abuse between family members other than IPV or abuse of children by adult family members or parents. It includes the abuse/neglect of older people, violence perpetrated by a child against their parent, violence perpetrated by a parent against an adult child and violence among siblings.

142 L. Reutter and K. Kusher, '"Health equity through action on the social determinants of health": taking up the challenge in nursing', *Nursing Inquiry,* vol. 17, no. 3, 2010, pp. 269–280.

143 H. Came., Institutional racism and the dynamic of privilege in public health, Germany, Lambert Publishing, 2013.

144 E. Stark, *Re-presenting Battered Women: Coercive Control and the Defense of Liberty,* paper prepared for Violence Against Women: Complex Realities and New Issues in a Changing World Conference: 29 May to 1 June 2011, Montreal, Québec, Canada, Québec, Les Presses de l'Université du Québec, 2012.

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

Matricide	A person kills their mother (or step-mother/non-biological mother).
Neonaticide	The killing of an infant who is less than 24 hours old.
Offender	The person(s) who killed another in the death event; in IPV death events the offender may be a predominant aggressor or a primary victim.
Overkill	The use of violence far beyond what would be necessary to cause death. Overkill encompasses the excessive use of one form of violence – such as multiple stabbings or severe prolonged beating – and/or the use of multiple forms of violence (eg, strangulation, sexual violence and stabbing).
Parricide	A family member kills a close relative.
Patricide	A person kills their father (or step-father/non-biological father).
Predominant aggressor	The person who is the principal aggressor and has exercised coercive control against their intimate partner.
Primary victim	The person who has experienced ongoing coercive and controlling behaviours from their intimate partner.
Resistance	IPV victims employ a range of strategies to counter the abuse that they experience. These strategies may be overt (such as 'fighting back' to protect themselves and children) or covert (for example, using alcohol to block out the experiences of abuse). A victim's resistance does not stop the abusive partner's use of violence.
Separation	Actions taken by primary victims to create physical distance between themselves and the predominant aggressor. Geographical distance does not separate primary victims from a predominant aggressor's coercive and controlling behaviours. Many primary victims have attempted to separate, often repeatedly. Predominant aggressors may respond to a primary victim's attempts to separate with continued abuse intended to limit the victim's ability to be self-determining.
Sororicide	A person kills their sister (or step-sister/non-biological sister).
Structural violence/inequity	Structures that promote unequal, inequitable or discriminatory responses to people belonging to groups that are socially disadvantaged.
Suspected death	Where an adult or child has died in circumstances where there is an identifiable history of family violence between the deceased and the suspected offender and the police commenced, but were unable to proceed with, a family violence homicide investigation. In these death events the police have referred the case to the coroner.
Suspicious death	Where an adult or child has died in circumstances that are unexplained, or where death should not have occurred in the context described, and there are concerns that the death has been inflicted but there is no evidence to directly implicate an offender.
Tier one	A standard set of data collected from a number of national agencies that is used for quantitative analysis of patterns and general trends in family violence in Aotearoa New Zealand.
Tier two	The qualitative information gathered for in-depth regional reviews on a subset of family violence deaths.

Torture	An act intended to inflict severe pain or suffering, whether physical or mental, on a person for one or more of the following purposes: • obtaining from her/him or a third person information or a confession • punishing her/him for an act she/he or a third person has committed or is suspected of having committed • intimidating or coercing her/him or a third person • for any reason based on discrimination of any kind.[146]
Violence within whānau	All forms of violence that occur against and within Māori whānau, including the violence of colonisation, institutional racism and interpersonal violence. The causes of violence that occurs within whānau are acknowledged as a complex mix of both historical and contemporary factors.
Whānau Ora	A holistic approach to the provision of services that is grounded in Māori cultural concepts and practices. Whānau Ora focuses on the aspirations of the whānau and achieving wellbeing and the best outcomes for the whānau as a collective and its members. Whānau Ora requires tailored approaches that draw on a range of services and strategies. For example, it involves health, education, housing, and work and income to assist whānau in meeting their employment, relationships, and wealth aspirations and needs. The principles of Whānau Ora include: • recognising the whānau as a collective entity • endorsing the whānau's capacity for self-determination • having an intergenerational dynamic • building on a Māori cultural foundation • asserting a positive role for whānau within society • involving a wide range of social and economic sectors.

