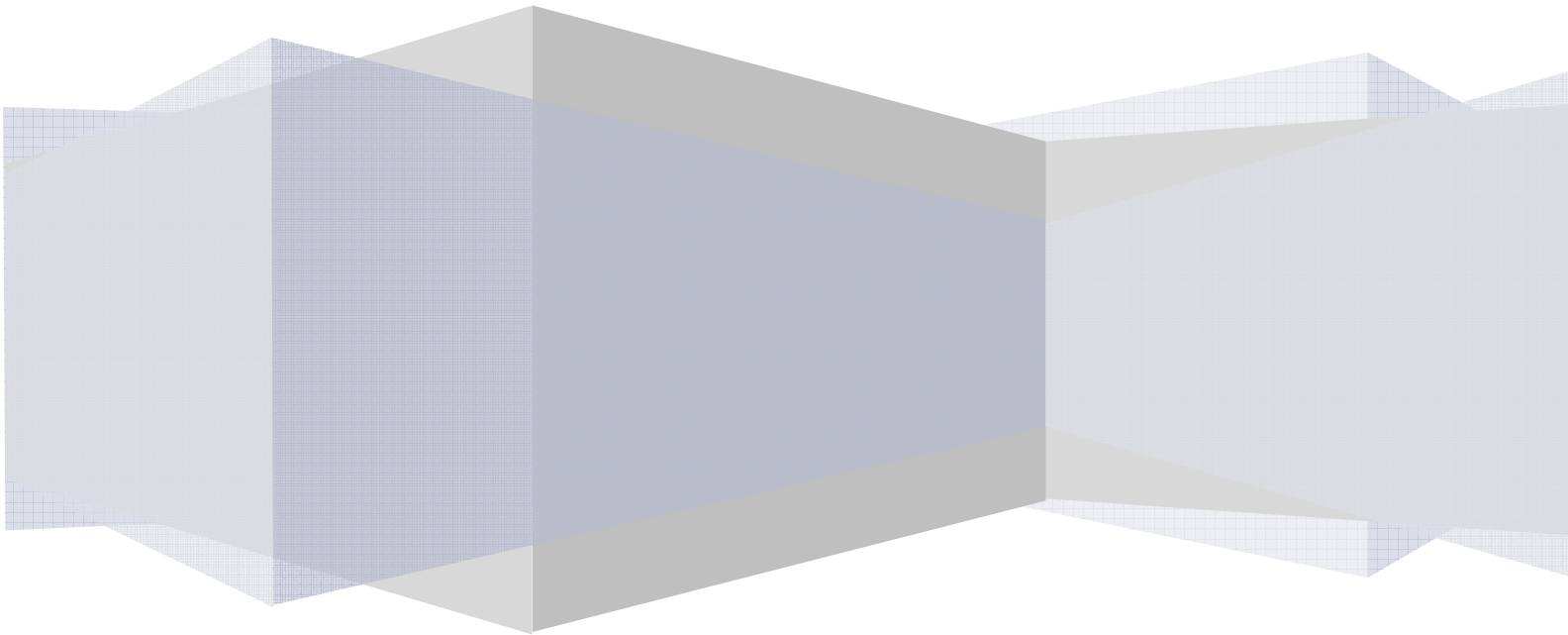
NSW GOVERNMENT | Attorney General & Justice

NSW Domestic Violence Death Review Team

ANNUAL REPORT 2011-2012



October 2012

NSW Domestic Violence Death Review Team

ANNUAL REPORT 2011-2012

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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 Domestic Violence Death Review Team– Schedule 3, clause 11 *Coroners Act 2009* (NSW).

Published in Sydney by the
Domestic Violence Death Review Team
PO Box 309
CAMPERDOWN BC 1450

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ISSN 1839-8073 (Print)
ISSN 1839-8219 (Online)

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October 2012

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

2011-12 Report of the Domestic Violence Death Review Team

Pursuant to section 101J(1) of the *Coroners Act 2009* (NSW), I am pleased to submit the second Annual Report of the Domestic Violence Death Review Team for the year ending 30 June 2012.

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

This is the second annual report of the New South Wales Domestic Violence Death Review Team and the first to contain substantive case reviews, recommendations and data concerning domestic violence deaths in New South Wales during the period 1 July 2000 to 30 June 2009.

Since the publication of its first annual report in 2011, the Team has moved out of its establishment phase and has become fully operational, generating important information in relation to the ongoing and serious issue of domestic violence deaths in New South Wales.

Domestic violence deaths continue to be a significant issue within our community at a state, national and international level. Of all closed cases during the data reporting period in New South Wales, there were 763 assault deaths that were examined and categorised by the Team. Of these 763 deaths, nearly 29% occurred in a context of domestic violence. For males, approximately 18% of all external cause assault deaths occurred in a context of domestic violence and nearly 52% of all female deaths during the data reporting period occurred in a domestic violence context.

These figures are alarming and clearly illustrate the extent of this serious problem in our community.

Since meeting for the first time in March 2011, the Team has conducted a significant number of in-depth case reviews, focusing on deaths that occurred between March 2008 and June 2009. Through this review process, the Team has been able to identify recurring issues and systemic failures. The Team subsequently developed recommendations, contained in this report, which aim to redress service gaps and limitations and facilitate improvement in our community's response to domestic violence.

The Team has also developed a database which captures extensive demographic, service contact and risk factor information for each assault death that has occurred in New South Wales since 1 July 2000. At the time of writing the Team's dataset comprises over 800 closed cases and this report contains comprehensive demographic information in relation to the 763 deaths that occurred during the data reporting period.

The Team's in-depth case reviews, combined with the extensive dataset, contribute to the development of a rich and comprehensive understanding of the dynamics of domestic violence deaths in New South Wales.

By providing publicly available information concerning the incidence, dynamics and nature of domestic violence deaths, the Team seeks to facilitate and promote community awareness. This reporting also provides an opportunity to develop a broader perspective, not only about the context in which domestic violence deaths occur, but about the dynamics of domestic violence generally.

In moving forward, the Team's immediate focus will be to continue to build on the existing dataset with the inclusion of detailed and complex information around risk factors and service contact for all domestic violence deaths. This will provide critical enhancement to the understanding of the context in which these deaths occur and will assist the Team in making further targeted recommendations to effect change.

Throughout the next reporting period, the Team is also looking to develop case review and data collection protocols to examine the relationship between suicide and experiences of domestic violence.

Finally, on behalf of the Team I wish to extend my condolences to the families and loved ones of all the individuals whose deaths are considered in this report. Every life lost to domestic violence is a tragedy and the Team will continue to strive to learn from these deaths to achieve its overarching goal of preventing further loss of life.

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

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PARTICIPANTS

DOMESTIC VIOLENCE DEATH REVIEW TEAM MEMBERS

Magistrate Mary Jerram[1]
NSW State Coroner
Convenor

Ms Cathrine Lynch[2]
Director, Primary Health and Community Partnerships
NSW Department of Health

Ms Gillian Ferguson[3]
Executive Director, Office for Women's Policy
Department of Premier and Cabinet

Assistant Commissioner Mark Murdoch[4]
Commander, Central Metropolitan Region
Corporate Spokesperson Domestic and Family Violence
NSW Police Force

Ms Trisha Ladogna[5]
Team Leader, Child Wellbeing Unit
Department of Education and Communities

The Hon James Wood AO QC[6]
Chairperson, NSW Law Reform Commission
Department of Attorney General and Justice

Ms Carolyn Thompson[7]
Manager, Domestic and Family Violence, Crime Prevention Division
Department of Attorney General and Justice

Ms Pam Swinfield[8]
Assistant Director, Child Deaths and Critical Reports
Community Services

Mr Peter Swain[9]
Director, Strategic Policy
Aboriginal Affairs NSW

[1] Appointed pursuant to s101E(2), *Coroners Act 2009* (NSW).
[2] Appointed pursuant to s101E(3)(b), *Coroners Act 2009* (NSW).
[3] Appointed pursuant to s101E(3)(c), *Coroners Act 2009* (NSW).
[4] Appointed pursuant to s101E(3)(d, *Coroners Act 2009* (NSW).
[5] Appointed pursuant to s101E(3)(e), *Coroners Act 2009* (NSW).
[6] Appointed pursuant to s101E(3)(f), *Coroners Act 2009* (NSW).
[7] Appointed pursuant to s101E(3)(f), *Coroners Act 2009* (NSW).
[8] Appointed pursuant to s101E(3)(g), *Coroners Act 2009* (NSW).
[9] Appointed pursuant to s101E(3)(h), *Coroners Act 2009* (NSW).

Ms Vivian Hanich[10]
Director, Service Development Strategy
Housing NSW

Ms Valda Rusis[11]
Deputy Chief Executive (Operations)
Juvenile Justice

Ms Melinda Smith[12]
Assistant Director, Police and Practice Team
Ageing, Disability and Home Care

Ms Betty Green[13]
Manager
Liverpool Women's Health Centre

Ms Dixie Link-Gordon[14]
Chief Executive Officer
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Dr Lesley Laing[15]
Senior Lecturer
Faculty of Education and Social Work
University of Sydney

Ms Martha Jabour[16]
Executive Director
Homicide Victims Support Group (Aust) Inc.

OFFICERS OF THE DOMESTIC VIOLENCE DEATH REVIEW TEAM

Ms Anna Butler
Manager

Ms Emma Buxton
Research Analyst[17]

Ms Donna Schriever
Administrative Assistant

[10] Appointed pursuant to s101E(3)(i), *Coroners Act 2009* (NSW).
[11] Appointed pursuant to s101E(3)(j), *Coroners Act 2009* (NSW).
[12] Appointed pursuant to s101E(3)(k), *Coroners Act 2009* (NSW).
[13] Appointed pursuant to s101E(5)(a), *Coroners Act 2009* (NSW).
[14] Appointed pursuant to s101E(5)(a), *Coroners Act 2009* (NSW).
[15] Appointed pursuant to s101E(5)(b), *Coroners Act 2009* (NSW).
[16] Appointed pursuant to s101E(5)(b), *Coroners Act 2009* (NSW).
[17] Ms Buxton was appointed to the position on a temporary basis from 30 January to 29 June 2012.

EXECUTIVE SUMMARY

This is the second annual report of the New South Wales Domestic Violence Death Review Team ('the Team') and the first to present substantive data, case reviews and recommendations in relation to domestic violence deaths in New South Wales.

DATA OVERVIEW

This report provides information in relation to all 763 closed external cause assault deaths which occurred between 1 July 2000 – 30 June 2009 ('data reporting period'). Of these deaths, which included 247 female deceaseds, 515 male deceaseds and 1 transgender deceased, the Team conducted analysis of all deaths which occurred in a context of domestic violence and all deaths which occurred in the context of a domestic relationship (including all intimate partner deaths or deaths occurring within a relationship of relative/kin but where there is no history of violence).

This report provides substantial demographic data in relation to 134 male deceaseds and 184 female deceaseds.

This report includes information in relation to:

- deceased and perpetrator age;
- deceased and perpetrator ATSI status;
- manner of death and location of fatal injury leading to death;
- outcomes through criminal justice/Coronial processes;
- relationship between perpetrator and deceased;
- perpetrator suicides/deaths; and
- Multiple Fatality Incidents.

This information is captured for all external cause assault deaths except for those which occur where there is no relationship between the perpetrator and deceased and no context of domestic violence, or where the identity of the perpetrator is unknown.

DEATHS OCCURRING IN A CONTEXT OF DOMESTIC VIOLENCE – SUMMARY OF DATA REPORTING PERIOD

- The majority of female external cause assault deaths occurred in a context of domestic violence (128 deaths or 51.82% of all female external cause assault deaths). For males, 18.06% of all external cause assault deaths during the reporting period occurred in a context of domestic violence (93 deaths).
- Of the females who were killed in a context of domestic violence, 78.91% were killed by their intimate partner and 21.1% were killed by a relative/kin.
- Of the males who were killed in a context of domestic violence, 32.26% were killed by their intimate partner and 49.46% were killed by a relative/kin.
- The majority of female external cause assault deaths were perpetrated by the current or former intimate partner of the deceased (128 deaths or 51.82% of all female external cause assault deaths). 6.99% of all male external cause assault deaths were perpetrated by the current or former intimate partner of the deceased (36 deaths).
- For deaths perpetrated by a relative/kin in a context of domestic violence, the highest number of deceaseds fell within the age range 0-4 years (21 male deceaseds and 15 female deceaseds).
- The highest number of deaths perpetrated by a relative/kin in a context of domestic violence were perpetrated by the father of the deceased (26 deaths including males and females), followed by the mother of the deceased (18 deaths including males and females). The majority of all deaths perpetrated by a relative/kin in a context of domestic violence were perpetrated by either the father or mother of the deceased (60.27%).

- Of all external cause assault deaths occurring in a context of domestic violence during the reporting period, 14.03% of all deceaseds identified as Aboriginal and/or Torres Strait Islander (16 males and 15 females – 31 deceaseds in total).

- Of all external cause assault deaths occurring in a context of domestic violence during the reporting period, 12.32% of all perpetrators identified as Aboriginal and/or Torres Strait Islander (17 males and 9 females – 26 perpetrators in total).

IN-DEPTH CASE REVIEWS - OVERVIEW

- This report provides in-depth case summaries and recommendations in relation to 16 closed cases between 30 March 2008 and 30 June 2009 (the 'case review period'). Each case review outlines the narrative of each case, any history of domestic violence and any service contact.

- This report sets out key themes and recurrent issues identified in the 16 in-depth case reviews, including:

    - History of domestic violence;
    - Child custody issues;
    - No contact with service agencies;
    - Friends and family aware of domestic violence;
    - Reluctance to engage legal pathways (such as police/legal avenues);
    - History of AVOs between deceased and perpetrator;
    - Vulnerability due to citizenship status;
    - Abuse of older people;
    - Deceased socially and geographically isolated;
    - Help-seeking behaviour from informal sources (such as religious or spiritual leaders/community leaders/school community); and
    - Relationship termination/separation.

- The Team has synthesized data and case review information to make 14 recommendations.

LIST OF RECOMMENDATIONS: 2011-2012 ANNUAL REPORT

RECOMMENDATION 1

That section 101B(1) of the *Coroners Act 2009* (NSW) be amended as follows:

"domestic violence death" means:

(a) the death of a person that is caused directly or indirectly by a person who was in a domestic relationship with the deceased person, ***and the death occurs in the context of domestic violence; or***
(b) ***the death of a person that is a third party to a domestic relationship, and the death occurs in the context of domestic violence.***

RECOMMENDATION 2

That section 101C(1)(d) of the *Coroners Act 2009* (NSW) be amended to omit the words ***and there have been previous episodes of domestic violence between them***.

RECOMMENDATION 3

That Part 9A(2) [s101E] of the *Coroners Act 2009* (NSW) relating to the Constitution and Procedure of the Domestic Violence Death Review Team be amended to include a representative from Corrective Services NSW (CSNSW).

RECOMMENDATION 4

That the NSW Police Force incorporate into the existing domestic and family violence Standard Operating Procedures a requirement whereby a COPS event must be promptly created by the responding officer/person handling the inquiry, within his or her shift, any time:

a) assistance/advice is sought in relation to a child custody issue, regardless of whether or not the child is considered to be at risk of harm;
b) assistance/advice is sought in relation to making an application for an ADVO; and
c) assistance/advice is sought in relation to a breach of an ADVO.

RECOMMENDATION 5

That the NSW Police Force include each of the following questions in the standard 'Domestic Violence Related Checklist':

a) Has the perpetrator previously threatened to commit suicide?
b) Has the perpetrator previously attempted to commit suicide?
c) Has the perpetrator previously threatened to kill the victim and/or other family members?
d) Has the perpetrator previously threatened or assaulted the victim and/or other family members with a weapon?
e) Are there any child custody issues (ask victim)?
f) Are there any child custody issues (ask perpetrator)?

RECOMMENDATION 6

That the NSW Police Force incorporate into its existing domestic and family violence Standard Operating Procedures the requirements that:

- in cases where the standard 'Domestic Violence Related Checklist' reveals the presence of any domestic violence risk factors, the police must inform the victim of the increased risk of lethality posed to them; and
- responding officers physically provide referral information to the domestic violence victim in the form of the Domestic Violence referral kit.

RECOMMENDATION 7

That the NSW Police Force develop specific Standard Operating Procedures for responding officers in domestic violence cases where the victim is reluctant to pursue legal pathways.

These Standard Operating Procedures should include the requirement that responding officers leave domestic violence support and referral information at the premises where the domestic violence incident occurred, even in cases where police entry to the premises is refused or where the victim presents as uncooperative.

RECOMMENDATION 8

That the NSW Police Force commission a review of the implementation of legislation within the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) that requires police officers to apply for ADVOs wherever they have fears for the safety of victims.

This review should ascertain the extent to which this provision is used, particularly with regards to Indigenous victims of domestic violence.

RECOMMENDATION 9

That as part of the NSW Ageing Strategy, the NSW Ministerial Advisory Committee on Ageing give strong consideration to using case reviews 8 and 9 of the 2011/2012 NSW Domestic Violence Death Review Team Annual Report to inform the development of training resources for the new NSW helpline dedicated to abuse of older people and the corresponding resource unit.

RECOMMENDATION 10

That the NSW Government commission the development and implementation of a public education strategy aimed at improving the reporting of domestic violence, including physical violence and controlling and coercive behaviour. This should be targeted at reporting by:

- victims;
- family, friends and neighbours of victims; and
- specific groups such as Indigenous women, young women and older women, and women who speak languages other than English.

The strategy should draw on international research, and should aim to educate the community about the nature and dynamics of domestic violence, including:

- the times when victims are most at risk such as at the point of separation, when disputes arise in relation to child custody and during pregnancy;
- the presence of risk factors such as stalking behaviour, coercive and controlling behaviour or economic abuse, which may fall outside of the paradigm of traditional physical domestic violence; and
- education regarding teen dating violence, healthy relationships, cyber abuse and identifying when conduct becomes serious criminal behaviour requiring police intervention.

The strategy should provide practical advice to victims, family, friends and neighbours and specific groups about:

- how to respond to domestic violence;
- where assistance can be sought including domestic violence help lines and the police; and
- how and when to contact police and emergency services.

RECOMMENDATION 11

That the NSW Government commission or undertake a study into Indigenous women's experiences of domestic and family violence. This study should inform the development of strategies to:

- encourage and support Indigenous victims to report family violence;
- facilitate continued participation of Indigenous victims throughout legal processes;
- strengthen access to relevant specialist Indigenous and mainstream services;
- ensure training is made available for police and other professionals in relation to the dynamics impacting on the reporting of violence by Indigenous victims;
- improve connections between Indigenous health services and domestic and family violence services;
- improve the response to victims and perpetrators who have complex needs, including needs arising from drug and alcohol misuse, mental illness and homelessness; and
- introduce and implement a family violence prevention program aimed at Indigenous youth.

RECOMMENDATION 12

That the NSW Government develop and implement an inter-faith working party on the issue of domestic violence. Such a party should:

- develop consistent strategies, policies and organisational plans within religious organisations for responding to domestic violence when such violence is suspected or apparent within the congregation or religious community;
- develop and implement training and education materials for religious leaders around issues of responding to and reporting domestic violence where such violence is suspected or apparent within the congregation or religious community; and
- develop and implement training and education materials for congregations or religious communities around domestic violence.

RECOMMENDATION 13

That the NSW Government encourage the Commonwealth Department of Immigration and Citizenship (DIAC) to:

- develop training programs for its agents/officers regarding the nature and dynamics of domestic violence, including the vulnerability caused by the actual/threatened withdrawal of sponsorship;

- adopt a proactive approach whereby all claims for the family violence provision are referred to an independent expert in family violence matters, and are not rejected or otherwise assessed in the negative by any agent or representative of DIAC other than an independent expert in family violence;
- require agents/officers who may be adjudicating claims for family violence provisions or who are responding to enquiries made in relation to such provisions to make appropriate referrals to law enforcement and social service agencies;
- ensure victims of domestic violence who make an application to DIAC for family violence provision have access to emergency funding or limited government benefits irrespective of their visa status; and
- require the agents/officers of DIAC to interview female and male partners separately in any cases where domestic violence is reported or suspected.

RECOMMENDATION 14

That the Department of Family and Community Services – Housing NSW remind operational staff to inform tenants of domestic violence services, where appropriate, when they become aware of domestic or family violence occurring within a public housing property.

REPORT STRUCTURE

This report is divided into 4 sections:

- Section I: Introduction and Report Overview;
- Section II: Database and Case Review Framework;
- Section III: Data Analysis; and
- Section IV: Case Reviews and Recommendations.

Section I sets out the establishment, objectives and functions of the Domestic Violence Death Review Team as well as the legislative and working definitions and terminology used by the Team. This section also considers the Team's confidentiality and access to information provisions and provides an overview of the Team's activities for 2011-2012.

Section II outlines the database and the case review frameworks in which the Team conducts its statutory functions, describing the scope of inquiry, case identification and categorisation processes and review criteria.

Section III provides a detailed analysis of all external cause assault deaths occurring in New South Wales between 1 July 2000 and 30 June 2009, focusing on those deaths which occurred in a context of domestic violence.

Section IV sets out case review summaries and recommendations related to those deaths which occurred in a context of domestic violence between 10 March 2008 and 30 June 2009.

SECTION I: INTRODUCTION & REPORT OVERVIEW

CHAPTER 1: INTRODUCTION

CHAPTER 1: OVERVIEW

- The Domestic Violence Death Review Team was established in 2010, thereby creating a permanent domestic violence fatality review process in New South Wales.
- The core functions of the Team are to review and analyse closed cases of domestic violence deaths, maintain a database of all closed external cause assault deaths from 1 July 2000 and develop recommendations and research which aims to prevent or reduce the likelihood of such deaths.

This is the second annual report of the New South Wales Domestic Violence Death Review Team ('the Team') and the first to contain substantive case reviews, recommendations and data concerning domestic violence deaths in New South Wales during the period 1 July 2000 – 30 June 2009 ('data reporting period').

The Team notes the recent publication of the NSW Auditor General's Report *Responding to Domestic and Family Violence* (2011) and the NSW Legislative Council Standing Committee on Social Issues '*Inquiry into domestic violence trends and issues in NSW*' (2012). These processes have resulted in extensive recommendations targeting NSW Government agencies, and this report does not duplicate those recommendations.

This Chapter outlines the establishment, objectives and functions of the Team as well as the legislative and working definitions and terminology used by the Team, and Team activities for the 2011-2012 reporting year.

For further detail regarding the Team's establishment, constitution and operation, refer to the 2010-2011 Annual Report.[18]

1.1 BACKGROUND & ESTABLISHMENT

An identifiable history of domestic violence is a common feature in a high proportion of domestic homicides, particularly in relation to intimate partner homicide.[19] As such, 'domestic violence deaths' are characterised by predictable elements and can accordingly be regarded as preventable.[20]

In many jurisdictions, the growing perception of domestic violence deaths as preventable has led to the establishment of domestic violence death review teams. Such teams generally operate as 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 victims and perpetrators of domestic violence.[21]

In December 2008 the New South Wales Government convened the Domestic Violence Homicide Advisory Panel to address the issue of establishing a domestic violence fatality review process in New South Wales.

The Panel handed down its report in mid-2009, unanimously recommending that a permanent domestic violence death review team be established in New South Wales 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.

[18] http://netcatstaging.agd.law.nsw/agdbasev7stgwr/_assets/coroners/m401601l5/dvdrt_annual_report_oct2011x.pdf, accessed October 2012.
[19] M. Aldridge & K. Browne, Perpetrators of Spousal Homicide: A Review (2003), 4(3) *Trauma, Violence & Abuse*.
[20] N. David, *Exploring the Use of Domestic Violence Fatality Review Teams*, Australian Domestic & Family Violence Clearinghouse Issues Paper no. 15 (2007) Sydney.
[21] Ibid.

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 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. This Chapter provides an overview of the key elements of the Team's legislative framework.

1.2 OBJECTIVES & FUNCTIONS

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.[22]

A key focus of the Team is to promote inter-agency collaboration, co-operation and communication in order to identify systemic and procedural deficiencies. The Team does not focus on the negligence or actions of individuals or individual agencies.

The core functions of the Team are to:

- review and analyse individual closed cases of domestic violence deaths;[23]
- 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.[24]

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

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

1.3 DEFINITIONS & TERMINOLOGY

1.3.1 DOMESTIC VIOLENCE

'Domestic violence' is not defined in the Team's establishing legislation. Furthermore, with definitions varying between jurisdictions as to the nature of the relationship encompassed and the types of violence included, there exists no internationally agreed definition of domestic violence.[25]

The term 'family violence' 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.[26] In particular, the phrase 'family violence' is said to more accurately reflect the extended nature

[22] *Coroners Act 2009* (NSW) s 101A.
[23] A domestic violence death is defined as 'closed' if the coroner has dispensed with or completed an inquest concerning the death/s, and any criminal proceedings (including appeals) concerning the death have been finally determined: *Coroners Act 2009* (NSW) s 101B(2).
[24] *Coroners Act 2009* (NSW) s 101F(1).
[25] Office for Women's Policy, *Discussion Paper on NSW Domestic and Family Violence Strategic Framework*, (2008) NSW Department of Premier and Cabinet; Australian Bureau of Statistics, *Conceptual Framework for Family and Domestic Violence*. (2009) ABS cat. no. 4529.0, Canberra.
[26] NSW Ombudsman, *Domestic Violence: Improving Police Practice* (2006) Sydney.

of Aboriginal and Torres Strait Islander communities, where kinship relationships may add a layer of complexity to the concept of domestic relationships and domestic violence.[27]

In New South Wales legislation,[28] '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.

1.3.2 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; 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 or parenting issues in relation to any children; asserting that the police and justice system will not assist, support or believe the victim; and denying an individual's reality;

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; 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.[29]

[27] Office for Women's Policy, *Discussion Paper on NSW Domestic and Family Violence Strategic Framework*, (2008) NSW Department of Premier and Cabinet.
[28] For example, the *Crimes (Domestic and Personal Violence) Act 2007* (NSW).
[29] 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*, (March 2009) Commonwealth of Australia; Australian Bureau of Statistics, *Conceptual Framework for Family and Domestic Violence* (2009) ABS cat. no. 4529.0, Canberra.

1.3.3 DOMESTIC VIOLENCE OFFENCE

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* (NSW). This 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.[30]

A 'personal violence offence' is defined by reference to a large number of criminal offences in the *Crimes Act 1900* (NSW)[31] as well as stalking or intimidation offences set out in the *Crimes (Domestic and Personal Violence) Act 2007* (NSW).[32]

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 Indigenous Australians.[33] It does not matter whether the relationship is a current or former relationship.

Regardless of whether a perpetrator's conduct constitutes a domestic violence offence, the Team acknowledges that all domestic violence behaviours are unacceptable and every person has the right to live their life safely and without fear.

1.3.4 DOMESTIC VIOLENCE DEATH

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.[34]

This recognises that the purview of the Team's work includes not only domestic homicides, but also those cases where fatal accidents were caused by domestic violence behaviour, or where domestic violence was a primary catalyst for suicide.

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.[35]

1.4 ACCESS TO & CONFIDENTIALITY OF INFORMATION

The effective operation of the Team relies on its ability to obtain as much information as possible about the circumstances in which domestic violence deaths occur.

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.

[30] *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 11.
[31] *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 4.
[32] *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 13.
[33] *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 5.
[34] *Coroners Act 2009* (NSW) s 101B(1).
[35] *Coroners Act 2009* (NSW) s 101C.

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; [36]
- issues relating to confidentiality; [37] and
- protection from liability.[38]

Each 'team related person'[39] has signed a confidentiality agreement acknowledging that they will observe the confidentiality provisions of the Act.

1.5 TEAM ACTIVITIES: 2011-2012

1.5.1 MEETINGS

In accordance with the Act,[40] the Team met four times during the review period, with meetings taking place on the following dates:

- 13 September 2011;
- 13 December 2011;
- 6 March 2012; and
- 12 June 2012.

1.5.2 CONFERENCES & PRESENTATIONS

- The Team's Manager presented the keynote address at the NSW Police, Domestic Violence Liaison Officer Conference, Goulburn in 2011.
- The Team's Manager attended the Victim's Advisory Board meeting in November 2011, providing a briefing in relation to the establishment and current activities of the Team.
- The Team Secretariat attended the 'Intimate Partner Violence & Homicide Symposium: Precursors, Pathways and Prevention', convened by Griffith University, in May 2012.

1.5.3 RESEARCH & COLLABORATIONS

Part of the legislative function of the Team is to undertake, alone or with others, research that aims to help prevent or reduce the likelihood of domestic violence deaths.[41] Current research projects are set out below.

[36] *Coroners Act 2009* (NSW) s 101L.
[37] *Coroners Act 2009* (NSW) s 101M.
[38] *Coroners Act 2009* (NSW) s 101O.
[39] *Coroners Act 2009* (NSW) s 101M(5).
[40] *Coroners Act 2009* (NSW), sch 3 cl 8.
[41] *Coroners Act 2009* (NSW) s101F(1)(e).

AUSTRALIAN DOMESTIC & FAMILY VIOLENCE DEATH REVIEW NETWORK

Following the implementation of domestic and family violence death review mechanisms in several Australian jurisdictions in recent years, the Australian Domestic and Family Violence Death Review Network ('the Network') was established in March 2011. The Network's Terms of Reference are set out at Annexure B.

The overarching goals of the Network are to:

- improve knowledge regarding the context and circumstances in which domestic and family violence deaths occur in order to identify changes to practices and systems that may assist in preventing future deaths;
- identify at a national level the context of, and risks associated with, domestic and family violence-related deaths;
- identify, collect, analyse and report national data on domestic and family violence-related deaths; and
- use domestic and family violence death review findings to enhance or influence programs at a national level.

The establishment of the Network aligns with Strategy 5.2 of the national policy agenda as detailed in *The National Plan to Reduce Violence Against Women and their Children 2010 – 2022*. This mandates that States and Territories work together to:

> **Strategy 5.2**: Strengthen leadership across justice systems.
>
> **Action 2** - Drive continuous improvement through sharing outcomes of reviews into deaths and homicides related to domestic violence.
>
> **Immediate national initiatives**: Monitor domestic violence-related homicide issues to inform ongoing policy development, including the Australian Institute of Criminology's National Homicide Monitoring Program to research domestic violence-related homicides, risk factors and interventions.

The Team's participation in the Network accords with the legislative function of the Team as set out at 101F(4) of the Act, which states that;

> 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.

As at 30 June 2012, the Network comprised representatives from each of the established Australian domestic violence death review teams, namely New South Wales, Queensland, South Australia and Victoria.

The Team's Manager is the current chair of the Network.

SECTION II: DATABASE & CASE REVIEW FRAMEWORK

CHAPTER 2: DATABASE FRAMEWORK

CHAPTER 2: OVERVIEW

- The Team conducts retrospective surveillance of all external cause assault deaths in New South Wales from 1 July 2000 and captures information for each death in the DVDRT Database.
- This annual report presents data in relation to all closed external cause assault deaths within the period 1 July 2000 – 30 June 2009.
- The Team categorises all external cause assault deaths by the relationship between the perpetrator and deceased and then further categorises the death based on whether or not the death occurred in a context of domestic violence. Each relationship is categorised as either 1A, 1B, 2A, 2B, 3A, 3B or 4, depending on both the relationship and domestic violence context of each death.
- The database captures extensive demographic, service contact and risk factor information for each death (with increased data capture capabilities for deaths occurring in a context of domestic violence).

A primary aspect of the Team's legislative function is the collection of data in relation to domestic violence deaths in New South Wales. Accordingly, the Team has developed the Domestic Violence Death Review Team Database ('DVDRT Database') which captures significant demographic information as well as information regarding risk factors, service contact and historical information for each 'external cause assault death' occurring in New South Wales.

An external cause death is defined as any death that results directly or indirectly from environmental events or circumstances that cause injury, poisoning and other adverse effects.[42] The Team's operational definition of an 'external cause death' is the death of a person caused by a perpetrator through the application of assaultive force or by criminal negligence (excluding 'vehicle manslaughter').

2.1 SCOPE OF INQUIRY

In order to create a robust dataset in relation to domestic violence deaths, the DVDRT Database is designed to capture a significant amount of information in relation to all external cause assault deaths that have occurred in New South Wales since 1 July 2000. This date coincides with the commencement date of the National Coroners Information System (described below) which is a primary research tool used by the Team.

This report presents data in relation to all closed external cause assault deaths within the period 1 July 2000 – 30 June 2009 ('data reporting period').

Although this report primarily presents demographic information for domestic violence deaths, future directions in the data reporting of the Team will include trends and patterns in relation to risk factors and service contact for domestic violence deaths, and suicides occurring in a context of domestic violence.

[42] World Health Organisation (WHO), (1992) International Statistical Classification of Diseases and Related Health Problems, 10th Revision.

2.2 CASE IDENTIFICATION PROCESS

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').[43]

To build and maintain the dataset of domestic violence deaths from 1 July 2000, therefore, requires retrospective surveillance of all external cause assault deaths caused by a perpetrator to determine the relationship between the perpetrator and the deceased and the context of the killing.

External cause assault deaths for the relevant timeframe are identified and data is collected using the following resources:

- the National Coroners Information System ('NCIS');
- NSW Justicelink;
- Prosecution and Coronial briefs;
- Agency Websites (NSW Police, Judicial Information Resources System);
- Media resources; and
- NSW Caselaw.

2.2.1 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.[44] While the NCIS is primarily a tool designed 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 the Victorian Institute of Forensic Medicine and is managed by the Victorian Department of Justice. The NCIS is funded by a range of different Commonwealth and State/Territory agencies.[45]

For every reportable death, the NCIS records extensive demographic information, 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 (for example, whether it occurred as a consequence of natural causes or external causes, including intentional self harm) and provides links to electronic copies of full text reports, including: the police narrative of circumstances of death; the autopsy and toxicology reports; and Coroner's findings.

Different search functions can be employed to either retrieve a specific case (for example, by name, local case number, or deceased's date of birth) or to search across multiple cases for common characteristics.

While some limitations exist in relation to the 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 the NCIS as the start date for case inclusion in the Team's dataset.

To assist in case identification and maintenance, the Team uses data derived from the NCIS in combination with data derived from other sources to cross-check the accuracy of information.

[43] The term 'perpetrator' is used to describe the person who causes, directly or indirectly, the death of the deceased. The Team acknowledges that a person who has been the victim of domestic violence abuse may be the perpetrator of a domestic violence death. Accordingly the Team uses the neutral term 'deceased' to describe a person who is killed.
[44] Queensland data is available from January 2001.
[45] http://www.ncis.org.au/index.htm, accessed October 2012.

2.2.2 NSW JUSTICELINK

Justicelink is the computer system used by NSW Local, District and Supreme Courts and it captures information in relation to both open and closed matters from all NSW courts.

The Team uses Justicelink to conduct law part code searches in relation to 'murder' and 'manslaughter' matters, in order to generate a list of persons charged in relation to external cause assault deaths. This generates lists which are then reviewed and cross-checked against lists of deceaseds identified from Coronial records.

This tool is also used to monitor the progress of cases through the criminal justice system and/or Coronial system to determine when matters are closed and are suitable for review and inclusion in the DVDRT Database.

2.2.3 BRIEFS OF EVIDENCE – PROSECUTION AND CORONIAL

To assist in case identification and categorisation procedures and to generate information in relation to risk factors and service contact history relevant to particular cases, the Team reviews briefs of evidence from the NSW Department of Public Prosecutions following the completion of criminal proceedings.

The Team also reviews Coronial briefs of evidence prepared for inquest and relevant information is extracted for inclusion in the database once matters are finalised and closed.

2.2.4 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.

2.2.5 AGENCY WEBSITES

To assist in case identification and monitoring, the Team regularly reviews websites monitored by NSW agency bodies, including the NSW Police Force and the Judicial Information Research System ('JIRS'). Constant surveillance of these information resources assists in the identification of new cases, and the monitoring of case outcomes through the criminal justice system.

2.2.6 MEDIA RESOURCES

The Team monitors local, regional and metropolitan newspapers and media services for articles concerning potential or confirmed external cause assault deaths. This assists in case identification, the identification of perpetrators and the monitoring of cases through criminal justice and/or Coronial proceedings.

2.3 CASE CATEGORISATION

2.3.1 RELATIONSHIP CATEGORISATION

Once an external cause assault 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) of the Act] includes the usual familial relationships (including in-laws of an intimate partner) and extended family or kin where kinship systems are relevant;

Category 3: No relationship – encompasses relationships that are neither intimate nor familial, including: non-intimate friends, acquaintances, carers, flat-mates, and strangers; or

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

All categories of external cause assault deaths are captured in the DVDRT Database.

2.3.2 DOMESTIC VIOLENCE CONTEXT CATEGORISATION

After categorizing the relationship between the perpetrator and the deceased, the Team then examines the circumstances surrounding the death to determine whether or not the death occurred in a context of domestic violence.

Research shows that domestic homicides typically occur where there has been a history of domestic violence between the parties. Domestic homicides that occur in circumstances where there is no prior history of violence can usually be attributed to other factors, for example, where the perpetrator is experiencing an acute mental health episode or financial pressures. In any event, these deaths (classified below as Category B) are comparatively rare and in the majority of domestic homicides, there has been a history of violence between the deceased and the perpetrator (see Chapter 4: Data Analysis Summary).

The characteristics of domestic homicides that do not occur in a context of domestic violence are markedly different to those where there has been a history of domestic violence. It is therefore important that they are appropriately distinguished within the Team's database and review process.

