NSW GOVERNMENT | Attorney General & Justice

Domestic Violence Death Review Team

Annual Report

2010-2011

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October 2011

A report of the Domestic Violence Death Review Team

A report of the Domestic Violence Death Review Team pursuant to section 101J(1) of the *Coroners Act 2009* (NSW).

The views expressed in this report do not necessarily reflect the private or professional views of individual Team members or the views of their individual organisations. A decision of the majority is a decision of the Team – Schedule 3, clause 11 *Coroners Act 2009* (NSW).

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28 October 2011

The Hon. Donald Harwin MLC
President Legislative Council
Parliament House
Macquarie St
SYDNEY NSW 2000

The Hon. Shelley Hancock
Speaker Legislative Assembly
Parliament House
Macquarie St
SYDNEY NSW 2000

Dear Mr President and Madam Speaker

2010-11 Report of the Domestic Violence Death Review Team

Pursuant to section 101J(1) of the *Coroners Act 2009*, I am pleased to submit the first Annual Report of the Domestic Violence Death Review Team for the year ending 30 June 2011.

In accordance with section 101K(2) of the Act, the Team recommends that the report be made public forthwith.

Yours sincerely

Magistrate Mary Jerram
NSW State Coroner
Convenor, Domestic Violence Death Review Team

CONVENOR'S MESSAGE

Domestic violence continues to be one of the most serious issues confronting us as a state and as a nation. The impact of domestic violence on individuals and communities is devastating. Physical, psychological and emotional trauma, homelessness, financial insecurity, and poverty are just some of the consequences of domestic violence.

Tragically, domestic violence can also lead to death and from 2003 to January 2008 there were 215 recorded domestic violence related deaths in New South Wales. Domestic violence can be fatal in other ways and this figure does not include those cases where domestic violence was a catalyst for suicide, bystanders were killed intervening in a domestic assault, or where fatal accidents were caused by domestic violence behaviour.

The overarching goal of the Domestic Violence Death Review Team is to contribute to the prevention of domestic violence deaths in New South Wales. By enhancing our understanding regarding the context and circumstances in which domestic violence deaths occur, the Team will endeavour to identify systemic issues and facilitate changes that may assist in reducing these deaths from occurring in the future.

The Team is a multidisciplinary committee and draws together senior representatives from key government and non-government service providers and sector experts. The members were appointed by the Attorney General in February this year and the committee that has been assembled brings an extraordinary wealth of experience and expertise and a steadfast commitment to fulfilling the Team's objective.

The Team met for the first time in March this year and, as is reflected in this report, has been engaged in navigating establishment issues, particularly in relation to information sharing, case identification, database construction, and case review protocols and processes. Having now worked through these foundational matters, the Team has commenced its first case reviews and the preliminary phase of data testing, the outcomes of which will be the subject of subsequent reports.

By viewing domestic violence related deaths in connection with each other, and not as isolated unrelated events, the Team is aiming to identify and redress systemic gaps and limitations and promote changes and improvements that may prevent further tragedy.

Magistrate Mary Jerram
NSW State Coroner
Convenor, Domestic Violence Death Review Team

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CHAPTER 1: BACKGROUND

1.1 INTRODUCTION

Some of the most extreme acts of violence and abuse that occur in our community take place within the family unit. Despite changing community attitudes regarding the criminality of this behaviour and decades of policy intervention, domestic violence remains one of the most serious issues confronting us as a state and as a nation.

In its most extreme form domestic violence can be fatal and while homicide remains a relatively infrequent occurrence in Australia, there is a substantial body of evidence which demonstrates that Australia's homicide demographic is significantly domestic in nature. Despite this evidence, there has not previously been a mechanism in place for the systematic review of domestic violence related fatalities.

In July 2010 the establishment of the Domestic Violence Death Review Team was announced, thereby creating a multidisciplinary committee of experts charged with the task of systematically reviewing deaths occurring in New South Wales in the context of domestic violence.

This chapter provides a brief overview of the key issues and central concepts which informed the establishment of the Domestic Violence Death Review Team and which will continue to guide the Team in its ongoing work.

1.2 DOMESTIC VIOLENCE IN AUSTRALIA

DEFINITIONS AND TERMINOLOGY

There is no single nationally or internationally agreed definition as to what constitutes 'domestic violence' with terminology varying between jurisdictions by reference to the nature of the relationships encompassed, the type of violence included, and whether gender differences between victims and perpetrators are emphasised.[1]

The term 'family violence' first emerged in the mid 1990s[2] and has achieved mainstream usage in many jurisdictions on the basis that it expands the focus of the experience of violence beyond that which occurs between intimate partners, to encompass violence within immediate and extended families.[3] In particular, the phrase 'family violence' is said to more accurately reflect the extended

[1] Office for Women's Policy, *Discussion Paper on NSW Domestic and Family Violence Strategic Framework*, NSW Department of Premier and Cabinet, 2008; Australian Bureau of Statistics, *Conceptual Framework for Family and Domestic Violence*. ABS cat. no. 4529.0, Canberra, 2009.
[2] Laing, L., *Progress, trends and challenges in Australian responses to domestic violence*, Australian Domestic and Family Violence Clearinghouse Issues Paper, Sydney, 2000.
[3] NSW Ombudsman, *Domestic Violence: Improving Police Practice*, Sydney, 2006.

nature of Aboriginal and Torres Strait Islander communities, where kinship relationships may add a layer of complexity to the concept of domestic violence.[4]

In New South Wales legislation, 'domestic violence' remains the common term and is, accordingly, adopted throughout this report to describe a pattern of behaviour whereby one person, intentionally and systematically, uses violence and abuse to gain and maintain power over another person with whom they share (or have shared) an intimate or family relationship.

At the heart of this definition is the perpetrator's use of fear to assert and maintain power and control over their victim.

DOMESTIC VIOLENCE BEHAVIOURS

Terminology aside, current Australian literature reflects a common recognition that the abuse which is used to engender fear can include a range of direct and indirect behaviours, including:

Physical abuse – [actual or threatened] including: any assault on the body (strangulation or choking, shaking, eye injuries, slapping, pushing, spitting, punching, or kicking); driving dangerously; destruction of property; abuse of pets in front of family members; denial of sleep, warmth or nutrition; denial of needed medical or personal care;

Sexual abuse – [actual or threatened] including: any form of sexual assault or sexual activity without consent; causing pain during sex; coercive unsafe sex; forcing the victim to pose for or watch pornography; forcing the victim to perform sexual acts; criticising or using sexually degrading insults;

Verbal abuse – including: swearing and continual humiliation, either in private or in public, with attacks following clear themes that focus on intelligence, sexuality, body image and capacity as a parent and partner.

Social abuse – including: systematic isolation from family and friends through techniques such as ongoing rudeness to family and friends to alienate them; instigating and controlling the move to a location where the victim has no established social circle or employment opportunities; forbidding or physically preventing the victim from going out and meeting people; and deliberately creating dependence;

Economic abuse – complete control of all finances, including: deprivation of basic necessities; seizure of income or assets; forbidding access to bank accounts; not allowing the victim to seek or hold employment; using all wages earned by the victim for household expenses; making the victim responsible for debts that are not their own;

Psychological abuse – including: making threats regarding custody of any children; asserting that the police and justice system will not assist, support or believe the victim; and denying an individual's reality.

4 Office for Women's Policy, *Discussion Paper on NSW Domestic and Family Violence Strategic Framework*, NSW Department of Premier and Cabinet, 2008.

Emotional abuse – including: blaming the victim for all adverse events; constantly comparing the victim with others to undermine self-esteem and self-worth; sporadic sulking; withdrawing all interest and engagement (for example weeks of silence); and

Spiritual abuse – including: denial and/or misuse of religious beliefs or practices to force victims into subordinate roles; or misuse of religious or spiritual traditions to justify physical violence or other forms of abuse.[5]

Domestic violence offences in New South Wales

The laws in each state and territory differ in relation to which domestic violence behaviours constitute a criminal offence.

In New South Wales, the principal legislation relating to domestic violence-specific offences is the *Crimes (Domestic and Personal Violence) Act 2007*.

The *Crimes (Domestic and Personal Violence) Act* defines a 'domestic violence offence' as:

> *a personal violence offence committed by a person against another person with whom the person who commits the offence has or has had a domestic relationship.* [6]

A 'personal violence offence' is defined by reference to a large number of criminal offences in the *Crimes Act 1900* (NSW)[7] as well as stalking or intimidation offences set out in the Act.[8]

Numerous types of relationships are recognised within the category of 'domestic relationship' including: marriage and de facto partnerships; intimate personal relationships; living or having lived in the same household; long term residents in the same residential facility; carers; relatives; and extended family or kin in the case of Aboriginal Australians.[9] It does not matter whether the relationship is past or current.

Regardless of whether a perpetrator's conduct constitutes a domestic violence offence, all domestic violence behaviours are unacceptable and every person has the right to live their life safely and free from fear.

[5] National Council to Reduce Violence against Women and their Children, *Background Paper to Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009-2021*, Commonwealth of Australia, March 2009; Australian Bureau of Statistics, *Conceptual Framework for Family and Domestic Violence*. ABS cat. no. 4529.0, Canberra, 2009.
[6] *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 11.
[7] Ibid s 4.
[8] Ibid s 13.
[9] Ibid s 5.

PREVALENCE OF DOMESTIC VIOLENCE IN AUSTRALIA

Domestic violence is a complex phenomenon that knows no geographical, socio-economic, age, ability, cultural or religious boundaries.[10] It is perpetrated by parents against children, by adult children against parents, between siblings and other family members, and between heterosexual and same sex intimate partners.

Both women and men can be perpetrators and/or victims however research demonstrates that overwhelmingly the majority of domestic violence is perpetrated by males against females.[11]

While underreporting of domestic violence makes it difficult to determine its true extent, a number of studies have endeavoured to identify and examine the incidence and prevalence of domestic violence within the Australian community.