146 Amended from: United Nations *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*. http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx.

APPENDIX 3: FVDRC MEMBERS

Current membership

Name	Position	Organisation
Dr Jacqueline Short (Chair)	Consultant Forensic Psychiatrist Honorary Senior Clinical Lecturer	Capital & Coast District Health Board University of Otago, Wellington
Denise Wilson (Deputy Chair)	Professor Māori Health	Auckland University of Technology
Julia Tolmie (Deputy Chair)	Professor of Law	University of Auckland
Jane Koziol-McLain	Professor of Nursing	Auckland University of Technology
Fiona Cram	Director	Katoa Ltd
Pamela Jensen	Barrister and Solicitor	Jensen Law
Paul von Dadelszen	Retired District and Family Court Judge	n/a
David White	Consumer representative	Advocate

Past members

Dawn Elder (Deputy Chair), Miranda Ritchie, Fia Turner, Ngaroma Grant (Deputy Chair), Barry Taylor, Wendy Davis (Inaugural Chair), Brenda Hynes, Patrick Kelly, George Ririnui, Alison Towns, Rob Veale and Vaoga Mary Watts.

Advisors

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

APPENDIX 4: CLASSIFICATION OF ABUSE HISTORY

This section describes the Family Violence Death Review Committee's 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 between (ex-)partners in relationships prior to the death event. In order to do this, it needs to consider the 'wider contextual framework' and look beyond the reported abuse episodes and who died in the death event. To establish whether the roles of predominant aggressor and primary victim 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 had 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 and controlling[147] behaviours towards their partner in the relationship before the death event.

Coercive tactics include:

- **violence** – pushing, slapping, assaults, severe beatings, attempted strangulation, sexual violence, use of weapons[148] and objects to inflict injury or death
- **intimidation** – threats, jealous surveillance, stalking,[149] shaming and degradation, and destruction of property. This can include violence directed at children and pets/animals.

Controlling tactics include:

- **isolation** – restricting the victim's contact with family, whānau, friends and networks of support, monitoring their movements and restricting their access to information and assistance[150]
- **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 intimate partner violence deaths

Predominant aggressor and primary victim

Deaths in which there is evidence of a history of abuse, with one partner using coercive and controlling behaviours towards the other, are cases that the Committee has classified as involving a predominant aggressor and a primary victim. While most primary victims will not have used violence themselves, as noted in this report some victims living with extremely physically abusive partners 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. The following are some important considerations.[151]

147 The definition of coercive and controlling behaviours has been taken from E. Stark, *Coercive Control. How Men Entrap Women in Personal Life,* 2007.

148 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.

149 This includes the behaviours listed in the stalking victimisation scales. There are eight stalking victimisation scales. Please see section D in M.P. Thompson et al., *Measuring Intimate Partner Violence Victimisation 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.

150 This can include threats directed at those attempting to help the victim, undermining the victim's relationships with family and friends, and isolating behaviours.

151 These indicators are taken from the Determining the Predominant Aggressor indicators available at: 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 is the nature of any injuries sustained (offensive or defensive) and how serious are the injuries received by each person?
- Who in the relationship has posed the greatest danger and had the potential to seriously injure the other?
- Was one person recorded as being fearful? Was one person 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 predominant aggressor and primary victim

In some cases, on the information that 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 with previous intimate partners for one or both in the couple raise strong suspicions that one of the parties is a predominant aggressor and the other the primary victim in an abuse history that precedes the death event. The Committee has labelled these cases as 'suspected predominant aggressor' and 'suspected primary victim'.

Uncertain death events

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 and, therefore, there are death events in which it is unable to say whether there is a history of abuse based on the information that exists. These death events will be classified as 'uncertain', meaning that more information about the history between the couple would be necessary to determine whether an abuse history is present or absent and whether one party is the predominant aggressor in that history.