Given the significant under-reporting of domestic violence it is, of course, possible that some individuals are killed by an intimate partner or family member without any history of domestic violence ever having been known or recorded. However, many individuals who experience domestic violence confide in friends and relatives, even in cases where such violence is not formally reported.

In order to ascertain whether or not a death has occurred in a context of domestic violence, the Team reviews all available case material for evidence of any relevant history of domestic violence between the perpetrator and deceased or other relevant parties,[46] whether reported formally to agencies or indicated informally to friends, family or other contacts.

[46] For example, there may be a history of domestic violence between intimate partners but the deceased is a child of the partnership and has not previously been the target of abuse.

A death that occurs in the course of the breakdown and/or separation of an intimate relationship or where there are known child custody issues[47] will be considered to have occurred in a context of domestic violence even where there is otherwise no identifiable history of domestic violence between the parties. This is because separation and child custody/parenting issues are well recognised risk factors in domestic violence killings.

Accordingly, Categories 1-3 [as described at 2.3.1] 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;[48]

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

2.3.3 MULTIPLE FATALITY INCIDENTS

In some cases a single perpetrator may kill multiple deceaseds (a 'Multiple Fatality Incident'). In these cases the relationship between the perpetrator and each deceased is considered individually.

For example, if a perpetrator kills his intimate partner and child, in the context of domestic violence, the death of the intimate partner would be a Category 1A death and the death of the child would be a Category 2A death.

2.3.4 MULTIPLE PERPETRATOR INCIDENTS

In some cases a deceased may be killed by multiple perpetrators acting together (a 'Multiple Perpetrator Incident'). In these cases the relationship between the deceased and each perpetrator may be such that the death sits in multiple categories.

For example, if a deceased is killed by both their intimate partner and their child, in the context of domestic violence, this would be both a Category 1A death (deceased killed by intimate partner) as well as a Category 2A death (deceased killed by relative/kin). In these circumstances the death is effectively counted twice, once as a Category 1A death and once a Category 2A death.

As a consequence, the individual deaths recorded in each category may not necessarily add up to the total number of deceaseds and adding the categories together may result in a greater number of deaths being recorded. Where a deceased is killed by multiple perpetrators and the relationship between the deceased and each perpetrator is such that death sits in only one relationship category (for example, if a child is killed by both parents), the issue of double counting does not arise.

[47] The Team uses the term 'child custody issue' to describe issues around contact or residency in relation to children, either in the context of an ongoing relationship or post separation. This terminology reflects common usage and is not intended to reflect existing legislative definitions set out in the *Family Law Act 1975* (Cth).
[48] 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 former partner.

When calculating the total number of deaths in the data reporting period, any double counting is rectified to ensure that the total number of deaths recorded is accurate.

While a Multiple Perpetrator Incident may result in a death sitting in more than one relationship category (i.e. Category 1, 2, or 3), the context in which a death occurs will always be either Category A (in a context of domestic violence) or Category B (no identifiable context of domestic violence) and never both. For instance, if a deceased is killed by their intimate partner (Category 1) and another person that they do not know (Category 3), and that death occurs in a context of domestic violence (Category A), the death will be categorised as a Category 1A death and a Category 3A death, notwithstanding that there was no domestic violence relationship between the deceased and the stranger who was involved in their death.

FIGURE 1: Domestic Violence Death Review Database Framework

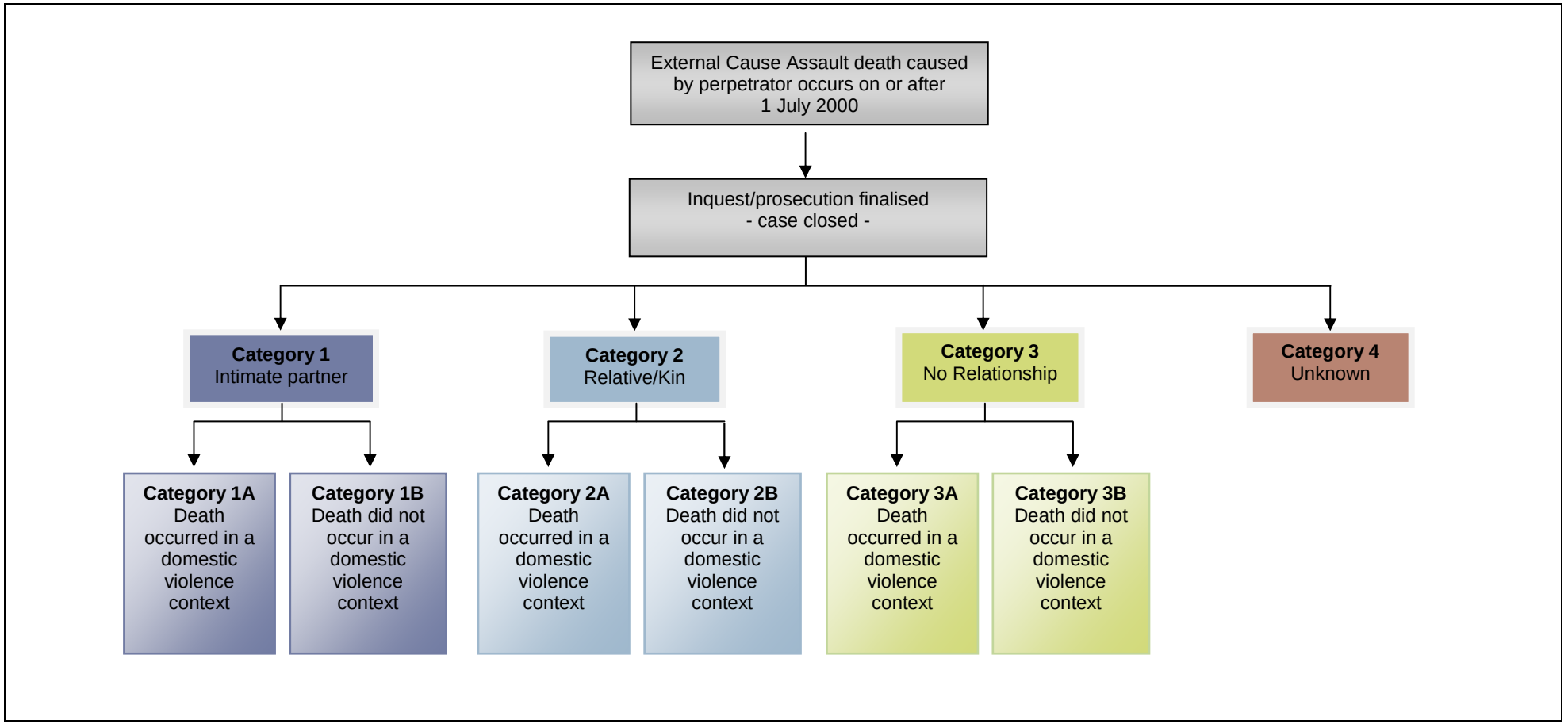
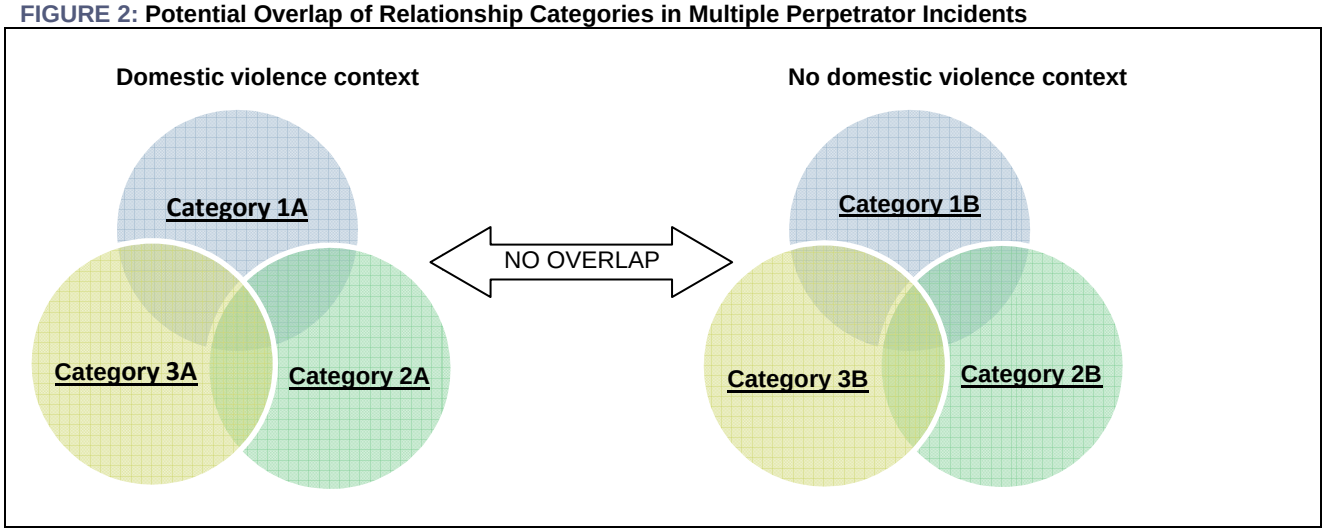


FIGURE 2: Potential Overlap of Relationship Categories in Multiple Perpetrator Incidents



2.4 THE DVDRT DATABASE

The DVDRT Database captures information concerning every external cause assault death from 1 July 2000. These deaths are identified and investigated using the process outlined above. The database captures demographic information in each category described above, including, in relation to both the deceased and the perpetrator:

- Name;
- Date of birth;
- Age;
- Postcode;
- Residence type;
- ATSI;
- Ethnicity;
- Country of birth;
- Disability status;
- Immigration status;
- Employment status;
- Usual occupation;
- Substance abuse history;
- Psychiatric history; and
- Criminal record.

The database, for all categories, also captures the following information with regard to the circumstances surrounding the death:

- Date of death;
- Manner of death;
- Location of fatal injury;
- Weapon used;
- Whether any children present at time of killing;
- Whether deceased was pregnant;
- Whether perpetrator committed suicide and if so, when this occurred in proximity to the killing;
- Relationship between perpetrator and deceased and category of relationship;
- If separation between perpetrator and deceased, length of separation;
- Any outcome (Coronial or criminal proceedings) including where relevant, plea, length of sentence and use of defences (e.g. provocation, self defence); and
- Use of substances (drugs and/or alcohol).

For all deaths occurring in a context of domestic violence (Categories 1A, 2A, and 3A), the database also captures:

- service contact history within 6 months of the death, and in period longer than 6 months of the death;
- risk factors; and
- the nature of the history of domestic violence between the deceased and the perpetrator, or other relevant parties (for example, children).

In conducting the data analysis presented in this report, the Team has aimed to present statistics regarding demographic and other information in relation to all external cause assault deaths, with a particular focus on deaths which have occurred in a context of domestic violence. Where necessary, explanations are included in combination with figures.

The Team only reviews, categorises, and reports on closed cases. Open cases are monitored until criminal or Coronial proceedings have concluded.

Future directions of the Team will include collecting and analysing further data around risk factors, service contact history and more detailed information around the history of relationships characterised by domestic violence. The 2012-2013 annual report will collate such data to facilitate the making of recommendations based on common risk factors, themes and trends surrounding domestic violence deaths.

CHAPTER 3: CASE REVIEW FRAMEWORK

CHAPTER 3: OVERVIEW

- The Team conducts in-depth case reviews of all closed external cause assault deaths caused by an intimate partner and all external cause assault deaths that occur in a context of domestic violence. The case review period for this Annual Report is 10 March 2008 – 30 June 2009.
- Case reviews are designed to provide information in relation to the demographics of perpetrators and deceaseds, the events leading up to the death and the circumstances surrounding the death, subject to review criteria. Case reviews are designed to highlight areas for reform in service responses to domestic violence and assist the Team to develop recommendations in accordance with its legislative function.

Case reviews are a powerful process as they enable experienced domestic violence stakeholders to contextualise and effectively analyse the specific facts of every reviewable case. The case review process used by the Team creates a unified forum for shared ideas and critical thinking and is a vital link to facilitate coordinated agency responses to domestic violence.

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

- the circumstances surrounding and the events leading up to the death of each deceased;
- any interaction with, and the effectiveness or otherwise of, support or other services provided for, or available to, both the deceased and the perpetrator;
- 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.[49]

3.1 SCOPE OF INQUIRY

The purpose of each case review is to examine all aspects of the case including:

- the demographics of the deceased and perpetrator;
- the events leading up to the death; and
- the circumstances surrounding the death.

This process is undertaken with a view to identifying limitations or weaknesses in service delivery, making recommendations in order to address such limitations, and developing intervention and prevention strategies so as to reduce the likelihood of deaths occurring in similar circumstances in the future.

For this report, the Team has conducted in-depth case reviews of all deaths that have occurred in a domestic violence context between 10 March 2008 – 30 June 2009, inclusive. The start date of the case review period (10 March 2008) has been selected as it coincides with the commencement of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) and the end date of the case review period ensures that that maximum number of cases are closed, while still being sufficiently recent to enable the Team to make meaningful recommendations to the various stakeholder agencies.

[49] *Coroners Act 2009* (NSW) s 101G.

3.2 REVIEW CRITERIA

For inclusion in this report, the Team has conducted in-depth case reviews of all closed cases in the following categories where the death occurred in the case review period:

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

In total, the Team has reviewed 16 closed cases where the deaths occurred during this review period.

Cases that fall within this period and were not closed as at 30 June 2012 will be reviewed in subsequent annual reports.

3.3 REFERRAL OF CASES FOR REVIEW

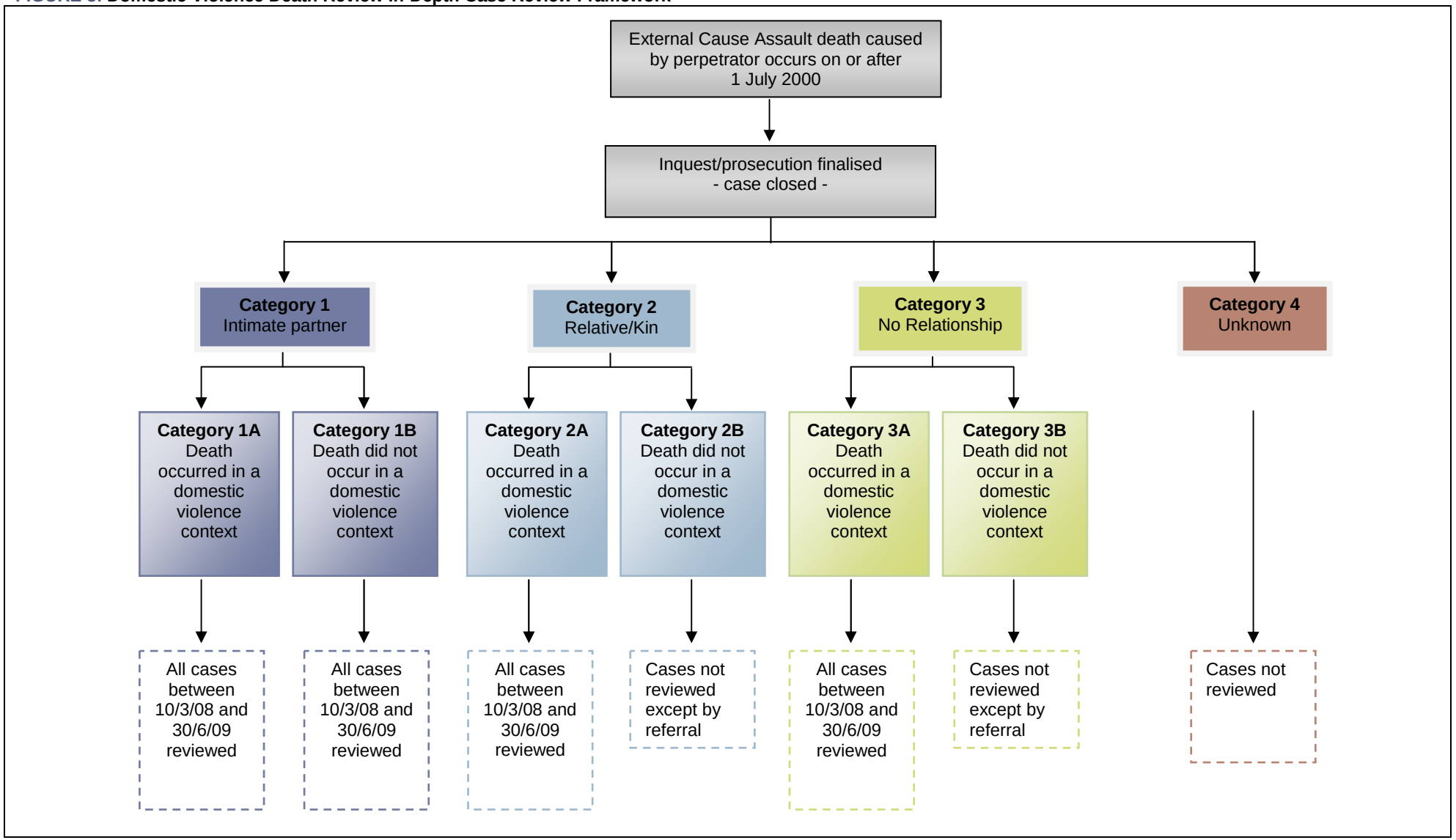
Notwithstanding the scope of inquiry and review criteria identified above, any person may refer a closed case of a domestic violence death to the Team for review.[50]

Such referrals are 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.

Such referrals are considered on a case-by-case basis and are reviewed subject to the same review protocols as cases within each specified review period.

[50] *Coroners Act 2009* (NSW) s 101H.

FIGURE 3: Domestic Violence Death Review In-Depth Case Review Framework



3.3.1 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 to conduct an in-depth review of the case.

At first instance this material 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 Secretariat and a comprehensive summary prepared which sets out, in as much detail as possible, information including:

- deceased/perpetrator profiles – including demographic information such as: 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 death;
- relationship history – including the nature, duration and history of the relationship between the deceased and the perpetrator;
- details of the death – 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 /parenting 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 of that information. A secondary call for that information is then made and the supplementary case material is incorporated into the case summary and is considered by the Team.

3.3.2 RECOMMENDATIONS

Where appropriate, the Team formulates recommendations with respect to legislation, policies, practices and services. These recommendations are developed based not only on individual cases where specific service contact/response or other issues are identified, but are also developed from reviewing the cases collectively, and are aimed at addressing systemic gaps and limitations in current service contact and response.

These recommendations are targeted for implementation by government and non-government agencies. The Team will undertake ongoing monitoring of any recommendations made, and subsequent annual reports will track the response and implementation of recommendations across agencies.

SECTION III: DATA ANALYSIS

CHAPTER 4: DATA ANALYSIS SUMMARY

CHAPTER 4: OVERVIEW

- The majority of female external cause assault deaths during the data reporting period occurred in a context of domestic violence.
- The majority of male external cause assault deaths occurred where there was no relative/kin or intimate relationship between the perpetrator and deceased, and there was no context of domestic violence.
- The majority of female external cause assault deaths were perpetrated by the intimate partner of the deceased. These deaths did not all occur in a context of domestic violence.

As outlined in Chapter 2, the Team reviews each closed external cause assault death. Each death is categorised by reference to the relationship between the deceased and the perpetrator and whether or not the death occurred in a context of domestic violence, as follows:[51]

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.[52]

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

Category 4 – Perpetrator is unknown.

During the data reporting period there were 724 incidents resulting in one or more external cause assault deaths caused by a perpetrator.[53]

From these 724 incidents, there were a total of 763 deceaseds.[54] Of the 763 deceaseds, 515 were male, 247 were female, and 1 deceased was transgender.[55]

The highest number of male external cause assault deaths (n=344) during the data reporting period were classified as Category 3B deaths.

The highest number of female external cause assault deaths (n=101) during the data reporting period were classified as Category 1A deaths.

[51] See Chapter 2 for further description of the categorisation process.
[52] 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 former partner. See section 2.3 for further detail.
[53] Including cases of manslaughter by criminal negligence but excluding 'motor vehicle manslaughter'.
[54] This figure includes Multiple Fatality Incidents where there is more than one external cause assault death caused by a perpetrator.
[55] It is noted that the one transgender death recorded is a Category 3B and hence no further data analysis is undertaken in relation to this death.

28.96% of all external cause assault deaths occurred in a context of domestic violence (Category 1A, 2A, and 3A deaths). This indicates that 221 of the 763 external cause assault deaths occurred in the context of domestic violence.

For males, 18.06% of all external cause assault deaths during the reporting period occurred in a context of domestic violence (93 out of 515 deaths). For females, 51.82% of all external cause assault deaths during the data reporting period occurred in a context of domestic violence (128 out of 247 deaths).

During the data reporting period, 51.82% of all females were killed by their intimate partner (128 out of 247 external cause assault deaths). 6.99% of all males were killed by their intimate partner (36 out of 515 external cause assault deaths).

During the data reporting period, 27 females were killed by a relative/kin in a context of domestic violence. 46 males were killed by a relative/kin in a context of domestic violence.

During the data reporting period, 1 female was killed by a person with whom she had no relationship, in a context of domestic violence. 19 males were killed by a person with whom they had no relationship, in a context of domestic violence (Category 3A).

Of the males who were killed in a context of domestic violence, 32.26% were killed by their intimate partner (30 out of 93 deaths) and 49.46% were killed by a relative/kin (46 out of 93 deaths).

Of the females who were killed in a context of domestic violence, 78.91% were killed by their intimate partner (101 out of 128 deaths) and 21.1% were killed by a relative/kin (27 out of 128 deaths).

Of all external cause assault deaths occurring in a context of domestic violence during the reporting period, 14.03% of all deceaseds identified as Aboriginal and/or Torres Strait Islander (16 males and 15 females – 31 out of 221 deceaseds).

Of all external cause assault deaths occurring in a context of domestic violence during the reporting period, 12.32% of all perpetrators identified as Aboriginal and/or Torres Strait Islander (17 males and 9 females – 26 out of 211 perpetrators).

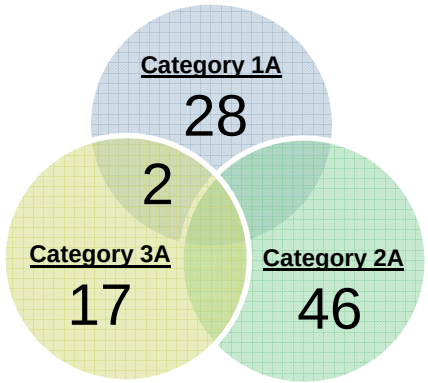
For the data reporting period, there were 6 deceaseds (4 males, 2 females) who were killed by multiple perpetrators and the relationship between the deceased and each perpetrator was such that the death sits across more than one relationship category.[56] This leads to a double count of 6 deceaseds which results in a total of 769 deaths being recorded (519 males, 249 females) when the individual categories are added together.

Comprehensive analysis for Category 1A, 1B, 2A, 2B, and 3A deaths is set out in the following chapters. No detailed analysis is carried out in relation to Category 3B or Category 4 deaths.

[56] As discussed above at section 2.3, where a deceased is killed by multiple perpetrators the death may be counted in multiple categories due to the different relationships between the deceased and each perpetrator. For example, a deceased who is killed by their son (Category 2B) and their intimate partner (Category 1B), where there is no identifiable domestic violence context. See 'Multiple Perpetrator Incident' in Annexure C: DVDRT Dictionary.

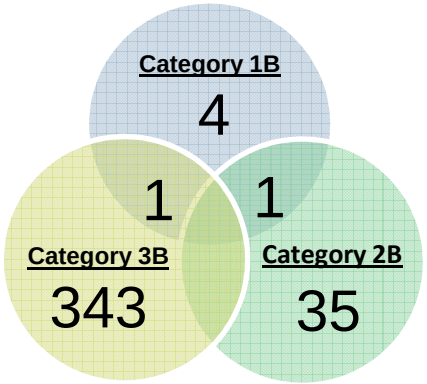
FIGURE 4: Total No. Deceaseds - Overlap of Relationship Categories in Multiple Perpetrator Incidents

Male deaths – domestic violence context (n=93)



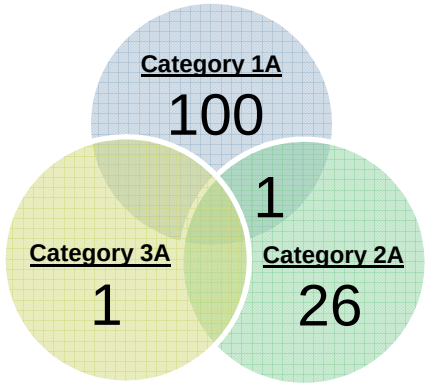
Category 1A: n=30 Category 2A: n=46 Category 3A: n=19

Male deaths – no domestic violence context (n=384)



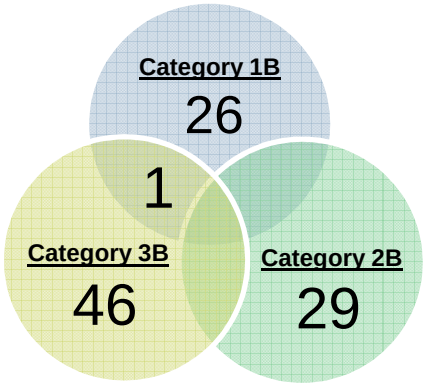
Category 1B: n=6 Category 2B: n=36 Category 3B: n=344

Female deaths – domestic violence context (n=128)



Category 1A: n=101 Category 2A: n=27 Category 3A: n=1

Female deaths – no domestic violence context (n=102)



Category 1B: n=27 Category 2B: n=29 Category 3B: n=47

FIGURE 5: Death Classification by Category

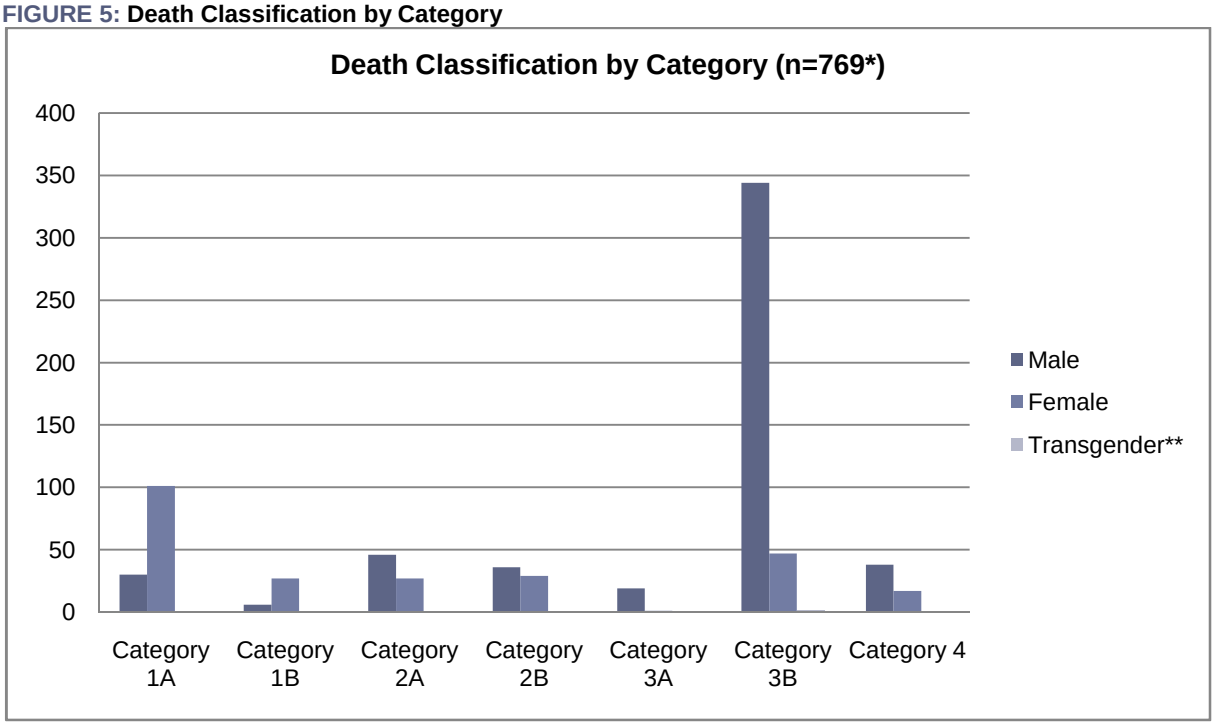


FIGURE 6: Death Classification by Category (Male)

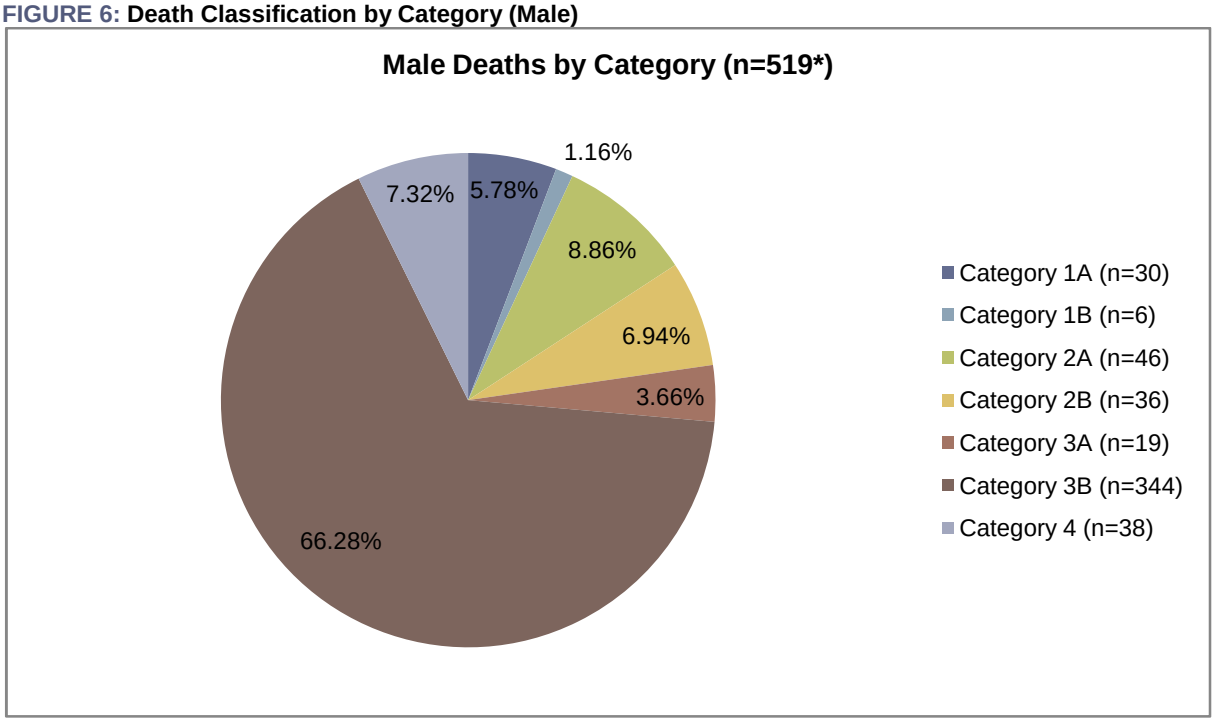
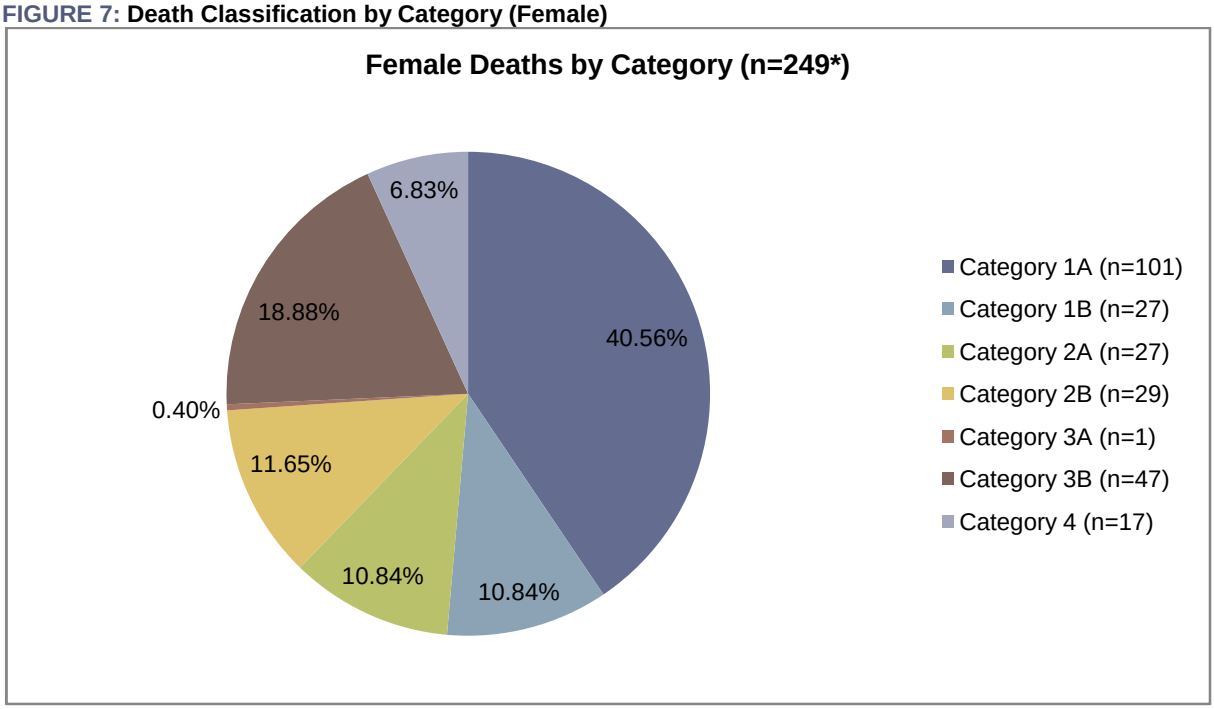


FIGURE 7: Death Classification by Category (Female)



* This number includes the double-counting of 6 deceaseds, who were killed by multiple perpetrators acting together, where the relationship between the perpetrators and the deceased sat across different categories.

** The 1 transgender deceased was a Category 3B death however due to the scale of the graph this deceased does not appear.

CHAPTER 5: CATEGORY 1A – INTIMATE PARTNER, DOMESTIC VIOLENCE CONTEXT

CHAPTER 5: OVERVIEW OF CATEGORY 1A DEATHS – INTIMATE PARTNER, DOMESTIC VIOLENCE CONTEXT

- The majority of male and female deaths in this category were caused by the current intimate partner of the deceased. The highest number of these deaths were perpetrated by the current de facto partner of the deceased.
- 35.64% of all female deaths in this category were perpetrated by the former intimate partner of the deceased.
- The majority of deceaseds in this category sustained fatal injuries at their residence.
- For both males and females, the highest number of deaths in this category occurred as a consequence of stab wounds.
- The majority of male perpetrators in this category were convicted of murder. Almost half of all female perpetrators were found guilty of manslaughter (12 out of 25 perpetrators).
- 17.56% of all deceaseds in this category identified as Aboriginal (including 12.87% of female deceaseds and 33.33% of male deceaseds). 14.62% of all perpetrators in this category identified as Aboriginal (including 32% of all female perpetrators and 10.48% of male perpetrators).

From all closed cases within the period 1 July 2000 – 30 June 2009, there were 131 incidents where a person was killed by their intimate partner, and the death occurred in the context of domestic violence. Some incidents also resulted in additional deaths, including deaths from other categories and/or perpetrator suicides.

In total, from these 131 incidents, there were 166 deaths.

From the 166 deaths that occurred in the 131 incidents:

- 131 were intimate partners of the perpetrator and the death occurred in a context of domestic violence (Category 1A deaths);
- 12 were 'other parties' (Category 2A and/or 3A deaths, depending on their relationship with the perpetrator), whose deaths are considered in their respective chapters; and
- 23 were perpetrator suicides/deaths.

5.1 CATEGORY 1A DEATHS

Of the 131 Category 1A deaths, 101 were female and 30 were male.

5.1.1 AGE (DECEASED)

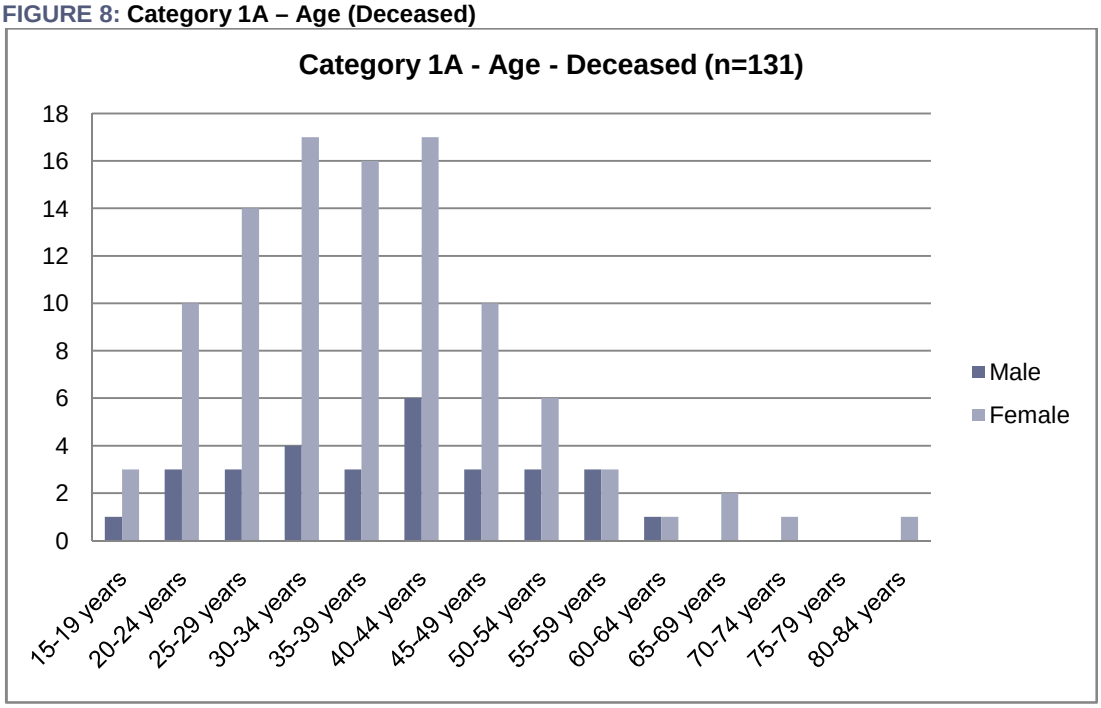
For the 30 Category 1A male deaths, the highest number of male deaths occurred in the age bracket 40-44 years (6 deaths or 20% of all Category 1A male deaths).