In 2006, the Australian Bureau of Statistics published the findings of the *Personal Safety Survey 2005* (PSS), a national survey of 16,400 Australian adults, capturing information about people's safety at home and in the community and, in particular, the nature and extent of violence against people in Australia. [12]

The PSS found that in the 12 months prior to the survey, an estimated:

- 5.8% of women and 10.8% of men had experienced some form of violence (physical or sexual, actual or threatened);
- 4.7% of women and 10% of men had experienced physical violence; and
- 31% of the women who had experienced physical violence were assaulted by a current and/or previous partner, compared to 4.4% of men. [13]

The PSS estimated that from the age of 15 years:

- 39.9% of women and 50.1% of men had experienced some form of violence;
- 29% of women and 41% of men had experienced physical assault;
- 17% of women and 4.8% of men had experienced sexual assault;
- 15% of women had experienced violence from a previous partner, compared with 4.9% of men; and
- 2.1% of women had experienced violence from a current partner, compared to 0.9% of men.[14]

The survey showed that while a small proportion of men are victims of domestic violence and sexual assault, the majority of people who experience this kind of violence are women, in a home, at the hands of men they know. Men, on the other hand, are more likely to be the victims of violence

[10] National Council to Reduce Violence against Women and their Children, *Background Paper to Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009-2021*, Commonwealth of Australia, March 2009.
[11] Australian Bureau of Statistics, *Personal safety survey Australia 2005*, ABS cat. no. 4906.9, Canberra, 2006.
[12] Ibid.
[13] Ibid.
[14] Ibid.

from strangers and in public, and accordingly different strategies are required to address these different types of violence.[15]

The International Violence Against Women Survey (IVAWS) is an international comparative survey designed to collect information from women aged between 18 and 69 regarding their experiences of violence, and in particular domestic violence and sexual assault.[16]

Utilising comparative methodology developed for the International Crime Victim Survey, the objective of the IVAWS project is to assess the level of victimisation of women in a number of countries world-wide, on a repeatable basis, with a view to informing the development of specific criminal justice responses.[17]

The IVAWS was conducted across Australia between December 2002 and June 2003, with almost 7,000 Australian women providing information about their experiences of physical and sexual violence.[18]

The IVAWS found that:

- 57% of women reported experiencing at least one act of physical or sexual violence by a man over their lifetime;
- 34% of women who had a current or former intimate partner had experienced at least one form of violence during their lifetime from an intimate male partner; and
- 37-40% of women in current relationships reported experiencing at least one type of controlling behaviour from their intimate partner (including name calling, insults or 'put downs', limiting contact with friends, and tracking whereabouts).[19]

The findings also demonstrated that while domestic violence pervades all aspects of society, the experience of violence across the community is not evenly spread.[20] For example, Indigenous women reported higher levels of physical violence during their lifetime than did non-Indigenous women, and the violence was more likely to include sexual violence. [21]

Other groups may also experience violence in a different and/or disproportionate way, for example: women with disability; women who identify themselves as lesbian, bisexual, transgender or intersex; and immigrant women.[22]

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[15] National Council to Reduce Violence against Women and their Children, Background Paper to Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009-2021, Commonwealth of Australia, March 2009.
[16] Mouzos, J. & Makkai, T., Women's experience of male violence: Findings from the Australian component of the international violence against women survey (IVAWS). Research and public policy series no. 56, Australian Institute of Criminology, Canberra, 2004.
[17] The European Institute for Crime Prevention and Control, affiliated with the United Nations (HEUNI), http://www.heuni.fi/Etusivu/Researchareas/Violenceagainstwomen/1198084791730, accessed October 2011.
[18] Ibid.
[19] Ibid.
[20] NSW Law Reform Commission, Family Violence: A National Response, Report 128, 2010.
[21] Ibid.
[22] Ibid.

Prevalence of domestic violence in New South Wales

While similar issues of underreporting mask the true incidence of domestic violence in NSW, some data are available that give an indication of the extent of the problem.

A recent report by the Bureau of Crime Statistics and Research examined the trends and patterns in domestic violence assaults in NSW from 2001 to 2010.[23] The report, which updates and extends a similar analysis conducted in 2005, found that in 2010, 39.7% (26,006) of all recorded assaults and 32.5% (9,386) of all recorded incidents of harassment, threatening behaviour and private nuisance were considered to be domestic violence related.

The rate of domestic assault increased between 2001 and 2003 before stabilising. By comparison, non-domestic assaults have been gradually declining over the reporting period.[24]

Females were more likely to be victims of a domestic assault than males (69.2% vs. 30.8%) and nearly half (48.3%) of all domestic assaults involved a female victim and a male offender who were in a partner relationship. Three quarters of domestic assault victims were women and children.[25]

The report found that overall the key patterns of domestic assault remained unchanged since the 2005 analysis.[26]

Reporting and help seeking

As noted above, the majority of domestic violence victims do not report the violence to police.

The *Personal Safety Survey* found that 63% of women who experienced physical violence by a current or former male intimate partner did not report the most recent assault to police.[27]

Some of the reasons for not reporting domestic violence include:

- the victim does not consider it serious enough;
- the victim dealt with it him/herself;
- the victim wants to keep the matter private, is ashamed or embarrassed;
- the victim is afraid of the offender;
- the victim does not think the police could or would do anything about it;
- community attitudes;
- the victim blames him/herself;
- the victim does not realise that help is available;
- the victim wants, or is under pressure, to keep the family together;
- the victim is financially dependent on his/her partner;
- alcohol or drug use;

[23] Grech, K. & Burgess, M., *Trends and patterns in domestic violence assaults: 2001 to 2010* Bureau Brief No. 42, NSW Bureau of Statistics Crime and Research, Sydney, 2010.
[24] Ibid.
[25] Ibid.
[26] Ibid.
[27] Australian Bureau of Statistics, *Personal safety survey Australia 2005*, ABS cat. no. 4906.9., Canberra, 2006.

- police officers know or are friends with the perpetrator;
- cultural differences are used to justify, hide or explain the abuse;
- the perpetrator may present as a victim or make a counter-claim; and
- mental health issues for either or both the victim or the perpetrator. [28]

CONSEQUENCES OF DOMESTIC VIOLENCE

Domestic violence has a devastating impact on individual victims, their families and friends, and the wider community. Domestic violence may result in social, psychological, health and financial consequences that have a profoundly negative impact on a victim's quality of life and significant flow-on effects for the local and broader community.

The social and health consequences experienced by domestic violence victims include: mental health problems; physical stress symptoms; suicide attempts and self harming behaviour; alcohol and drug misuse; unemployment; and homelessness.[29]

Research undertaken by VicHealth found that violence perpetrated by an intimate partner is the leading risk factor of death, disability, and illness for Victorian women aged 15 to 44 years.[30]

Domestic violence has a significant economic impact, both directly to victims and their families, and to the community at large.

In 2004, Access Economics reported the estimated total annual cost of domestic violence to the Australian economy in 2002–03 was $8.1 billion. The largest contributor was pain, suffering and premature mortality at $3.5 billion. The remaining costs totalled $4.6 billion. The largest part was consumption costs, of which the largest component was lost household economies of scale. The next largest categories were production and administration at $484 million and $480 million respectively.[31]

In its most extreme form, domestic violence can be fatal and while homicide remains a relatively infrequent occurrence in Australia, there is a substantial body of evidence which demonstrates that Australia's homicide demographic is significantly domestic in nature.

1.3 DOMESTIC HOMICIDE IN AUSTRALIA

The Australian Institute of Criminology, through the National Homicide Monitoring Program (NHMP), has been monitoring trends and patterns of homicide across Australia since 1989.

[28] Drabsch, T., *Domestic Violence in NSW*, Briefing paper no 7/07, NSW Parliamentary Library Research Service, 2007.
[29] Laing, L., *Progress, trends and challenges in Australian responses to domestic violence*, Australian Domestic and Family Violence Clearinghouse Issues Paper, Sydney, 2000.
[30] VicHealth, *The Health Costs of Violence: Measuring the Burden of Disease Caused by Intimate Partner Violence*, Victorian Health Promotion Foundation, Carlton South, 2004.
[31] Access Economics Pty Ltd, *The Cost of Domestic Violence to the Australian Economy*, Commonwealth of Australia, Canberra, 2004.

The NHMP classifies homicides into three primary categories according to the principle relationship shared between the victim and the offender, namely:

Domestic homicide: the killing of a family member or other person from a domestic relationship, including the following sub-classifications:

Intimate partner homicide - where the victim and offender share a current or former intimate relationship, including homosexual and extramarital relationships;

Infanticide - where a mother suffering post-natal mental health issues kills an infant less than one year of age;

Filicide - where a custodial or non-custodial parent (including step-parent) kills a child (not including infanticide);

Parricide - where a child kills a custodial or non-custodial parent or step-parent;

Sibilicide - where one sibling kills another; and

Other family homicide - where the victim and offender are related by another familial relationship

Acquaintance homicide: a homicide where the victim and offender were known to each but were not related to each other, nor living in a domestic relationship; and

Stranger homicide: a homicide where the victim and offender were not known to each other.[32]

Between 2007 and 2008 there were 260 homicides in Australia which resulted in 273 victim deaths, 112 females and 161 males.[33]

Over half of all homicide victims for this period were killed by a person with whom they shared a current or former domestic/family relationship (n=144, 53%), followed by an acquaintance, stranger, and unclassified (see Fig. 1).

Of the 144 domestic homicide victims, 87 were female and 57 male. Over three-quarters (78%) of all female homicides victims were, therefore, killed by someone with whom they shared a current or former domestic relationship. By comparison, males were more frequently killed by an acquaintance (42%), followed by a person with whom they shared a domestic relationship (35%).

Analysis of the sub-classification of domestic homicides shows that over half (56%) of all domestic homicide victims were killed by a person with whom they shared a current or former intimate relationship, followed by filicide, parricide, other family homicide, sibilicide and finally infanticide (see Fig. 2).

Of the 80 intimate partner homicide victims, 62 were female and 18 male. Accordingly, 71% of female domestic homicide victims, and over half of all female homicide victims (55%), were killed by a current or former intimate partner. By comparison, 32% of male domestic homicide victims and 11% of male homicide victims overall were killed by a current or former intimate partner.

[32] Virueda, M. & Payne, J., *Homicide in Australia: 2007 – 08 National Homicide Monitoring Program annual report*, Monitoring Report No. 13, Australian Institute of Criminology, Canberra, 2010.
[33] Ibid. This figure includes 40 juveniles, 24 boys and 16 girls.