Aberrational death events

Some death events have aberrational features. While 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. Examples are death events in which the offender appears to have killed the deceased for material gain, or where the offender had mental health issues but had not shown any previous coercive or controlling behaviours towards the deceased. The Committee has labelled these as 'aberrational' death events.

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 and 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 assaults[152] and it would, therefore, be extremely rare to find cases of mutual fighting resulting in an intimate partner death event.[153] 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.

152 M.P. Johnson, *Types of Domestic Violence,* 2008.

153 Gulliver and Fanslow's research could not identify all types of IPV described by Johnson. They suggest that mutually exclusive types of violent relationships do not exist. P. Gulliver and J.L. Fanslow, 'The Johnson Typologies of Intimate Partner Violence: An Investigation of Their Representation in a General Population of New Zealand Women', *Journal of Child Custody,* vol. 12, no. 1, 2015, pp. 25-46.

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 when classifying each case. Second, those cases for which committee members who made the preliminary classification but have not reached clear agreement on are then discussed by the full committee until a consensus is reached.

Section 1: Deaths that have direct evidence of a history of coercive and controlling behaviours and an identified predominant aggressor and primary victim

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 primary victim (PV) and predominant aggressor (PA) in that history (Table E1).

1.2 If there is strong evidence (from either informal and/or formal sources) of an abuse history that involves at least two coercive and 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 point 1(b), 4, 5 or 6 in Table E2 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.

Table E1: Classifying deaths that have direct evidence of a history of coercive and controlling behaviours and an identified predominant aggressor and primary victim

Point	Prior abuse history indicator in the relationship*	Considerations	PA or PV role indicator	Direct evidence of a PA and PV	Definite Yes/No
A	Evidence of coercive and 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 and controlling behaviours is considered the PA.		
B	Agency record(s) of past coercive and 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. *Consider the length of time of the relationship/dating history as this may influence whether they may or may not be agency records. With short histories greater weight may be given to the nature and method of the killing and recorded histories with respect to prior partners.*	The PA is considered to be the person whose recorded episodes of abuse indicate that in the majority of episodes they used coercive and 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 and no protection order. A trespass order 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.		

* Relationship here encompasses the following partnerships: current partners, separated partners and ex-partners.

Table E1 continued overleaf

Point	Prior abuse history indicator in the relationship	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)†	DA (excluding questions 2, 4, 8, 11 and 12)‡ *Physical violence increased in severity/ frequency over past year?* *Separation after living together during the past year?* *Abuser used a weapon against you or threatened you with a lethal weapon?* *Abuser threatened to kill you?* *Abuser avoided being arrested for domestic violence?* *Abuser forced you to have sex?* *Abuser tried to choke you?* *Abuser controls most/all of your daily activities?* *Abuser is violently and constantly jealous of you?* *Victim ever been beaten by abuser while pregnant?* *Abuser ever threatened/tried to commit suicide?* *Abuser threatened to harm your children?* *Do you believe the abuser is capable of killing you?* *Abuser follows or spies on you, leaves threatening notes or messages, destroys your property or calls you when you don't want them to?* *Victim ever threatened or tried to commit suicide?* 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. *Specific cultural expertise may need to be sought to consider the abuse histories and how they are interpreted.*	Answering yes to two or more lethality risk factors listed is evidence of being a PV.		

† 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.

‡ 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? 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.

Table E1 continued overleaf

Point	Prior abuse history indicator in the relationship	Considerations	PA or PV role indicator	Direct evidence of a PA and PV	Definite Yes/No
E	Victim or family/ friends fearful or express concerns about victim's partner's behaviour	Such as the victim has made a will 'in case' anything happens to them 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.		

PA = predominant aggressor.

PV = primary victim.

Section 2: Deaths where there is a strong suspicion that there was a history of coercive and controlling behaviours involving a suspected predominant aggressor and a suspected primary victim

2.1 'Indirect evidence' of an abuse history, such as the nature of the homicide event (for example, that it is premeditated, 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 PA and the other the suspected PV.