For the 101 Category 1A female deaths, the highest number of deaths occurred in the age brackets 30-34 years and 40-44 years (17 deaths or 16.83% of all Category 1A female deaths in each age bracket).

For Category 1A male deaths, the mean age is 40.47 years, the median is 40 years and the standard deviation is 12.77.

For Category 1A female deaths, the mean age is 37.35 years, the median is 37 years and the standard deviation is 11.61.

FIGURE 8: Category 1A – Age (Deceased)



5.1.2 ATSI (DECEASED)

23 of the 131 Category 1A deceaseds identified as Aboriginal (17.56% of all Category 1A deceaseds).

This included 13 females (12.87% of all Category 1A female deaths), and 10 males (33.33% of all Category 1A male deaths).

5.1.3 MANNER OF DEATH

For both male and female Category 1A deaths the highest number of deaths occurred as a consequence of stab wounds – 21 males (70% of all Category 1A male deaths) and 32 females (31.68% of all Category 1A female deaths).

For female deaths, the second highest number of deaths occurred as a consequence of assault (26 females or 25.74% of all Category 1A female deaths), and the third highest number of deaths occurred as a consequence of shooting (18 females or 17.82% of all Category 1A female deaths).

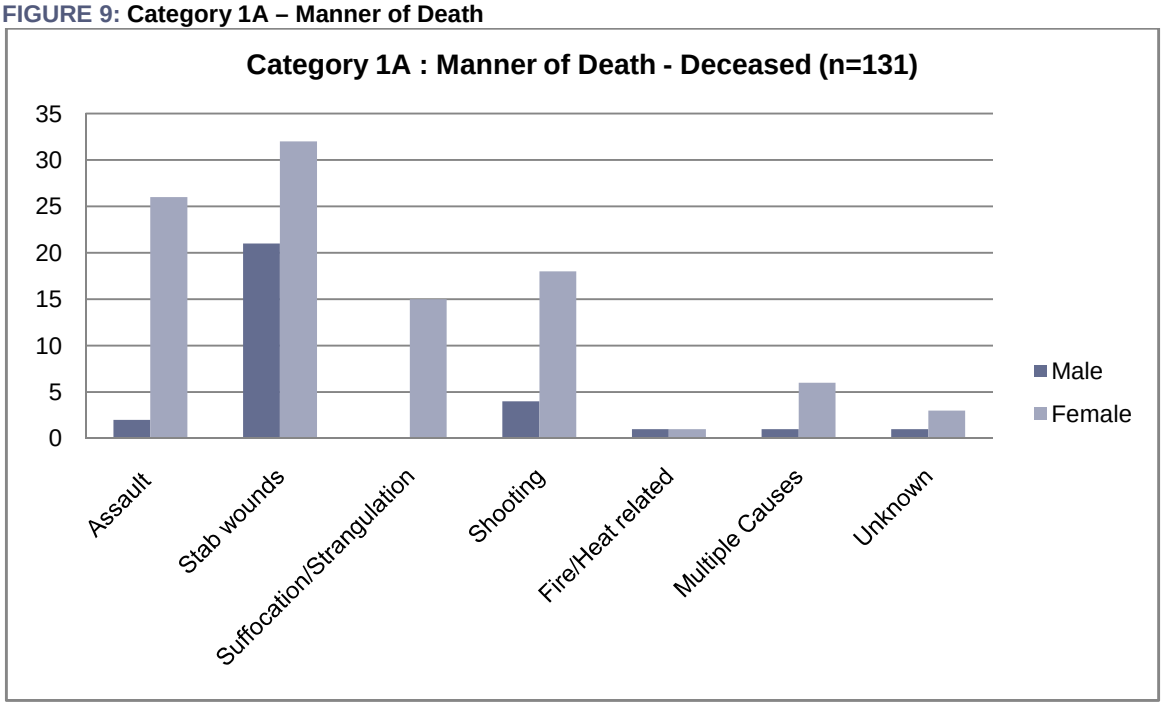
For male deaths, the second highest number of deaths occurred as a consequence of shooting (4 males or 13.33% of all Category 1A male deaths) and the third highest number of deaths occurred as a consequence of assault (2 males or 6.67% of all Category 1A male deaths).

Suffocation/strangulation resulted in the deaths of 15 females (14.85% of all Category 1A female deaths). No males were killed by suffocation/strangulation in this category during the reporting period.

A total of 7 deaths occurred as a consequence of multiple causes, meaning that multiple causes of death were identified as the 'primary cause of death' in the deceased's post-mortem report.

In 4 cases, the manner of death is unknown (3 females; 1 male).

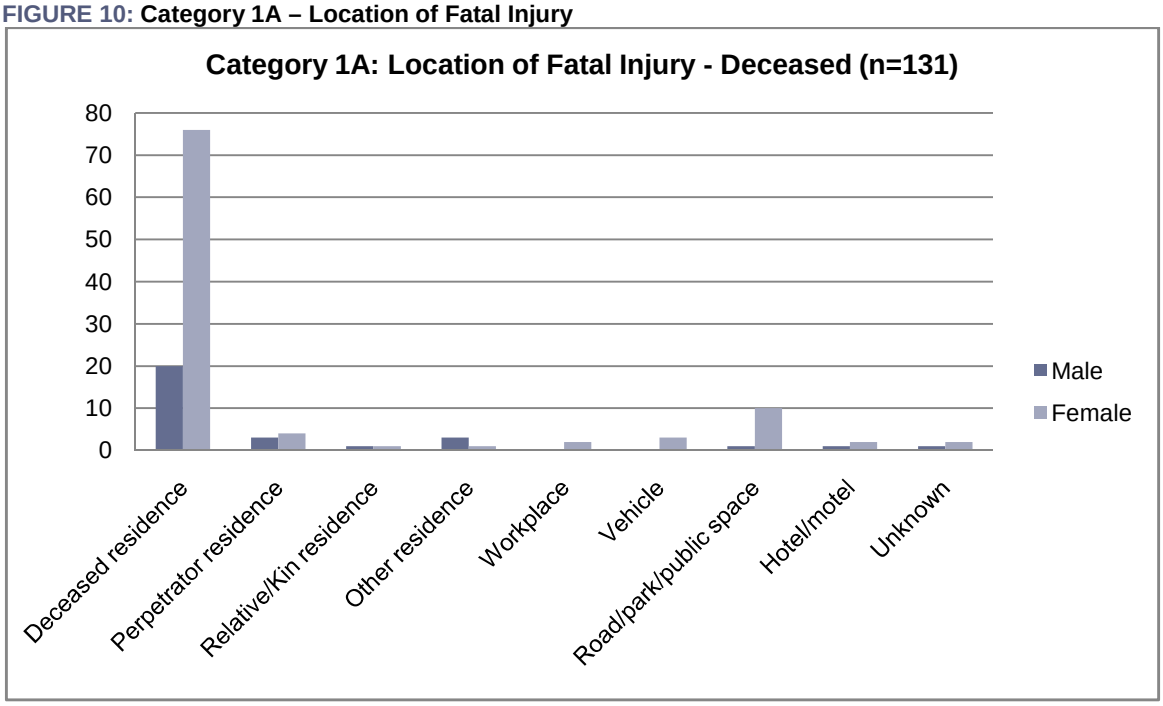
FIGURE 9: Category 1A – Manner of Death



5.1.4 LOCATION OF FATAL INJURY (LEADING TO DEATH)

For both male and female Category 1A deceaseds, 73.28% of all deaths resulted from fatal injuries inflicted at the deceased's residence (76 female deaths and 20 male deaths). 66.67% of all Category 1A male deaths resulted from fatal injuries inflicted at their residence (20 males). 75.25% of all Category 1A female deaths resulted from fatal injuries inflicted at their residence (76 females).

FIGURE 10: Category 1A – Location of Fatal Injury



5.2 CATEGORY 1A PERPETRATORS

Of the 131 incidents resulting in Category 1A deaths, 3 incidents involved multiple perpetrators, i.e. the intimate partner of the deceased acting together with another party or parties.

Accordingly, for the 131 incidents resulting in Category 1A deaths, there were:

- 130 Category 1A perpetrators;[57] and
- 4 additional (non-intimate partner) perpetrators.

Of the 130 Category 1A perpetrators, 105 were males and 25 were females.

[57] It is noted that one male Category 1A perpetrator separately killed 2 intimate partners within the data reporting period, 8 months apart.

5.2.1 AGE (PERPETRATOR)

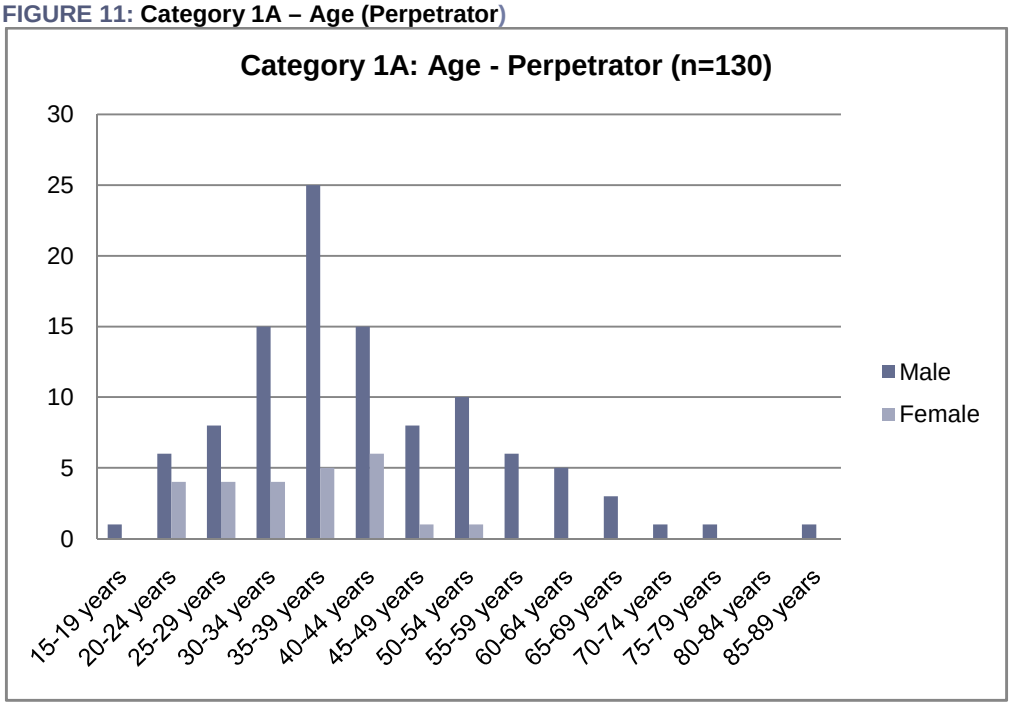
During the data reporting period, the highest number of Category 1A male perpetrators fell within the age bracket 35-39 years (25 perpetrators or 23.81% of all Category 1A male perpetrators). The highest number of female perpetrators fell within the age bracket 40-44 years (6 perpetrators or 24% of all Category 1A female perpetrators).

In the age bracket 15-19 years, there was 1 male perpetrator who killed his 15 year-old girlfriend.

For Category 1A male perpetrators, the mean age is 41.76 years, the median is 39 years and the standard deviation is 12.96.

For Category 1A female perpetrators, the mean age is 34.4 years, the median is 35 years and the standard deviation is 8.84.

FIGURE 11: Category 1A – Age (Perpetrator)



5.2.2 ATSI (PERPETRATOR)

19 of the 130 Category 1A perpetrators identified as Aboriginal (14.62% of all Category 1A perpetrators).

This included 8 females (32% of all Category 1A female perpetrators) and 11 males (10.48% of all Category 1A male perpetrators).

5.2.3 OUTCOMES

Murder Conviction

During the data reporting period, 27 Category 1A male perpetrators entered a plea of guilty to murder (25.71% of all Category 1A male perpetrators) and 28 Category 1A male perpetrators were found guilty of murder at trial (26.67% of all Category 1A male perpetrators). 52.38% of all Category 1A male perpetrators were convicted of murder (55 males).

2 Category 1A female perpetrators entered a plea of guilty to murder (8% of all Category 1A female perpetrators) and 1 Category 1A female perpetrator was found guilty of murder at trial (4% of all Category 1A female perpetrators). 12% of all Category 1A female perpetrators were convicted of murder (3 females).

Altogether, 22.31% of Category 1A perpetrators entered a plea of guilty to murder and 22.31% were found guilty of murder at trial. This means that the outcome for 44.62% of all Category 1A perpetrators was a murder conviction.

Manslaughter Conviction

During the data reporting period, 15 Category 1A male perpetrators entered a plea of guilty to manslaughter (14.29% of all Category 1A male perpetrators) and 4 Category 1A male perpetrators were found guilty of manslaughter at trial (3.81% of all Category 1A male perpetrators). 18.1% of all Category 1A male perpetrators were convicted of manslaughter (19 males).

10 Category 1A female perpetrators entered a plea of guilty to manslaughter (40% of all Category 1A female perpetrators), and 2 Category 1A female perpetrators were found guilty of manslaughter at trial (8% of all Category 1A female perpetrators). 48% of all Category 1A female perpetrators were convicted of manslaughter (12 females).

Altogether, 19.23% of Category 1A perpetrators entered a plea of guilty to manslaughter and 4.62% were found guilty of manslaughter at trial. The outcome for 23.85% of all Category 1A perpetrators was a manslaughter conviction.

Not Guilty by Reason of Mental Illness

During the data reporting period, 5 Category 1A male perpetrators were found not guilty by reason of mental illness at trial. There were no Category 1A female perpetrators found not guilty by reason of mental illness.

3.85% of all Category 1A perpetrators were found not guilty by reason of mental illness.

Trial – Acquittal

During the data reporting period, 1 Category 1A male perpetrator and 5 Category 1A female perpetrators were acquitted at trial.

In total, 4.62% of all Category 1A perpetrators were acquitted at trial.

Matter No Billed

There were 2 Category 1A female perpetrators and 1 Category 1A male perpetrator who, during proceedings, had proceedings discontinued (no billed) after committal.

Coronial Finding

During the data reporting period, there were 23 Category 1A perpetrators who committed suicide/died, resulting in a Coronial finding. Of these 23 perpetrators, 1 was female and 22 were male.

In 17.69% of all cases, a Coronial finding was the recorded outcome for the perpetrator.

FIGURE 12: Category 1A – Outcome (Perpetrator)

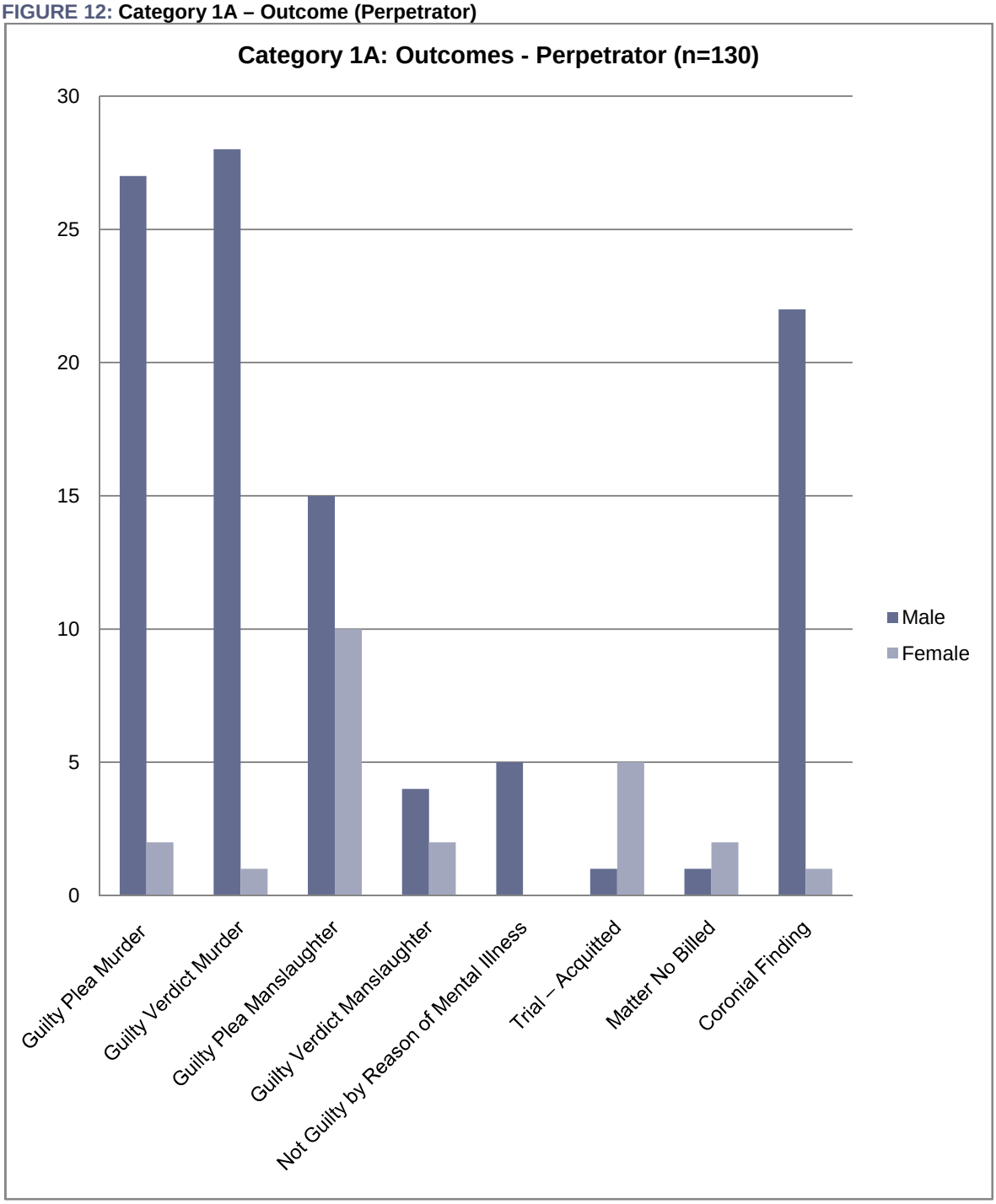


FIGURE 13: **Category 1A – Outcome - Perpetrator (Male)**

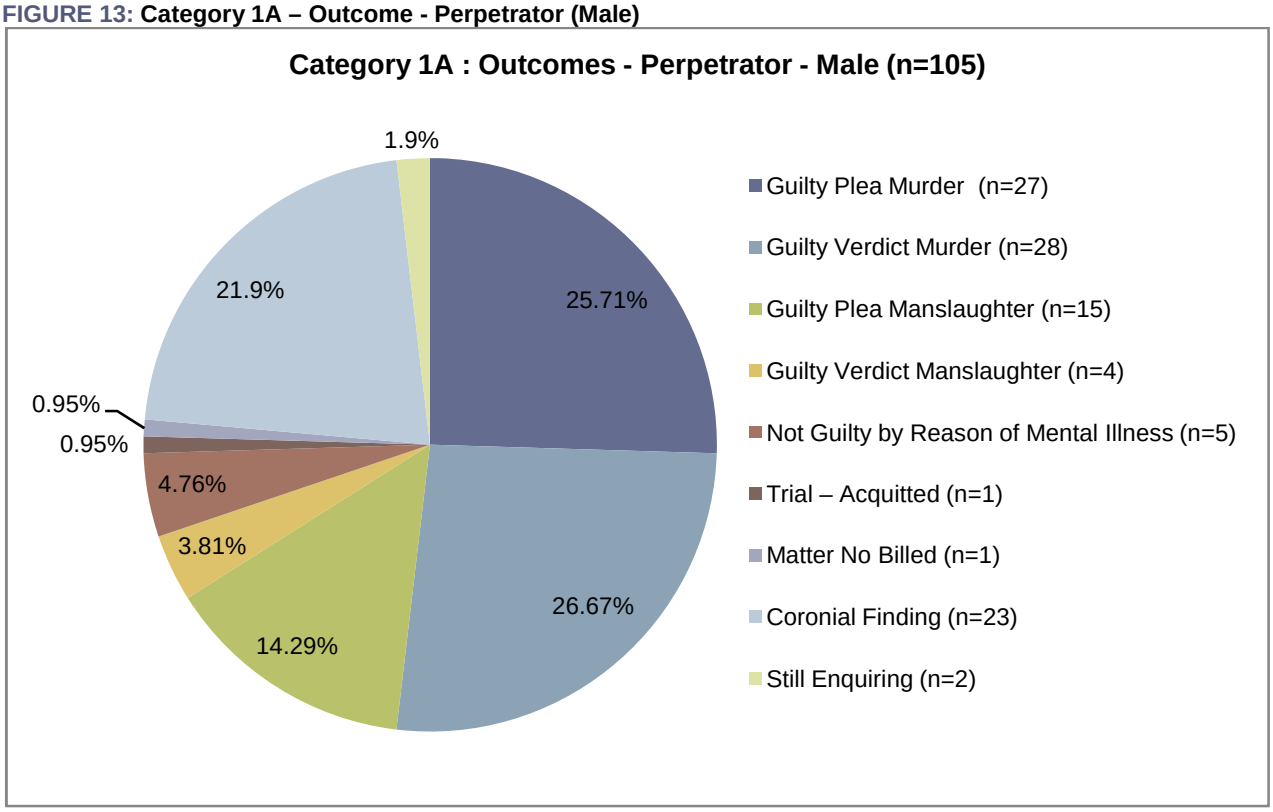
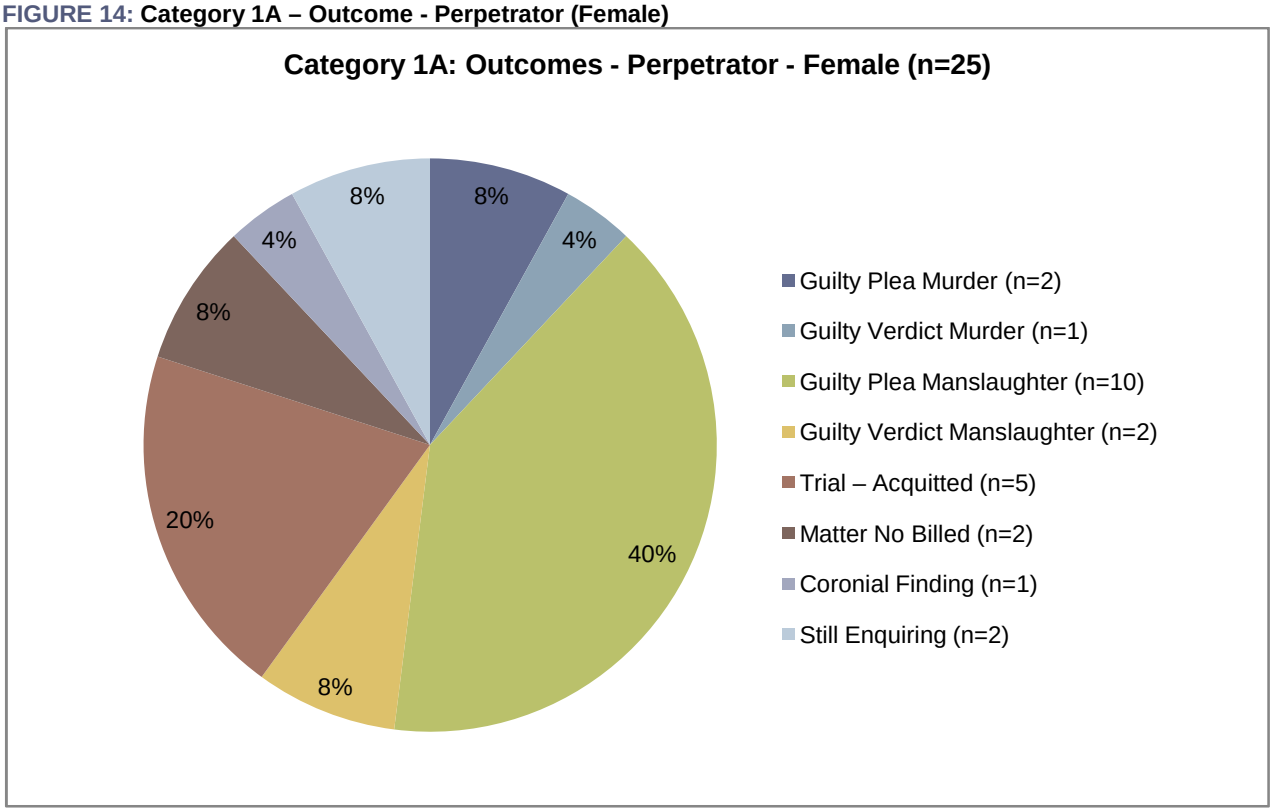


FIGURE 14: **Category 1A – Outcome - Perpetrator (Female)**



5.2.4 PERPETRATOR SUICIDE/DEATH

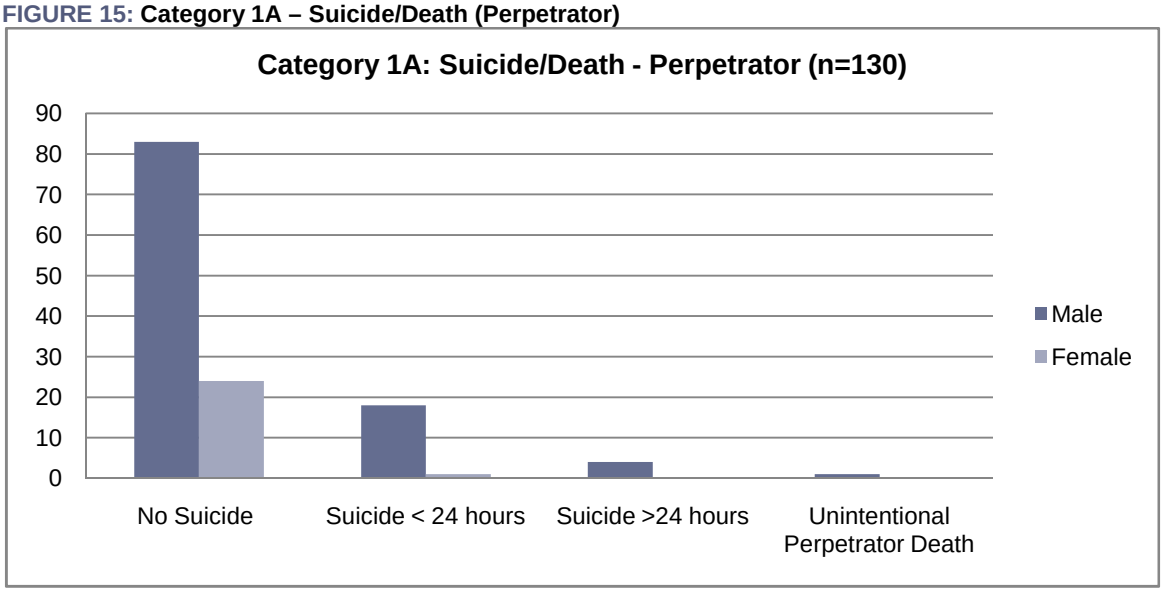
During the data reporting period, out of the 130 Category 1A perpetrators, 22 perpetrators committed suicide (16.92%) and 1 died unintentionally.

Of the 22 Category 1A perpetrators who committed suicide, 21 were male and 1 was female.

18 Category 1A perpetrators committed suicide within 24 hours of killing the deceased and 4 Category 1A perpetrators committed suicide at varying times, more than 24 hours after killing the deceased (while in custody).

1 Category 1A perpetrator died unintentionally from burns within 24 hours of killing his intimate partner and his de facto step-son.

FIGURE 15: Category 1A – Suicide/Death (Perpetrator)



5.3 CATEGORY 1A RELATIONSHIP TYPE

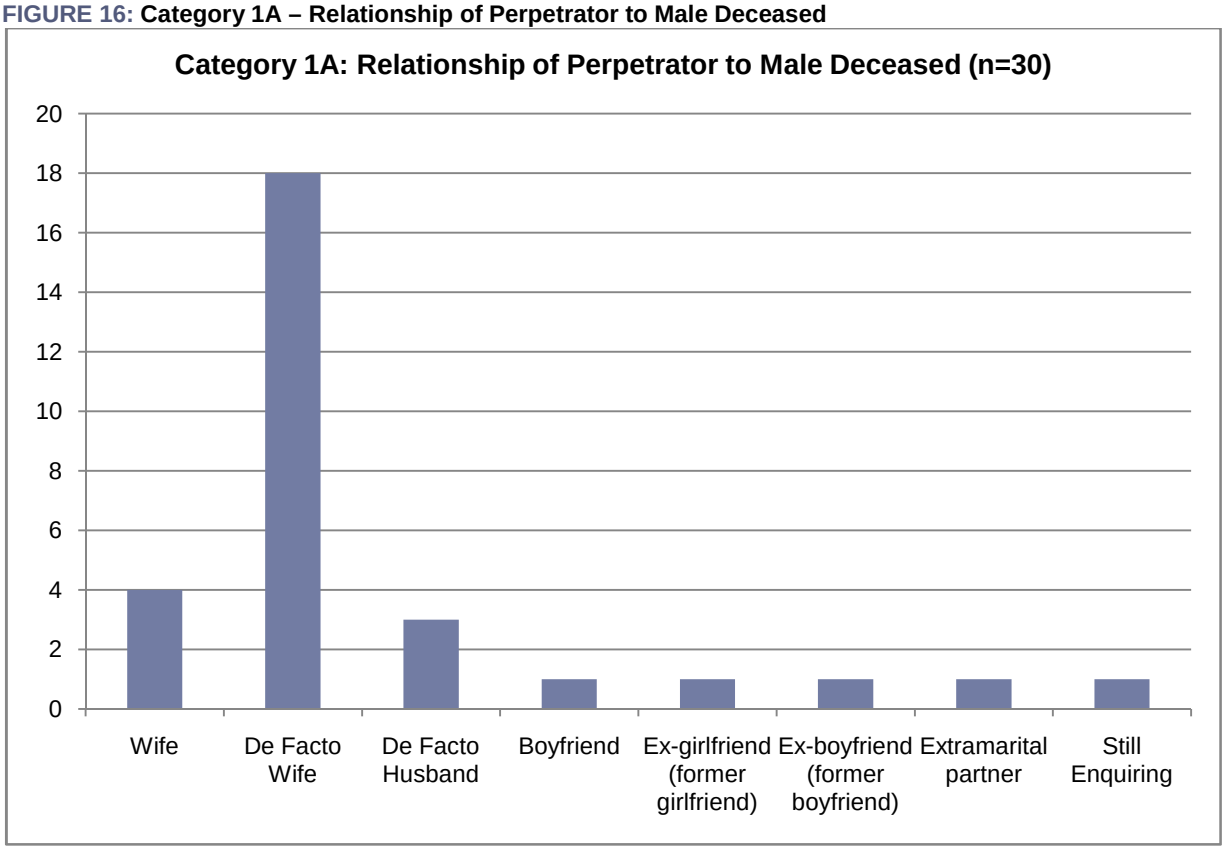
5.3.1 CATEGORY 1A MALES (N=30)

During the data reporting period, the highest number of Category 1A male deaths were perpetrated by the de facto wife of the deceased (18 males or 60% of all Category 1A male deaths). The second highest number of Category 1A male deaths were perpetrated by the wife of the deceased (4 males or 13.33% of all Category 1A male deaths). The third highest number of Category 1A male deaths were perpetrated by the de facto husband of the deceased (3 males or 10% of all Category 1A male deaths).

Of the 30 Category 1A male deaths:

- 26 Category 1A male deaths were perpetrated by a current partner (86.67% of all Category 1A male deaths);
- 2 Category 1A male deaths were perpetrated by an ex-partner (6.67% of all Category 1A male deaths);
- 1 Category 1A male death was perpetrated by an extramarital partner; and
- 1 Category 1A death requires further investigation to identify the precise relationship type ('Still enquiring').

FIGURE 16: Category 1A – Relationship of Perpetrator to Male Deceased



CATEGORY 1A FEMALES (N=101)

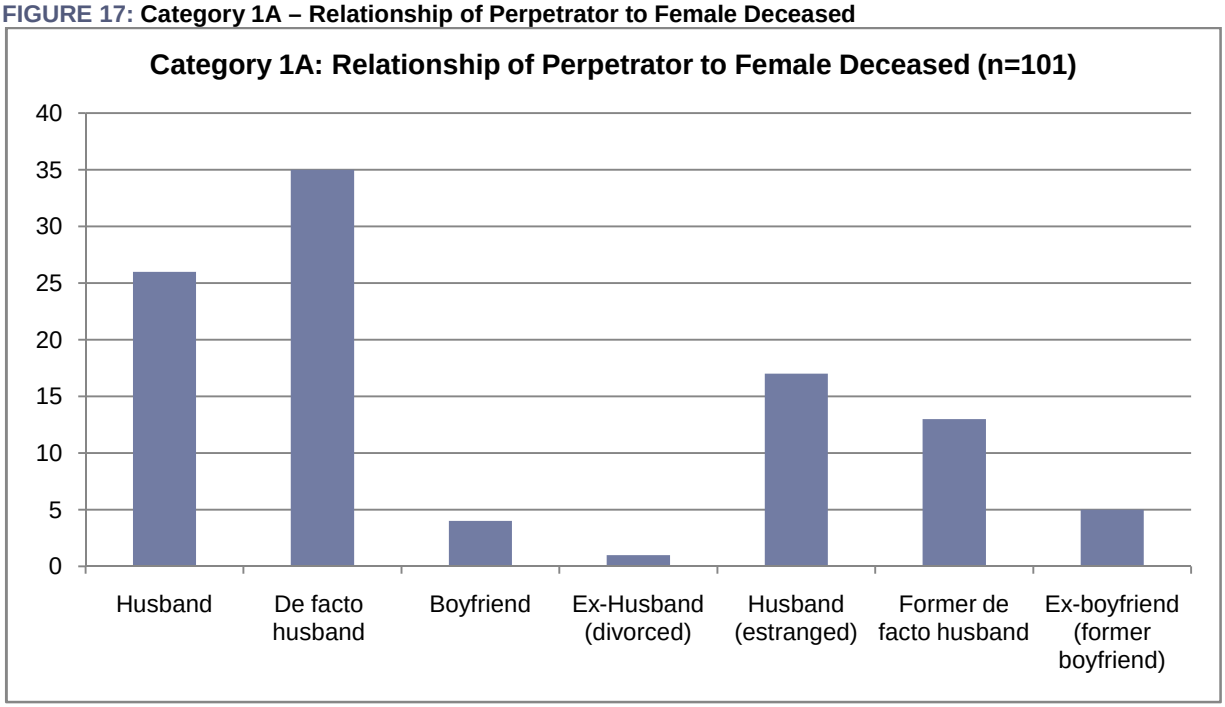
During the data reporting period, the highest number of Category 1A female deaths were perpetrated by the de facto husband of the deceased (35 females or 34.65% of all Category 1A female deaths). The second highest number of Category 1A female deaths were perpetrated by the husband of the deceased (26 deaths or 25.74% of all Category 1A female deaths).

17 Category 1A female deaths were perpetrated by the estranged husband of the female deceased (16.83% of all Category 1A female deaths).

Of the 101 Category 1A female deaths:

- 65 were perpetrated by a current partner (64.36% of all Category 1A female deaths);
- 36 Category 1A female deaths were perpetrated by a former partner (35.64% of all Category 1A female deaths).

FIGURE 17: Category 1A – Relationship of Perpetrator to Female Deceased



5.4 CATEGORY 1A MULTIPLE FATALITY INCIDENTS

Of the 131 Category 1A incidents, there were 9 which are coded as 'Multiple Fatality Incidents' involving more than one death. This number excludes those cases where the perpetrator kills one individual and then suicides. These are not considered Multiple Fatality Incidents.

The 9 Multiple Fatality Incidents resulted in 21 deaths, including the deaths of 9 intimate partners and 12 'other parties'. The 12 'other parties' included:

- 5 biological children of the Category 1A deceased and the Category 1A perpetrator;
- 2 biological children of the Category 1A deceased, the step-children of the Category 1A perpetrator;
- 2 grandchildren of the Category 1A deceased and the Category 1A perpetrator;
- 2 relatives related by blood to the Category 1A deceased, related in law to the Category 1A perpetrator; and
- 1 new partner of the Category 1A deceased, no relationship to perpetrator ('Category 3A death').