Domestic homicide in New South Wales

An examination of the homicides in New South Wales for the same reporting period reveals figures consistent with the national data.

Of the 98 homicide victims in New South Wales in 2007-08, just over half were killed by a person with whom they shared a current or former domestic/family relationship (n=50, 51%), followed by an acquaintance, stranger, and unclassified (see Fig. 3).

Of the 50 domestic homicide victims, 30 were female and 20 male. The vast majority (81%) of all female homicide victims were, therefore, killed by a person with whom they shared a current or former domestic relationship. Again, males were more frequently killed by an acquaintance (36%, followed by a person with whom they shared a domestic relationship (33%).

Analysis of the sub-classification of domestic homicides for New South Wales shows that half of all domestic homicide victims were killed by a person with whom they shared a current or former intimate relationship, followed by filicide, parricide, sibilicide, and finally other family homicide (see Fig. 4). It is noted that for the 2007-08 reporting period there were no recorded infanticide fatalities in New South Wales.

Of the 25 intimate partner homicide victims, 20 were female and 5 male. Accordingly, two-thirds of female domestic homicide victims, and over half of all female homicide victims (54%), were killed by a current or former intimate partner. By comparison, 25% of male domestic homicide victims and 8% of male homicide victims overall were killed by a current or former intimate partner.

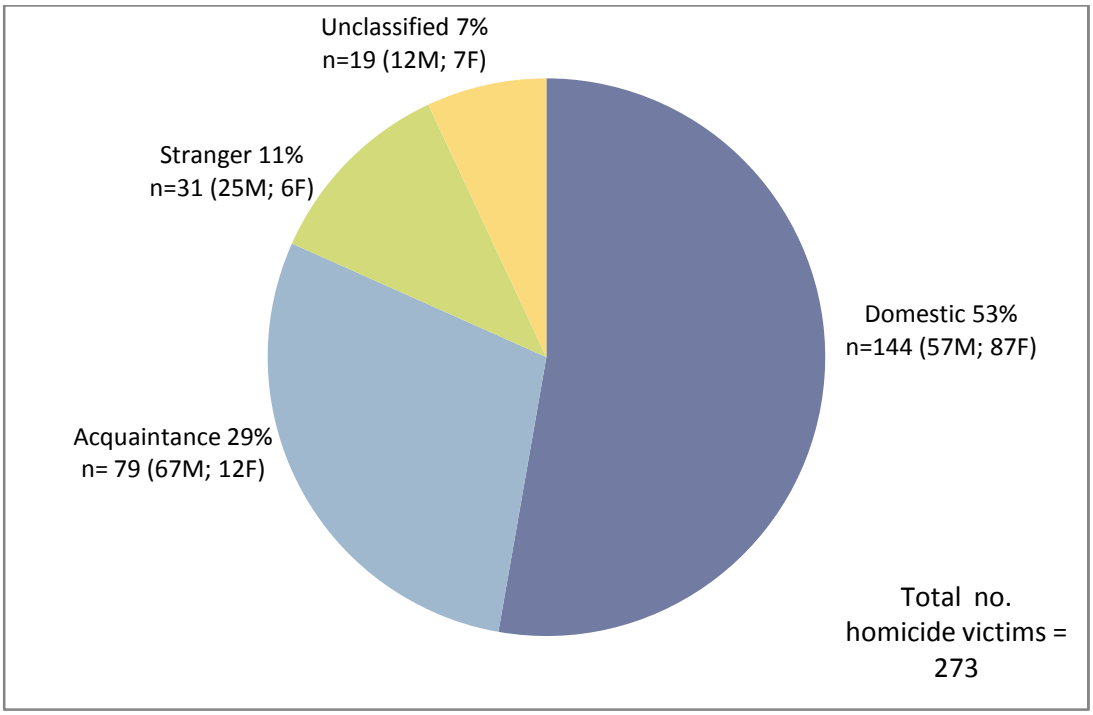
These figures are consistent with the findings from a Bureau of Crime Statics and Research report which examined trends and characteristics of domestic homicides in NSW over the period January 2003 to June 2008.[34]

Over the five year reporting period, there were 215 victims of domestic homicide, 115 females and 100 males.[35] Of the 215 domestic homicide victims, 93 (43%) were killed by a person with whom they shared a current or former intimate relationship, 70 females and 23 males. Accordingly, intimate partner homicide accounted for 61% of female domestic homicides and 23% of male domestic homicides.[36]

Over the past decade the rate of homicide has been generally declining, at both a state and national level. However, this is primarily because of a decrease in the number of acquaintance homicides with overall rates of domestic homicide remaining stable.[37]

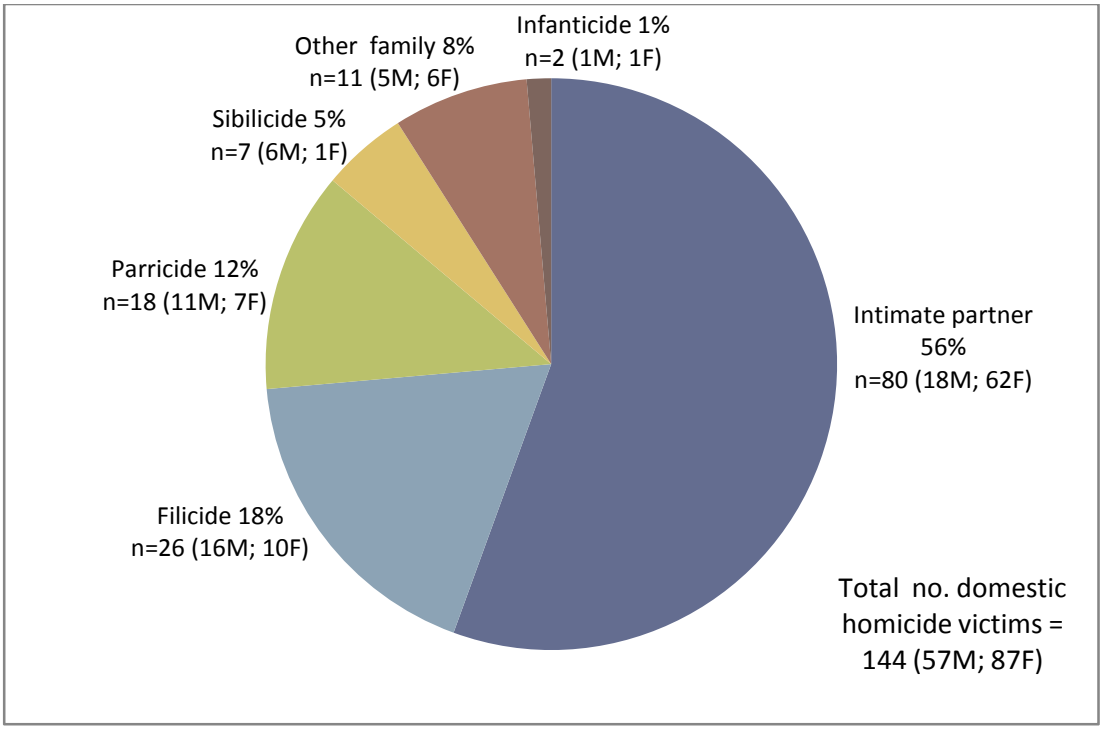
[34] Ringland, C. & Rodwell, L., *Domestic Homicide in NSW, January 2003-June2008*. Issues paper no. 42, NSW Bureau of Crime Statistics and Research, Sydney, 2009.
[35] It is noted that in the BOCSAR report, the definition of 'domestic relationship' is based on the *Crimes (Domestic and Personal Violence) Act 2007* and is broader than that used by the NHMP.
[36] Ringland, C. & Rodwell, L., *Domestic Homicide in NSW, January 2003-June2008*. Issues paper no. 42, NSW Bureau of Crime Statistics and Research, Sydney, 2009.
[37] Virueda, M. & Payne, J., *Homicide in Australia: 2007 – 08 National Homicide Monitoring Program annual report*, Monitoring Report No. 13, Australian Institute of Criminology, Canberra, 2010.

Fig. 1 Homicide in Australia 2007-2008, Classification



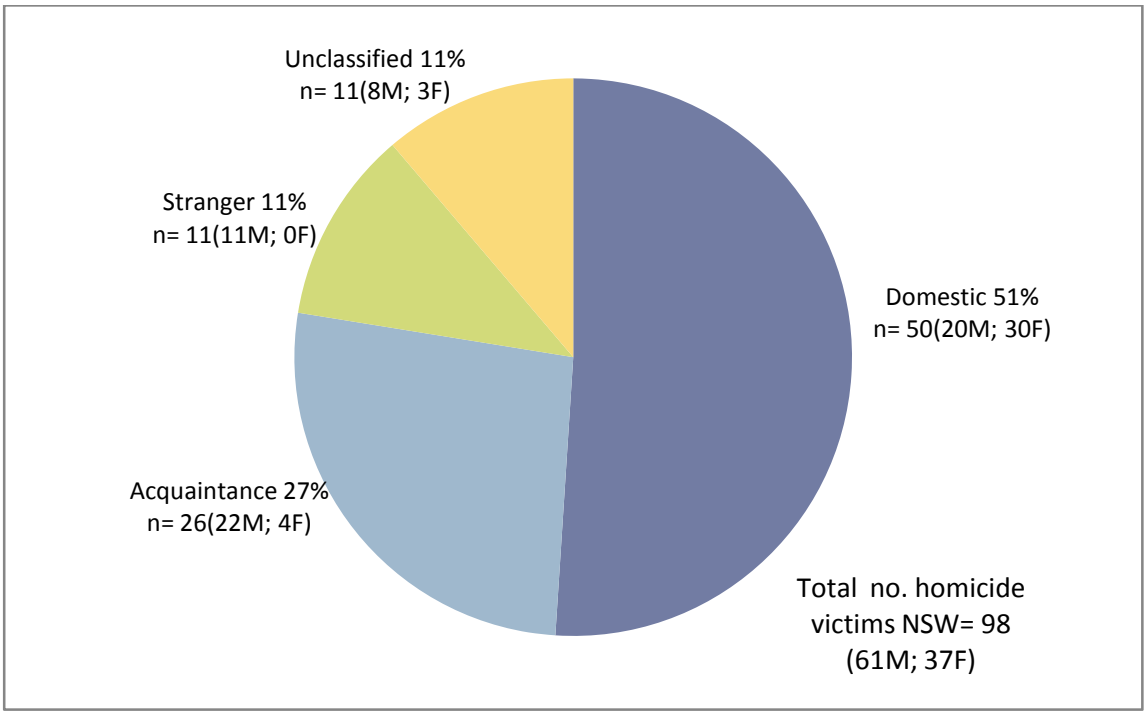
Source: AIC NHMP 2007-08 [computer file]

