Agreement in Principle

Ms JODI MCKAY (Newcastle—Minister for Tourism, Minister for the Hunter, Minister for Science and Medical Research, and Minister for Women) [10.08 a.m.]: I move:

That this bill be now agreed to in principle.

I am pleased to introduce the Coroners Amendment (Domestic Violence Death Review Team) Bill 2010. The bill establishes an expert, multidisciplinary team, convened by the State Coroner, to review deaths that occur in the context of domestic violence. The Government remains committed to preventing domestic violence in all its forms. Part of this process involves identifying gaps in services and systems with the aim of developing a better understanding of how these can be improved to ensure that people who are victims of domestic violence do not fall through the cracks.

The establishment of a mechanism to review domestic violence-related deaths follows the recommendations contained in the 2009 report of the Domestic Violence Homicide Advisory Panel. The panel was convened following the tragic death of Melissa Cook, who was fatally shot by her estranged husband on 19 December 2008.The Government has acted quickly to progress the key recommendation of the report, being the establishment of a domestic violence death review team. New South Wales will become one of the first jurisdictions in the country to introduce a mechanism to review domestic violence deaths. The fundamental premise on which the team is established is that one domestic violence-related death is one too many. Many deaths occurring in a domestic violence context are preventable and the team will have as a primary focus prevention and intervention at its core.

The establishment of a domestic violence death review mechanism in New South Wales also supports work being done at the Commonwealth level. The release of "Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children" in May 2009 identified the establishment of domestic homicide review processes in all States and Territories as a priority area for action. The Prime Minister has referred Time for Action to the Council of Australian Governments for its consideration and has proposed that a national plan to reduce violence against women be developed by 2010.

Community advocates have been involved throughout the process, were represented on the Domestic Violence Homicide Advisory Panel and have been consulted on the development of this bill. They have long argued that a domestic violence death review process provides governments with the information required to identify practices, protocols, behaviours and attitudes associated with service and criminal justice response systems that lead to fatalities. To this end, the bill will empower the team comprised of Government and non-government representatives to compile information from agencies and organisations who may have had contact with victims of domestic violence where there has been a fatality. This information will enable the team to identify potential intervention points and to establish where policies, procedures and services require review. Through this process, systemic issues can be addressed in a cohesive, progressive manner.

Let me be clear, the object of the team will not be to apportion blame. Rather, the focus will be on collaboration and information sharing about deaths that occur in a domestic violence context. Through this process we can enhance our understanding of the causes of these tragedies and work to improve systems and practices with the goal of reducing their incidence.

I now turn to the detail of the bill. The object of the bill is to create a statutory framework that will support the operation of the expert, multidisciplinary Domestic Violence Death Review Team. The team will through its functions work to identify systemic issues and causes of deaths occurring in a domestic violence context. The focus is on reducing the incidence of these types of deaths through facilitating improvements in systems and services. The review process is not a coronial investigation; it does not reinvestigate matters. The Domestic Violence Death Review Team will have a collaborative approach and will be informed by and learn from domestic violence deaths with the aim of identifying areas of service delivery or intervention that can be improved. Its ability to share information with similar review mechanisms and the involvement and active participation of key stakeholders ensures a holistic approach.

The Domestic Violence Death Review Team is to have the following functions: review closed cases of domestic violence deaths in New South Wales, or a death of a person who usually resides in New South Wales; analyse data to identify patterns and trends related to such deaths; make recommendations to prevent or reduce the likelihood of such deaths; establish and maintain a database about such deaths; and undertake research that aims to help prevent or reduce the likelihood of such deaths. The bill also enables the team to review a death, notwithstanding the fact that it may be the subject of review by the Child Death Review Team, and contains provisions that enable information transfer between the two review mechanisms.

Importantly, the bill will enable the convenor of the team to enter into agreements or arrangements for the exchange of information between the team and a person or body having functions similar to those of the team in other States or Territories, where the information is relevant to the functions of the team. This will enable the team to feed into the National Coroners Information System [NCIS]. Coroners in all Australian jurisdictions have access to NCIS, which is a national Internet-based data storage and retrieval system for Australian coronial cases. Information about every death reported to an Australian coroner since July 2000, or January 2001 for Queensland, is stored within the system, providing a valuable hazard identification and death prevention tool for coroners and research agencies. The NCIS has a primary role to assist coroners in their role as death investigators by providing them with the ability to review previous coronial cases that may be similar in nature to current investigations, thereby enhancing their ability to identify and address systemic hazards within their jurisdiction.