Of the 12 'other parties' who were killed in Category 1A incidents, 8 of the deceased were male and 4 were female. All except 3 of the deceased were below the age of 18. Of the 3 deceased persons over the age of 18, 2 were male and 1 was female.

Of the 9 Multiple Fatality Incidents, 8 were perpetrated by a male offender and 1 incident was perpetrated by a female offender.

CHAPTER 6: CATEGORY 1B – INTIMATE PARTNER, NO DOMESTIC VIOLENCE CONTEXT

CHAPTER 6: OVERVIEW OF CATEGORY 1B DEATHS – INTIMATE PARTNER, NO DOMESTIC VIOLENCE CONTEXT

- The highest number of male deceaseds in this category were killed by their estranged wife.
- The highest number of female deceaseds were killed by their husband.
- Over a third of all male perpetrators in this category committed suicide.
- The highest number of female deaths in this category occurred as a consequence of suffocation/strangulation. The highest number of male deaths occurred as a consequence of stab wounds.
- The majority of fatal injuries in this category occurred at the deceaseds residence.
- 6.10% of all deceaseds in this category identified as Aboriginal, and no perpetrators in this category identified as Aboriginal.

From all closed cases within the data reporting period, there were 33 incidents where a person was killed by their intimate partner and the death did not occur in the context of domestic violence. Some of these incidents also resulted in additional deaths from other categories and/or perpetrator suicide.

In total, from these 33 incidents, there were 45 deaths.

From the 45 deaths that occurred in the 33 incidents:

- 33 were intimate partners of the perpetrator, and there was no domestic violence context (Category 1B deaths);
- 2 were 'other parties' (Category 2B or 3B deaths, depending on their relationship with the perpetrator); and
- 10 were perpetrator suicides/deaths.

6.1 CATEGORY 1B DEATHS

Of the 33 Category 1B deaths, 6 were male and 27 were female.

6.1.1 AGE (DECEASED)

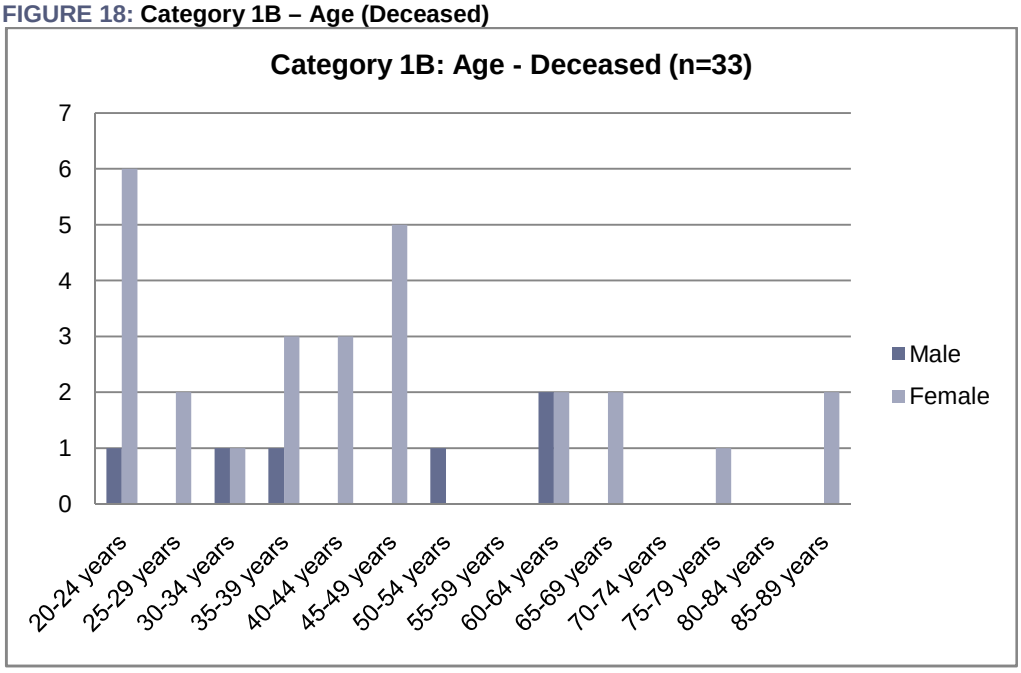
For the 6 Category 1B male deaths, the highest number occurred in the age bracket 60-64 years (2 deaths or 33.33% of all Category 1B male deaths).

For the 27 Category 1B female deaths, the highest number of deaths occurred in the age bracket 20-24 years (6 deaths or 22.22% of all Category 1B female deaths).

The mean age for Category 1B male deaths is 43.67 years, the median age is 44 years and the standard deviation is 17.28.

The mean age for Category 1B female deaths is 44.22 years, the median age is 41 years and the standard deviation is 19.68.

FIGURE 18: Category 1B – Age (Deceased)



6.1.2 ATSI (DECEASED)

In 2 of the 33 Category 1B deaths, the deceased identified as Aboriginal (6.06% of all Category 1B deceaseds).

This included 1 Category 1B female death (3.70% of all Category 1B female deaths), and 1 Category 1B male death (16.67% of all Category 1B male deaths).

6.1.3 MANNER OF DEATH

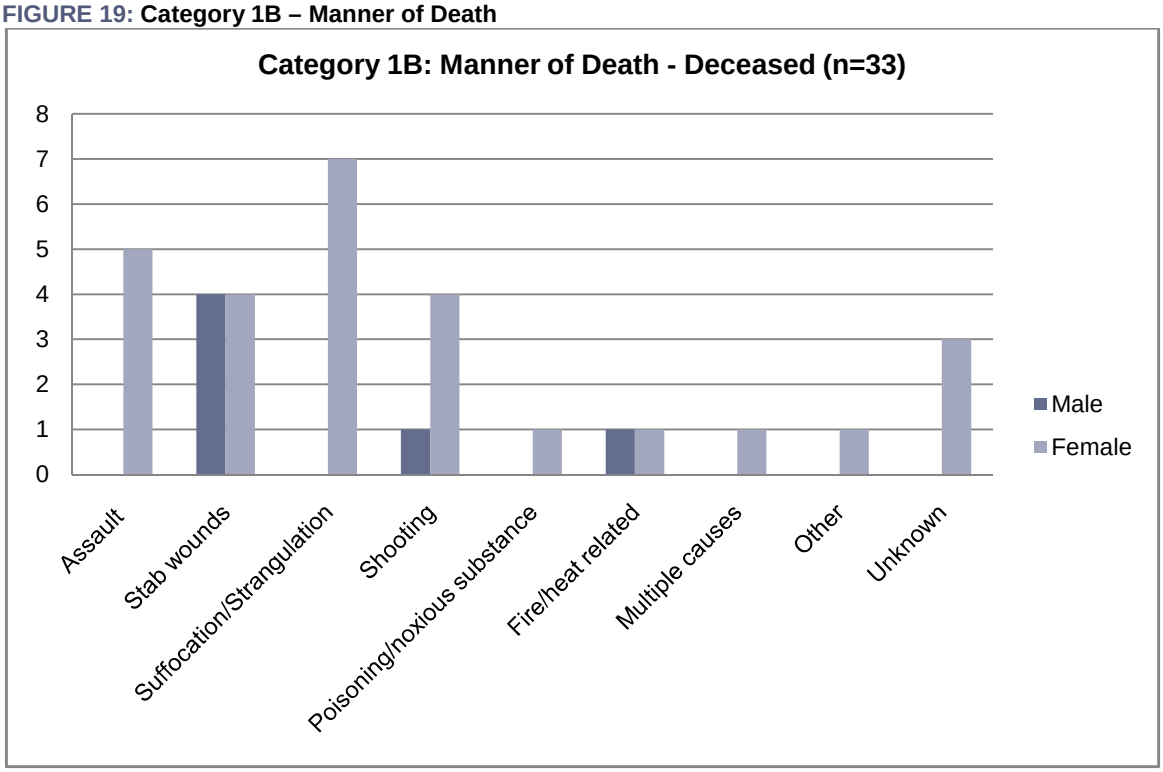
For the 6 Category 1B male deaths, the highest number of deaths occurred as a consequence of stab wounds (4 deaths or 66.67% of all Category 1B male deaths); 1 male death occurred as a consequence of shooting; and 1 male death occurred as a consequence of fire/heat related injuries.

For the 27 Category 1B female deaths, the highest number of deaths occurred as a consequence of suffocation/strangulation (7 deaths or 25.93% of all Category 1B female deaths). The second highest number of Category 1B female deaths were attributable to assault with 5 deaths (18.52% of all Category 1B female deaths).

In Category 1B female deaths, 4 deaths occurred due to stab wounds (14.81% of all Category 1B female deaths); 4 deaths occurred as a consequence of shooting (14.81% of all Category 1B female deaths); and 1 female death occurred as a consequence of fire/heat-related injuries.

The manner of death was unknown in the case of 4 Category 1B female deaths and 1 further Category 1B female death occurred as a consequence of 'multiple causes'.

FIGURE 19: Category 1B – Manner of Death



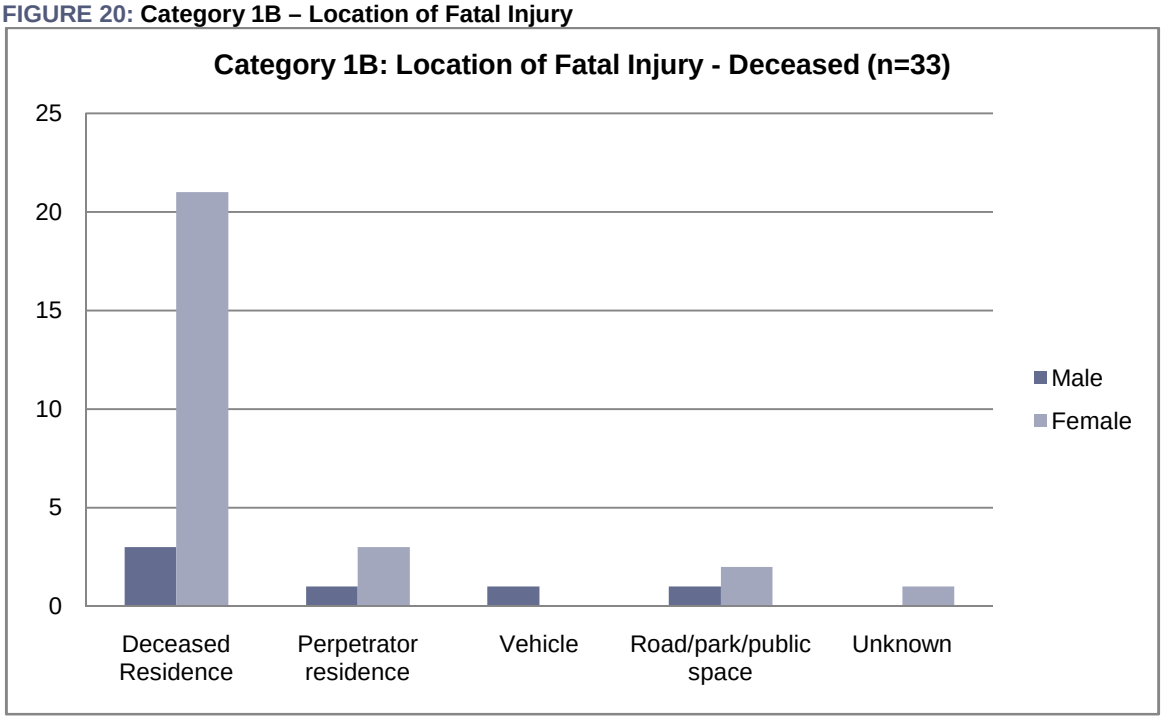
6.1.4 LOCATION OF FATAL INJURY (LEADING TO DEATH)

For both male and female Category 1B deaths, the highest number of fatal injuries leading to death occurred at the deceased's residence (21 females and 3 males).

For Category 1B male deceaseds, 50% (3 males) had fatal injuries inflicted at their residence and for Category 1B female deceaseds, 77.78% (21 females) had fatal injuries inflicted at their residence.

1 Category 1B male death occurred as a consequence of fatal injuries sustained at the perpetrator residence and for 3 Category 1B female deaths fatal injuries were sustained at the perpetrator residence.

FIGURE 20: Category 1B – Location of Fatal Injury



6.2 CATEGORY 1B PERPETRATORS

Of the 33 incidents resulting in Category 1B deaths, 3 incidents involved multiple perpetrators, i.e. the intimate partner of the deceased acting together with another party or parties. In one of the Multiple Perpetrator Incidents, the deceased was killed by his intimate partner and their child. In the two other Multiple Perpetrator Incidents, the deceased were killed by their intimate partner and the perpetrator's (other or new) intimate partner.

Accordingly, for the 33 incidents resulting in Category 1B deaths, there were:

- 33 Category 1B perpetrators; and
- 3 additional non-intimate partner perpetrators.

Of the 33 Category 1B perpetrators, 27 were male and 6 were female.

6.2.1 AGE (PERPETRATOR)

The highest number of Category 1B male perpetrators fell within the age bracket 45-49 years (7 perpetrators or 25.93% of all Category 1B male perpetrators).

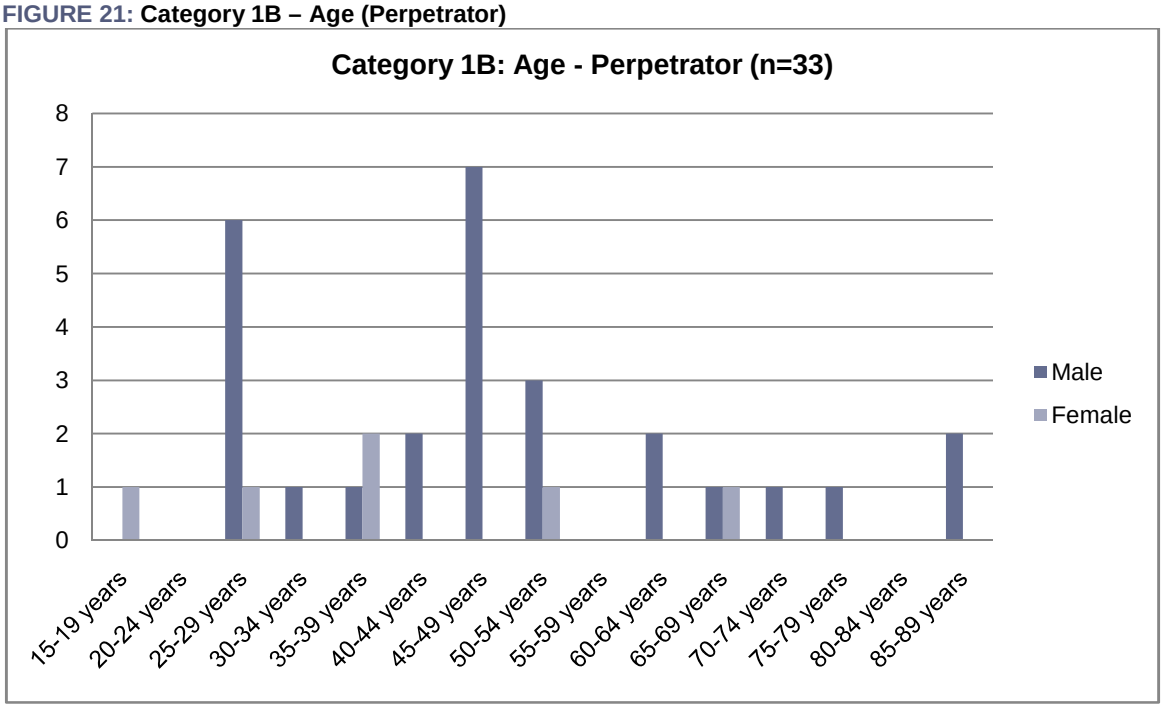
The highest number of Category 1B female perpetrators fell within the age bracket 35-39 years (2 perpetrators or 33.33% of all Category 1B female perpetrators).

There was 1 female perpetrator between the age 15-19 years, who, together with her current boyfriend, killed her ex-boyfriend.

For Category 1B male perpetrators, the mean age is 48.70 years, the median is 47 years and the standard deviation is 17.61.

For Category 1B female perpetrators, the mean age is 39.5 years, the median is 37.5 years and the standard deviation is 18.58.

FIGURE 21: Category 1B – Age (Perpetrator)



6.2.2 ATSI (PERPETRATOR)

No Category 1B perpetrators identified as Aboriginal, Aboriginal and Torres Strait Islander or Torres Strait Islander.

6.2.3 OUTCOMES

Murder Conviction

During the data reporting period, 14.81% of Category 1B male perpetrators entered a plea of guilty to murder (4 males) and 14.81% of Category 1B male perpetrators were found guilty of murder at trial (4 males). 29.63% of all Category 1B male perpetrators were convicted of murder (8 males).

For Category 1B female perpetrators, 16.67% entered a plea of guilty to murder (1 female) and 16.67% were found guilty of murder at trial (1 female). 33.33% of all Category 1B female perpetrators were convicted of murder (2 females).

Altogether, 15.15% of Category 1B perpetrators entered a plea of guilty to murder and 15.15% were found guilty of murder at trial. Accordingly, 30.30% of Category 1B perpetrators were convicted of murder.

Manslaughter Conviction

During the data reporting period, 18.52% of Category 1B male perpetrators entered a plea of guilty to manslaughter (5 males), and 3.70% of Category 1B male perpetrators were found guilty of manslaughter at trial (1 male). 22.22% of all Category 1B male perpetrators were convicted of manslaughter (6 males).

For Category 1B female perpetrators, 16.67% entered a plea of guilty to manslaughter (1 female), and 16.67% were found guilty of manslaughter at trial (1 female). 33.33% of all Category 1B female perpetrators were convicted of manslaughter (2 females).

Altogether, 18.18% of Category 1B perpetrators entered a plea of guilty to manslaughter, and 6.06% were found guilty of manslaughter at trial. Accordingly, 24.24% of Category 1B perpetrators were convicted of manslaughter.

Not Guilty by Reason of Mental Illness

During the data reporting period, 3 Category 1B male perpetrators (11.11% of all Category 1B male perpetrators) and 2 Category 1B female perpetrators (33.33% of all Category 1B female perpetrators) were found not guilty by reason of mental illness at trial. Altogether, 15.15% of all Category 1B perpetrators were found not guilty by reason of mental illness at trial.

Coronial Finding

During the data reporting period, there were 10 Category 1B perpetrators who committed suicide, resulting in a Coronial finding. Accordingly, for 30.30% of all Category 1B perpetrators, a Coronial finding was the recorded outcome.

All of the Category 1B perpetrators who committed suicide were male.

FIGURE 22: Category 1B – Outcome (Perpetrator)

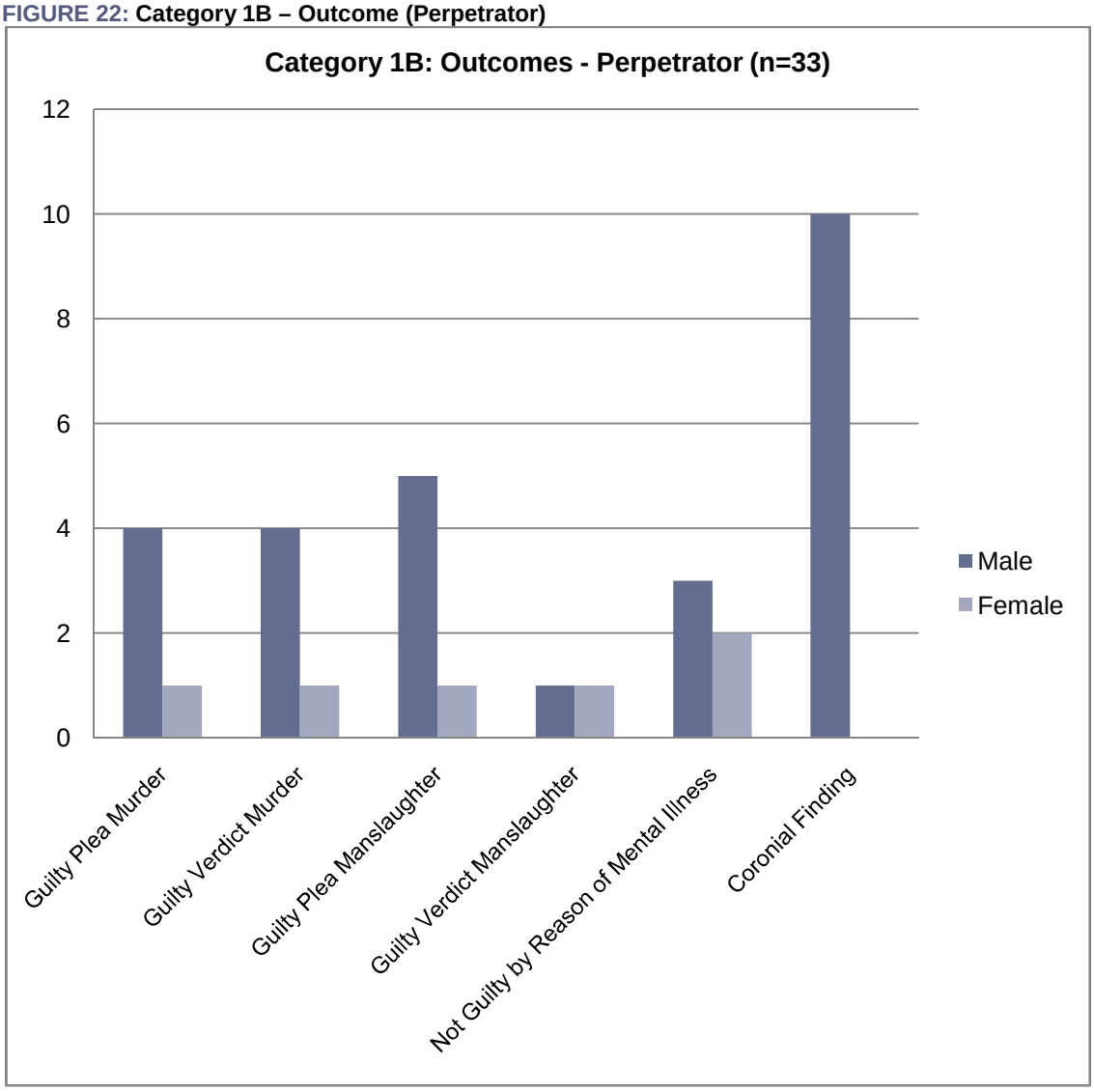


FIGURE 23: Category 1B – Outcome - Perpetrator (Male)

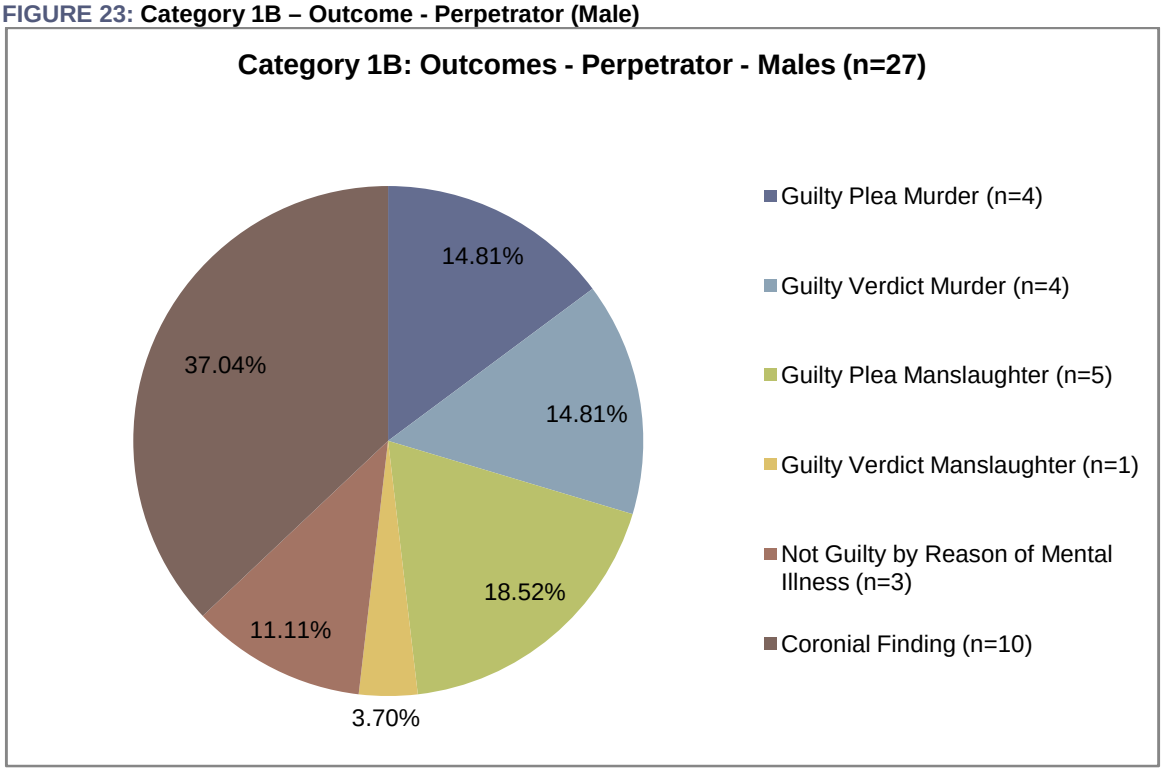
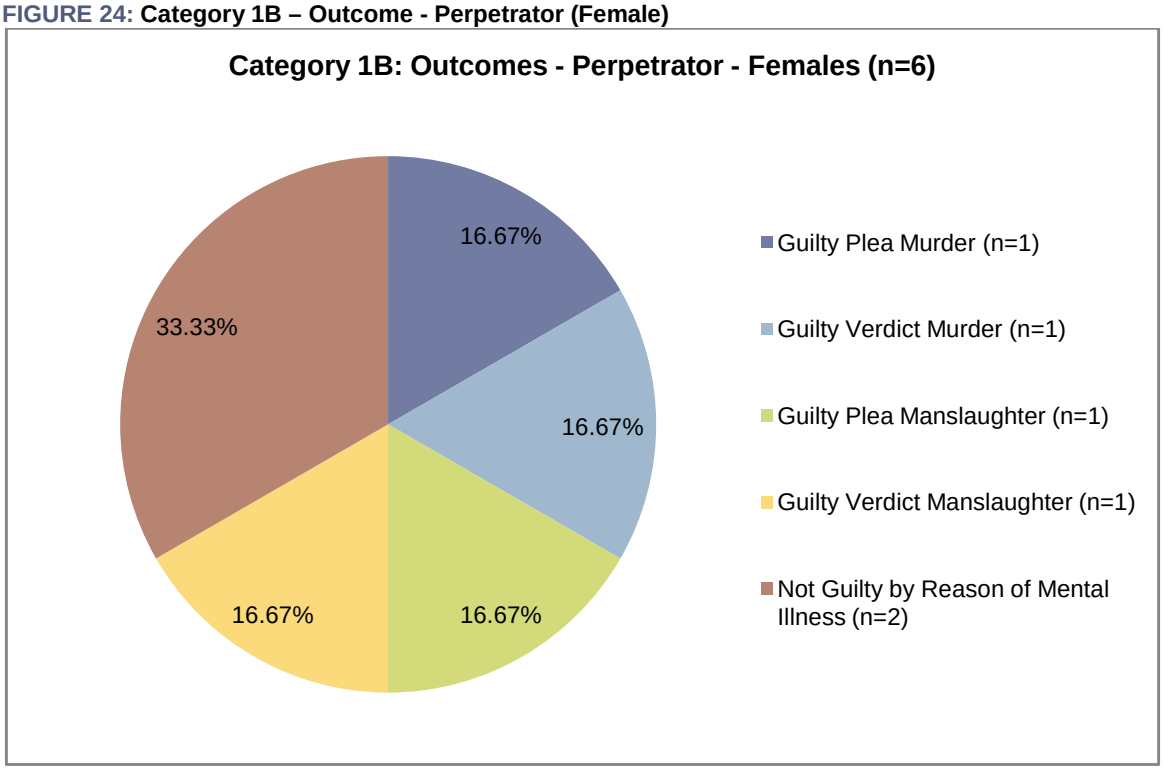


FIGURE 24: Category 1B – Outcome - Perpetrator (Female)

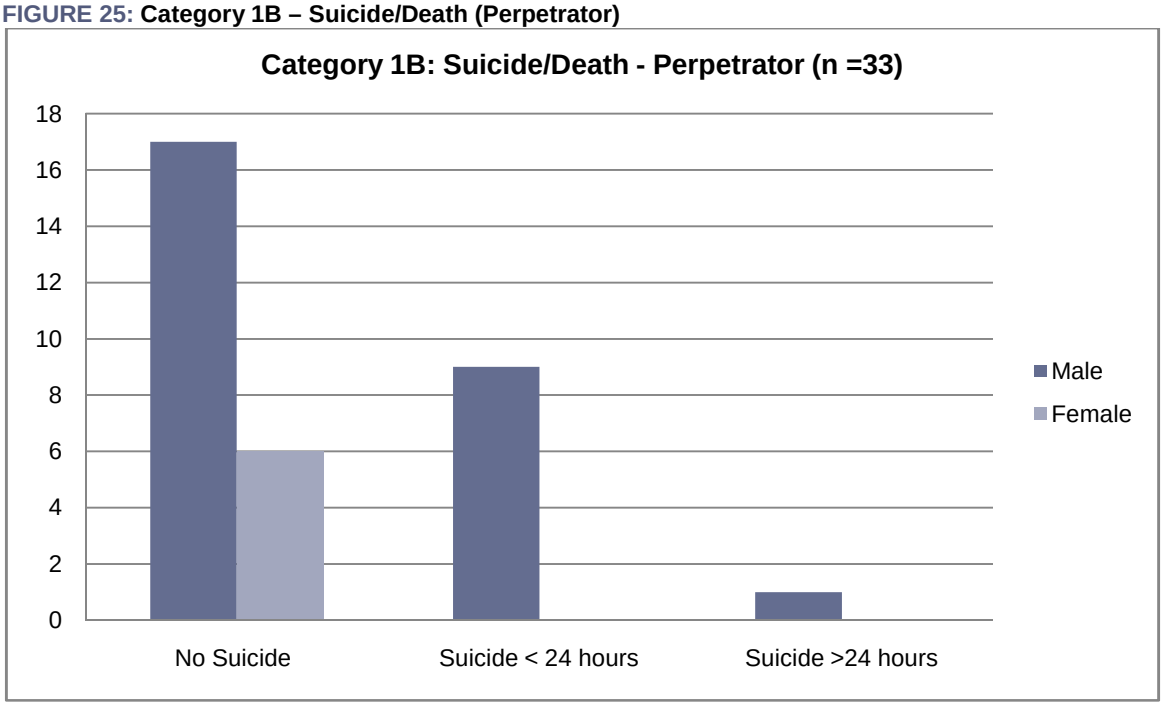


6.2.4 PERPETRATOR SUICIDE/DEATH

During the data reporting period, 10 out of the 33 Category 1B perpetrators committed suicide (30.30% of all Category 1B perpetrators).

All 10 perpetrators who committed suicide were male. 9 Category 1B perpetrators committed suicide within 24 hours of killing the deceased and 1 Category 1B perpetrator committed suicide in the period longer than 24 hours after killing the deceased (while in custody).

FIGURE 25: Category 1B – Suicide/Death (Perpetrator)



6.3 CATEGORY 1B RELATIONSHIP TYPE

6.3.1 MALE CATEGORY 1B DEATHS (N=6)

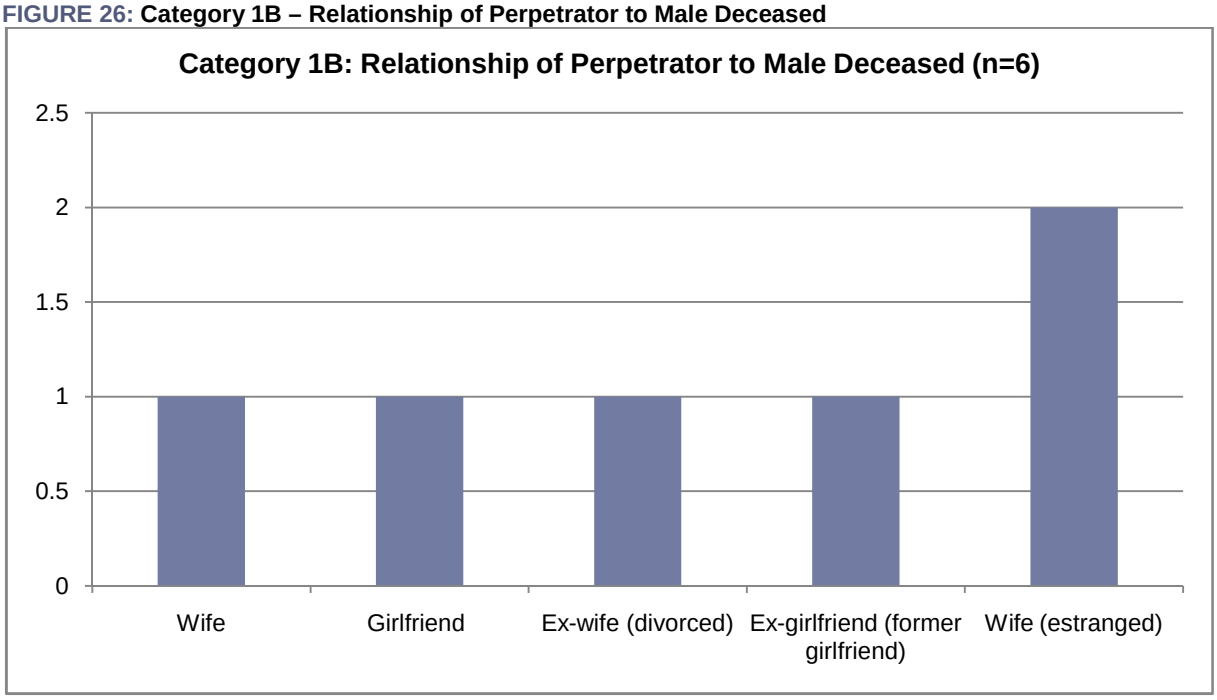
During the data reporting period, the highest number of Category 1B male deaths were perpetrated by the estranged wife of the deceased (2 deaths or 33.33% of all Category 1B male deaths).

There was 1 Category 1B death in each other relationship category (wife, ex-wife, girlfriend and ex-girlfriend).

2 Category 1B male deaths were caused by a current intimate partner (33.33% of all Category 1B male deaths).

4 Category 1B male deaths were caused by a former intimate partner (66.67% of all Category 1B male deaths).

FIGURE 26: Category 1B – Relationship of Perpetrator to Male Deceased



6.3.2 FEMALE CATEGORY 1B DEATHS (N=27)

During the data reporting period, the highest number of Category 1B female deaths were perpetrated by the husband of the deceased (13 deaths or 48.15% of all Category 1B female deaths). The second highest number of Category 1B female deaths were caused by the de facto husband of the deceased (5 deaths or 18.52% of all Category 1B female deaths). The third highest number of Category 1B female deaths were caused by extramarital partner of the deceased (4 deaths or 14.81% of all Category 1B female deaths).

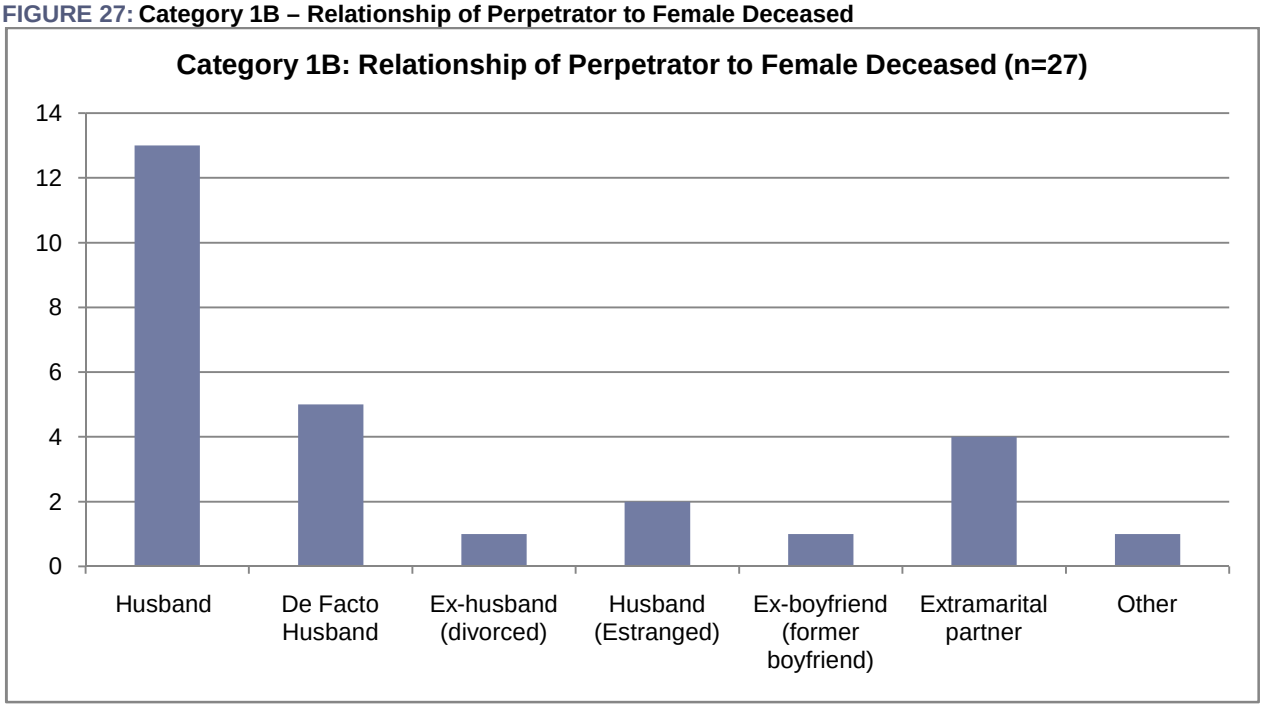
In one case the relationship between the deceased and the perpetrator was classified as 'other' as the relationship was between a paid sex worker and her regular male client, whom she also appeared to be dating.