Fig. 2 Domestic homicide in Australia 2007-2008, Sub classification



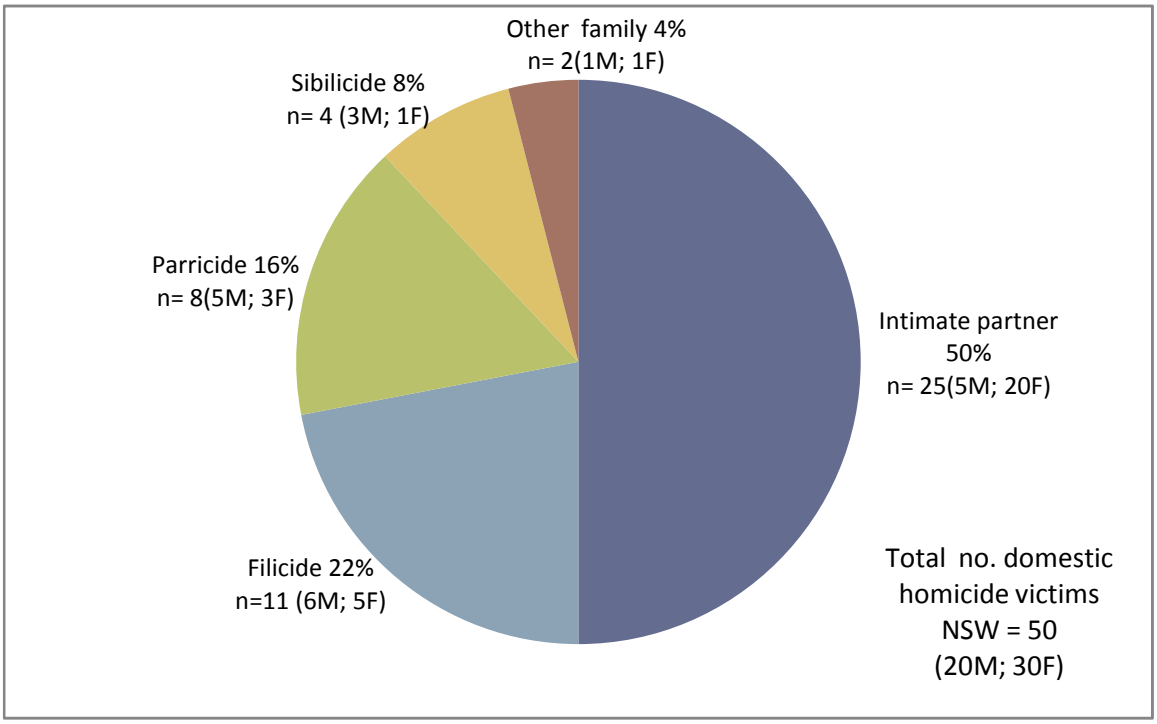
Source: AIC NHMP 2007-08 [computer file]

Fig. 3 Homicide in New South Wales, 2007-2008, Classification



Source: AIC NHMP 2007-08 [computer file]

Fig. 4 – Homicide in New South Wales, 2007-2008, Sub-classification



Source: AIC NHMP 2007-08 [computer file]

1.4 DOMESTIC VIOLENCE DEATH REVIEW TEAMS

RATIONALE, DEVELOPMENT & OBJECTIVE

Despite the high prevalence of deaths occurring between intimate partners and family members, there has not previously been a mechanism for the systematic review of domestic homicides in New South Wales.

Domestic homicides warrant particular attention, not only because of their high prevalence, but because they are seldom without warning.

Research has found that a history of domestic violence is a common feature in a high proportion of domestic homicides, particularly in relation to intimate partner homicide.[38] In many cases the death is the end result of a culmination of numerous prior acts of domestic violence. Such 'domestic violence deaths' have predictive elements to them and when viewed as the escalation of a foreseeable pattern of behaviour, can be regarded as preventable.[39]

In many jurisdictions, the growing perception of domestic violence deaths as predictable and preventable has led to the establishment of domestic violence death review teams - multi-agency committees whose overarching goal is to reduce the incidence of deaths occurring in a context of domestic violence by improving service delivery to domestic violence victims and perpetrators.[40]

Review teams conduct comprehensive analysis of domestic violence deaths and collect and collate extensive data about these cases. By examining the demographics of the victim and perpetrator, the events prior to the death, and the circumstances surrounding the death, review teams aim to:

- identify trends and patterns about domestic homicides;
- identify and understand any limitations or weaknesses in service delivery;
- make recommendations to rectify such limitations; and
- develop and promote further intervention and prevention strategies so as to reduce the likelihood of deaths occurring in similar circumstances in the future.[41]

Review teams first began to emerge in the United States in the early 1990s in response to a high prevalence of domestic violence related deaths and amidst a growing concern that agencies at the frontline of domestic violence service delivery were failing to adequately coordinate and provide care and protection to victims of domestic violence.[42]

Since that time, review teams have been established in Canada, New Zealand, and the United Kingdom and despite significant jurisdictional differences in relation to their constitution, review

[38] Aldridge, M. & Browne, K., Perpetrators of Spousal Homicide: A Review, *Trauma, Violence & Abuse* , vol. 4 no. 3, 2003.
[39] David, N., *Exploring the Use of Domestic Violence Fatality Review Teams*, Australian Domestic & Family Violence Clearinghouse Issues Paper no 15, Sydney, 2007.
[40] Ibid.
[41] Ibid.
[42] Ibid.

criteria and mode of operation, each review team is underpinned by a common objective and a shared philosophy.

Review teams adopt a non-judgmental, 'no blame' philosophy. The purpose of a review team is holistic, positive, and forward looking - focussing on systemic and procedural issues, not the actions or negligence of individuals. It is the operating procedures, laws and systems in place at the time of the death that come under scrutiny.[43]

Review teams seek to provide a better understanding of agencies' roles and constraints in responding to domestic violence, and to identify where resources need to be focused and what is needed to implement change.[44]

Review teams recognise that reducing and preventing domestic violence and domestic violence deaths requires communication, cooperation, and collaboration between the various domestic violence response agencies, that have traditionally worked separately and sometimes at odds with each other.[45] By promoting an environment of information sharing and partnership, review teams seek to help agencies improve their capacity to respond to potentially fatal situations.

CALL FOR A NSW DOMESTIC VIOLENCE DEATH REVIEW TEAM

From the early 2000s advocates began campaigning for a domestic violence death review process to be established in New South Wales.

By the mid 2000s this call was garnering support from various government agencies. The NSW Ombudsman's 2006 report into policing of domestic violence indicated support for the establishment of review process on the basis that it would improve the collective understanding and knowledge of agencies about how domestic homicides occur and what strategies and practices may reduce the risk of their occurrence.[46]

This period also saw the development of a broad range of strategic initiatives aimed at tackling the issue of domestic violence, including:

- the introduction of the Staying Home Leaving Violence program;
- the establishment of the Domestic Violence Intervention Court Model pilot;
- the expansion of the Legal Aid Women's Domestic Violence Court Advocacy Service;
- the commencement of the *Crimes (Domestic and Personal) Violence Act 2007*; and
- the release of the NSW Domestic and Family Violence Strategic Framework discussion paper.

[43] Report of the Domestic Violence Homicide Advisory Panel, 2009, http://www.ipc.nsw.gov.au/lawlink/Corporate/ll_corporate.nsf/vwFiles/251109_domestic_violence.pdf/$file/251109_domestic_violence.pdf, accessed October 2011.
[44] Ibid.
[45] Ontario Domestic Violence Death Review, Annual Report to the Chief Coroner, 2002, http://www.crvawc.ca/documents/DVDRC%202002%20Report.pdf, accessed October 2011.
[46] NSW Ombudsman, *Domestic Violence: Improving Police Practice*, Sydney, 2006.

The Domestic Violence Homicide Advisory Panel

Against this background, and in the wake of a number of highly publicised domestic violence related fatalities, in December 2008 the Government convened the Domestic Violence Homicide Advisory Panel to address the issue of establishing a domestic violence fatality review process in NSW.

To assist and inform the Panel in its task, the NSW Bureau of Crime Statistics and Research (BOCSAR) was asked to conduct an analysis of trends and patterns in domestic violence related fatalities in NSW over a five-year period, the report of which was referred to earlier in this chapter.[47]

The Domestic Violence Homicide Advisory Panel's terms of reference were to develop an appropriate definition of domestic violence related homicide; consider the findings of the BOCSAR review; and consider the merit, key elements and best practice model of an ongoing review mechanism for NSW.

The Panel handed down its report in mid 2009, unanimously recommending that a permanent domestic violence death review team be established in NSW and setting out the essential functions and features of such a review mechanism. The critical element identified by the Panel was the need for a strong legislative framework that clearly defines the review's objectives and terms of reference, and addresses issues around confidentiality, access to information, and protection from liability.

It is noted that the commencement of the Panel's work in December 2008 coincided with the announcement by the Victorian government that a Systemic Review of Family Violence Deaths would be undertaken through the Coroners Prevention Unit (CPU).

The CPU is a specialist service that was established in October 2008 with the primary aim of strengthening the prevention role of coroners. The CPU is comprised of investigative teams that deal with the prevention of deaths caused intentionally; unintentionally; as well as deaths that occur in a healthcare setting. The Intentional Death Investigation Team oversees the family violence death review, which effectively became operational in May 2009, the first of its kind in Australia.[48]

On 25 November 2009, the Government formally announced the establishment of an ongoing domestic violence death review process for New South Wales, to be convened by the NSW State Coroner and to commence operation in 2010.[49]

[47] Ringland, C. & Rodwell, L., Domestic Homicide in NSW, January 2003-June2008. Issues paper no. 42, NSW Bureau of Crime Statistics and Research, Sydney, 2009.