2.3 When there is strong evidence supporting two of the criteria in Table E2, the Committee would classify the death as involving a suspected PA and suspected PV (this must include point 1b, point 5 or point 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 suspected PA and suspected PV.

2.4 Table E2 outlines the type of information that must be assessed when considering whether there was a suspected abuse history between the couple.

Table E2: Classifying deaths where there is a strong suspicion that there was a history of coercive and controlling behaviours involving a suspected predominant aggressor and a suspected primary victim

1a	**Suspected PV – no known agency history/ informal information that indicates they have used a pattern of coercive and controlling behaviour in:** • **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 suspected PV.		
1b	**AND suspected PA – recorded agency history/ informal information of abuse episodes or pattern of coercive and controlling behaviour towards (ex-) partners** Suspected PA is mainly recorded as being the offender in current or previous relationships.	Protection order(s) against the suspected PA in favour of previous partners. Family violence charges against the suspected PA 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 suspected PA.		
2	**Significant PV vulnerabilities**	A clear power imbalance between partners. For example, a marked discrepancy in age where there is an older man and a young woman. Sex worker. Pattern of family violence victimisation (other than victimisation mentioned in 1a). For example, a history of child abuse victimisation. Degree of entrapment (which impacts on reporting/help-seeking/ ability to leave) – for example, gang involvement; chronic intergenerational histories of abuse; limited social supports.	Indicators of previous and/or current vulnerability indicate the person is a suspected PV.		
3	**Who was trying to end the relationship?**	Suspected PV is more likely to have a history of attempting to leave.	The person trying to leave the relationship is considered the suspected PV.		

Table E2 continued overleaf

No	Suspected abuse indicators	Considerations	Suspected PA or suspected PV role indicator	Indirect evidence of a suspected PA and suspected PV	Suspected Yes/No
4	**The context of the death event suggests there were jealousy and control issues in the relationship**	The killing is triggered by the suspected PV wanting a separation, separating or being 'unfaithful' (real or imagined). The new partner of the suspected PV is killed.	The person who killed the deceased due to separation, 'infidelity' or presence of a new partner is considered the suspected PA.		
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**	There was an element of premeditation or flavour of 'execution' to the killing. Death event included strangulation. The killing was particularly violent (overkill in the execution of the death – eg, multiple stab wounds). Stalking/intimidation was part of death event, eg, pursuing the victim in order to inflict injuries. Pattern of offensive or defensive injuries. Murder–suicide.	The person is considered the suspected PA in a death event where they killed the deceased including one or more of the following: • execution-type killing • overkill • strangulation • active pursuit of the deceased before death • killer completed suicide/ attempted suicide afterwards.		