19 Category 1B female deaths were caused by a current intimate partner (70.37% of all Category 1B female deaths) including the 1 'other' death.

4 Category 1B female deaths were caused by a former intimate partner (14.81% of all Category 1B female deaths).

4 Category 1B female deaths were caused by the extramarital partner of the deceased (14.81% of all Category 1B female deaths).

FIGURE 27: Category 1B – Relationship of Perpetrator to Female Deceased



6.4 CATEGORY 1B MULTIPLE FATALITY INCIDENTS

Of the 33 Category 1B incidents, there was 1 Multiple Fatality Incident.

This Multiple Fatality Incident involved a male perpetrator killing his intimate partner and their 2 children.

CHAPTER 7: CATEGORY 2A – RELATIVE/KIN, DOMESTIC VIOLENCE CONTEXT

CHAPTER 7: OVERVIEW OF CATEGORY 2A DEATHS – RELATIVE/KIN, DOMESTIC VIOLENCE CONTEXT

- Almost half of all deceaseds in this category were between 0-4 years of age. The median age for male deceaseds is 5 years and the median age for female deceaseds is 4 years.
- The highest number of male and female deceaseds in this category died as a consequence of assault.
- The majority of deceaseds in this category sustained fatal injuries at their residence.
- A quarter of male perpetrators in this category committed suicide/died.
- The majority of female perpetrators in this category were convicted of manslaughter.
- The highest number of deceaseds in this category were killed by their father.
- 9.59% of all deceaseds in this category identified as Aboriginal (7 deceaseds). 6 of the 7 Aboriginal deceaseds were children below the age of 2.
- 11.48% of all perpetrators in this category identified as Aboriginal.

From all closed cases within the data reporting period there were 58 incidents where a person was killed by a relative/kin and the death occurred in the context of domestic violence. A number of these incidents also resulted in additional deaths, including deaths from other categories and/or perpetrator suicides.

In total, from these 58 incidents, there were 93 deaths.

From these 93 deaths:

- 73 were relatives/kin of the perpetrator and the death occurred in a context of domestic violence (Category 2A deaths);
- 8 were 'other parties' (Category 1A and/or 3A deaths, depending on their relationship with the perpetrator); and
- 12 were perpetrator suicides/deaths.

7.1 CATEGORY 2A DEATHS

Of the 73 Category 2A deceaseds, 27 were female and 46 were male.

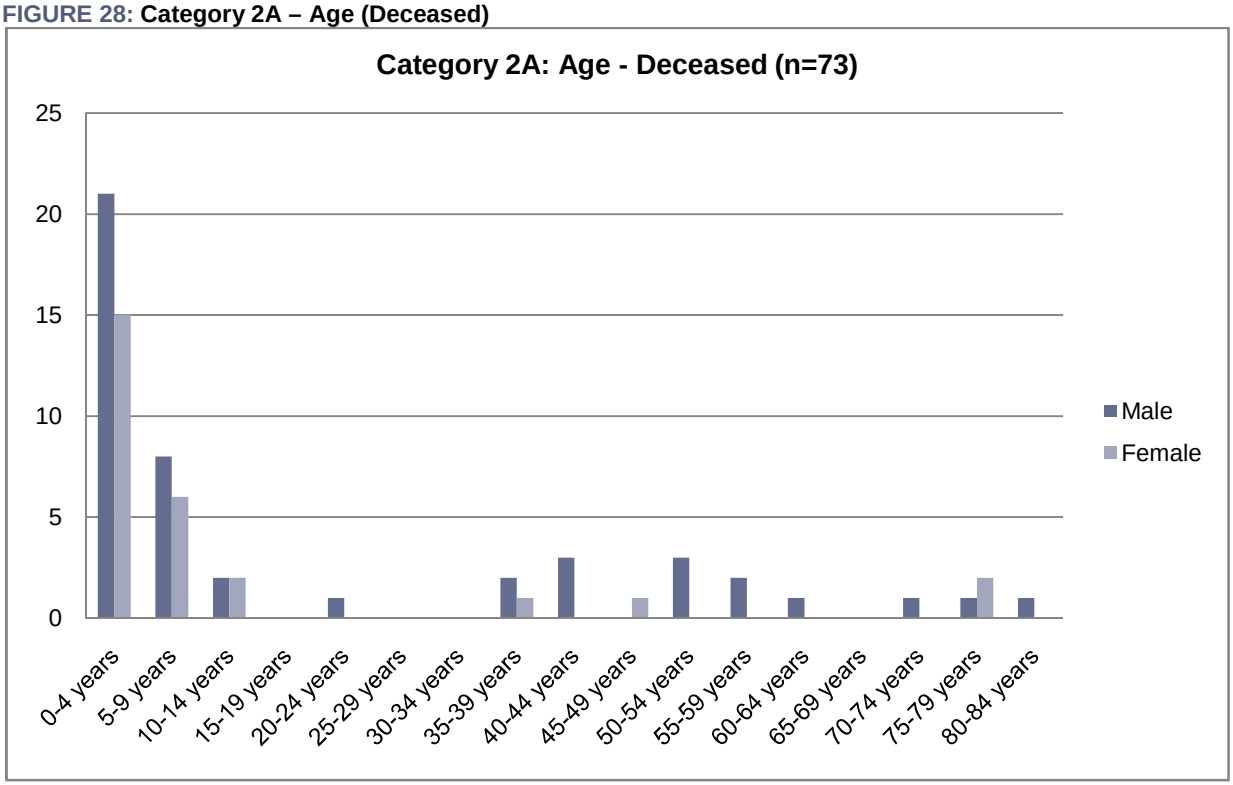
7.1.1 AGE (DECEASED)

For both male and female Category 2A deaths, the highest number of deaths occurred in the age bracket 0-4 years (21 male deaths or 45.65% of all Category 2A male deaths; 15 female deaths or 55.56% of all Category 2A female deaths).

For Category 2A deceased males, the mean age is 19.37 years, the median age is 5 years and the standard deviation is 24.99.

For Category 2A deceased females, the mean age is 12.22 years, the median age is 4 years and the standard deviation is 21.48.

FIGURE 28: Category 2A – Age (Deceased)



7.1.2 ATSI (DECEASED)

Of the 73 Category 2A deaths, 7 deceaseds identified as Aboriginal (9.59% of all Category 2A deceaseds).

This includes 2 females (7.41% of all Category 2A female deaths) and 5 males (10.87% of all Category 2A male deaths).

6 of the deceaseds in Category 2A were children below the age of 2 (85.71% of all the deceaseds that identified as Aboriginal in Category 2A).

7.1.3 MANNER OF DEATH

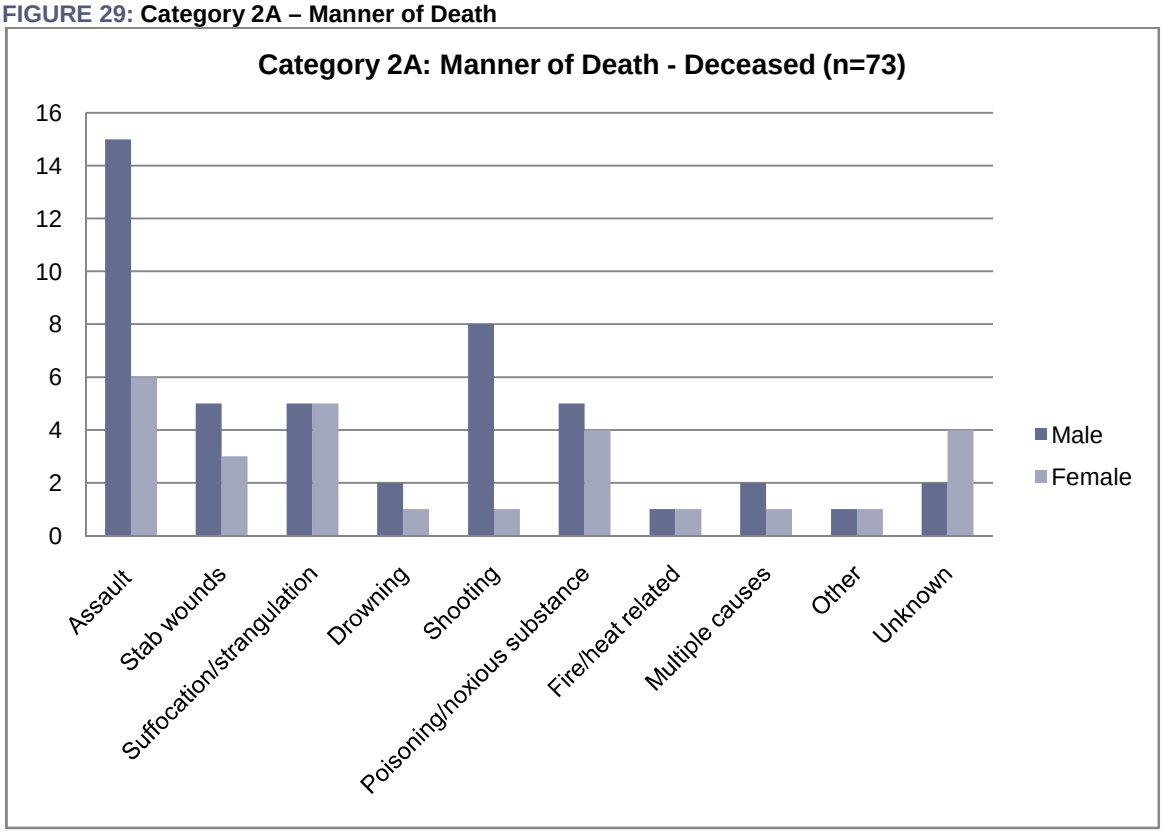
For Category 2A male deaths the highest number of deaths occurred as a consequence of assault (15 deaths or 32.61% of all Category 2A male deaths). The second highest number of Category 2A male deaths occurred as a consequence of shooting (8 deaths or 17.39% of all Category 2A male deaths).

For Category 2A female deaths, the highest number of deaths occurred as a consequence of assault (6 deaths or 22.22% of all Category 2A female deaths). The second highest number of Category 2A female deaths occurred as a consequence of suffocation/strangulation (5 deaths or 18.52% of all Category 2A female deaths).

3 Category 2A deaths were attributed to multiple causes, and the manner of death was unknown for 6 Category 2A deaths.

9 Category 2A deaths were attributed to poisoning/noxious substance, 3 Category 2A deaths were attributed to drowning and for 2 Category 2A deaths the manner of death was fire/heat-related.

FIGURE 29: Category 2A – Manner of Death



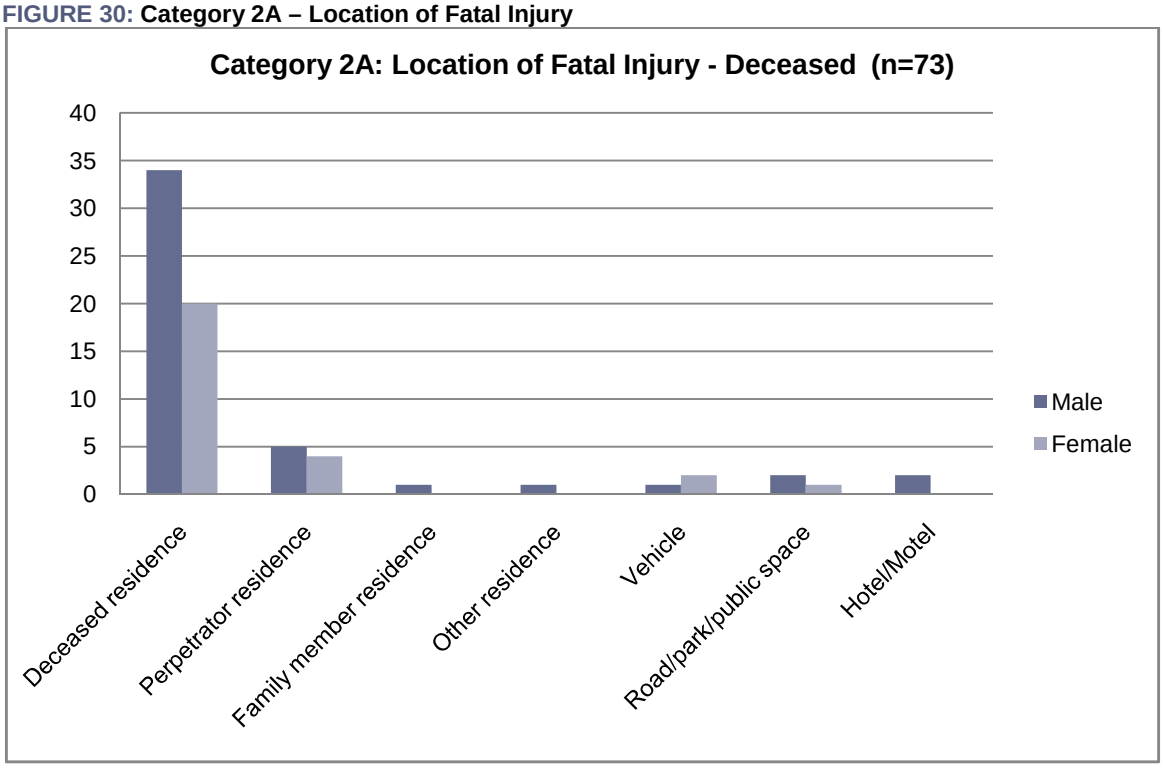
7.1.4 LOCATION OF FATAL INJURY (LEADING TO DEATH)

For both male and female Category 2A deaths, the highest number of fatal injuries occurred at the deceased's residence (34 males and 20 females). This was a total of 73.97% of all Category 2A deaths.

For Category 2A males, 73.91% sustained fatal injuries at their residence (34 males) and for Category 2A females, 74.07% sustained fatal injuries at their residence (20 females).

5 Category 2A males sustained fatal injuries at the perpetrator residence and 4 Category 2A females sustained fatal injuries at the perpetrator residence.

FIGURE 30: Category 2A – Location of Fatal Injury



7.2 CATEGORY 2A PERPETRATORS

Of the 58 incidents resulting in Category 2A deaths, 3 incidents involved multiple perpetrators, ie. two or more relatives/kin of the deceased acting together, or one relative/kin of the deceased acting together with another party or parties. 1 of the multiple perpetrator incidents involved a female deceased being killed by her intimate partner and her 2 children. In the other two multiple perpetrator incidents, the deceased was killed by both parents.

Accordingly, for the 58 incidents resulting in Category 2A deaths, there were:

- 61 Category 2A perpetrators ; and
- 1 additional non-family/kin perpetrator.

Of the 61 Category 2A perpetrators, 21 were female and 40 were male.

7.2.1 AGE (PERPETRATOR)

The highest number of Category 2A male perpetrators fell within the age group 30-34 years (13 perpetrators or 32.5% of all Category 2A male perpetrators).

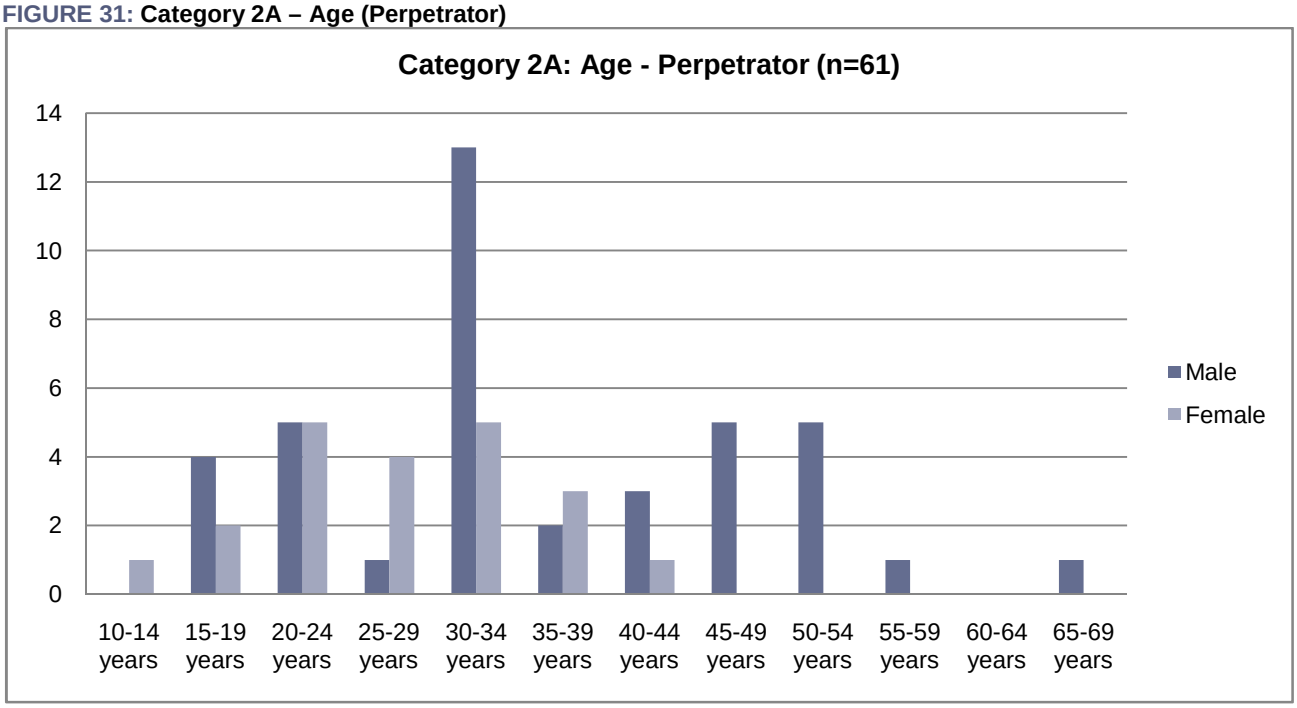
The highest number of Category 2A female perpetrators fell within the age groups 20-24 years (5 perpetrators or 23.81% of all Category 2A female perpetrators) and 30-34 years (5 perpetrators or 23.81% of all Category 2A female perpetrators).

There was 1 Category 2A female perpetrator within the age bracket 10-14 yrs. This case involved a 13 year-old female who stabbed her de facto step-father when he was attacking her mother.

For Category 2A male perpetrators, the mean age is 35.95 years, the median is 33 years and the standard deviation is 12.39.

For Category 2A female perpetrators, the mean age is 27.76 years, the median is 29 years and the standard deviation is 7.73.

FIGURE 31: Category 2A – Age (Perpetrator)



7.2.2 ATSI (PERPETRATOR)

7 of the Category 2A perpetrators identified as Aboriginal. In total, 11.48% of all Category 2A perpetrators identified as Aboriginal.

This included 6 male perpetrators (15% of all Category 2A male perpetrators) and 1 female perpetrator (4.76% of all Category 2A female perpetrators).

7.2.3 OUTCOMES

Murder Conviction

During the data reporting period, 7 Category 2A male perpetrators entered a plea of guilty to murder (17.5% of all Category 2A male perpetrators) and 5 Category 2A male perpetrators were found guilty of murder at trial (12.5% of all Category 2A male perpetrators). 30% of all Category 2A male perpetrators were convicted of murder (12 males).

2 Category 2A female perpetrators entered a plea of guilty to murder (9.52% of all Category 2A female perpetrators) and 2 Category 2A female perpetrators were found guilty of murder at trial (9.52% of all Category 2A female perpetrators). 19.05% of all Category 2A female perpetrators were convicted of murder (4 females).

Altogether, 14.75% of Category 2A perpetrators entered a plea of guilty to murder and 11.48% were found guilty of murder at trial. Accordingly, in 26.23% of cases, the Category 2A perpetrator was convicted of murder.

Manslaughter Conviction

During the data reporting period, 22.5% of Category 2A male perpetrators entered a plea of guilty to manslaughter (9 male perpetrators), and 10% of Category 2A male perpetrators were found guilty of manslaughter at trial (4 male perpetrators). 32.5% of all Category 2A male perpetrators were convicted of manslaughter (13 males).

For Category 2A female perpetrators, 42.86% entered a plea of guilty to manslaughter (9 female perpetrators), and 14.29% were found guilty of manslaughter at trial (3 female perpetrators). 57.15% of all Category 2A female perpetrators were convicted of manslaughter (12 females).

Altogether, 29.51% of Category 2A perpetrators entered a plea of guilty to manslaughter, and 11.48% were found guilty of manslaughter at trial. Accordingly, in 40.98% of cases, the Category 2A perpetrator was convicted of manslaughter.

Not Guilty by Reason of Mental Illness

During the data reporting period, 3 Category 2A male perpetrators and 1 Category 2A female perpetrator were found not guilty by reason of mental illness at trial. Altogether, 6.56% of all Category 2A perpetrators were found not guilty by reason of mental illness at trial.

Coronial Finding

During the data reporting period, there were 12 Category 2A perpetrators who died, 11 as a result of suicide and 1 as a result of burns sustained accidentally. Accordingly, for 19.67% of all Category 2A perpetrators a Coronial finding was the recorded outcome.

FIGURE 32: Category 2A – Outcome (Perpetrator)

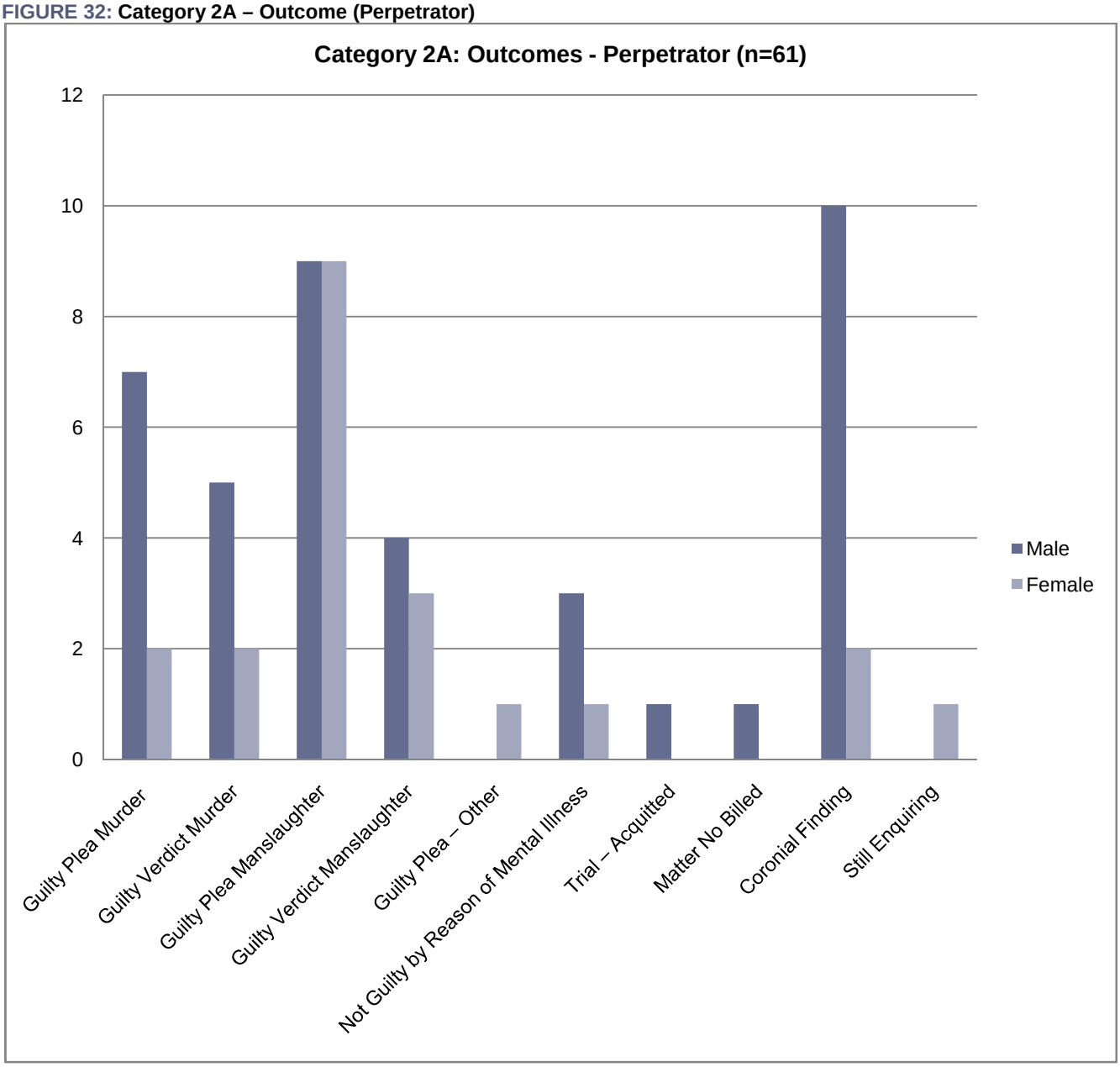


FIGURE 33: Category 2A – Outcome - Perpetrator (Male)

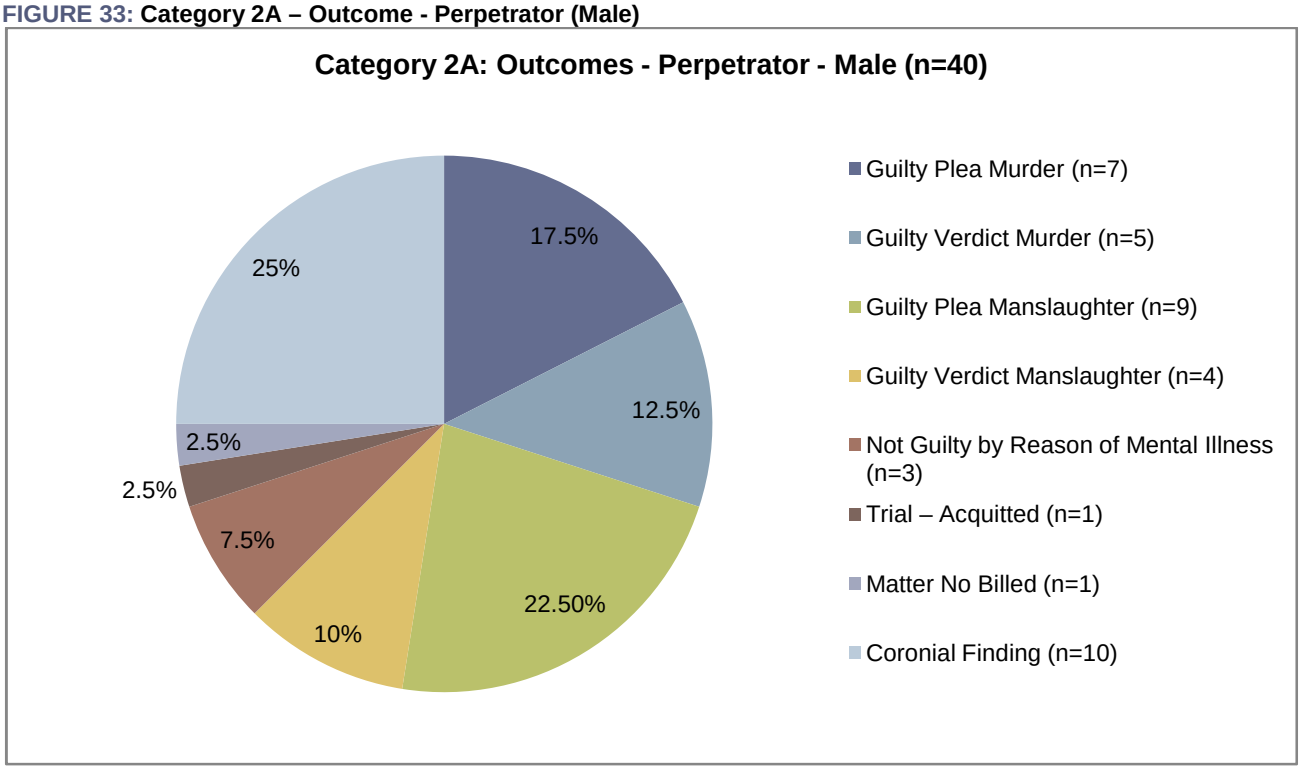
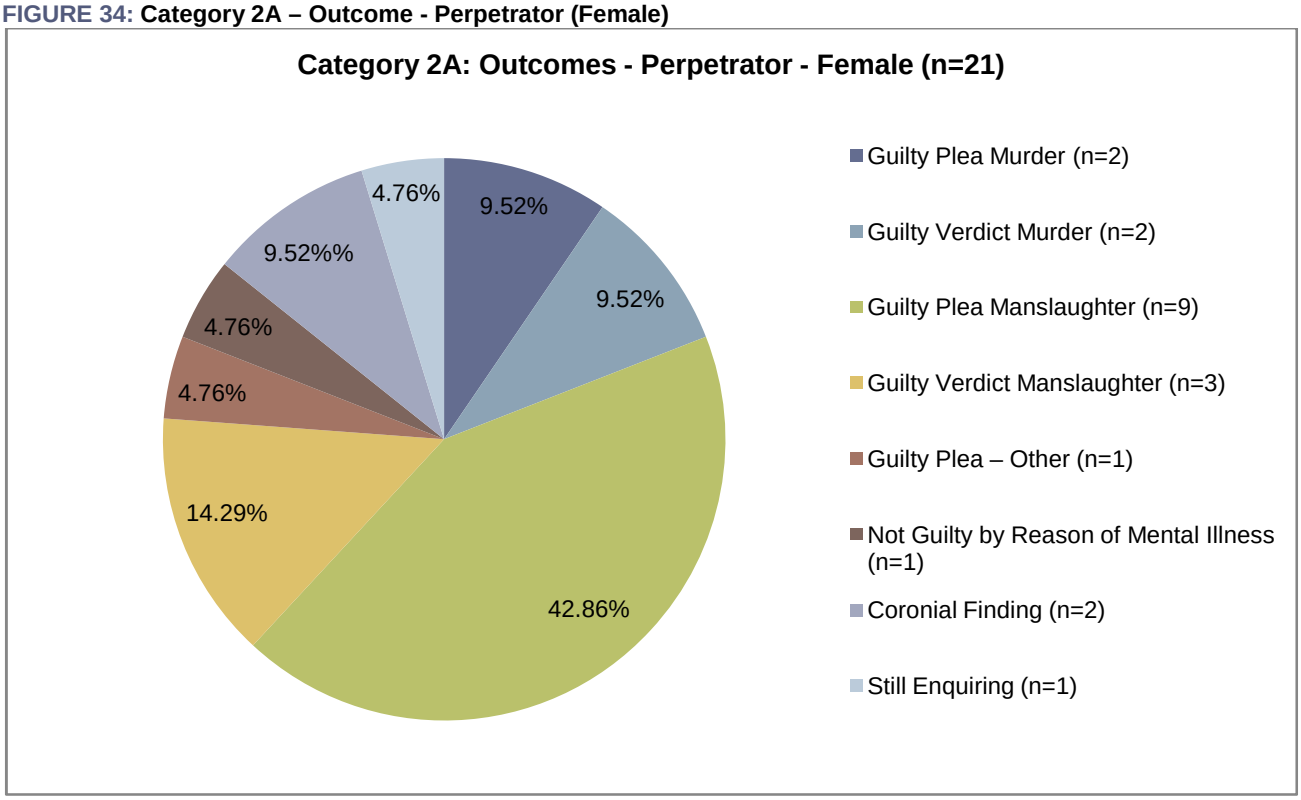


FIGURE 34: Category 2A – Outcome - Perpetrator (Female)



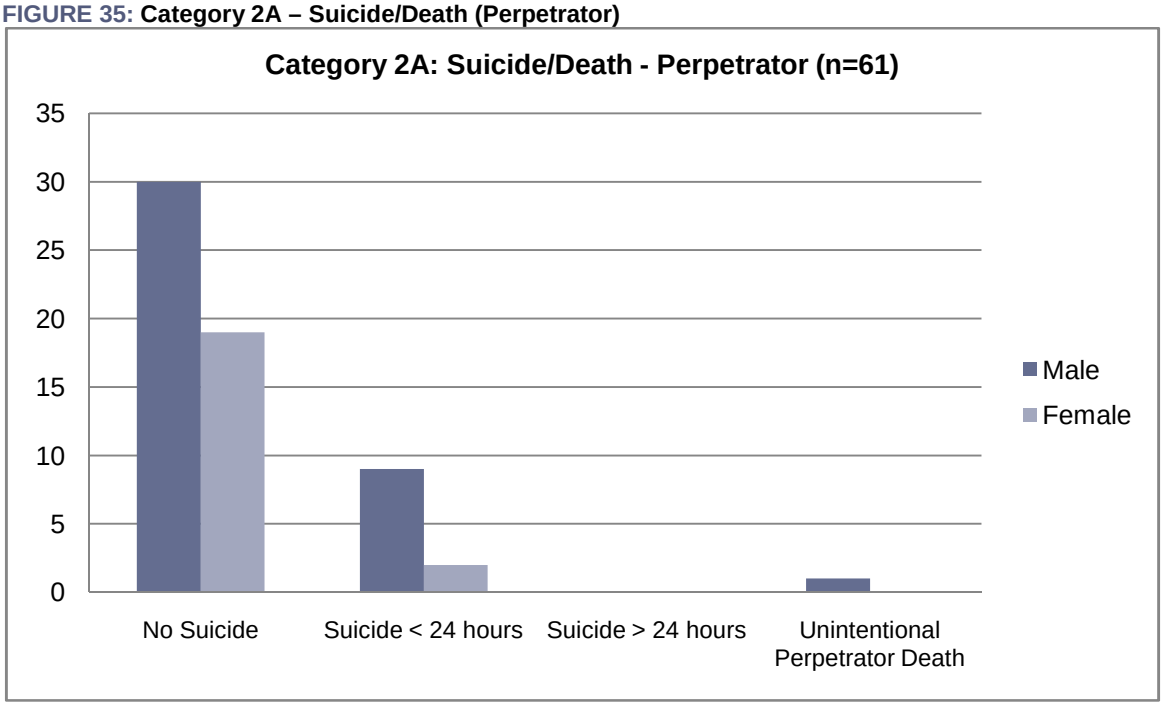
7.2.4 PERPETRATOR SUICIDE/DEATH

During the data reporting period, out of the 61 Category 2A perpetrators, 11 perpetrators committed suicide (18.03% of all Category 2A perpetrators) and 1 died unintentionally from burns sustained during the incident.

Of the 11 Category 2A perpetrators who committed suicide, 9 were male and 2 were female. All 11 perpetrators committed suicide within 24 hours of the fatal incident.

1 perpetrator died unintentionally from burns within 24 hours of killing his son (and his intimate partner).

FIGURE 35: Category 2A – Suicide/Death (Perpetrator)



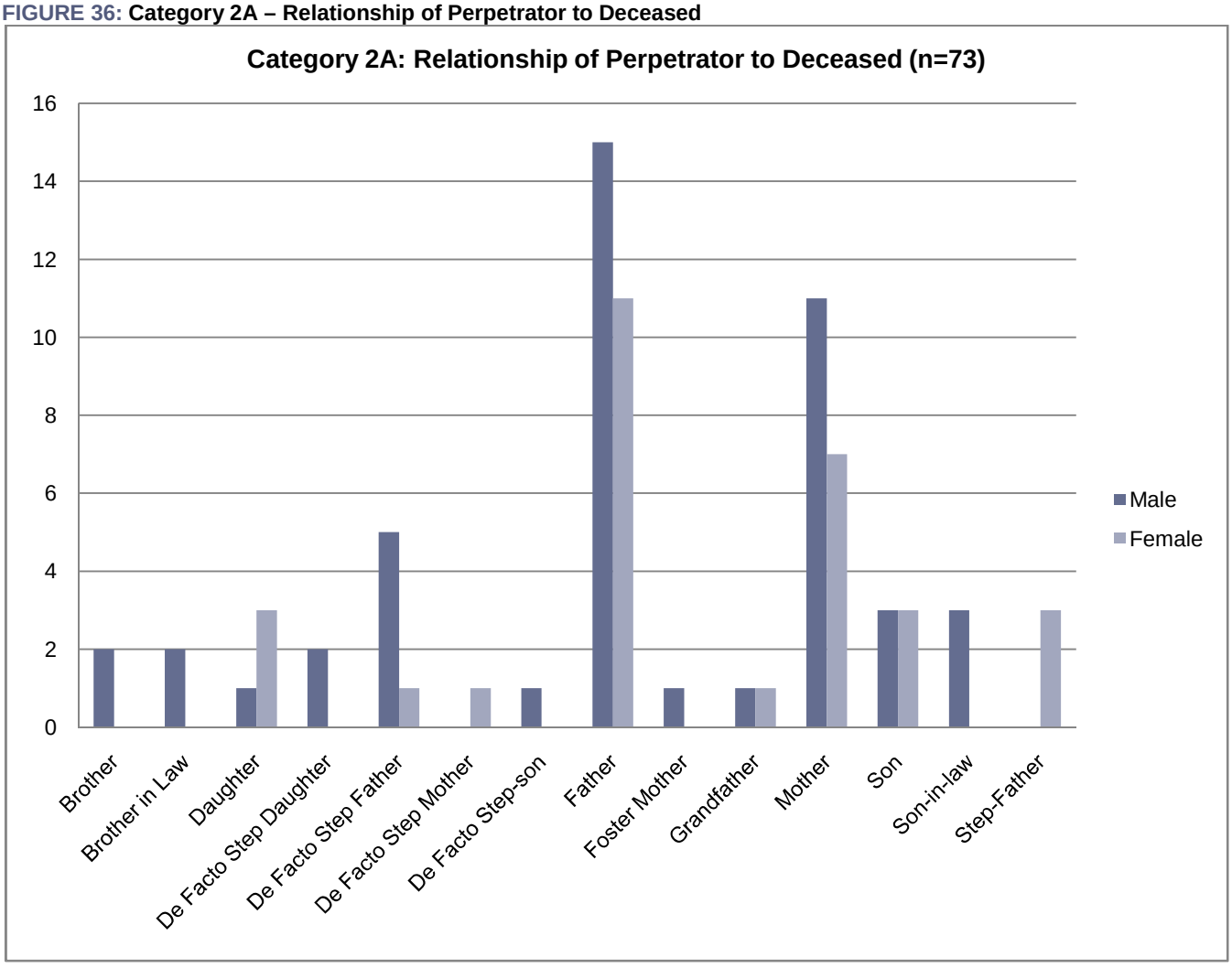
7.3 CATEGORY 2A RELATIONSHIP TYPE

During the data reporting period, the highest number of Category 2A male deaths were perpetrated by the father of the deceased (15 deaths). The second highest number of Category 2A male deaths were perpetrated by the mother of the deceased (11 deaths). The third highest number of Category 2A male deaths were perpetrated by the de facto step-father of the deceased (5 deaths).