[48] While there are significant differences between the Victorian and NSW review mechanisms, the CPU has provided extremely valuable assistance and advice to NSW Domestic Violence Death Review Team throughout its establishment phase, for which the Team extends its gratitude.

[49] Domestic violence death reviews have also very recently been established within the coronial jurisdictions of Queensland, and South Australia. Review Teams in all Australian jurisdictions will be extremely valuable partners for the New South Wales review process

CHAPTER 2: ESTABLISHMENT OF THE NSW DOMESTIC VIOLENCE DEATH REVIEW TEAM

2.1 INTRODUCTION

On 16 July 2010 the *Coroners Amendment (Domestic Violence Death Review Team) Act 2010* commenced, amending the *Coroners Act 2009* (the Act) by inserting Chapter 9A and thereby establishing the Domestic Violence Death Review Team (the Team). Chapter 9A of the Act is set out at Annexure A.

The Act sets out in detail the Team's functions, powers, constitution, confidentiality and access to information, thereby giving effect to the Advisory Panel's recommendation regarding the essential features necessary to ensure the effectiveness of a review mechanism.

This Chapter provides an overview of the key elements of the Team's legislative framework in the context of some of the background issues identified in Chapter 1.

2.2 OBJECTIVE

The Team's overarching objective or mandate is to provide for the investigation of the causes of domestic violence deaths in New South Wales, so as to:

- reduce the incidence of domestic violence deaths, and
- facilitate improvements in systems and services.[50]

This objective emphasises the 'no blame' approach of the Team and makes clear that the focus is on improving service responses to domestic violence.

A key focus of the Team will be to promote inter-agency collaboration, co-operation and communication to identify systemic and procedural deficiencies, as opposed to focussing on the negligence or actions of individuals or individual agencies.

2.3 DEFINITIONS

The Team's legislative definition of a *domestic violence death* is:

> *the death of a person that is caused directly or indirectly by a person who was in a domestic relationship with the deceased person.*[51]

Adopting the recommendations of the Advisory Panel, this definition recognises that domestic violence can be fatal in many ways, both directly and indirectly. It provides that not only domestic

[50] *Coroners Act 2009* (NSW) s 101A.
[51] Ibid s 101B(1).

violence homicides fall within the purview of the Team's work, but also those cases where fatal accidents were caused by domestic violence behaviour , or where domestic violence was a primary catalyst for suicide.

It is acknowledged that the complexity of human behaviour is such that identifying and reviewing cases of suicide where domestic violence is determined to be a significant contributing factor does present unique challenges. However, the relationship between suicide and experiences of domestic violence has long been recognised and a solid research base has identified domestic violence as one of the most important precipitants of female suicide.[52] It is critical, therefore, that the Team adopts an inclusive definition so that this class of domestic violence death is not overlooked.

A broad definition of 'domestic relationship' is adopted to ensure that a comprehensive range of deaths occurring in a domestic violence context fall within the operational scope of the Team, and includes a variety of current and former intimate partnerships, family members, and extended family or kin where kinship is relevant to a person's culture.[53]

2.4 CONSTITUTION

The Team is convened by the NSW State Coroner, Magistrate Mary Jerram, and is constituted by representatives from key government stakeholders, including law enforcement, justice, health and social services, as well as four representatives from non-government agencies (see Annexure B for full membership details).[54]

The eleven Government representatives were nominated by the Minister responsible for their individual agencies. The four non-Government representatives were selected following a publicly advertised Expression of Interest process and were chosen for their demonstrated experience and expertise in the area of domestic violence and for their ability to provide relevant expert advice and guidance to the Team.

The convenor and Team members were appointed by the Attorney General on 18 February 2011 for a period of two years.

Indigenous representatives and appointment of experts

The over-representation of Indigenous people as victims and perpetrators of domestic violence and domestic homicides has been widely documented.

In relation to domestic assault, such over-representation has not changed over the last decade and research continues to show that Indigenous women experience domestic assault at six times the

[52] Stewart, S., *Interpersonal violence, suicide & cultural diversity – what are the links?*, Australian Domestic and Family Violence Clearinghouse Newsletter 20, Sydney, 2004.
[53] *Coroners Act 2009* (NSW) s 101C.
[54] Ibid s 101E.

rate of non-Indigenous women.[55] Similarly, in 2006/07, Indigenous women were reported to be nine times as likely as their non-Indigenous counterparts to be a victim of homicide.[56]

The Team includes members with experience and expertise in relation to issues affecting the Indigenous community and this will promote the development of recommendations that are culturally specific and sensitive.

To further support the Team in making recommendations and developing intervention and prevention strategies that are both relevant and appropriate, the Convenor may engage experts to advise and assist the Team in the exercise of its functions.[57]

Currently, the Manager and an administrative assistant make up the Team's secretariat. The Team's budget allocation also provides for a research/analyst position and, as the Team has now moved out of its establishment phase and is effectively operational, recruitment for that position is currently being progressed.

2.5 FUNCTIONS

The core functions of the Team are to:

- review and analyse individual closed cases of domestic violence deaths;[58]
- establish and maintain a database so as to identify patterns and trends relating to such deaths; and
- develop recommendations and undertake research that aims to prevent or reduce the likelihood of such deaths.[59]

By synthesizing and analysing information gathered in the course of carrying out these functions, the Team will aim to identify key themes and systemic issues in relation to domestic violence deaths in New South Wales.

Where appropriate, the Team will formulate recommendations with respect to legislation, policies, practices and services, for implementation by government and non-government agencies and the community, in order to achieve its ultimate objective of reducing the incidence of such deaths.

[55] Grech, K. & Burgess, M., *Trends and patterns in domestic violence assaults: 2001 to 2010* Bureau Brief No. 42, NSW Bureau of Statistics Crime and Research, Sydney, 2010.
[56] Ringland, C. & Rodwell, L., Domestic Homicide in NSW, January 2003-June2008. Issues paper no. 42, NSW Bureau of Crime Statistics and Research, Sydney, 2009.
[57] *Coroners Act 2009* (NSW) s 101I(1).
[58] A domestic violence death is defined as 'closed' if the coroner has dispensed with or completed an inquest concerning the deaths, and any criminal proceedings (including appeals) concerning the death have been finally determined: *Coroners Act 2009* (NSW) s 101B(2).
[59] *Coroners Act 2009* (NSW) s 101F(1).

When conducting reviews of closed domestic violence deaths, the Team is to have regard to:

- the circumstances surrounding and the events leading up to the death of the deceased person;
- any interaction with, and the effectiveness or otherwise of, support or other services provided for, or available to, victims and perpetrators of domestic violence;
- the general availability of those services, and
- any failures in systems or services that may have contributed to, or failed to prevent, the domestic violence death.[60]

Case reviews are a powerful process because they bring together case-specific facts and experienced domestic violence stakeholders who can contextualize and effectively analyse those facts. This process creates a unified forum for shared ideas and critical thinking, and is a vital link in a community's coordinated response to domestic violence.

2.6 ACCESS TO AND CONFIDENTIALITY OF INFORMATION

The effective operation of the Team relies on its ability to obtain as much information as possible about those affected by domestic violence deaths.

In this regard, the Advisory Panel made specific recommendations, identifying as critical for any review: the ability for the review mechanism to compel information from relevant agencies; immunity to those who disclose information to the review that would ordinarily be confidential or privileged; exemptions from freedom of information legislation; protection from disclosure in legal proceedings; and a requirement that members are bound by confidentiality provisions.

Each of these key elements is reflected in the Team's legislative framework which sets out extremely detailed provisions addressing:

- the duty of a person to assist the Team; [61]
- issues relating to confidentiality; [62] and
- protection from liability.[63]

Each 'Team related person'[64] has signed a confidentiality agreement acknowledging that they will observe the confidentiality provisions of the Act (see Annexure C).

[60] Ibid s 101G.
[61] Ibid s 101L.
[62] Ibid s 101M.
[63] Ibid s 101O.
[64] Ibid s 101M(5).

2.7 MEETINGS

The Team held its inaugural meeting on 29 March 2011, and is to meet no less than four times each calendar year.[65]

Subsequent meetings have been held on 7 June 2011 and 13 September 2011, and the final meeting for 2011 is scheduled for 13 December 2011.

[65] Ibid sch 3 cl 8.

CHAPTER 3: OPERATION OF THE DOMESTIC VIOLENCE DEATH REVIEW TEAM

3.1 INTRODUCTION

As discussed in the previous sections, the Act provides an essential framework to guide the work of the Team. There remains, however, considerable operational scope in relation to how the Team approaches the task of fulfilling its legislative functions.

This Chapter describes the processes and protocols the Team has developed in relation to its core activities of data collection and case review.

3.2 DATABASE FRAMEWORK

SCOPE OF INQUIRY

Without detracting from the seriousness or tragedy of domestic violence deaths, from a statistical perspective they are relatively rare. It is, therefore, difficult to collect sufficient data to identify patterns, trends, and risk factors associated with characteristics of the incidents, victims and offenders.

To overcome these research challenges and to ensure as robust a dataset as possible, retrospective surveillance is conducted, capturing information from domestic violence deaths occurring on or after 1 July 2000. This date is referrable to the introduction of one of the key case identification tools, discussed below.

The complexity of identifying 'domestic violence suicides' has been raised in the previous section and this category of death will be considered once the first phase of database testing is completed and the case review process is settled.

CASE IDENTIFICATION

As discussed in Chapter 2, the Team is charged with the task of examining closed domestic violence deaths which are defined by reference to the relationship between the deceased and the person who, directly or indirectly, caused their death (the perpetrator).[66]

To build the dataset of domestic violence deaths from 1 July 2000, therefore, requires retrospective surveillance of all unnatural and violent deaths[67] caused by a perpetrator, to determine the relationship between the perpetrator and the deceased.

[66] The term 'perpetrator' is used to describe the person who causes the death although it is noted that a person who has been the victim of domestic violence may be the perpetrator of a domestic violence death.