Table E2 continued overleaf

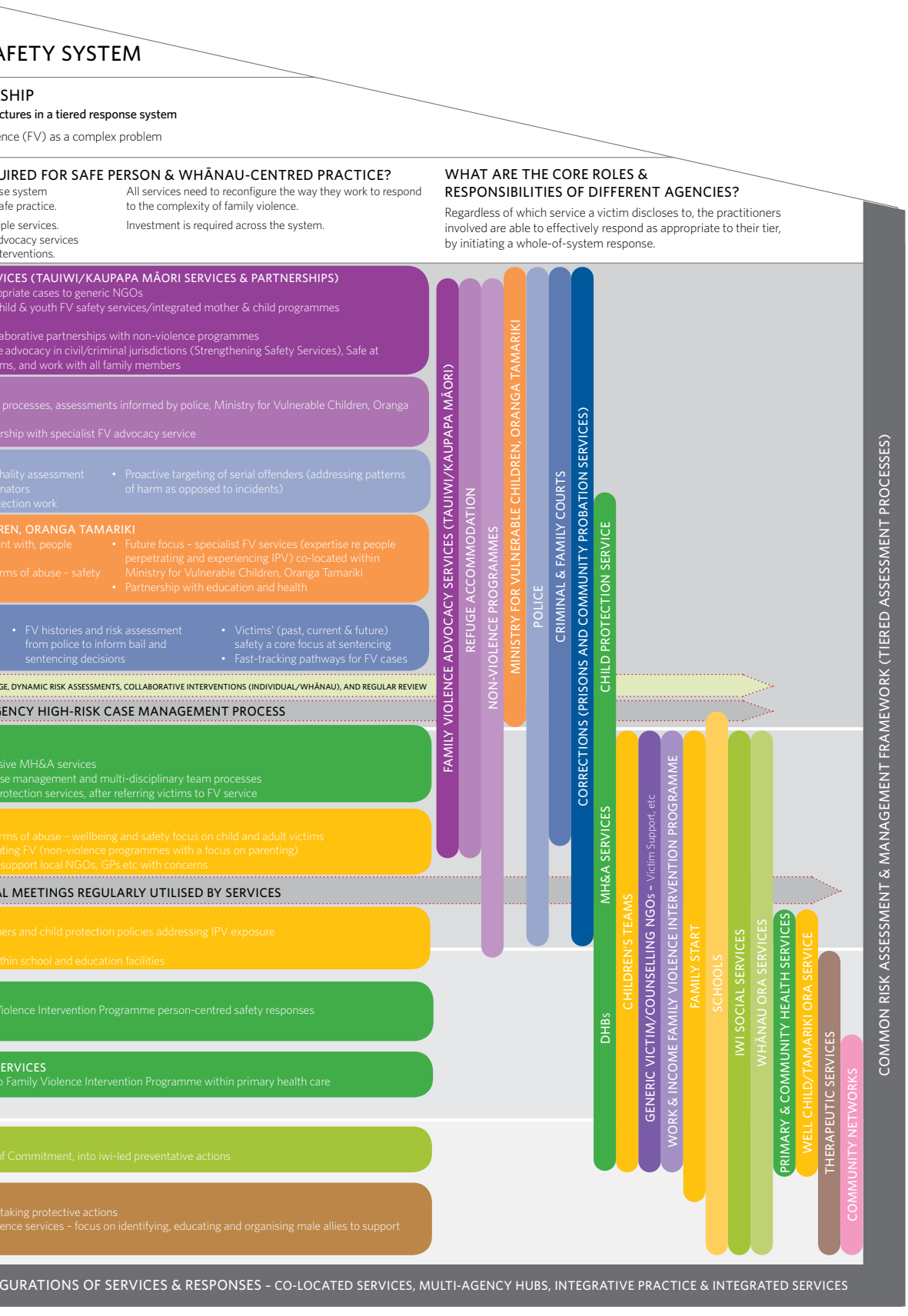
No	Suspected abuse indicators	Considerations	Suspected PA or suspected PV role indicator	Indirect evidence of a suspected PA and suspected PV	Suspected Yes/No
6	**The nature and method of the killing, and nature of the injuries sustained by both parties raises strong suspicions that the offender was acting defensively**	Use of serious physical violence from the deceased against the offender before the death event. Offender had tried to make the deceased leave prior to the killing or had been backed into a corner. Spontaneous killing – no premeditation evident and, in some cases, the killing itself has an 'accidental' element (even if the offender has deliberately armed themselves). Weapon used readily available (kitchen knife). No overkill evident, one or two injuries. Defensive injuries present on offender.	The person who did the killing is considered the suspected PV.		

PA = predominant aggressor.

PV = primary victim.

APPENDIX 5: INTEGRATED SAFETY SYSTEM

Note: This figure is taken from pp66–67 of the *Fifth Report* of the Family Violence Death Review Committee, available www.hqsc.govt.nz/our-programmes/mrc/fvdrc/publications-and-resources/publication/2434/.



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APPENDIX 6: POSITION BRIEF, FEBRUARY 2017[154]

Six reasons why we cannot be effective with either intimate partner violence or child abuse and neglect unless we address both together

FAMILY VIOLENCE DEATH REVIEW COMMITTEE'S[1] POSITION BRIEF: FEBRUARY 2017

1 Intergenerational violence requires an intergenerational response

Many children are born into families and whānau experiencing intergenerational violence. The cumulative patterns of harm that affect their wellbeing and development may include:

- historical trauma (the ongoing legacy of colonisation)
- abuse impacting multiple generations of victims – as children and adults
- multiple forms of child abuse and neglect.