During the data reporting period, the highest number of Category 2A female deaths were perpetrated by the father of the deceased (11 deaths). The second highest number of Category 2A female deaths were perpetrated by the mother of the deceased (7 deaths). The third highest number of Category 2A female deaths were perpetrated by either the daughter, son or step-father of the deceased (3 in each relationship type).

60.27% of all Category 2A deaths (44 deaths) were perpetrated by either the father or mother of the deceased.

FIGURE 36: Category 2A – Relationship of Perpetrator to Deceased



7.4 CATEGORY 2A MULTIPLE FATALITY INCIDENTS

Of the 58 incidents resulting in Category 2A deaths, there were 16 Multiple Fatality Incidents.

The 16 Multiple Fatality Incidents resulted in 39 deaths:

- 31 Category 2A deaths; and
- 8 'other parties'.

The 8 'other parties' comprised of 8 intimate partners (7 females and 1 male). These are not considered Category 2A deaths but are Category 1A deaths and are described in Chapter 5.

Of the 16 Multiple Fatality Incidents, 12 were committed by a male perpetrator and 4 incidents were committed by a female perpetrator.

8 Multiple Fatality Incidents involved the perpetrator killing only family members, and 8 Multiple Fatality Incidents involved the perpetrator killing their spouse as well as family member/s.

Of the 8 Multiple Fatality Incidents where only family members were killed:

- 6 involved perpetrator killing only their biological children;
- 1 involved a daughter killing her two parents; and
- 1 involved a perpetrator killing their biological children and father-in-law.

The 16 Multiple Fatality Incidents were committed by 16 perpetrators, 7 of whom committed suicide and 1 who died accidentally as a consequence of burns.

CHAPTER 8: CATEGORY 2B – RELATIVE/KIN, NO DOMESTIC VIOLENCE CONTEXT

CHAPTER 8: OVERVIEW OF CATEGORY 2B DEATHS – RELATIVE/KIN, NO DOMESTIC VIOLENCE CONTEXT

- Approximately a third of all deceaseds in this category were killed by their son.
- The majority of female perpetrators in this category were found not guilty by reason of mental illness.
- Over a third of male perpetrators in this category were found not guilty by reason of mental illness.
- The highest number of male and female deceaseds in this category died as a consequence of stab wounds.
- The majority of deceaseds in this category sustained fatal injuries at their residence.
- 10.77% of all deceaseds in this category identified as Aboriginal (7 deceaseds). 3 deceaseds in this category were below the age of 1.
- 14.52% of all perpetrators in this category identified as Aboriginal.

From all closed cases within the data reporting period there were 59 incidents where a person was killed by a relative/kin and there was no identifiable domestic violence context. A number of these incidents also resulted in additional deaths, including deaths from other categories and/or perpetrator suicides.

In total, from these 59 incidents, there were 69 deaths.

From these 69 deaths:

- 65 were relatives/kin of the perpetrator and there was no identifiable domestic violence context (Category2B deaths);
- 1 was an 'other party' (Category 1B deceased); and
- 3 were perpetrator suicides.

8.1 CATEGORY 2B DEATHS

Of the 65 Category 2B deaths, 29 were females and 36 were males.

8.1.1 AGE (DECEASED)

For all Category 2B deaths, the highest number of deaths occurred in the age bracket 0-4 years (8 deaths or 12.31% of all Category 2B deaths).

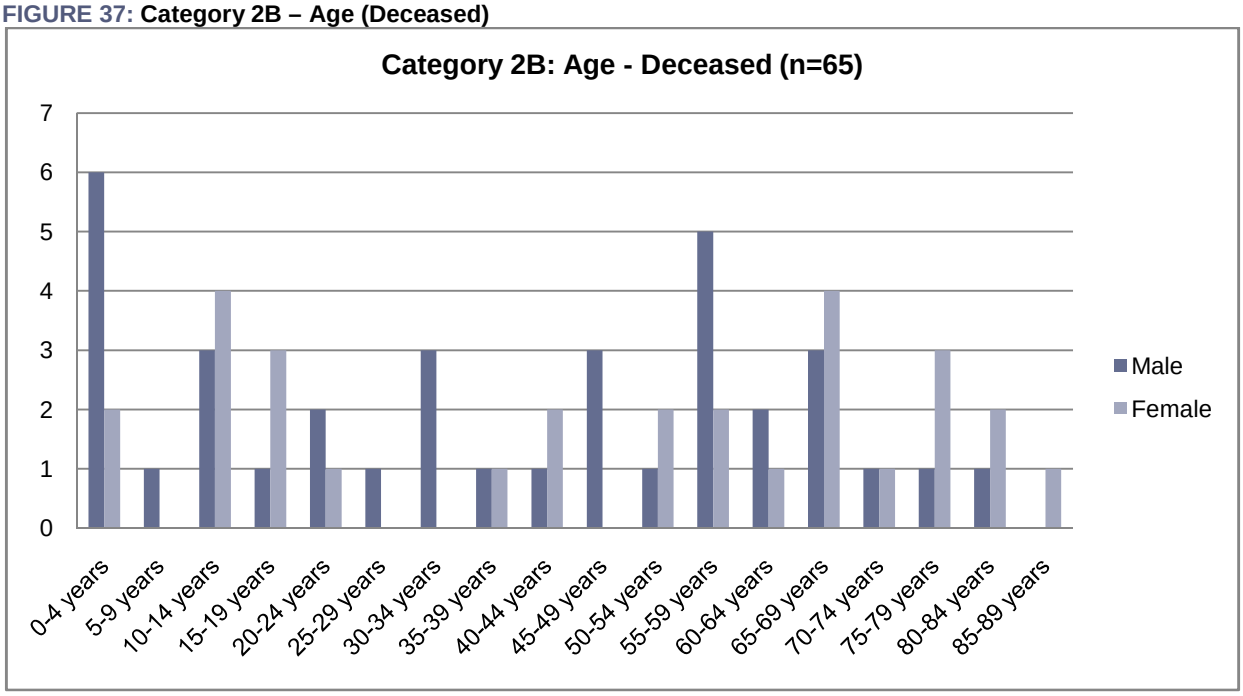
For males, the highest number of deaths occurred in the age bracket 0-4 years (6 deaths or 16.67% of all Category 2B male deaths).

For females, the highest number of deaths occurred in the age bracket 10-14 years (4 deaths or 13.79% of all Category 2B female deaths) and the age bracket 65-69 years (4 deaths or 13.79% of all Category 2B female deaths).

The mean age for Category 2B male deaths is 37 years, the median age is 39.5 years and the standard deviation is 25.56.

The mean age for Category 2B female deaths is 46.24 years, the median age is 53 years and the standard deviation is 28.21.

FIGURE 37: Category 2B – Age (Deceased)



8.1.2 ATSI (DECEASED)

Of the 65 Category 2B deceaseds, 7 identified as Aboriginal (10.77% of all Category 2B deceaseds).

This included 1 female (3.45% of all Category 2B female deceaseds) and 6 males (16.67% of all Category 2B male deceaseds).

3 of the Aboriginal-identified deceaseds in Category 2B were children below the age of 12 months.

8.1.3 MANNER OF DEATH

For Category 2B male deaths the highest number of deaths occurred as a consequence of stab wounds (16 deaths or 44.44% of all Category 2B male deaths). The second highest number of deaths occurred as a consequence of assault (8 deaths or 22.22% of all Category 2B male deaths).

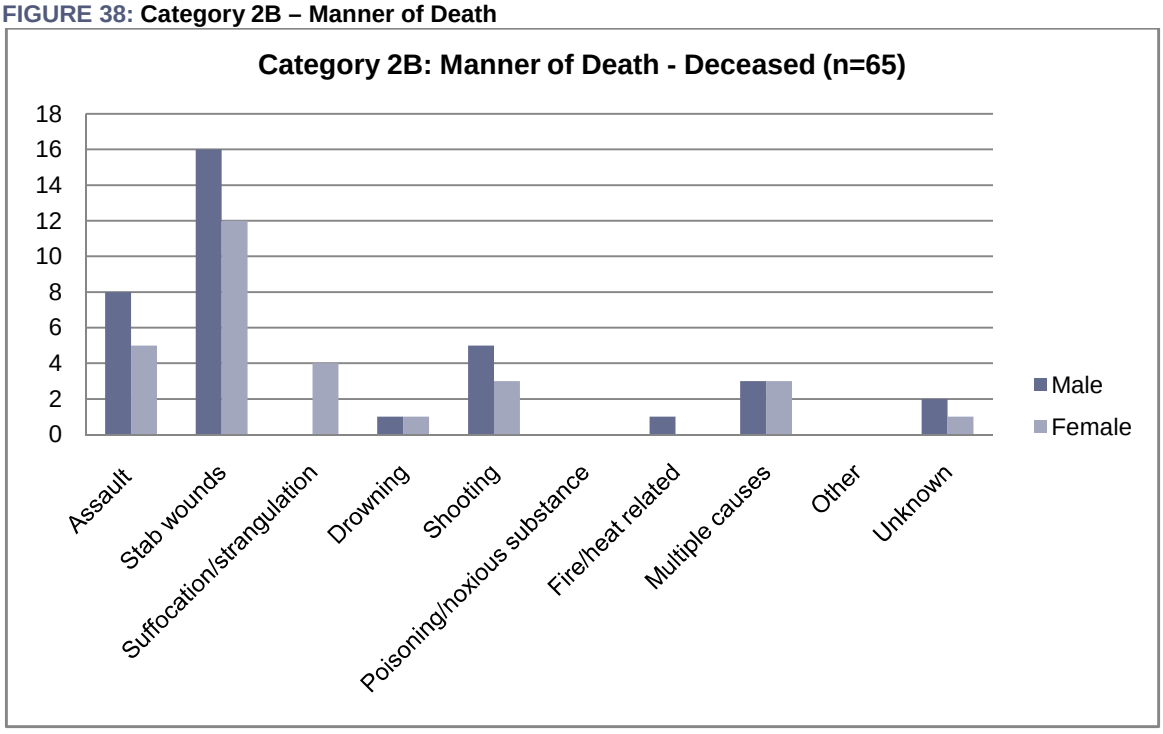
For female Category 2B deaths, the highest number of deaths occurred as a consequence of stab wounds (12 deaths or 41.38% of all Category 2B female deaths). The second highest number of deaths occurred as a consequence of assault (5 deaths or 17.24% of all Category 2B female deaths).

6 deaths were attributed to multiple causes, and in 3 deaths the manner of death was unknown. 4 female deaths were attributable to suffocation/strangulation and no male deaths.

2 deaths (1 male, 1 female) occurred as a consequence of drowning.

8 deaths were attributable to shooting.

FIGURE 38: Category 2B – Manner of Death

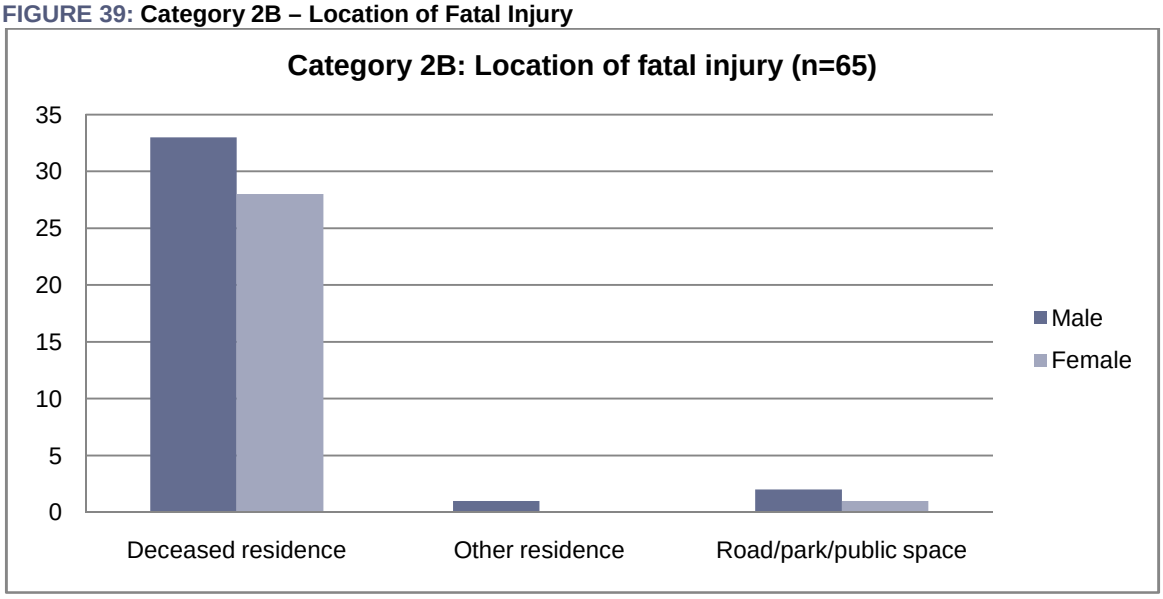


8.1.4 LOCATION OF FATAL INJURY (LEADING TO DEATH)

For both male and female Category 2B deceaseds, the highest number sustained fatal injuries at their residence (33 males and 28 females). 93.85% of all Category 2B deceaseds sustained fatal injuries leading to death at their place of residence.

For males, 91.67% sustained fatal injuries leading to death at their residence and for females, 96.55% sustained fatal injuries leading to death at their residence.

FIGURE 39: Category 2B – Location of Fatal Injury



8.2 CATEGORY 2B PERPETRATORS

Of the 59 incidents result in Category 2B deaths, 4 incidents involved multiple perpetrators, i.e. two or more relatives/kin of the deceased acting together, or one relative/kin of the deceased acting together with another party or parties. Of the 4 Multiple Perpetrator Incidents:

- 1 involved a male deceased being killed by his intimate partner and his son;
- 1 involved a male deceased being killed by his son and grandson;
- 1 involved a male deceased being killed by his step-brother and another extended family member; and
- 1 involved a male deceased being killed by both his parents.

Accordingly, for the 59 incidents resulting in Category 2B deaths, there were:

- 62 Category 2B perpetrators; and
- 1 'other' perpetrator (in this case, a Category 1B perpetrator)

Of the 62 Category 2B perpetrators, 49 were males and 13 were females.

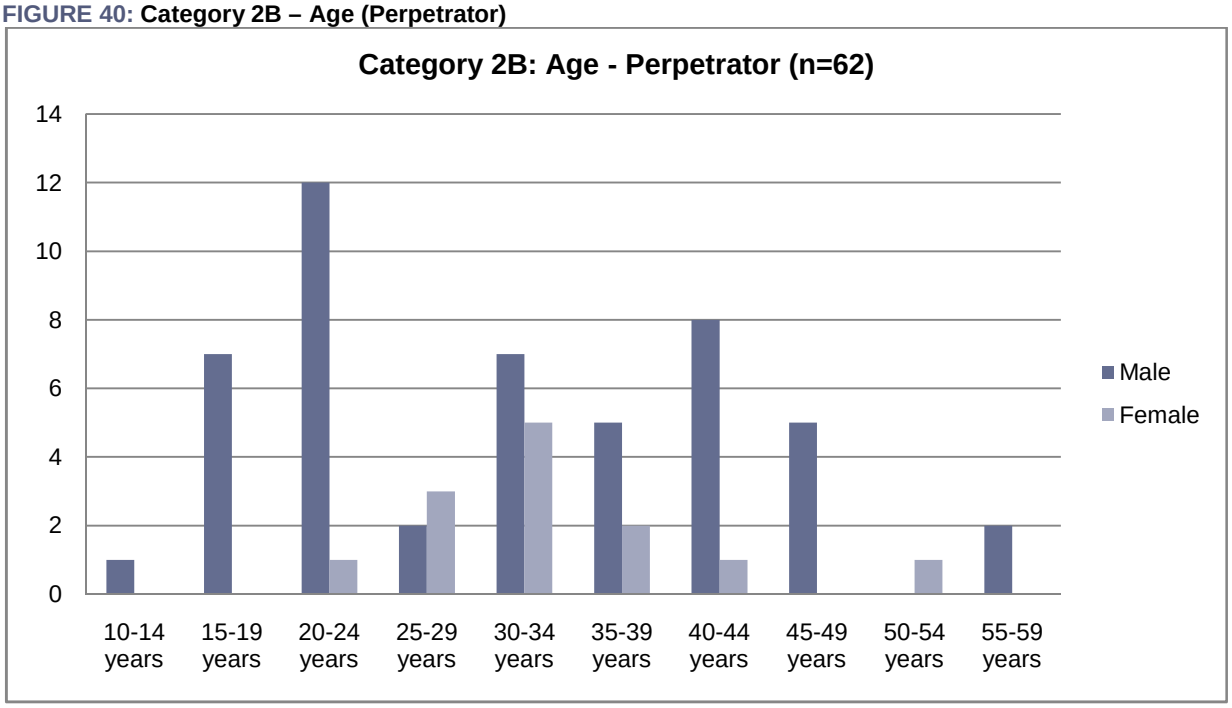
8.2.1 AGE (PERPETRATOR)

The highest number of Category 2B male perpetrators fell within the age bracket 20-24 years (12 male perpetrators or 24.49% of all Category 2B male perpetrators). The highest number of Category 2B female perpetrators fell within the age bracket 30-34 years (5 perpetrators or 38.46% of all Category 2B female perpetrators).

The mean age for Category 2B male perpetrators is 31.22 years, the median age is 30 years and the standard deviation is 11.44.

The mean age for Category 2B female perpetrators is 33 years, the median age is 32 years and the standard deviation is 8.59.

FIGURE 40: Category 2B – Age (Perpetrator)



8.2.2 ATSI (PERPETRATOR)

9 of the 62 Category 2B perpetrators identified as Aboriginal (14.52% of all Category 2B perpetrators).

This included 8 males (16.33% of all Category 2B male perpetrators) and 1 female (7.69% of all Category 2B female perpetrators).

8.2.3 OUTCOMES

Murder Conviction

During the data reporting period, 16.33% of Category 2B male perpetrators entered a plea of guilty to murder (8 perpetrators) and 14.29% of Category 2B male perpetrators were found guilty of murder at trial (7 males). 30.61% of all Category 2B male perpetrators were convicted of murder (15 males).

No female perpetrators entered a plea of guilty to murder, and no female perpetrators were found guilty of murder at trial.

24.19% of all Category 2B perpetrators were convicted of murder.

Manslaughter Conviction

During the data reporting period, 10.2% of Category 2B male perpetrators entered a plea of guilty to manslaughter (5 perpetrators), and 12.24% of Category 2B male perpetrators were found guilty of manslaughter at trial (6 males). 22.45% of all Category 2B male perpetrators were convicted of manslaughter (11 males).

For Category 2B female perpetrators, 23.08% entered a plea of guilty to manslaughter (3 females), and 7.69% were found guilty of manslaughter at trial (1 female). 30.77% of all Category 2B female perpetrators were convicted of manslaughter (4 females).

Altogether, 12.9% of perpetrators entered a plea of guilty to manslaughter, and 11.29% were found guilty of manslaughter at trial. This means that in 24.19% of cases, the perpetrator was convicted of manslaughter.

Not Guilty by Reason of Mental Illness

During the data reporting period, 18 male perpetrators (36.73% of all Category 2B male perpetrators) and 8 female perpetrators (61.54% of all Category 2B female perpetrators) were found not guilty by reason of mental illness at trial.

Altogether, 41.94% of all Category 2B perpetrators were found not guilty by reason of mental illness at trial.

Not fit to stand trial

During the data reporting period, there were 2 Category 2B male perpetrators who were declared not fit to stand trial.

Coronial Finding

During the data reporting period, there were 3 Category 2B perpetrators who committed suicide, resulting in a Coronial finding (3 males and 0 females).

Guilty Plea Other

During the data reporting period, 1 Category 2B female perpetrator, who had killed her child, entered a guilty plea to the charge of infanticide.

FIGURE 41: Category 2B – Outcome (Perpetrator)

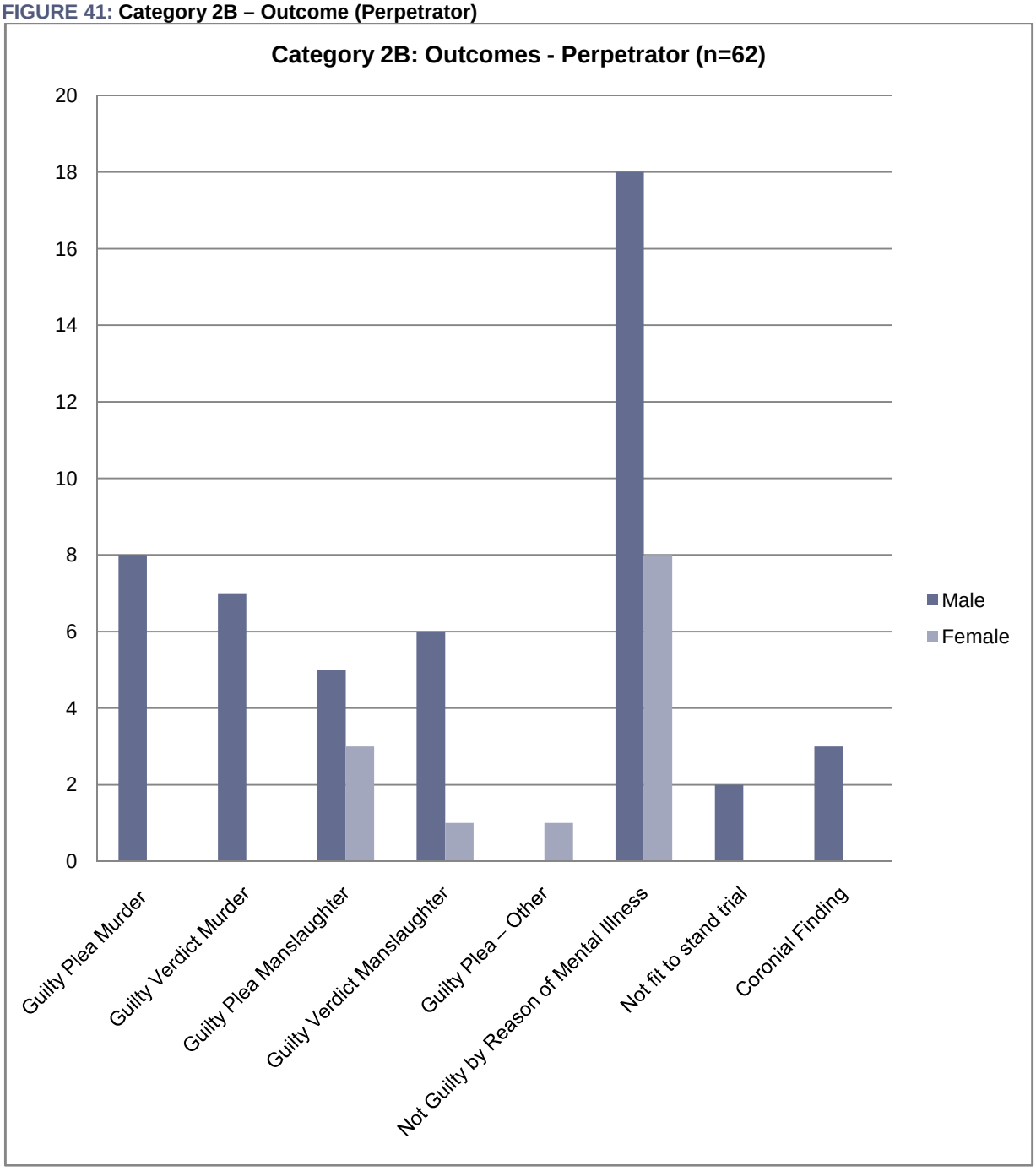


FIGURE 42: Category 2B – Outcome – Perpetrator (Male)

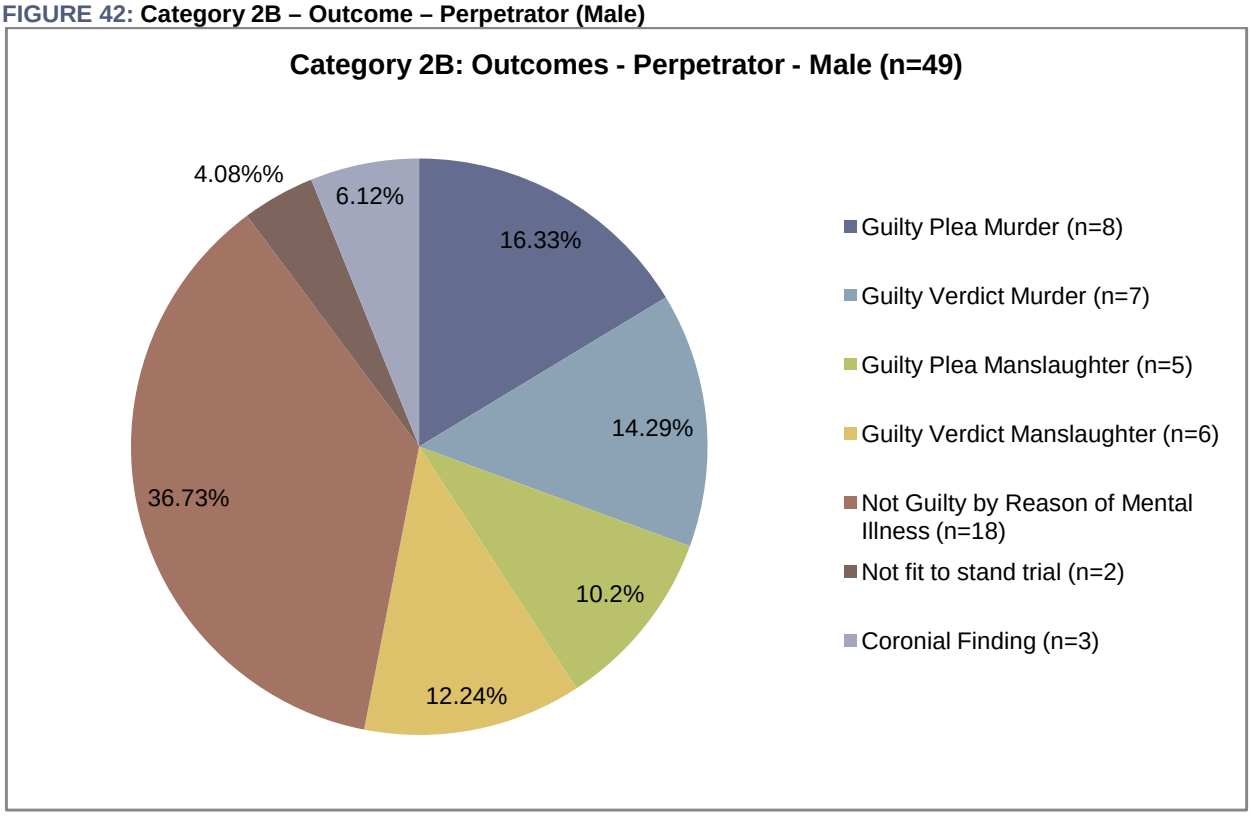
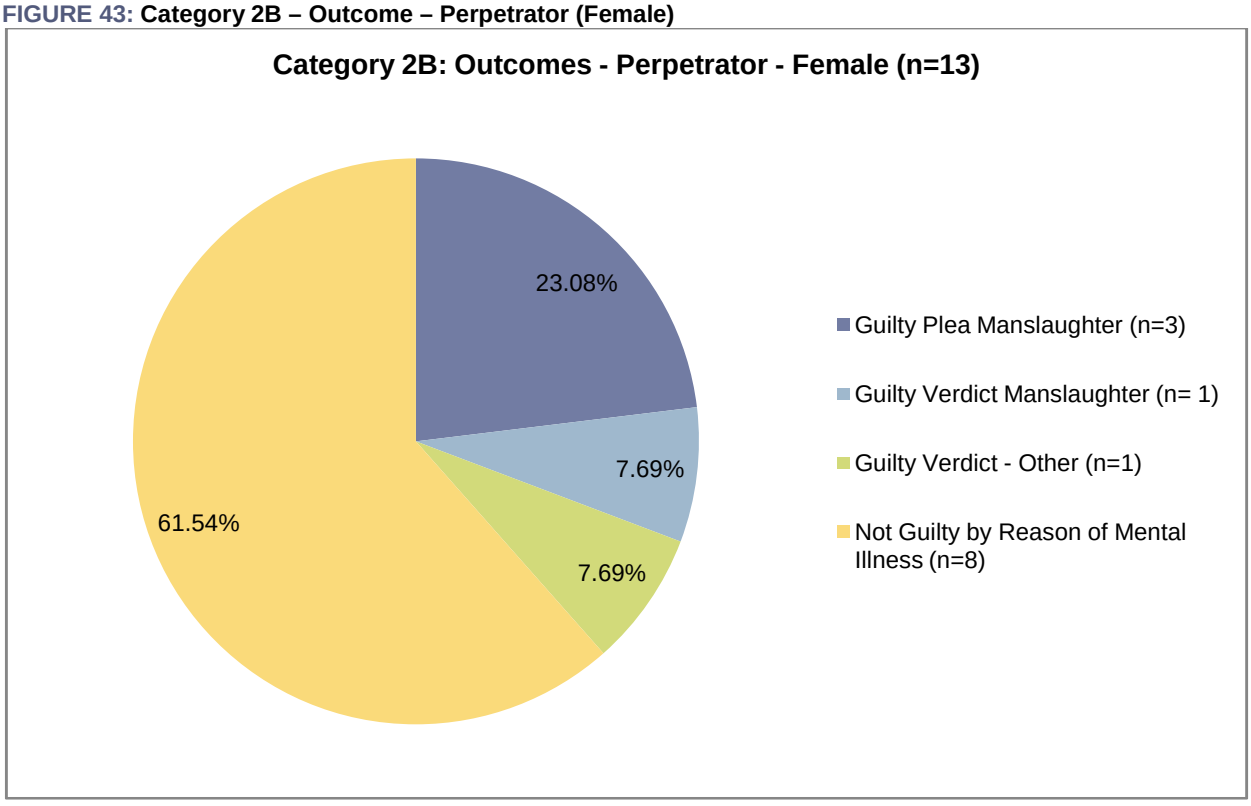


FIGURE 43: Category 2B – Outcome – Perpetrator (Female)



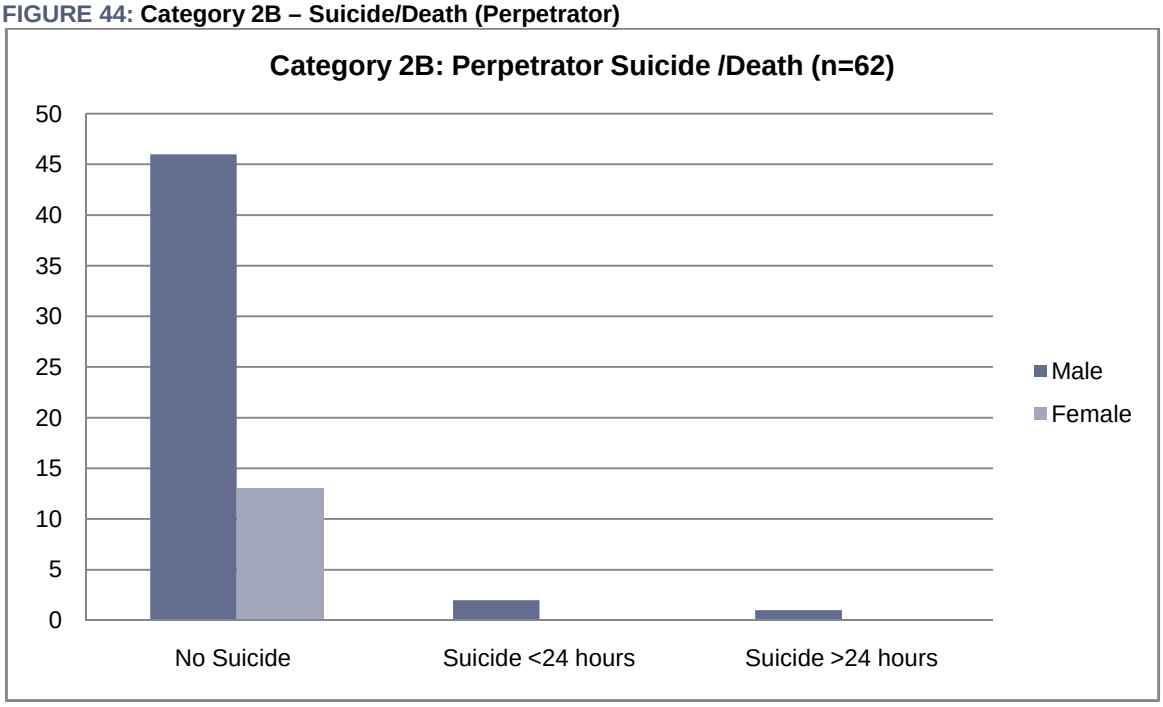
8.2.4 PERPETRATOR SUICIDE/DEATH

During the data reporting period, 3 out of the 62 Category 2B perpetrators committed suicide (4.84%).

All Category 2B perpetrators who committed suicide were male.

2 perpetrators committed suicide within 24 hours of the fatal incident. Additionally 1 perpetrator committed suicide more than 24 hours after the fatal incident (while in custody).

FIGURE 44: Category 2B – Suicide/Death (Perpetrator)



8.3 CATEGORY 2B RELATIONSHIP TYPE

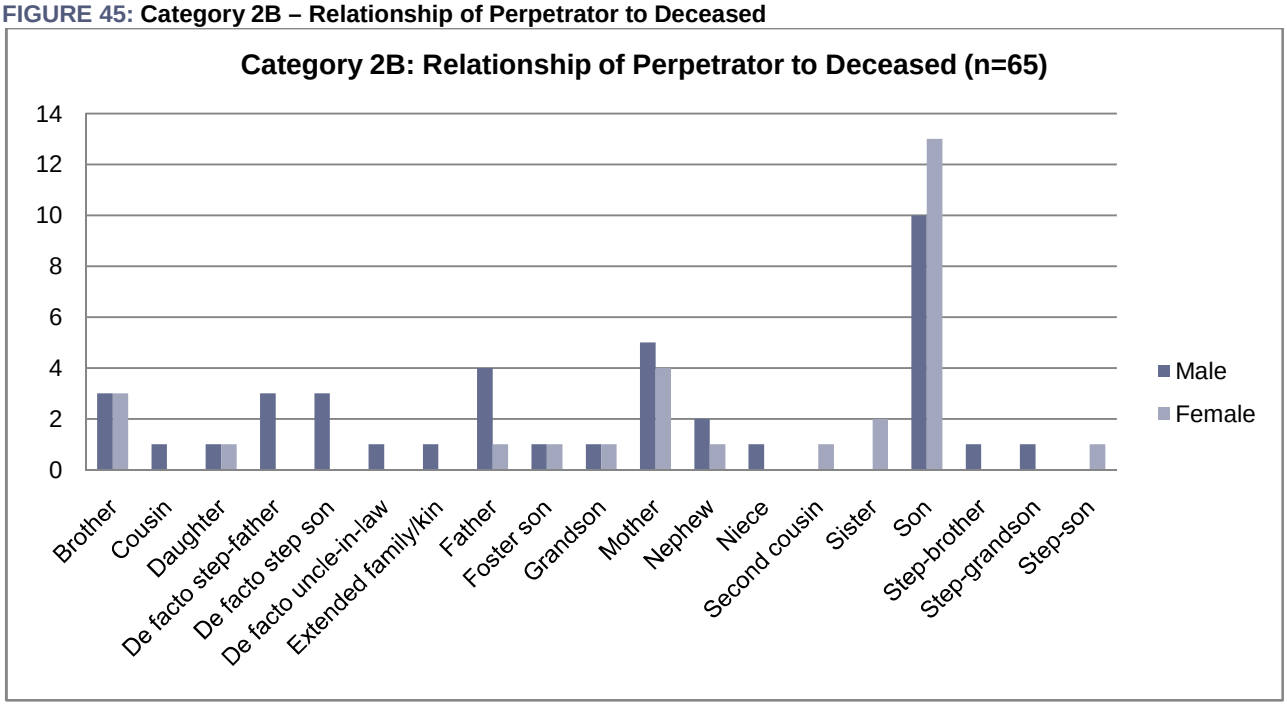
During the data reporting period, the highest number of Category 2B deaths were perpetrated by the son of the deceased (23 deaths). This included the deaths of 13 males and 10 males.