Such 'unnatural and violent' deaths for the relevant timeframe are identified using the following resources:

- the National Coroners Information System;
- Coroner's Courtnet; and
- NSW Caselaw.

The National Coroners Information System

The National Coroners Information System (NCIS) is a national internet based data storage and retrieval system which stores information about every death reported to an Australian coroner since 1 July 2000.[68] While primarily a tool to assist coroners, approved research and government agencies also utilise the NCIS to obtain information to assist in the development of community health and safety strategies. The NCIS is based at and managed by the Victorian Institute of Forensic Medicine and is funded by a number of different Commonwealth and State/Territory agencies.[69]

For every reportable death, the NCIS records extensive detail, including: the deceased's name, age, sex, date of birth, place of usual residence, country of birth, employment status, usual occupation, and Indigenous status.

The NCIS also records information about the nature of the death (eg. natural or external causes, intentional self harm etc) and provides links to electronic copies of full text reports, including: the police narrative of circumstances of death, the autopsy report, and coroner's findings.

Different search functions can be employed to either retrieve a specific case (eg., by name, local case number, deceased's date of birth etc) or to search across multiple cases for common characteristics. While some limitations exist in relation to NCIS, it is an extremely valuable research tool and in order to take full advantage of this resource and thereby maximise the capacity of its database, the Team has nominated the 1 July 2000 commencement of NCIS as the start date for case inclusion in the Team's dataset.

Coroner's CourtNet

CourtNet is the Coroner's Court file management system which records extensive information about the deceased, next of kin, investigating police, circumstances of the death, manner and cause of death, together with any findings and recommendations.

CourtNet's search function is limited to specific case retrieval however the Information Services Branch of the Department of Attorney General and Justice is able to prepare reports which set out, for a specific timeframe, every death in NSW grouped according to the manner and cause of death.

[67] Including consensual violence, neglect, and starvation; excluding negligent or dangerous driving occasioning death.
[68] Queensland data is available from January 2001.
[69] http://www.ncis.org.au/index.htm, accessed October 2011.

Where the 'manner of death' code is indicative of an unnatural or violent death (eg. shooting, beating/bashing assault, stabbing etc) the matter is examined to determine the circumstances of death and whether the death was caused by a perpetrator.

NSW Caselaw

NSW Caselaw was developed in 1999 to publish decisions of New South Wales Courts and Tribunals administered by the NSW Department of Attorney General and Justice.

A catchword search for 'murder' and 'manslaughter' identifies all published decisions relating to homicide matters before New South Wales Courts.

By cross-referencing the cases identified using the various research tools, the Team is able to identify, with a high degree of accuracy, the population of deaths relevant to its work.

CASE CLASSIFICATION: STEP 1 - RELATIONSHIP

Once an unnatural/violent death has been identified and the details of the case examined, the matter is categorised by reference to the relationship between the perpetrator and the deceased, as follows:

Category 1: Intimate partner – [as set out in ss 101C(1)(a)-(c) of the Act] includes: spouse, separated spouse, de facto, ex-de facto, extramarital partner, former extramarital partner, boyfriend, ex-boyfriend, girlfriend, ex-girlfriend;

Category 2: Relative/kin – [as set out in ss 101C(1)(e) and 101C(2)] includes the usual familial relationships (including in-laws of an intimate partner) and extended family or kin where kinship systems are relevant to a person's culture;

Category 3: No relationship – encompasses non-intimate friends, acquaintances, flat-mates, and strangers; or

Category 4: Unknown – the identity of the perpetrator is unknown

CASE CLASSIFICATION: STEP 2 – DOMESITC VIOLENCE CONTEXT

The strong correlation between a history of domestic violence and domestic homicide has been discussed in Chapter 1. However, research has shown that in a significant minority of domestic homicide cases, the fatality was the first episode of violence. In such cases, other factors appear to have had a greater explanatory role for the fatality, such as the perpetrator experiencing an acute mental health episode or the existence of a financial dispute. The characteristics of these cases are markedly different to those with a history of domestic violence and it is important that they are appropriately distinguished in the Team's database.

Given the significant under-reporting of domestic violence it is, of course, possible that some people are killed by an intimate partner or family member, without the domestic violence history ever having been known or recorded by third parties. By conducting a comprehensive analysis of all available material, the Team will endeavour to identify any history of domestic violence. It is

acknowledged, however, that there may be instances in which this information will never be known to the Team.

Whether or not a death is held to have occurred in a context of domestic violence is determined by reviewing all available case material for any evidence or reference to a relevant history of domestic violence behaviour (as described in Chapter 1) between the perpetrator and deceased or other relevant parties.[70]

A death that occurs following a recent relationship breakdown/separation or where there are known child custody issues will be considered to have occurred in a context of domestic violence regardless of an otherwise unknown history of domestic violence between the parties.

Accordingly, categories 1-3 from step 1 are further classified, as follows:

Category 1A – Perpetrator and deceased were intimate partners and the death occurred in a context of domestic violence;

Category 1B – Perpetrator and deceased were intimate partners but there is no identifiable domestic violence context;

Category 2A – Perpetrator and deceased were relatives/kin and the death occurred in a context of domestic violence;

Category 2B – Perpetrator and deceased were relatives/kin but there is no identifiable domestic violence context;

Category 3A – Perpetrator and deceased were not intimate partners or relatives/kin but the death occurred in a context of domestic violence;[71]

Category 3B – Perpetrator and deceased were not intimate partners or relatives and there is no identifiable domestic violence context.

The Team's database captures basic demographic information for each category of death.

Where a death is identified as having occurred in the context of domestic violence, a comprehensive range of data variables capture detailed information about: the deceased, the perpetrator, their relationship, the fatality, identifiable risk and vulnerability indicators, and service contact history.

By analysing the data captured, the Team will aim to identify patterns, trends, and risk factors associated with characteristics of the fatality, victims and offenders, the details of which will be set out in subsequent annual reports.

[70] For example, a history of domestic violence between intimate partners but where the person killed is a child of the partnership.
[71] For example, bystanders or police who are killed intervening in a domestic violence dispute, or the killing of a person's new intimate partner by their ex-partner.

3.3 CASE REVIEW FRAMEWORK

SCOPE OF INQUIRY

As discussed in Chapter 1, the purpose of a case review is to examine the demographics of the victim and perpetrator, the events prior to the death, and the circumstances surrounding the death, with a view to identifying limitations or weaknesses in service delivery, make recommendations to rectify such limitations, and develop intervention and prevention strategies so as to reduce the likelihood of deaths occurring in similar circumstances in the future.

The Team has determined that case reviews will be conducted for all deaths meeting the review criteria occurring on or after 10 March 2008. This date, which coincides with the commencement of the *Crimes (Domestic and Personal Violence) Act 2007*, has been selected as it enables sufficient time for the cases to be closed, while still being recent enough for the Team to make meaningful recommendations.

REVIEW CRITERIA

The Team will conduct case reviews on the following categories of deaths occurring on or after 10 March 2008 (see Figure 5):

- all Category 1;
- all Category 2A; and
- all Category 3A.

REFERRAL OF CASES FOR REVIEW

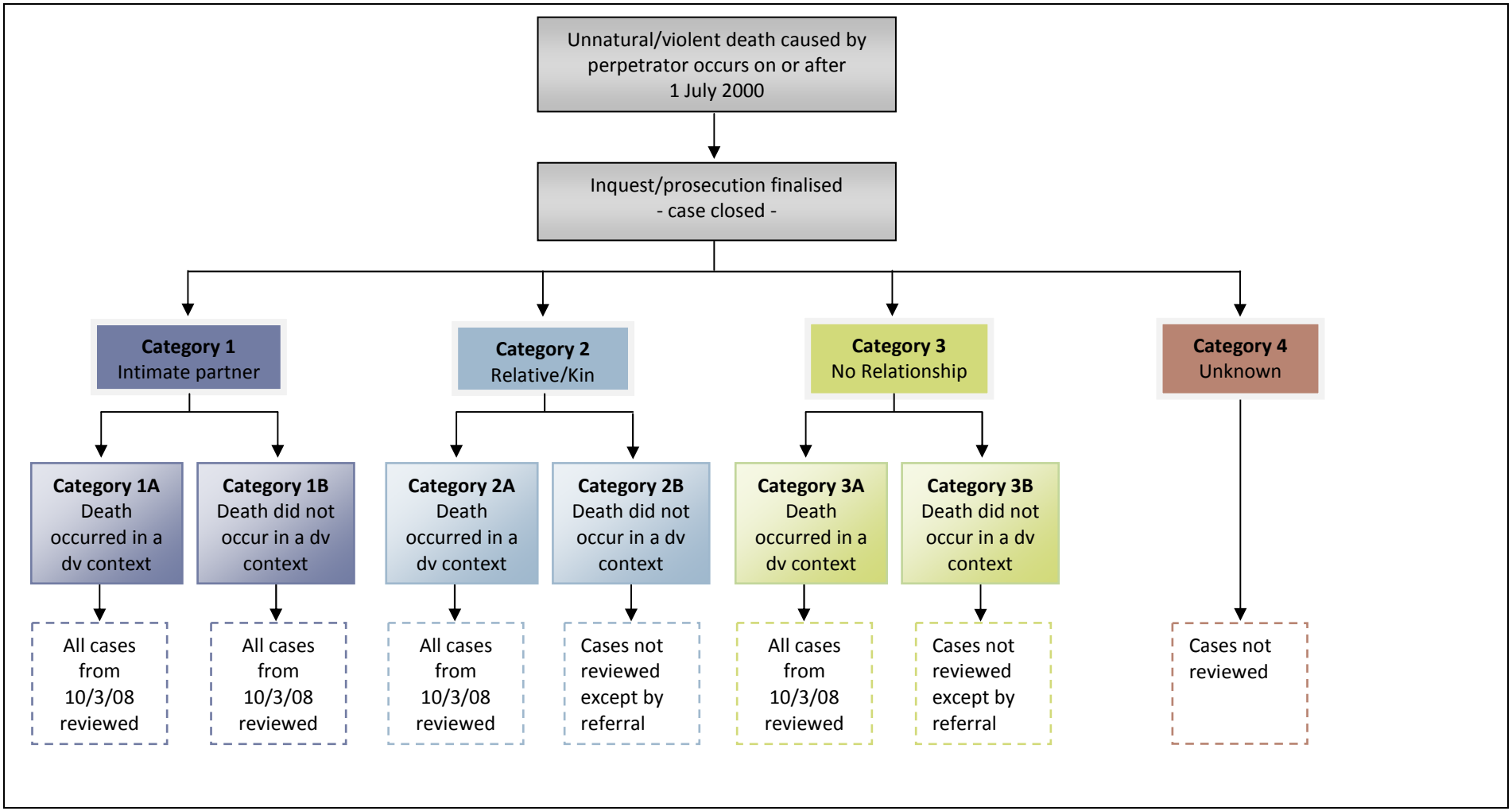
Notwithstanding the scope of inquiry and review criteria identified above, any person may refer a closed case of a domestic violence death to the Team for review.[72]

Referrals are to be made in writing to the Convenor or the Manager of the Team, identifying the name of the deceased person and a brief explanation as to why a review is being sought, having regard to the powers and functions of the Team.