The Domestic Violence Death Review Team is to consist of at least 15 and not more than 19 members appointed by the Attorney General. The convenor is to be a current or former State or Deputy State Coroner. Key government service providers are to be represented, including the New South Wales Police Force, the Department of Health, the Department of Premier and Cabinet, the Department of Education and Training, the Department of Justice and Attorney General, the Department of Human Services, including representatives from within Community Services, Housing New South Wales, Aboriginal Affairs, Juvenile Justice and Ageing, Disability and Homecare. The team will also have representation from two non-government service providers and another two persons with expertise appropriate to the functions of the team. The bill provides for the appointment of an Aboriginal or Torres Strait Islander member who is representative of a non-government service provider agency.

The bill sets out the definition of "domestic relationship" that enables a range of people living in a domestic context to be included within the definition. The Report of the Domestic Violence Homicide Advisory Panel recommended a definition that was consistent with the Crimes (Domestic and Personal Violence) Act 2007 to the extent of the section that deals with what is commonly known as an intimate relationship. The bill substantially adopts the provisions of that section, but excludes those not in an intimate relationship, for example, those in carer relationships and flatmates. The definition in the bill recognises the seriousness of domestic violence by placing an emphasis on the nature of those involved in relationships where one person exercises control and power over another in the relationship.

The bill will allow the team to review a range of deaths occurring in a domestic violence context, including the homicide of a spouse, partner or children, as well as suicides or fatal accidents that are domestic violence related. The effective operation of the Domestic Violence Death Review Team relies on its ability to obtain information about the services accessed by those affected by domestic violence-related deaths. The bill includes provisions that impose a duty on certain persons, including department heads, chief executive officers and senior members of any government department, the Police Commissioner, medical practitioners and health care professionals to provide the team with access to records that will enable the team to obtain this information.

The bill enables the provision of this information to the team notwithstanding that there may be provisions of Acts or laws that denies access to such records. The access to and use of this information is restricted and protected by provisions requiring all persons associated with the team to keep such information confidential and not disclose for any reason, other than those exceptions contained in the bill. These exceptions include situations where a disclosure is made in good faith for the purpose of exercising a relevant function; authorised by the convenor to be made in connection with related research—this relates to de-identified information only; or made by the convenor to the relevant authorities for a range of specific purposes. Examples of the latter may include investigating possible criminal offences; reporting children at risk of harm; providing information relating to a death within the State Coroner's jurisdiction; providing information to the Child Death Review Team in relation to its functions; providing information to the Ombudsman concerning a death relevant to the Ombudsman's function; and providing information to the NCIS.

Before I conclude, I would like to acknowledge the tireless work of the community sector, whose workers support women experiencing domestic violence on a daily basis. I also want to acknowledge the sector's strong advocacy for a domestic violence death review team, which has helped to inform the Government's decision on this issue. In particular, I thank those non-government members who were represented on the Domestic Violence Homicide Advisory Panel: the Chair, Dr Lesley Laing, who is also the Deputy Chair of the Premier's Council on Preventing Violence Against Women; Professor Julie Stubbs, criminologist at the University of Sydney; and Ms Betty Green, also a Premier's Council Member and the convenor of the Domestic Violence Committee Coalition, which has been instrumental in drawing attention to the need for a domestic violence death review team. On behalf of the Government, I thank and commend them for the tireless and critical work they have done in this area.

The establishment of the Domestic Violence Death Review Team through this bill is representative of the Government's commitment to tackling domestic violence and delivers on the key recommendation of the Domestic Violence Homicide Advisory Panel made in 2009. Violence is unacceptable in all its manifestations. Domestic and family violence has a devastating impact not only on the victims and their families but also on the broader community. The New South Wales Government will not falter in its commitment to doing all it can to

prevent its occurrence and to improve systems and service delivery to those who need it most. The establishment of the Domestic Violence Death Review Team will help us to identify where and how we can make changes to reduce the incidence of deaths arising from domestic violence. I commend the bill to the House.