**Submission No 33**

# INQUIRY INTO DOMESTIC VIOLENCE TRENDS AND ISSUES IN NSW

**Organisation**: Domestic Violence Death Review Team, NSW State Coroner's Office

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## THE DOMESTIC VIOLENCE DEATH REVIEW TEAM

Background

Fortunately, homicide is a relatively rare occurrence in Australia. There is, however, a substantial body of evidence which demonstrates that Australia's homicide demographic is significantly domestic in nature.

Between 2007-2008 there were 260 homicide incidents in Australia which resulted in 273 victim deaths.[1] Of the 273 victims, 161 were males and 112 females.[2] For the same reporting period, NSW recorded 88 homicide incidents resulting in 98 deaths, with a comparable proportion of 61 males to 37 females.

Over half (53%) of all Australian homicide victims for this period were killed by a person with whom they shared a current or former domestic/family relationship. Of the 144 domestic homicide victims, 87 were female and 57 were males. Accordingly, 78% of all female homicides and 35% of male homicides can be classified as having occurred in a domestic context. Again, the proportion of deaths occurring in a domestic context were comparable for the same reporting period in NSW.

While the rate of homicide in Australia has been generally declining over the past decade, it appears that this is primarily because of a decrease in the number of 'acquaintance homicides' and rates of domestic homicide have remained relatively stable.

Despite the high prevalence of deaths that occur between intimate partners and family members, domestic violence related fatalities have not previously been systematically reviewed in NSW.

Establishment of the Domestic Violence Death Review Team

In July 2010, following recommendations made in 2009 by the Domestic Violence Homicide Advisory Panel, 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).

The Act sets out in detail the Team's functions, powers, constitution and operation, picking up the recommendation made by the advisory panel that an adequate review team must have a strong legislative framework that clearly defines its mandate, Terms of Reference, and address issues around confidentiality, access to information, and protection from liability.

Objective

Section 101A sets out the Team's overarching objective or mandate, namely 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.

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[1] Virueda, M. and Payne, J. 2010, *Homicide in Australia: 2007 – 08 National Homicide Monitoring Program annual report*, Monitoring Report No. 13, Australian Institute of Criminology, Canberra. This figure does not include the suicide deaths of perpetrators.

[2] Figures include 40 juveniles – 24 boys and 16 girls.

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

Definitions

Section 101B defines a domestic violence death as 'the death of a person that is caused directly or indirectly by a person who was in a domestic relationship with the deceased person'. This definition provides that homicides, homicide-suicides, accidental deaths, and suicides that occur in a context of domestic violence will fall within purview of the Team's work.

The relationship between suicide and experiences of interpersonal violence has long been recognised and a solid research base has identified domestic violence as one of the single most important precipitants of female suicide, both in Australia and overseas. Identifying and reviewing cases of suicide where domestic violence is determined to be a significant contributing factor does, however, present unique challenges and will be considered once the work of the Team is further progressed.

The Act, at s 101C, adopts a broad definition of 'domestic relationship' so as 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.

Constitution

The Team is convened by the NSW State Coroner, Mary Jerram, and is constituted by representatives from 11 key government stakeholders, including law enforcement, justice, health and social services, as well as four representatives from non-government agencies.

Legislative functions

Section 101F sets out the Team's legislative functions, namely to:

- review and analyse individual closed cases of domestic violence deaths;
- establish and maintain a database relating to such deaths; and
- undertake research that aims to help prevent or reduce the likelihood of such deaths.

When conducting the in depth 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 of any support or other services provided for or available to victims and perpetrators of domestic violence;[3]
- 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.

The Team will synthesize and analyse information gathered in the course of carrying out these functions so as to identify key themes and systemic issues in relation to domestic violence deaths in New South Wales. Where appropriate, the Team will then 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 the its ultimate objective of reducing the incidence of such deaths.

[3] Information regarding the existence of and compliance with any Apprehended Domestic Violence Orders will be captured in the Team's database and case reviews.

Referral of cases for review

Section 101H provides that any person may refer a closed case of a domestic violence death to the Team for inclusion in a review.

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.

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 the advisory panel's recommendation regarding the essential features for any review team, it identified the need for a strong legislative framework incorporating: 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 privileges; 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 are reflected in the Act which sets out, at ss 101L to 101O, extremely detailed provisions addressing the duty of a person to assist the team, confidentiality and protection from liability.

Meetings and reporting requirements

The Team held its inaugural meeting on 29 March 2011 and must meet no less than four times in a calendar year.

Section 101J provides that the Team is to prepare and furnish to the Presiding Officer of each House of Parliament, a report on the domestic violence deaths reviewed in the previous year. The report may include, but is not limited to the identification of systemic and procedural failures that may contribute to domestic violence deaths, 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, and in time can include details of the extent to which previous recommendations have been accepted. The Team can also recommend to have the report made public.

The work of the Team will be reviewed after 3 years of operation.