Referrals will be considered on a case-by-case basis and it is noted that the role of the Team is not to reinvestigate particular matters but rather is to view these deaths through a domestic violence lens so as to identify and redress systemic gaps and limitations and promote changes and improvements in the response to domestic violence.

[72] Section 101H, *Coroners Act 2009*

Figure 5. Domestic Violence Death Review Dataset and Case Review Framework



CASE REVIEW PROCESS

Once a matter has been identified as meeting the review criteria, requests are made, pursuant to s 101L of the Act, for material to assist the Team in its task of conducting an in depth review of the matter.

At first instance this will generally consist of the inquest or prosecution brief of evidence; any available judgments where the perpetrator has been prosecuted; and, where the death is a reviewable child death, any report that has been prepared by the NSW Ombudsman.

The material is reviewed by the Manager and a comprehensive summary prepared which sets out, in as much detail as possible, the following:

- deceased/perpetrator profiles – including: age; sex; ethnicity; family history; education history; relationship status; housing status; employment history; and criminal history.
- chronology of events – including any relevant events, both proximal and distal, to the fatality;
- relationship history – including the nature, duration and history of the relationship between the deceased and the perpetrator;
- fatality details – as determined by the available material;
- any criminal justice outcome;
- domestic violence risk and vulnerability indicators – such as: history of domestic violence; escalation of violence; prior threats to kill deceased; excessive alcohol and or drug misuse; and child custody issues; and
- service contact and response history – including: the availability and effectiveness of any services and systems, and any failures that may have contributed to, or failed to prevent, the death.

The Team considers the case summary to determine if additional information is required and what agency or department is likely to be the most reliable source for that information. A secondary call for that information is then made and the supplementary case summary considered by the Team.

Where appropriate, the Team will formulate recommendations with respect to legislation, policies, practices and services, for implementation by government and non-government agencies and the community, in order to achieve its ultimate objective of reducing the incidence of such deaths.

The details of any recommendations will be set out in subsequent annual reports.

3.4 SUMMARY

Through its data collection and case review process, the establishment of the Domestic Violence Death Review Team provides an opportunity to develop a broader perspective not only about the context in which domestic violence deaths occur but about the culture of domestic violence generally.

By adopting a non-judgmental philosophy and promoting inter-professional information sharing, the team will seek to provide a better understanding of agencies' roles and constraints in responding to domestic violence, and to identify where resources need to be focused and what is needed to implement change.

By viewing these deaths in connection with each other, and not as isolated unrelated events, the Team will aim to identify and redress systemic gaps and limitations and promote changes and improvements that may result in preventing further tragedy.

ANNEXURE A – CHAPTER 9A, *CORONERS ACT 2009* (NSW)

CORONERS ACT 2009

Chapter 9A Domestic Violence Death Review Team

Part 9A.1 Preliminary

101A Object of Chapter

The object of this Chapter is, through the constitution of the Domestic Violence Death Review Team, to provide for the investigation of the causes of domestic violence deaths in New South Wales, so as to:

reduce the incidence of domestic violence deaths, and

(a) facilitate improvements in systems and services.

101B Interpretation

(1) In this Chapter:

Child Death Review Team means the Child Death Review Team established under Part 7A of the *Commission for Children and Young People Act 1998*.

Convenor means the person appointed as Convenor of the Team under this Chapter.

domestic violence death means the death of a person that is caused directly or indirectly by a person who was in a domestic relationship with the deceased person.

Team means the Domestic Violence Death Review Team.

(2) For the purposes of this Chapter, a case of a domestic violence death is ***closed*** if:

(a) the coroner has dispensed with or completed an inquest concerning the death, and

(b) any criminal proceedings (including any appeals) concerning the death have been finally determined (as defined in section 79 (4)).

101C Meaning of "domestic relationship"

(1) For the purposes of this Chapter, a person was in a *domestic relationship* with a deceased person if the person:

(a) was or had been married to the deceased person, or

(b) was or had been a de facto partner of the deceased person, or

(c) had or has had an intimate personal relationship with the deceased person, whether or not the intimate relationship involved or had involved a relationship of a sexual nature, or

(d) was or had been a relative of the deceased person and there have been previous episodes of domestic violence between them, or

(e) in the case of an Aboriginal person or a Torres Strait Islander, was or had been part of the extended family or kin of the deceased person according to the Indigenous kinship system of the person's culture, or

(f) was in any other relationship with the deceased person of a kind prescribed by the regulations.

(2) For the purposes of this Chapter, a person was a ***relative*** of a deceased person if the person was or is:

(a) a father, mother, grandfather, grandmother, step-father, step-mother, father-in-law or mother-in-law, or
(b) a son, daughter, grandson, grand-daughter, step-son, step-daughter, son-in-law or daughter-in-law, or
(c) a brother, sister, half-brother, half-sister, step-brother, step-sister, brother-in-law or sister-in-law, or
(d) an uncle, aunt, uncle-in-law or aunt-in-law, or
(e) a nephew or niece, or
(f) a cousin,

of the deceased person, or of the spouse or a de facto partner of the deceased person.

Part 9A.2 Constitution and procedure of the Team

101D Establishment of Team

The Domestic Violence Death Review Team is constituted by this Act.

101E Members of Team

(1) The Team is to consist of the Convenor of the Team and other persons appointed by the Minister.
(2) The Minister is to appoint as Convenor of the Team the State Coroner, a Deputy State Coroner or a former State Coroner or Deputy State Coroner.
(3) The Team is to include representatives of each of the following:
(a) the Department of Human Services,
(b) the Department of Health,
(c) the Department of Premier and Cabinet,
(d) the NSW Police Force,
(e) the Department of Education and Training,
(f) the Department of Justice and Attorney General,
(g) Community Services, within the Department of Human Services,
(h) Aboriginal Affairs NSW, within the Department of Human Services,
(i) Housing NSW, within the Department of Human Services,
(j) Juvenile Justice, within the Department of Human Services,
(k) Ageing, Disability and Home Care, within the Department of Human Services.
(4) Each representative referred to in subsection (3) is to be nominated by the Minister responsible for the organisation concerned.
(5) In addition, the Team is to include the following persons:
(a) 2 non-government service provider representatives,
(b) 2 persons who, in the opinion of the Minister, have expertise appropriate to the functions of the Team.

(6) The Minister is to appoint 1 person who is an Aboriginal person or a Torres Strait Islander and who is a non-government service provider representative as a member of the Team.
(7) The Team must consist of not less than 15 members (in addition to the Convenor) and not more than 19 members (in addition to the Convenor) at any one time.
(8) A person who is a member of the Legislative Council or the Legislative Assembly is not eligible to be a member of the Team.
(9) Schedule 3 contains provisions with respect to the members and procedure of the Team.

Part 9A.3 Functions of the Team

Division 1 General functions

101F Functions of Team

(1) The Team has the following functions:
   (a) to review closed cases of domestic violence deaths occurring in New South Wales,
   (b) to analyse data to identify patterns and trends relating to such deaths,
   (c) to make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths,
   (d) to establish and maintain a database (in accordance with the regulations) about such deaths,
   (e) to undertake, alone or with others, research that aims to help prevent or reduce the likelihood of such deaths.

(2) The Team may review a domestic violence death even though the death is or may be the subject of action by the Child Death Review Team.

(3) Any function of the Team with respect to domestic violence deaths may be exercised with respect to the death of a person who dies outside New South Wales while ordinarily resident in New South Wales.

(4) The Convenor may enter into an agreement or other arrangement for the exchange of information between the Team and a person or body having functions in another State or Territory that are substantially similar to the functions of the Team, being information relevant to the exercise of the functions of the Team or that person or body.

101G Matters to be considered in reviews

(1) In carrying out a review of closed cases of domestic violence deaths, the Team is to consider the following matters:
   (a) the events leading up to the death of the deceased persons,
   (b) any interaction with, and the effectiveness of, any support or other services provided for, or available to, victims and perpetrators of domestic violence,
   (c) the general availability of any such services,
   (d) any failures in systems or services that may have contributed to, or failed to prevent, the domestic violence deaths.

(2) This section does not limit the matters that the Team may consider or examine in any review of closed cases of domestic violence deaths.

101H Referral of cases for review to Team

(1) The Team may select the domestic violence death cases that are to be the subject of a review by the Team.

(2) Any person may refer a closed case of a domestic violence death to the Team for inclusion in a review. The Team may, but is not required to, select any such case for review.

101I Appointment of expert advisers

(1) The Convenor may, otherwise than under a contract of employment, appoint persons with relevant qualifications and experience to advise the Team in the exercise of its functions.

(2) A person so appointed is entitled to be paid such remuneration and allowances (including travelling and subsistence allowances) as may be determined by the Minister in respect of the person.

Division 2 Reports by Team

101J Reports

(1) The Team must prepare, within the period of 4 months after 30 June in each year, and furnish to the Presiding Officer of each House of Parliament, a report on domestic violence deaths reviewed in the previous year.

(2) Without limiting subsection (1), the report may include the following:

(a) identification of systemic and procedural failures that may contribute to domestic violence deaths,

(b) recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths,

(c) details of the extent to which its previous recommendations have been accepted.