The second highest number of Category 2B deaths were perpetrated by the mother of the deceased. This included the deaths of 5 males and 4 females.

Out of the 59 incidents which resulted in a Category 2B death, 3 involved the killing of the deceased by multiple family members. Of these 3 incidents:

- 1 involved the killing of the deceased by his son and grandson;
- 1 involved the killing of the deceased by his step-brother and another family member; and
- 1 involved the killing of the deceased by both parents.

FIGURE 45: Category 2B – Relationship of Perpetrator to Deceased



8.4 CATEGORY 2B MULTIPLE FATALITY INCIDENTS

Of the 59 incidents, there were 4 Multiple Fatality Incidents which resulted in more than one death.

The 4 Multiple Fatality Incidents resulted in 11 deaths, including; 10 relatives/kin and 1 'other' party who was the female intimate partner of the perpetrator (Category 1B deceased).

Of the 4 Multiple Fatality Incidents, 3 were committed by a male perpetrator and 1 was committed by a female perpetrator.

2 of the Multiple Fatality Incidents involved the perpetrator killing both parents and a sibling; 1 involved the perpetrator killing one parent and a sibling; and one involved the perpetrator killing their intimate partner and two biological children.

CHAPTER 9: CATEGORY 3A – NO RELATIONSHIP, DOMESTIC VIOLENCE CONTEXT

CHAPTER 9: OVERVIEW OF CATEGORY 3A DEATHS – NO RELATIONSHIP, DOMESTIC VIOLENCE CONTEXT

- Over half of the deceaseds in this category were killed by the former intimate partner of their current intimate partner.
- The majority of deaths in this category occurred as a consequence of stab wounds.
- The majority of deceaseds in this category sustained fatal injuries at the perpetrator's residence.
- 1 deceased identified as Aboriginal, and no perpetrators identified as Aboriginal.

As discussed in section 2.3, a Category 3A death occurs where there is no relationship between the deceased and the perpetrator, but there is nonetheless a context of domestic violence. Examples of this category of death may include: bystanders or police who are killed intervening in a domestic violence dispute; or the killing of a person's new intimate partner by their former partner.

From all closed cases within the data reporting period, there were 20 incidents where a person was killed by a person that was neither an intimate partner, nor a relative/kin, but the death occurred in the context of domestic violence. A number of these incidents resulted in additional deaths, including deaths from other categories and/or perpetrator suicides.

In total, from these 20 incidents there were 21 deaths.

From the 21 deaths that occurred in the 20 incidents:

- 20 had no relationship with the perpetrator but the death occurred in a context of domestic violence; and
- 1 was an 'other' party (a Category 1A death).

9.1 CATEGORY 3A DEATHS

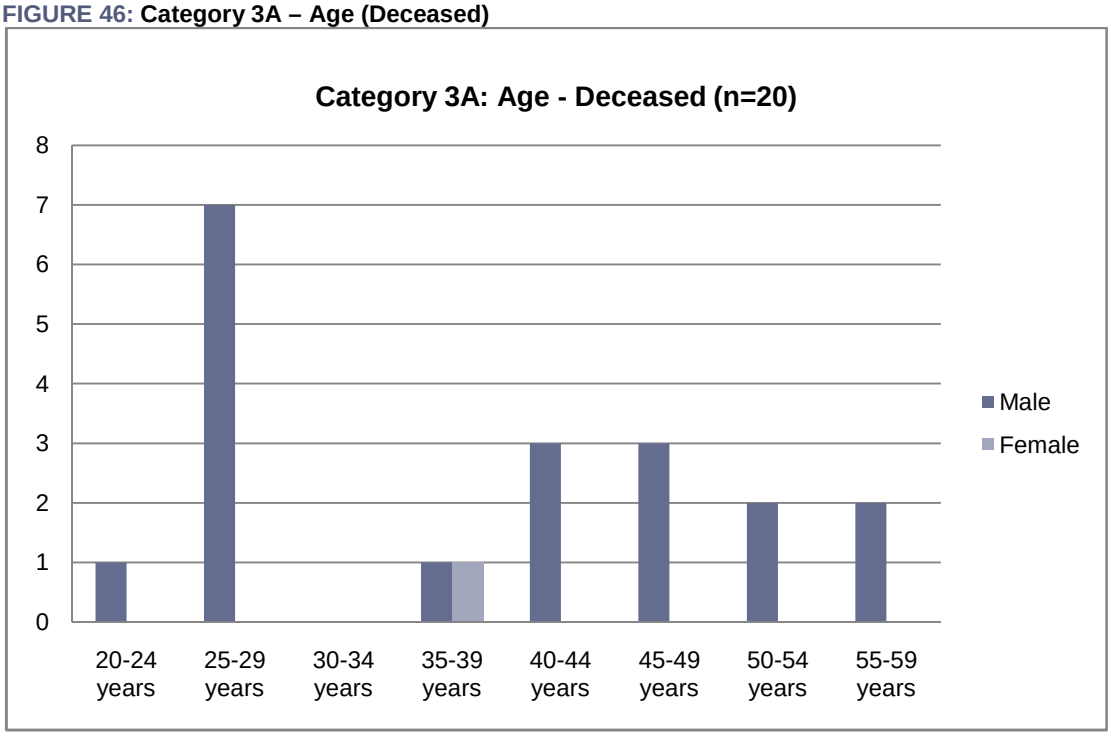
Of the 20 Category 3A deaths, 1 was a female and 19 were males.

9.1.1 AGE (DECEASED)

The highest number of Category 3A deaths occurred in the age bracket 25-29 years (7 deaths or 35% of all Category 3A deaths). There were no Category 3A deaths under the age of 20 years.

The mean age for Category 3A male deaths is 38.84 years, the median age is 43 years and the standard deviation is 11.73.

FIGURE 46: Category 3A – Age (Deceased)



9.1.2 ATSI (DECEASED)

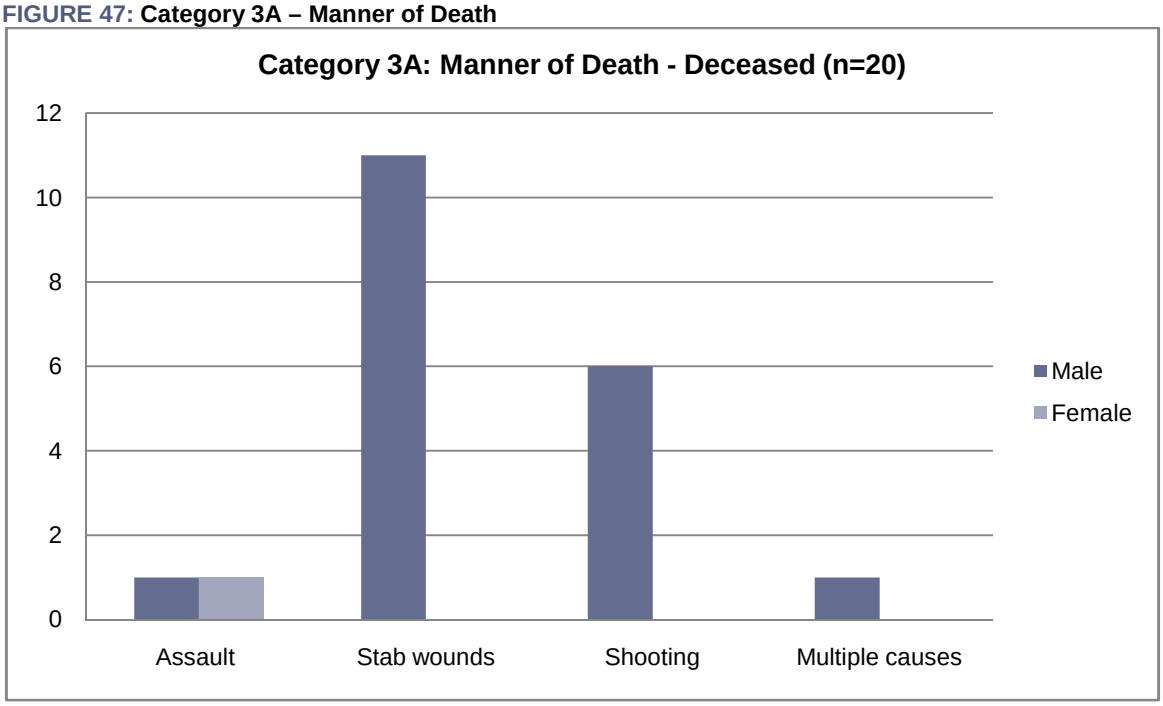
Of the 20 Category 3A deceaseds, 1 male deceased identified as Aboriginal. Accordingly, 5% of all Category 3A deceaseds identified as Aboriginal.

9.1.3 MANNER OF DEATH

For Category 3A male deaths, the highest number of deaths occurred as a consequence of stab wounds (11 deaths or 57.89% of all Category 3A male deaths). The second highest number of Category 3A male deaths occurred as a consequence of shooting (6 deaths or 31.58% of all Category 3A male deaths).

The single female deceased in Category 3A was killed as a consequence of assault.

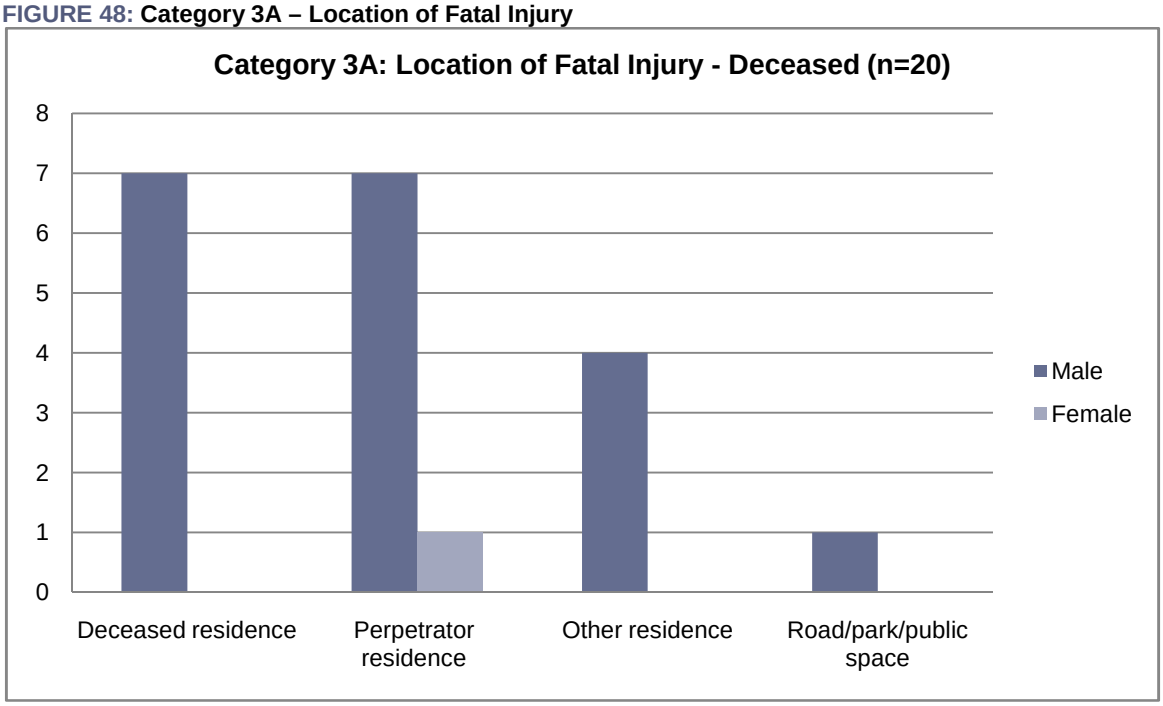
FIGURE 47: Category 3A – Manner of Death



9.1.4 LOCATION OF FATAL INJURY (LEADING TO DEATH)

The highest numbers of fatal injuries leading to death in Category 3A occurred at the perpetrator residence (8 deaths or 40% of all Category 3A deaths). The second highest number of fatal injuries leading to death in Category 3A occurred at the deceased's residence (7 deaths or 35% of all Category 3A deaths). In 4 cases (20% of all Category 3A deaths), fatal injuries were inflicted on the deceased at a residence that was not the residence of the deceased or the perpetrator ('Other residence').

FIGURE 48: Category 3A – Location of Fatal Injury



9.2 CATEGORY 3A PERPETRATORS

From the incidents that resulted in Category 3A deaths, there were 20 Category 3A perpetrators and 2 other perpetrators.

In 2 of the 20 incidents the deceased was killed by multiple perpetrators. 1 multiple perpetrator incident involved a former girlfriend of the deceased and her current intimate partner killing the deceased. In the other multiple perpetrator incident, a former female intimate partner of the deceased (extramarital) and her husband killed the deceased.

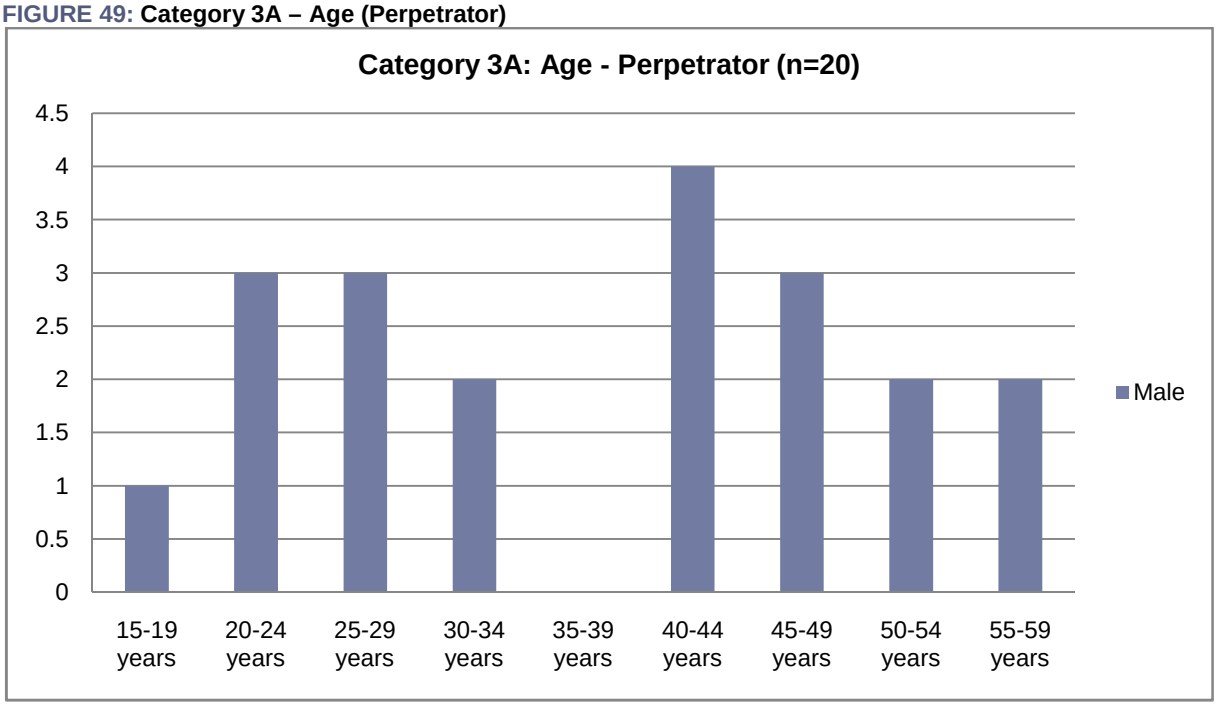
Of the 20 Category 3A perpetrators, there were 20 male perpetrators and 0 female perpetrators.

9.2.1 AGE (PERPETRATOR)

The highest number of Category 3A perpetrators appear in the age bracket 40-44 years (4 perpetrators or 20% of all Category 3A perpetrators).

For Category 3A perpetrators, the mean age is 37.4, the median age is 41.5 years and the standard deviation is 12.55.

FIGURE 49: Category 3A – Age (Perpetrator)



9.2.2 ATSI (PERPETRATOR)

No Category 3A perpetrators identified as either Aboriginal, Torres Strait Islander or Aboriginal and Torres Strait Islander.

9.2.3 OUTCOMES

Murder Conviction

During the data reporting period, 30% of all Category 3A perpetrators entered a guilty plea to murder (6 perpetrators). 15% of all Category 3A perpetrators were found guilty of murder at trial (3 perpetrators).

Altogether, 45% of all Category 3A perpetrators were convicted of murder (9 perpetrators).

Manslaughter Conviction

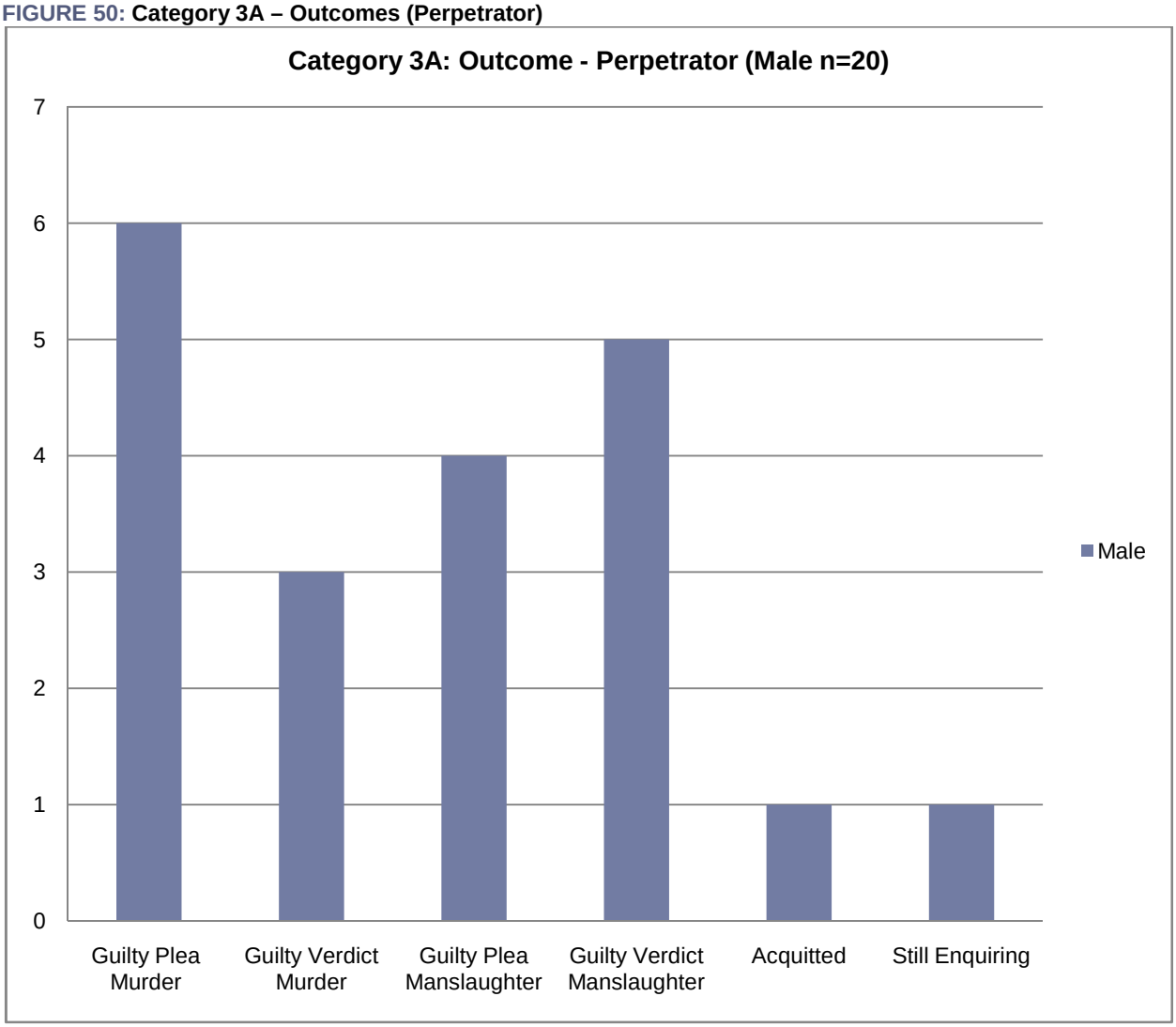
During the data reporting period, 20% of Category 3A perpetrators entered a guilty plea to manslaughter (4 perpetrators). 25% of all Category 3A perpetrators were found guilty of manslaughter at trial (5 perpetrators).

Altogether, 45% of all Category 3A perpetrators were convicted of manslaughter (9 perpetrators).

Acquitted

1 Category 3A perpetrator was acquitted by judicial direction at trial.

FIGURE 50: Category 3A – Outcomes (Perpetrator)



9.2.4 PERPETRATOR SUICIDE/DEATH

No Category 3A perpetrators committed suicide or died of killing the deceased/s.

9.3 CATEGORY 3A RELATIONSHIP TYPE

During the data reporting period, the highest number of Category 3A male deaths were perpetrated by an acquaintance or friend of the deceased (16 deaths or 84.21% of all Category 3A male deaths).

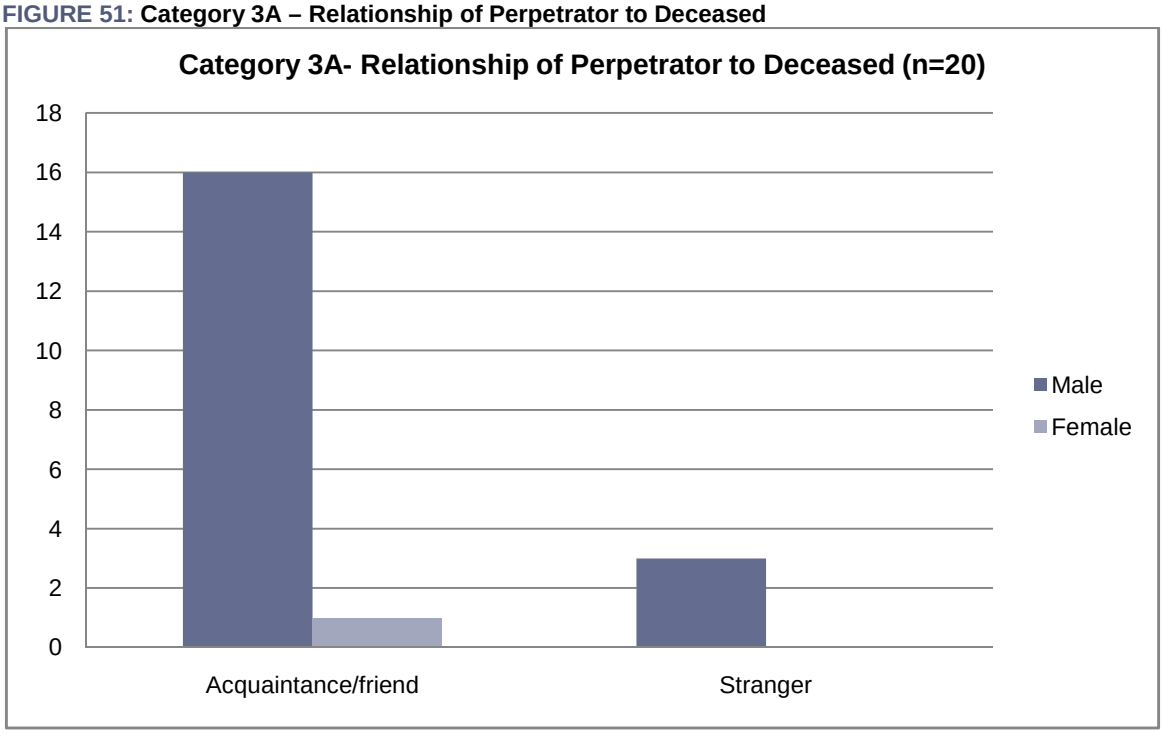
3 Category 3A male deaths were perpetrated by a stranger (15.79% of all Category 3A male deaths).

The single female death in Category 3A was perpetrated by an acquaintance/friend of the deceased.

Of the 20 Category 3A deaths:

- 11 were killed by the former intimate partner of their current intimate partner;
- 1 was killed by the current intimate partner of their former intimate partner;
- 2 were killed by the former intimate partner of a friend;
- 2 were killed by their daughter's intimate partner;
- 2 were killed intervening in a domestic violence incident (1 male, 1 female);
- 1 was killed by the current intimate partner of a woman with whom he was obsessed/stalking; and
- 1 was killed by the husband of a woman with whom he was having an affair.

FIGURE 51: Category 3A – Relationship of Perpetrator to Deceased



9.4 CATEGORY 3A MULTIPLE FATALITY INCIDENTS

During the data reporting period, there was 1 Multiple Fatality Incident involving a Category 3A death. In this incident, a husband killed both his estranged wife (Category 1A deceased) and her current intimate partner (Category 3A deceased).

SECTION IV: CASE REVIEWS & RECOMMENDATIONS

CHAPTER 10: 2011-2012 CASE REVIEWS

As discussed in Chapter 3, the Team has conducted in-depth case reviews of all deaths that occurred in a domestic violence context between 10 March 2008 and 30 June 2009 (inclusive). This start date has been selected as it coincides with the commencement of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) and the end date of the case review period ensures that the maximum number of cases are closed, while still being sufficiently recent to enable the Team to make meaningful recommendations to the various stakeholder agencies.

Across cases there are also a number of key issues and themes, some of which appear in many different cases, and these have led to the development of general recommendations in addition to recommendations arising from specific service issues or deficits. These recurrent themes and issues are identified in each case review summary.

Common themes and issues include:

- History of domestic violence;
- Child custody issues;
- No contact with service agencies;
- Friends and family aware of domestic violence;
- Reluctance to engage legal pathways (such as police/legal avenues);
- History of AVOs between deceased and perpetrator;
- Vulnerability due to citizenship status;
- Abuse of older people;
- Deceased socially and geographically isolated;
- Help-seeking behaviour from informal sources (such as religious or spiritual leaders/community leaders/school community); and
- Relationship termination/separation.

For the case review period, 10 March 2008 – 30 June 2009, the Team conducted in-depth case reviews of all 16 closed cases. The summaries and recommendations arising from these cases are included below.

WARNING: The case summaries include information that some people may find distressing.

CASE REVIEW 1 (DVDRT REF. 2964)

This case involved the killing of a 41 year-old female by her 51 year-old estranged husband. The couple had been in a relationship for 12 years but had separated 2 years prior to her death. The perpetrator was an incomplete quadriplegic as the result of an old accident. He could walk unaided but had impaired balance.

In the years leading up to the killing, neighbours described seeing and hearing numerous loud verbal and physical fights between the couple and believed the deceased was the instigator. The deceased reported to friends from her church that she was being psychologically, emotionally, and financially abused by the perpetrator who would frequently lock her out of the house, refused to divorce her and threatened that if she left him, he would either assume custody or withdraw all financial support for their 8 year-old daughter.

The couple sought relationship counselling through Relationships Australia but ultimately the relationship failed and the deceased moved out with her daughter. The couple had an informal child custody arrangement and this was the source of much tension and hostility. The deceased had sought informal legal advice regarding custody, but had not sought formal orders.

The day before she was killed the deceased sought assistance from police when the perpetrator refused to return her daughter after an access visit. The situation was ultimately resolved when a police officer negotiated over the phone with the perpetrator who agreed that the deceased could collect their daughter the following day. When the deceased arrived to collect her daughter from the perpetrator the following day, a fight erupted on the front porch. In the course of the ensuing struggle the perpetrator killed the deceased by strangulation.

THEMES INCLUDE:

- History of domestic violence;
- Child custody issues; and
- Friends and family aware of domestic violence.

RECOMMENDATIONS – CASE REVIEW 1

- **Recommendation 4** – NSW Police Force - Records of Child Custody Enquiries or ADVO Enquiries
- **Recommendation 10** – NSW Government - Public Education Strategies

CASE REVIEW 2 (DVDRT REF. 2965)

This case involved the killing of a 48 year-old woman by her 30 year-old de facto husband. The couple had been together for approximately 12 months prior to her death and lived in public housing premises in the Lismore area. Both the deceased and the perpetrator identified as Aboriginal.

The deceased and the perpetrator would regularly drink alcohol to excess and this frequently led to loud, verbally abusive arguments. The deceased told friends that the she was regularly assaulted by the perpetrator and that on one occasion he had stabbed her in the leg.

Police were regularly called by the deceased and neighbours to attend the couple's premises in relation to domestic disputes. On one occasion the deceased sought police assistance because the perpetrator was threatening her with a knife. When the police arrived, the deceased, though apparently unharmed, was significantly affected by alcohol, uncooperative, verbally abusive and would not allow the police to access the house.

Neighbours made numerous noise complaints to Housing NSW over the course of the 12 month relationship which Housing NSW followed up as tenancy management issues.

On the day of the killing, the perpetrator and deceased had been drinking and arguing all day. That evening the perpetrator was drinking with a large group of people at a nearby reserve and was seen to be carrying a knife. The group dispersed after the police attended the gathering and at some stage after the police left, the perpetrator returned to the house and stabbed the deceased once below the tip of the right shoulder. The perpetrator was found wandering the streets in the early hours of the morning and told police the deceased had stabbed herself.

THEMES INCLUDE:

- History of domestic violence;
- Friends and family aware of domestic violence;
- Reluctance to engage legal pathways (such as police/legal avenues); and
- History of AVOs between deceased and perpetrator.

RECOMMENDATIONS – CASE REVIEW 2

- **Recommendation 7** – NSW Police Force - Procedures regarding victims who are reluctant to take legal pathways
- **Recommendation 8** – NSW Police Force - Use of ADVOs
- **Recommendation 10** – NSW Government - Public Education Strategies
- **Recommendation 11 –** NSW Government - Study into Indigenous Women's Experiences of Domestic Violence
- **Recommendation 14 –** Housing NSW - Domestic Violence Referral

CASE REVIEW 3 (DVDRT REF. 2969)

This case involved the killing of a woman and her 9 year-old daughter by the woman's husband (the girl's step-father). All three parties were born in India; the perpetrator had lived in Australia for 10 years and was an Australian citizen; the mother and daughter were in Australia on tourist visas and were in the process of obtaining a Combined Spouse Visa, which was being sponsored by the perpetrator. The couple had been married for 13 months at the time of the killings.

The perpetrator was controlling, domineering and jealous and neighbours described hearing extremely loud and angry arguments on at least a weekly basis. The perpetrator was known to police to be a perpetrator of domestic violence in relation to his first wife and had a significant criminal record in relation to domestic violence.

Approximately 3 months before the killings, police were called to the couple's premises in response to a serious domestic dispute when the perpetrator refused to return to his wife personal papers including her passport. The following day the perpetrator sent two letters to the Department of Immigration and Citizenship ('DIAC'), the first requesting that the application for a spouse visa be withdrawn, and the second rescinding the withdrawal. The letters were sent almost simultaneously. The perpetrator continued to threaten his wife with withdrawal of sponsorship up to the time of the killings.

The day after the dispute, the woman sought assistance from a local domestic violence refuge. The refuge tried to find alternative emergency accommodation for the woman and the daughter as they could not accommodate women accompanied by children. The woman was told by Centrelink that she was not eligible for any financial assistance because of her visa status, and this had the further consequence of making her ineligible for the alternative emergency refuge accommodation the original service found for her, as the service required payment and she had no money with which to pay for it.

Some days after initially visiting the domestic violence refuge, the woman advised staff at the refuge that she had made contact with DIAC, who had advised she could not receive any financial income in Australia without permanent residency. Furthermore, she indicated that DIAC had advised her that her options were to return to her husband, or return to India. The DIAC file of the woman contained no reference to any such contact, although it contained the two letters sent by the perpetrator regarding sponsorship.

The woman also indicated that she had attended the police station to make enquiries in relation to obtaining an ADVO against the perpetrator, The woman indicated to staff at the refuge that she was informed by police that there were insufficient grounds to issue an AVO. There is no police record of this contact.

Around this time, approximately 3 months prior to the killings, the woman met with the daughter's school Principal. She was very distressed and told the Principal about the recent domestic dispute attended by the police. She indicated to the principal that she and her daughter had left the family home and were staying with her sister. This was causing difficulties in relation to the daughter's transport to school and she asked the Principal for advice. The Principal suggested that the daughter transfer to a different local school.

After the killing, the Principal reported that in the week following this, the woman and the perpetrator attended the principal's office to discuss their daughter. According to the Principal, it appeared as though the woman was under the perpetrator's control, but she informed the Principal that everything was ok.

On the evening of the killing the perpetrator and his wife argued and he strangled her and then his step-daughter. He disposed of the bodies in rugged bushland; two bushwalkers coming across their remains about one month later.

THEMES INCLUDE:

- History of domestic violence;
- Friends and family aware of domestic violence;
- Vulnerability due to citizenship status;
- Deceased socially and geographically isolated; and

- Help-seeking behaviour from informal sources (such as religious or spiritual leaders/community leaders/school community).

RECOMMENDATIONS – CASE REVIEW 3

- **Recommendation 4** – NSW Police Force - Records of Child Custody Enquiries or ADVO Enquiries
- **Recommendation 10** – NSW Government - Public Education Strategies
- **Recommendation 13** – NSW Government - DIAC Family Violence Policies and Training

CASE REVIEW 4 (DVDRT REF. 2968)

This case involved the killing of a 37 year-old woman by her 39 year-old de facto husband. The couple had been living together in an intimate relationship for 6 months. The deceased told friends that the relationship had 'volatile moments' and complained that the perpetrator was controlling in respect of her relationships with other people and that he would 'lose his temper over the smallest things'.

The perpetrator, who had a history of substance abuse and depression, stopped taking his anti-depressant medication 3 months prior to the death. He became more irritable and recommenced using cannabis and drinking excessively.

About 3 weeks before the killing, the deceased sought assistance from the minister at her church to intervene in a domestic dispute between her and the perpetrator. The perpetrator was being verbally abusive and was intoxicated and agitated when the minister arrived. Two doors in the house had also been kicked in. The perpetrator eventually calmed down and the three of them had a conversation about the perpetrator's history of depression and his non-compliance with his prescribed anti-depressants.

On the afternoon of the killing the deceased confronted the perpetrator over his cannabis use and the two began arguing. The deceased was upset so she telephoned the minister and as the minister was not there she spoke to his wife. The deceased told her that she intended to ask the perpetrator to move out and, concerned that he would take this news badly, arranged for her two children to stay at the minister's home that night.

That evening the perpetrator telephoned the deceased from the foyer of a pub and she told him to collect his belongings which she had left outside the house. The perpetrator was observed by hotel staff to be visibly angry after this phone call.

The perpetrator returned to the house and broke in through a window, at which time the deceased telephoned the police. The perpetrator armed himself with a knife and stabbed the deceased at least 16 times in the chest, arms and legs. He then stabbed himself a number of times in the stomach and also called police asking for help and admitting that he had just killed the deceased.

THEMES INCLUDE:

- History of domestic violence;
- Friends and family aware of domestic violence;
- Reluctance to engage legal pathways (such as police/legal avenues);
- Help-seeking behaviour from informal sources (such as religious or spiritual leaders/community leaders/school community); and
- Relationship termination/separation.

RECOMMENDATIONS – CASE REVIEW 4

- **Recommendation 10** – NSW Government - Public Education Strategies
- **Recommendation 12** – NSW Government - Inter-Faith Working Party on Domestic Violence

CASE REVIEW 5 (DVDRT REF. 2971)

This case involved the killing of a 26 year-old woman by her 27 year-old boyfriend. The couple, who had commenced their relationship just 4 months before the killing, were living with the perpetrator's relatives and had no fixed abode. Both the deceased and the perpetrator identified as Aboriginal.

The perpetrator had a series of convictions arising from assaults on previous intimate partners and at the time he killed the deceased, he was on parole in relation to a charge of malicious wounding.

Approximately 2 weeks before killing the deceased, the perpetrator assaulted the deceased, dragging her by the hair across the floor, hitting her across the face and head and threatening to stab her before leaving the premises. Police attended and escorted the deceased to the police station. The deceased refused to make a statement as she didn't want to the perpetrator to go back to gaol. The police officer made an application in his own name seeking an interim apprehended violence order which was served on the perpetrator the following morning.

On the day of the killing, the deceased and perpetrator were drinking and socialising with a group of friends. Following an argument between the perpetrator and a friend, the deceased and the perpetrator, who was described as very drunk, left the group and went home. Shortly after arriving home, the perpetrator sought assistance from a nearby house saying there was something wrong with the deceased. The deceased was found on the lounge room floor with a single stab wound to the back.

THEMES INCLUDE:

- History of domestic violence;
- Friends and family aware of domestic violence;
- Reluctance to engage legal pathways (such as police/legal avenues); and
- History of AVOs between deceased and perpetrator.