Protection for these children requires interrupting intergenerational patterns of violence and the associated transmission of trauma by providing the appropriate support to children and their families and whānau.

2 The decision to abuse a child's parent is a harmful, unsafe parenting decision

Abusive behaviour towards a partner who is a parent has a significant impact on family and whānau functioning. The decision to abuse a partner who is a parent is a decision about how to parent and it will affect how the victim will parent. Adult victims are parenting under siege. Abusive behaviour towards a partner/parent is an attack on the relationship between the adult victim and her children[2] and thwarts her ability to provide for her children's basic needs.

The impact of the partner's/parent's abusive behaviour on the overall family and whānau functioning requires assessment of housing security, maternal mental health and substance abuse, child mental health and substance abuse, extended family, whānau and community support, health care, employment and educational stability. Support is needed to rebuild the parenting relationship between adult victims and their children.

3 'Failure to protect' approaches fail to respond to both child and adult victims' safety needs

Expecting adult victims to protect their children themselves gives them the responsibility for stopping their partner's violence. This is an impossible task and fails to acknowledge the barriers (coercive control, structural violence and inequities) they face in attempting it. While adult victims generally resist the abuse of their children and themselves, this resistance does not stop their partner's violence.

Focusing on what adult victims are doing to keep their children safe diverts attention away from the partner/parent using violence. This results in a failure to assess and address the level of risk and danger his behaviour poses to both child and adult victims.

Practice influenced by a 'failure to protect' approach can unintentionally increase the likelihood of harm towards both child and adult victims. Children can be harmed by the partner/parent using violence and further harmed by being removed from the care of the adult victim who is not able to protect them.

4 Protecting children means acting protectively towards adult victims

To protect children, services must also act protectively and collaboratively towards adult victims. Safety and wellbeing for child and adult victims can only be achieved by practitioners, communities, families and whānau acting as safety allies with child *and* adult victims. Safety allies work in partnership with adult victims, and take supportive actions to maximise the safety of child and adult victims.

5 To prevent family violence, we must work with the people using violence

To prevent family violence reoccurring, we need to work with fathers, men and their communities in ways that respectfully challenge them to take responsibility for their behaviour and to be the parent their family and whānau needs. Without ongoing support to sustain behaviour changes, including trauma responses, or escalating consequences for continued abuse, a partner/parent will take his pattern of abusive behaviour into subsequent relationships. His trajectory of violence towards new partners, children, step-children and other family members may be fatal.

6 Victims' safety is a collective responsibility: it cannot be achieved by individuals or individual agencies acting alone

The complexities of the lives of those affected by family violence and violence within whānau requires the development of culturally responsive and multi-layered responses. Victims' safety is dependent on collective action taken to curtail the partner's/parent's abusive behaviour and provide appropriate support. If we wrap support around child and adult victims, their families and whānau, and curtail people's violence, then fewer children are likely to enter state care – resulting in better life outcomes for all.

1 This information is summarised from: Family Violence Death Review Committee. 2016. *Fifth Report: January 2014 to December 2015*. Wellington: Family Violence Death Review Committee. www.hqsc.govt.nz/our-programmes/mrc/fvdrc/publications-and-resources/publication/2434/.

2 In this position brief adult victims are referred to as women because women are the primary group affected as victims. Similarly, in most cases, the person using violence is male. The Family Violence Death Review Committee recognises men can be victims from their female and male partners, and that intimate partner violence (IPV) occurs in heterosexual and LGBTQI (lesbian, gay, bisexual, transgender, queer or questioning, and intersex) partnerships. While individual men can be victims of IPV, social patterns of harm reflect the fact that structural inequity and community values and beliefs support the perpetuation of male violence against women. Also see: World Health Organization. 2010. *Violence Prevention: The Evidence*. Geneva: World Health Organization. pp 79–94.

Family Violence Death Review Committee

He tao huata e taea te karo

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154 Available online at: www.hqsc.govt.nz/our-programmes/mrc/fvdrc/publications-and-resources/publication/2831.

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