101K Reporting to Parliament

(1) A copy of a report furnished to the Presiding Officer of a House of Parliament under this Part must be laid before that House on the next sitting day of that House after it is received by the Presiding Officer.

(2) The Team may include in a report a recommendation that the report be made public forthwith.

(3) If a report includes a recommendation that a report be made public forthwith, a Presiding Officer of a House of Parliament may make it public whether or not that House is in session and whether or not the report has been laid before that House.

(4) A report that is made public by a Presiding Officer of a House of Parliament before it is laid before that House attracts the same privileges and immunities as if it had been laid before that House.

(5) A Presiding Officer need not inquire whether all or any of the conditions precedent have been satisfied as regards a report purporting to have been furnished in accordance with this Part.

(6) In this Part, a reference to a Presiding Officer of a House of Parliament is a reference to the President of the Legislative Council or the Speaker of the Legislative Assembly. If there is a vacancy in the office of President, the reference to the President is taken to be a reference to the Clerk of the Legislative Council and, if there is a vacancy in the office of the Speaker, the reference to the Speaker is taken to be a reference to the Clerk of the Legislative Assembly.

Part 9A.4 Access to and confidentiality of information

101L Duty of persons to assist Team

(1) It is the duty of each of the following persons to provide the Team with full and unrestricted access to records that are under the person's control, or whose production the person may, in an official capacity, reasonably require, being records to which the Team reasonably requires access for the purpose of exercising its functions:

(a) the Department Head, chief executive officer or senior member of any department of the Government, statutory body or local authority,

(b) the Commissioner of Police,

(c) a coroner,

(d) a medical practitioner or health care professional who, or the head of a body which, delivers health services,

(e) a person who, or the head of a body which, delivers welfare services.

(2) A person subject to that duty is not required to provide access to records if the person reasonably considers that doing so may prejudice an existing investigation or inquiry of a matter under an Act being undertaken by or for the person.
(3) Access to which the Team is entitled under subsection (1) includes the right to inspect and, on request, to be provided with copies of, any record referred to in that subsection and to inspect any non-documentary evidence associated with any such record.
(4) A provision of any Act or law that restricts or denies access to records does not prevent a person subject to a duty under subsection (1) from complying, or affect the person's ability to comply, with that subsection.
(5) The regulations may make provision with respect to the duty to provide access to records under subsection (1), including prescribing limitations and conditions on that duty.
(6) In this section, *record* means any document or other source of information compiled, recorded or stored in written form or on film, or by electronic process, or in any other manner or by other means.

101M Confidentiality of information

(1) A Team-related person must not make a record of, or directly or indirectly disclose to any person, any information (including the contents of any document) that was acquired by the person by reason of being a Team-related person, unless:
  (a) the record or disclosure is made in good faith for the purpose of exercising a function under this Chapter, or
  (b) the record or disclosure is authorised to be made by the Convenor in connection with research that is undertaken for the purpose of helping to prevent or reduce the likelihood of domestic violence deaths in New South Wales, or
  (c) the record or disclosure is made by the Convenor for the purpose of:

    (i) providing information to the Commissioner of Police in connection with a possible criminal offence, or
    (ii) reporting to the Director-General of the Department of Human Services that a child or class of children may be at risk of harm, or
    (iii) providing information to the State Coroner that may relate to a death that is within the jurisdiction of the State Coroner, whether or not the death has been the subject of an inquest under this Act, or
    (iv) providing information to the Child Death Review Team in connection with that Team's functions, or
    (v) providing information to the Ombudsman concerning the death of a person that is relevant to the exercise of any of the Ombudsman's functions, or
    (vi) giving effect to any agreement or other arrangement entered into under this Chapter or with coroners in other jurisdictions for the exchange of information, or
    (vii) providing information to a national database compiled for the purposes of, and contributed to by, coroners of States and Territories, or
  (d) the record or disclosure is made by a member of the Team to a Minister, or to a Department Head, chief executive officer or senior member of any department of the Government or a statutory body, in connection with a draft report prepared for the purpose of this Chapter.

  Maximum penalty: 50 penalty units or imprisonment for 12 months, or both.

(2) A Team-related person who makes a record or disclosure that is authorised under this section in connection with research that is undertaken for the purpose of helping to prevent or

reduce the likelihood of domestic violence deaths in New South Wales must ensure that the information does not identify a person who is the subject of the information.

(3) A Team-related person is not required:
  (a) to produce to any court any document or other thing that has come into the person's possession, custody or control, or
  (b) to reveal to any court any information that has come to the person's notice, by reason of being a Team-related person.

(4) Any authority or person to whom any information referred to in subsection (1) is revealed, and any person or employee under the control of that authority or person:
  (a) is subject to the same obligations and liabilities under subsections (1) and (2), and
  (b) enjoys the same rights and privileges under subsection (3),

  in respect of that information as if he or she were a Team-related person who had acquired the information for the purpose of the exercise of the functions of the Team. Failure to comply with obligations and liabilities referred to in this subsection is taken to be a contravention of subsection (1).

(5) In this section:

court includes any tribunal or person having power to require the production of documents or the answering of questions.

produce includes permit access to.

Team-related person means a member of the Team, a member of staff of the Team and any person engaged to assist the Team in the exercise of its functions, including persons appointed under section 101I.

Part 9A.5 Miscellaneous

101N Execution of documents
A document required to be executed by the Team in the exercise of its functions is sufficiently executed if it is signed by the Convenor or another member authorised by the Convenor.

101O Protection from liability
(1) A matter or thing done or omitted by the Team, a member of the Team or a person acting under the direction of the Team does not, if the matter or thing was done or omitted in good faith for the purposes of executing this or any other Act, subject the member of the Team or person so acting personally to any action, claim or demand in respect of that matter or thing.
(2) However, any such liability attaches instead to the Crown.

101P Review of Chapter
(1) The Minister is to review this Chapter to determine whether the policy objectives of this Chapter remain valid and whether the terms of this Chapter remain appropriate for securing those objectives.
(2) The review is to be undertaken as soon as possible after the period of 3 years from the commencement of this Chapter.
  A report on the outcome of the review is to be tabled in each House of Parliament within 12 months after the end of the period of 3 years.

ANNEXURE B – DOMESTIC VIOLENCE DEATH REVIEW TEAM MEMBERS

Magistrate Mary Jerram[73]
NSW State Coroner
Convenor

Ms Cathrine Lynch[74]
Director, Primary Health and Community Partnerships
NSW Department of Health

Ms Gillian Ferguson[75]
Executive Director, Office for Women's Policy
Department of Premier and Cabinet

Assistant Commissioner Mark Murdoch[76]
Commander, Central Metropolitan Region,
Corporate Spokesperson Domestic and Family Violence
NSW Police

Ms Trisha Ladogna[77]
Acting Director, Child Wellbeing Unit
Department of Education and Training

The Hon James Wood AO QC[78]
Chairperson, NSW Law Reform Commission
Department of Attorney General and Justice

Ms Carolyn Thompson[79]
Manager, Domestic and Family Violence, Crime Prevention Division
Department of Attorney General and Justice

Ms Pam Swinfield[80]
Assistant Director, Child Deaths and Critical Reports
Community Services

Mr Peter Swain[81]
Director, Strategic Policy
Aboriginal Affairs NSW

[73] Appointed pursuant to s101E(2), Coroners Act 2009 (NSW).
[74] Appointed pursuant to s101E(3)(b), Coroners Act 2009 (NSW).
[75] Appointed pursuant to s101E(3)(c), Coroners Act 2009 (NSW).
[76] Appointed pursuant to s101E(3)(d, Coroners Act 2009 (NSW).
[77] Appointed pursuant to s101E(3)(e), Coroners Act 2009 (NSW).
[78] Appointed pursuant to s101E(3)(f), Coroners Act 2009 (NSW).
[79] Appointed pursuant to s101E(3)(f), Coroners Act 2009 (NSW).
[80] Appointed pursuant to s101E(3)(g), Coroners Act 2009 (NSW).
[81] Appointed pursuant to s101E(3)(h), Coroners Act 2009 (NSW).

Ms Vivian Hanich[82]
Director, Service Development
Housing NSW

Ms Valda Rusis[83]
Deputy Chief Executive (Operations)
Juvenile Justice

Ms Melinda Smith[84]
Assistant Director, Police and practice Team
Ageing, Disability and Home Care

Ms Betty Green[85]
Manager
Liverpool Women's Health Centre

Ms Dixie Link-Gordon[86]
Chief Executive Officer
Mudgin-Gal Aboriginal Corporation Women's Centre

Dr Lesley Laing[87]
Senior Lecturer, School of Social Work and Policy Studies
University of Sydney

Ms Martha Jabour[88]
Executive Director
Homicide Victims Support Group (Aust) Inc.

[82] Appointed pursuant to s101E(3)(i), Coroners Act 2009 (NSW).
[83] Appointed pursuant to s101E(3)(j), Coroners Act 2009 (NSW).
[84] Appointed pursuant to s101E(3)(k), Coroners Act 2009 (NSW).
[85] Appointed pursuant to s101E(5)(a), Coroners Act 2009 (NSW).
[86] Ibid.
[87] Appointed pursuant to s101E(5)(b), Coroners Act 2009 (NSW).
[88] Ibid.

ANNEXURE C – CONFIDENTIALITY AGREEMENT

NSW GOVERNMENT | Attorney General & Justice

DOMESTIC VIOLENCE DEATH REVIEW TEAM

CONFIDENTIALITY AGREEMENT

I acknowledge that, pursuant to section 101E of the *Coroners Act 2009* (the Act), I have been appointed as a member of the Domestic Violence Death Review Team, which appointment commenced on 18 February 2011.

I acknowledge that I have read and understood section 101M of the Act, a copy of which is annexed to this agreement, and that pursuant to section 101M(5) I am a 'Team-related person'.

I undertake to observe the confidentiality provisions detailed in section 101M of the Act.

I understand that the maximum penalty for contravening the provisions of section 101M of the Act is a fine of 50 penalty units or imprisonment for 12 months, or both.

Signature	Name	Date
Witness	Name	
Signature	State Coroner Jerram	Date
Witness	Name	