RECOMMENDATIONS – CASE REVIEW 5

- **Recommendation 3 –** NSW Government - Appointment of Corrective Services NSW member to Team
- **Recommendation 6** – NSW Police Force - Risk factors and the Domestic Violence Related Checklist
- **Recommendation 7** – NSW Police Force - Procedures regarding victims who are reluctant to take legal pathways
- **Recommendation 8** – NSW Police Force - Use of ADVOs
- **Recommendation 10** – NSW Government - Public Education Strategies
- **Recommendation 11 –** NSW Government - Study into Indigenous Women's Experiences of Domestic Violence

CASE REVIEW 6 (DVDRT REF. 2579)

This case involved the killing of three young children (aged 8 years, 7 years, and 15 months) by their 44 year-old father, who also committed suicide. The family were residing in a remote area in Southern New South Wales at the time of their deaths.

The perpetrator and his wife (the mother of the children) had been in a 12 year relationship. The perpetrator had been verbally and physically abusive and displayed jealousy and controlling behaviour towards the deceased throughout the duration of the relationship.

When the verbal and physical abuse would escalate the wife would leave to stay with friends or relatives. At the insistence of the perpetrator, some or all of the children would remain with him when this occurred. The couple usually reconciled a very short time later. The children were never the direct target of physical abuse but were frequently present during the abusive episodes against their mother. Two reports were made to Community Services in relation to children being exposed to domestic violence.

The day before the killings, the perpetrator was charged with assault and intimidation and taken into custody following a violent assault against his wife. The perpetrator returned home the following day and the couple again had an argument, and the wife indicated that she was leaving and taking the children. The perpetrator refused to let her take the children with her and she left to stay at a friend's house.

That afternoon police spoke with the woman and discussed why the children were with the perpetrator, the conditions on the Provisional AVO, the woman's future plans and referral to a domestic violence agency. The woman indicated that she did not have any concerns about the children's wellbeing.

In the hours after the police officer spoke to the perpetrator, he dosed the children with phenergan, put them in the back seat of their car which had been rigged to take in the car's exhaust, and they all died as a result of carbon monoxide poisoning.

THEMES INCLUDE:

- History of domestic violence;
- Child custody issues;
- Friends and family aware of domestic violence;
- History of AVOs between deceased and perpetrator;
- Deceased socially and geographically isolated; and
- Relationship termination/separation.

RECOMMENDATIONS – CASE REVIEW 6

- **Recommendation 5 –** NSW Police Force - Amendments to the Domestic Violence Related Checklist
- **Recommendation 6** – NSW Police Force - Risk factors and the Domestic Violence Related Checklist
- **Recommendation 10** – NSW Government - Public Education Strategies

CASE REVIEW 7 (DVDRT REF. 2976)

This case involved the killing of 49 year-old woman by her 51 year-old former de facto husband. The couple had been in a relationship for 9 years and separated for 1 year prior to her death.

The couple ran their own business and continued to work together after the relationship had broken down. The perpetrator refused to accept that the relationship was over and about 12 months before killing the deceased, police were called to their work premises following an argument which culminated in the perpetrator damaging work property. The deceased declined to make a statement and was informed by police that they would be making an application for an ADVO which was in force at time of the killing.

Shortly before she was killed, the deceased had commenced a new relationship and had also sought legal advice about removing the perpetrator as director of the company. She was advised that she could lawfully do so and a letter to that effect was written and faxed to the perpetrator 5 days before he killed the deceased.

On the evening of the killing, the deceased and perpetrator were at their workplace discussing financial matters relative to the break up. The perpetrator hit the deceased in the back of the head with a hockey stick. The deceased and perpetrator struggled and the cause of death was strangulation, with head injuries a possible contributing cause.

The perpetrator put the deceased's body in the rear tray of his utility and left the vehicle at a train station which was located the next day by relatives. The perpetrator handed himself into police two days later.

THEMES INCLUDE:

- History of domestic violence;
- Relationship termination/separation.
- Friends and family aware of domestic violence; and
- History of AVOs between deceased and perpetrator.

RECOMMENDATIONS – CASE REVIEW 7

- **Recommendation 10** – NSW Government - Public Education Strategies

CASE REVIEW 8 (DVDRT REF. 2978)

This case involved the killing of a 76 year-old woman by her 53 year-old son. The two lived together in a privately owned residence in the Snowy Mountains area. The property had been the perpetrator's family home prior to the breakdown of his marriage. The deceased purchased the ex-wife's share in the home, paid out the balance of the mortgage, and the title was transferred to her when she moved in to live with her son, three years prior to the killing.

As part of the deceased's aged care plan she was referred to see a psychologist, who she met for the first time about 6 months prior to her death. The history given by the deceased indicated: that the perpetrator had been verbally abusive since she had moved in with him; that he was trying to get her to move out of the home; that she was feeling very isolated and the perpetrator refused to have her in his car; she was not allowed to speak with her grandchildren when they visited; that she had to pay all the household bills; and that she was scared of the perpetrator.

A safety plan was developed which consisted of the deceased: 1 – going to her neighbour; 2 – ringing the police; and 3 – ringing the psychologist.

In the month prior to the killing, the deceased reported to her psychologist that the emotional and verbal abuse from the perpetrator had increased and that she was frightened of the perpetrator. The psychologist made a booking for her to stay in crisis accommodation however the deceased declined to go at the last minute.

About 6 months prior to her death, the perpetrator's three youngest sons had also spoken to the school counsellor following an assault where the perpetrator had hit two of the boys with a baseball bat. The boys indicated that the perpetrator was a bully and that they were scared of him. They indicated that the perpetrator's abusive and erratic behaviour extended to their grandmother and that they were not allowed to speak to her when they visited the perpetrator's home.

On the afternoon of the killing, the perpetrator and the deceased argued over the proposed sale of the house. The perpetrator grabbed his mother by the throat, and strangled her with an extension lead. The perpetrator put the body in his car and drove to an isolated property where he and buried the deceased. The perpetrator handed himself in to police one week later.

THEMES INCLUDE:

- Abuse of older people;
- History of domestic violence;
- Friends and family aware of domestic violence; and
- History of AVOs between deceased and perpetrator.

RECOMMENDATIONS – CASE REVIEW 8

- **Recommendation 9 –** NSW Government - NSW Ministerial Advisory Council on Ageing Training Materials
- **Recommendation 10** – NSW Government - Public Education Strategies

CASE REVIEW 9 (DVDRT REF. 2985)

This case involved the killing of an 80 year-old woman by her 85 year-old husband. The couple had been married for 19 years and lived in a privately owned house in northern New South Wales. The perpetrator used a wheelchair following a leg amputation which he suffered shortly after the couple were married.

Three years before the killing, the perpetrator was admitted to hospital with suicidal ideation and delusions about the deceased's infidelity. The deceased was extremely distressed by these allegations. The perpetrator was diagnosed with morbid jealousy syndrome and was treated for this condition with medication, after which he reported the disappearance of the delusional symptoms.

The perpetrator was periodically non-compliant with his medication and had a number of relapses and hospital admissions over the next 3 years.

On the morning of the killing, after unremarkable visits from the community nurse and the deceased's daughter, the perpetrator obtained a kitchen knife, went to the bedroom where the deceased was lying on the bed and stabbed her a number of times to the neck and upper chest.

The perpetrator then phoned the police indicating that he had just killed his wife because she was having an affair with the next door neighbour.

THEMES INCLUDE:

- Abuse of older people;
- History of domestic violence; and
- Friends and family aware of domestic violence.

RECOMMENDATIONS – CASE REVIEW 9

- **Recommendation 9 –** NSW Government - NSW Ministerial Advisory Council on Ageing Training Materials
- **Recommendation 10** – NSW Government - Public Education Strategies

CASE REVIEW 10 (DVDRT REF. 2995)

This case involved the death of a 29 year-old woman who was shot and killed by her 39 year-old estranged husband who also killed himself. The couple were married for 8 years and had been separated for approximately 3 months prior to her death.

The relationship was described by family members as 'troubled from the outset' and the perpetrator was physically and verbally abusive, and controlling towards the deceased who he regularly denigrated publicly.

In the year before the killing the deceased left the perpetrator on a number of occasions but each time the perpetrator would beg her to return and the couple would reconcile. On one occasion the deceased left after the perpetrator held a shotgun to her head and then his own, threatening to kill himself if she left him.

The couple again separated approximately 3 months before the shooting, and the perpetrator began harassing the deceased at her workplace. Police were contacted and an interim AVO was granted and police noted the concerns that the perpetrator may have access to firearms, although none were found on a search of the perpetrator's house.

Over the next weeks the perpetrator continued to contact the deceased by phone and threatened, via the couple's solicitor, to kill himself if she didn't speak to him. The deceased reported the calls to police however the breaches were not responded to for a number of weeks because of administrative and organisational issues around the processing of domestic violence matters.

On the day of the killing the perpetrator drove to the deceased's workplace, walked up to the counter and shot her once in the chest. He immediately left the scene, drove home and once inside, shot himself in the head.

THEMES INCLUDE:

- History of domestic violence;
- Friends and family aware of domestic violence;
- History of AVOs between deceased and perpetrator; and
- Relationship termination/separation.

RECOMMENDATIONS – CASE REVIEW 10

- **Recommendation 5 –** NSW Police Force - Amendments to the Domestic Violence Related Checklist
- **Recommendation 6** – NSW Police Force - Risk factors and the Domestic Violence Related Checklist

CASE NO. 11(DVDRT REF. 2612)

This case involved the killing of a 47 year-old man by his 43 year-old de facto wife. The couple had been together for 4 years and both identified as Aboriginal.

Both the deceased and the perpetrator were alcoholics and the relationship was characterised by daily drinking sessions which frequently led to verbal arguments, many of which descended into physical violence by the deceased towards the perpetrator and occasionally by the perpetrator towards the deceased.

The police were called to the couple's premises on numerous occasions over the course of the relationship and the deceased charged with assault a number of times. One of these assaults occurred two months prior to the killing when the deceased passed the blunt edge of a knife across the perpetrator's throat and made shallow cuts in her arm. On a number of occasions the perpetrator would call the police but failed to engage with the police or let them into the premises once they arrived.

On the morning of the killing the perpetrator and the deceased began drinking. That afternoon the perpetrator and deceased were heard arguing and swearing at each other and the neighbours saw the deceased emerge from his house and start to walk up the street.

The perpetrator was then seen by neighbours to pick up a kitchen knife that was lying on a table and run after the deceased, yelling and swearing at him. The deceased was goading her to try and catch him and the perpetrator approached and stabbed the deceased once in the chest and left the scene. She was arrested a short time later and it was apparent that she had no idea of the seriousness of the injury she had inflicted on the deceased. When told of the deceased's death at the police station, the perpetrator became extremely distressed.

THEMES INCLUDE:

- History of domestic violence;
- Friends and family aware of domestic violence; and
- Reluctance to engage legal pathways (such as police/legal avenues).

RECOMMENDATIONS – CASE REVIEW 11

- **Recommendation 6** – NSW Police Force - Risk factors and the Domestic Violence Related Checklist
- **Recommendation 7** – NSW Police Force - Procedures regarding victims who are reluctant to take legal pathways
- **Recommendation 8** – NSW Police Force - Use of ADVOs
- **Recommendation 10** – NSW Government - Public Education Strategies
- **Recommendation 11 –** NSW Government - Study into Indigenous Women's Experiences of Domestic Violence

CASE REVIEW NO. 12 (DVDRT REF. 3003)

This case involved the killing of a 42 year-old woman by her recently separated 45 year-old de facto husband. The couple had been in a full time relationship for 9 years and an on-off extramarital relationship (which produced one daughter) for 6 years prior to that.

The perpetrator was physically, verbally and psychologically abusive and was also jealous and controlling of the deceased. Friends of the deceased stated that they regularly saw her with bruises on her arms and cheeks and sometimes with a split lip. The daughter told police that the perpetrator was regularly violent towards her mother and, to a lesser extent, herself. She recalled one such assault where the deceased was left with dark bruising around her throat after being choked by the perpetrator.

About 3 weeks prior to the killing, the deceased ended the relationship with the perpetrator and ordered him to leave the premises or she would call the police. The perpetrator left and travelled interstate.

The day before the killing the perpetrator had returned to New South Wales and the deceased agreed to let him stay at her house for the night. The next morning the couple began to argue, as the deceased had indicated that she and their daughter were intending to move interstate. The perpetrator strangled the deceased, wrapped her body in a blanket and put her body in a small storage area under the stairs. The following day the perpetrator and the daughter left Sydney and commenced travelling north.

About 3 weeks later the deceased's mother reported her daughter and granddaughter missing. Police gained entry to the deceased's premises and found her body under the stairwell and two days later the perpetrator and the daughter were located in Queensland.

THEMES INCLUDE:

- History of domestic violence;
- Child custody issues;
- No contact with service agencies;
- Friends and family aware of domestic violence; and
- Relationship termination/separation.

RECOMMENDATIONS – CASE REVIEW 12

- **Recommendation 10** – NSW Government - Public Education Strategies

CASE REVIEW NO. 13 (DVDRT REF. 2625)

This case involved the killing of a 47 year-old man by the ex-boyfriend of his 15 year-old daughter. The perpetrator was aged 16 years at the time of the killing, lived with his parents, and had never before been in trouble with the police.

The perpetrator and the daughter commenced a boyfriend/girlfriend relationship about 2 years before the killing. Friends described the relationship as 'volatile' and the girl told her mother of a fight where the perpetrator had become angry and punched a wall and another occasion when he threw a phone at the wall.

The young woman terminated the relationship about 6 months before the killing and changed schools, enrolling in a local non-government school. The perpetrator did not take the break up well and tried to monitor who the girl associated with at her new school. In particular, the perpetrator was jealous of her friendship with one boy ('S') who was a fellow student at her new school, and sent him numerous threatening phone messages. He also sent the girl a text message picture of a bullet and a gun, and threatened to publish naked photographs he had of her if she didn't get back together with him.

'S' informed the Principal of the girl's new school about some of the threatening behaviour exhibited by the perpetrator. The Principal told him to 'ignore' the behaviour. The young woman's mother became aware of the threats being made against 'S' and spoke with his father and the perpetrator's mother about this.

About 4 weeks before the killing, the daughter commenced a new relationship and the perpetrator also began sending threatening messages to the new boyfriend.

In the early hours of the morning of the killing, the perpetrator, armed with a kitchen knife he brought from his home, broke into the kitchen of the deceased's house, was confronted by the deceased and stabbed him numerous times in the chest. The deceased's wife, roused by the commotion, was then attacked and stabbed numerous times as she tried to escape.

The daughter confronted the perpetrator, and the perpetrator said to her, 'You caused this' and, 'Bet you love me now.' The perpetrator left the premises and was found by his parents a short time later and taken into custody where he eventually admitted that he had attacked the girl's parents.

THEMES INCLUDE:

- History of domestic violence;
- No contact with service agencies;
- Friends and family aware of domestic violence;
- Reluctance to engage legal pathways (such as police/legal avenues); and
- Help-seeking behaviour from informal sources (such as religious or spiritual leaders/community leaders/school community).

RECOMMENDATIONS – CASE REVIEW 13

- **Recommendation 10** – NSW Government - Public Education Strategies

ADDITIONAL COMMENTARY – CASE REVIEW 13

Under '*Keep Them Safe: A shared responsibility for child wellbeing*', a Child Wellbeing Unit has since been established in the Department of Education and Communities and in three other government departments in 2010.

The Child Wellbeing Unit assists principals to help ensure early support, referrals and assistance are offered and implemented for children, young people and their families, in need of assistance outside the statutory child protection system, including for domestic violence issues.

CASE REVIEW NO. 14 – (DVDRT REF.2963)

This case involved the accidental killing of a woman by her husband who, after immediately notifying family members of the death, went to a shed on the property and killed himself.

The couple had been married for 17 years and had no history of domestic violence, no financial difficulties, and were said to be extremely happy.

At inquest it was determined that the perpetrator had manually asphyxiated the deceased during sexual intercourse. It was found that a moderate amount of force had been used, that there were no signs of resistance and the death of the deceased was determined to be by misadventure.

This case had no identifiable domestic violence context.

NO IDENTIFIABLE THEMES LEADING TO RECOMMENDATIONS

RECOMMENDATIONS – CASE REVIEW 14

Nil.

CASE REVIEW NO. 15 – (DVDRT REF. 2606)

This case involved the death of a man who was stabbed multiple times by his intimate partner. The couple had been dating for a few months at the time of the killing.

The perpetrator had a significant history of mental health issues and was suffering from an acute psychotic episode at the time of the killings. The perpetrator was found not guilty by reason of mental illness.

This case had no identifiable domestic violence context.

NO IDENTIFIABLE THEMES LEADING TO RECOMMENDATIONS

RECOMMENDATIONS – CASE REVIEW 15

Nil.

CASE REVIEW NO. 16 – (DVDRT REF. 3015)

This case involved the killing of an elderly woman by her elderly husband. The deceased and perpetrator had been married for over 50 years and there was no evidence of any domestic violence context.

The evidence presented at inquest indicated that the perpetrator killed the deceased and then killed himself.

NO IDENTIFIABLE THEMES LEADING TO RECOMMENDATIONS

RECOMMENDATIONS – CASE REVIEW 16

Nil.

CHAPTER 11: KEY THEMES & RECOMMENDATIONS

In developing recommendations for this report, the Team has not only studied the individual cases in order to identify specific instances of service failures or deficits, but has also identified similar and recurrent themes across cases during the case review period. Although in developing recommendations for this report the Team has not relied upon data analysis, this will be an anticipated future direction for analysis and recommendations in coming years.

Further, the Team, having moved out of its establishment phase to become fully operational, has had the opportunity to critically assess its establishing legislation and has made a number of recommendations in relation to this.

11.1 KEY THEMES

Themes identified across cases studied in the current case review period include:

- History of domestic violence;
- Child custody issues;
- No contact with service agencies;
- Friends and family aware of domestic violence;
- Reluctance to engage legal pathways (such as police/legal avenues);
- History of AVOs between deceased and perpetrator;
- Vulnerability due to citizenship status;
- Abuse of older people;
- Deceased socially and geographically isolated;
- Help-seeking behaviour from informal sources (such as religious or spiritual leaders/community leaders/school community); and,
- Relationship termination/separation.

Although themes such as an identifiable history of domestic violence are to be expected due to the nature of the categorisation and case review process, other themes have also been prevalent across the case review period.

In four of the case reviews, the death occurred in a context of post-separation child custody issues. In one case, the death occurred the morning after a child custody issue had resulted in police involvement.

In a number of cases, the deceased was socially and geographically isolated due to factors including ethnicity, age or geographic location. Isolation was a theme across both cases where older women were killed in a context of domestic violence. In another case, a deceased experienced vulnerability due to her uncertain citizenship status and social isolation due to her limited social interaction with others.

Two cases involved the deceased reaching out or seeking help from community leaders such as ministers and school principals. A lack of appropriate referrals in these cases indicated to the Team a need for further education surrounding domestic violence for community leaders, organisations and representatives.

In a number of cases there was a history of current or past AVOs or ADVOs between parties. Because of this recurrent theme the Team has resolved to undertake an in-depth study of AVOs for the next annual report.

Across a number of cases there was also a marked reluctance to engage legal pathways, including a resistance to engage with the police or the legal system. This reluctance indicated to the Team the need to provide further education, in the form of materials, to victims and perpetrators of domestic violence even where attempts to do so were resisted.

In the overwhelming majority of cases which occurred in a domestic violence context, friends and/or family were aware of the domestic violence history or incidents between the perpetrator and deceased. This indicated to the Team that within New South Wales there remains a need to improve public knowledge of the dynamics of domestic violence and

encourage friends and family to intervene and help victims of domestic violence to engage with specialist domestic violence services.

Finally, in two cases there was no relevant service contact with agencies (including specialist domestic violence agencies or the police). In one case, this was because the domestic violence relationship between a young girl and young man (the perpetrator) was being treated as bullying behaviour, rather than domestic violence behaviour.

These themes have led to the development of recommendations. In addition to recommendations that have been made as a result of reviewing the cases as a whole, a number of cases have resulted in the development of specific recommendations.

11.2 RECOMMENDATIONS: AMENDMENTS TO THE *CORONERS ACT 2009* (NSW)

Having had the opportunity to review the establishing legislation of the Team, the Team makes the following recommendations to ensure that the legislation enables reviews to take place subject to clear and uniform criteria.

The Team recommends that the definition of 'domestic violence death' be expanded to include the deaths of third parties to domestic relationships (for example, where someone kills the new partner of their former partner). Furthermore, the Team also recommends that the legislation be amended to only facilitate review of those cases where the death occurs in a domestic violence context.

Accordingly, the Team recommends:

RECOMMENDATION 1

That section 101B(1) of the *Coroners Act 2009* (NSW) be amended as follows:

"domestic violence death" means:

(a) the death of a person that is caused directly or indirectly by a person who was in a domestic relationship with the deceased person**, *and the death occurs in the context of domestic violence; or***

(b) ***the death of a person that is a third party to a domestic relationship, and the death occurs in the context of domestic violence.***

The Team further recommends that the following be omitted to be consistent with the changes set out in Recommendation 1:

RECOMMENDATION 2

That section 101C(1)(d) of the *Coroners Act 2009* (NSW) be amended to omit the words ***and there have been previous episodes of domestic violence between them***.

The Team recognises that both victims and perpetrators of domestic violence may have had relevant service contact with Corrective Services NSW. The Team recognises that Corrective Services NSW has a valuable role to play in the development of intervention and prevention strategies in relation to domestic violence. The Team considers therefore that the work of the Team would benefit from the addition of a representative from Corrective Services NSW.

Accordingly, the Team recommends:

RECOMMENDATION 3

That Part 9A(2) [s101E] of the *Coroners Act 2009* (NSW) relating to the Constitution and Procedure of the Domestic Violence Death Review Team be amended to include a representative from Corrective Services NSW (CSNSW).

11.3 RECOMMENDATIONS: NSW POLICE FORCE

In light of Case Reviews 1, 2, 3, 5, 6, 10 and 11, the Team recognises the critical role that the NSW Police Force plays in responding to domestic violence.

The NSW Police Force has demonstrated an ongoing commitment to improving operational responses to domestic violence and providing improved support and referral information for victims and perpetrators of domestic violence.

In order to support the NSW Police Force in their ongoing critical work in this area, the Team makes the following recommendations to improve service delivery and engagement.

Issues around child custody are serious issues within families and the Team recognises that children can be used as a tool of coercive control in domestic violence relationships. As such, it is important for police to make accessible records where assistance or advice is sought in relation to child custody issues.

Similarly, given the high levels of underreporting of domestic violence, when a person approaches the police making enquiries about ADVO applications, it is recommended that accessible records be made of this service contact.

Finally, where police advice is sought in relation to a breach of an ADVO, it is important that accessible records be made of this contact in every situation regardless of the outcome.

Improved documentation can assist in providing a clear and accurate history of domestic violence behaviours and can improve the investigation and management of domestic violence.

Accordingly, the Team recommends:

RECOMMENDATION 4

That the NSW Police Force incorporate into the existing domestic and family violence Standard Operating Procedures a requirement whereby a COPS event must be promptly created by the responding officer/person handling the inquiry, within his or her shift, any time:

a) assistance/advice is sought in relation to a child custody issue, regardless of whether or not the child is considered to be at risk of harm;
b) assistance/advice is sought in relation to making an application for an ADVO; and
c) assistance/advice is sought in relation to a breach of an ADVO.

In light of Case Reviews 1, 6, 10 and 11, the perpetrator making prior threats to commit suicide, previously attempting suicide, making threats to kill the victim/other family members or threatening/assaulting the victim/other family members with a weapon are all relevant issues which can assist officers to respond appropriately to a report of domestic violence. Awareness of these factors can improve the investigation and management of domestic violence.

Accordingly, the Team recommends:

RECOMMENDATION 5

That the NSW Police Force include each of the following questions in the standard 'Domestic Violence Related Checklist':

a) Has the perpetrator previously threatened to commit suicide?
b) Has the perpetrator previously attempted to commit suicide?
c) Has the perpetrator previously threatened to kill the victim and/or other family members?
d) Has the perpetrator previously threatened or assaulted the victim and/or other family members with a weapon?
e) Are there any child custody issues (ask victim)?
f) Are there any child custody issues (ask perpetrator)?

Following from this, the Team recommends that responding officers who use the Domestic Violence Related Checklist inform victims of domestic violence of the increased risk of lethality when risk factors identified in the Checklist apply to them.

Furthermore, the Team recommends that referral information be physically provided by police officers to victims of domestic violence when responding officers attend domestic violence incidents.

Accordingly, the Team recommends:

RECOMMENDATION 6

That the NSW Police Force incorporate into its existing domestic and family violence Standard Operating Procedures the requirements that:

- in cases where the standard 'Domestic Violence Related Checklist' reveals the presence of any listed domestic violence risk factors, the police must inform the victim of the increased risk of lethality posed to them; and
- responding officers physically provide referral information to the domestic violence victim in the form of the Domestic Violence referral kit.

The Team acknowledges the high levels of underreporting of domestic violence. In light of Case Reviews 2, 5 and 11, the Team also recognises that the complexity of domestic violence is such that many victims are reluctant to engage with services or pursue legal pathways, and may appear unco-operative to responding officers. While many victims may contact police for assistance in acute situations, there can nonetheless be barriers which prevent victims from further engaging with police or taking further action against the perpetrator.

In light of this and to further encourage engagement with services, the Team recommends:

RECOMMENDATION 7

That the NSW Police Force develop specific Standard Operating Procedures for responding officers in domestic violence cases where the victim is reluctant to pursue legal pathways.

These Standard Operating Procedures should include the requirement that responding officers leave domestic violence support and referral information at the premises where the domestic violence incident occurred, even in cases where police entry to the premises is refused or where the victim presents as uncooperative.

Under the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) Police officers are required to apply for ADVOs where they have fears for the safety of victims.

As noted above, due to the complex issues surrounding domestic violence there can be barriers which prevent victims from accessing legal remedies such as ADVOs when they experience domestic violence.

In light of Case Reviews 2, 5 and 11, it is recommended that the implementation of legislation be reviewed, to ensure that this legislation is being used effectively and appropriately.

Accordingly, the Team recommends:

RECOMMENDATION 8

That the NSW Police Force commission a review of the implementation of legislation within the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) that requires police officers to apply for ADVOs wherever they have fears for the safety of victims.

This review should ascertain the extent to which this provision is used, particularly with regards to Indigenous victims of domestic violence.

11.4 RECOMMENDATIONS: NSW GOVERNMENT

The NSW whole-of-government Ageing Strategy was released in July 2012. The NSW Ageing Strategy (the Strategy) is a key step in the NSW Government's response to the challenges of population ageing. A high level committee of senior departmental representatives as well as representatives of the non-government sector, local government and the Ministerial Advisory Council on Ageing is being established to oversee implementation of the Strategy. Its first meeting is scheduled for November 2012.

A key activity under the Strategy is for the Government to establish a helpline and resource unit to reduce the abuse of older people, including financial and psychological abuse experienced by older people living in their own homes. This new service will provide practical assistance to older people, family members and frontline/support workers (including police and care workers) on ways to prevent and respond to abuse. It will act as a one-stop shop for information, assistance, referral and data collection. The unit will work to raise awareness about abuse and provide training for service providers. These services are scheduled to commence operation in early 2013.

There is also an interagency Steering Committee - Abuse of Older People currently being reconstituted to provide expert advice and support key initiatives aimed at reducing the incidence of abuse of older people in the community. Committee representatives will include Government agencies, consumer advocates and expert advisors. Its terms of reference are yet to be formalised by the new high level committee. However, it is anticipated that its role will include supporting key

initiatives of the NSW Ageing Strategy including overseeing the establishment and development of the helpline and resource unit and the review and effective implementation of the revised *Interagency Protocol for Responding to the Abuse of Older People 2007.*

The 2007 Interagency Protocol contains an extensive description of different forms of abuse of older people, principles for responding to abuse of older people, and key concepts in responding to the abuse of older people. This protocol is currently being reviewed as part of the process of establishing state-wide policy to guide implementation of the helpline and resource unit.

Training materials will be developed as part of the processes involved in establishing the new helpline and resource unit as a part of this initiative.

Accordingly, the Team recommends:

RECOMMENDATION 9

That as part of the NSW Ageing Strategy, the NSW Ministerial Advisory Committee on Ageing give strong consideration to using case reviews 8 and 9 of the 2011/2012 NSW Domestic Violence Death Review Team Annual Report to inform the development of training resources for the new NSW helpline dedicated to abuse of older people and the corresponding resource unit.

In the overwhelming majority of Case Reviews where a death occurred in a domestic violence context, friends and/or family were aware of the domestic violence history between the perpetrator and deceased.

This indicated to the Team that within New South Wales there remains a need to improve public knowledge of the dynamics of domestic violence and encourage friends and family to intervene and help victims of domestic violence engage with specialist domestic violence service agencies.

Accordingly, the Team recommends:

RECOMMENDATION 10

That the NSW Government commission the development and implementation of a public education strategy aimed at improving the reporting of domestic violence, including physical violence and controlling and coercive behaviour. This should be targeted at reporting by:

- victims;
- family, friends and neighbours of victims; and
- specific groups such as Indigenous women, young women and older women, and women who speak languages other than English.

The strategy should draw on international research, and should aim to educate the community about the nature and dynamics of domestic violence, including:

- the times when victims are most at risk such as at the point of separation, when disputes arise in relation to child custody and during pregnancy;
- the presence of risk factors such as stalking behaviour, coercive and controlling behaviour or economic abuse, which may fall outside of the paradigm of traditional physical domestic violence; and
- education regarding teen dating violence, healthy relationships, cyber abuse and identifying when conduct becomes serious criminal behaviour requiring police intervention.

(cont'd)

The strategy should provide practical advice to victims, family, friends and neighbours and specific groups about:

- how to respond to domestic violence;
- where assistance can be sought including domestic violence help lines and the police; and
- how and when to contact police and emergency services.

The Team notes that domestic violence is a serious problem facing Indigenous Australians. Data presented by the Team in Section III of this report indicates that a high proportion of domestic violence deaths involve an Indigenous deceased and/or an Indigenous perpetrator.

In light of Case Reviews 2, 5 and 11, the Team recommends that the NSW Government further investigate this issue with a view to improving service responses in relation to domestic violence for Indigenous victims or offenders.

The Team notes that Women NSW is currently developing a new NSW Domestic and Family Violence Framework to reform the approach to domestic violence in NSW. The Team recommends that the following be incorporated in the processes related to the development of this framework.

RECOMMENDATION 11

That the NSW Government commission or undertake a study into Indigenous women's experiences of domestic and family violence. This study should inform the development of strategies to:

- encourage and support Indigenous victims to report family violence;
- facilitate continued participation of Indigenous victims throughout legal processes;
- strengthen access to relevant specialist Indigenous and mainstream services;
- ensure training is made available for police and other professionals in relation to the dynamics impacting on the reporting of violence by Indigenous victims;
- improve connections between Indigenous health services and domestic and family violence services;
- improve the response to victims and perpetrators who have complex needs, including needs arising from drug and alcohol misuse, mental illness and homelessness; and
- introduce and implement a family violence prevention program aimed at Indigenous youth.

The Team notes that individuals who experience domestic violence often seek support and help from informal sources including community and religious leaders. Such representatives are often in a position of trust and are in a unique position to encourage victims and perpetrators of domestic violence to seek professional assistance.

In light of Case Review 4, the Team recommends that the NSW Government implement a working party comprised of religious leaders from various faiths, in order to develop strategies and plans for dealing with and responding to domestic violence within religious communities.

The Team therefore recommends:

RECOMMENDATION 12

That the NSW Government develop and implement an inter-faith working party on the issue of domestic violence. Such a party should:

- develop consistent strategies, policies and organisational plans within religious organisations for responding to domestic violence when such violence is suspected or apparent within the congregation or religious community;
- develop and implement training and education materials for religious leaders around issues of responding to and reporting domestic violence where such violence is suspected or apparent within the congregation or religious community; and
- develop and implement training and education materials for congregations or religious communities around domestic violence.

The Team acknowledges the unique vulnerability experienced by victims of domestic violence where there are current citizenship issues (such as uncertain visa status). The Team further recognises that victims in these situations may experience social isolation and may experience further barriers to accessing domestic violence services.

In light of Case Review 3, the Team recommends that the NSW Government approach the Department of Immigration and Citizenship to strengthen responses to domestic violence through the use of the family violence provision.

The Team also indicates its strong support for Recommendations 20-1 through to 20-6 of the *Family Violence and Commonwealth Laws – Improving Legal Frameworks* report of the Australian Law Reform Commission (ALRC Report No. 117 - February 2012).

Accordingly, the Team recommends:

RECOMMENDATION 13

That the NSW Government encourage the Commonwealth Department of Immigration and Citizenship (DIAC) to:

- develop training programs for its agents/officers regarding the nature and dynamics of domestic violence, including the vulnerability caused by the actual/threatened withdrawal of sponsorship;
- adopt a proactive approach whereby all claims for the family violence provision are referred to an independent expert in family violence matters, and are not rejected or otherwise assessed in the negative by any agent or representative of DIAC other than an independent expert in family violence;
- require agents/officers who may be adjudicating claims for family violence provisions or who are responding to enquiries made in relation to such provisions to make appropriate referrals to law enforcement and social service agencies;
- ensure victims of domestic violence who make an application to DIAC for family violence provision have access to emergency funding or limited government benefits irrespective of their visa status; and
- require the agents/officers of DIAC to interview female and male partners separately in any cases where domestic violence is reported or suspected.

11.5 RECOMMENDATIONS: HOUSING NSW

As the data reported in Section III indicates, the majority of deceaseds who die in a context of domestic violence sustain fatal injuries at their residences.

The Team considers therefore that Housing NSW has an important and unique role in responding to suspected or actual domestic violence by virtue of their ongoing contact with Housing NSW tenants. Housing NSW, as the landlord of public housing residences, are in a position to share and exchange information with the NSW Police Force when violence is brought to their attention. The Team understands that this is currently the practice of Housing NSW when they become aware of domestic violence behaviours taking place in tenanted properties.

Accordingly, the Team recommends:

RECOMMENDATION 14

That the Department of Family and Community Services – Housing NSW remind operational staff to inform tenants of domestic violence services, where appropriate, when they become aware of domestic or family violence occurring within a public housing property.

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

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:

(a) reduce the incidence of domestic violence deaths, and
(b) 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: AUSTRALIAN DOMESTIC AND FAMILY VIOLENCE DEATH REVIEW NETWORK, TERMS OF REFERENCE

BACKGROUND AND POSITION SUMMARY

Domestic and family violence has a devastating impact on individuals and communities. It is a complex phenomenon and includes: child and elder abuse; violence between siblings; violence by adolescents against parents; carer abuse; violence between same-sex partners; and violence perpetrated by women against their male intimate partners. However, in the overwhelming majority of cases, domestic and family violence is perpetrated by men against women. Australian research reports that one in three women has experienced physical violence and one in five has experienced sexual violence since the age of 15 (ABS, 2005). The vast majority of these violent acts against women have been perpetrated by their current or former male intimate partner.

Domestic and family violence can also be fatal. The most recent data from the National Homicide Monitoring Program reveals that in 2007-2008 in Australia there were 260 homicide events resulting in 273 deaths, 161 males and 112 females (Viruda & Payne, 2010). Over half of all homicide victims for this period were killed by a person with whom they shared a domestic relationship, ie a current or former intimate partner or family member. Women are significantly over represented in this category of homicide. Of all female homicide victims during this period, 78% were killed by someone with whom they shared a domestic relationship, compared with only 35% of all male homicide victims.

Domestic and family violence deaths rarely occur without warning. In many fatal cases, there have been repeated incidents of abuse prior to the homicide, as well as identifiable indicators of risk. There have typically also been many opportunities for individuals or agencies to intervene before the death. When viewed as the escalation of a predictable pattern of behaviour, domestic violence deaths can be seen as largely preventable.

Despite the high prevalence of deaths that occur in the context of domestic and family violence, there has not, until recently, been a mechanism for the systematic review of these deaths in any Australian jurisdiction. For well over a decade, domestic and family violence death review processes have been operational in a number of international jurisdictions, most notably in the United States of America where domestic violence fatality review teams were first established in the early 1990s. Since that time, domestic and family violence death reviews have also been established in Canada, the United Kingdom and New Zealand.

The broad objective of these reviews is to identify potential areas for improvement in systemic responses to domestic and family violence. Whereas individual death investigations treat domestic violence-related deaths as isolated events, domestic and family violence death reviews are undertaken with a view to identifying patterns and commonalities between deaths for the purposes of reform. Research has shown that such death review processes have been effective in identifying and addressing weaknesses in service delivery and systems related to domestic and family violence.

Since the mid-2000s, there has been a growing call for the establishment of domestic violence death review processes in Australia. Within the past two years, Victoria, Queensland, New South Wales, and South Australia have each implemented a domestic and family violence death review function with dedicated resources.

Following the implementation of domestic and family violence death review mechanisms in several Australian jurisdictions in recent years, the Australian Domestic and Family Violence Death Review Network ('the Network') was established in March 2011.

ADFVDR NETWORK OVERVIEW

As at 30 June 2012, the Network comprises representatives from each of the established Australian death review teams, namely New South Wales, Queensland, South Australia and Victoria. An overview of each death review is set out below.

Domestic Violence Death Review Team (New South Wales)

On 16 July 2010, following recommendations made in 2009 by the Domestic Homicide Advisory Panel, the *Coroners Amendment (Domestic Violence Death Review Team) Act 2010* commenced, amending the *Coroners Act 2009* by inserting Chapter 9A and thereby establishing the Domestic Violence Death Review Team (the 'DVDRT').

The DVDRT is convened by the NEW SOUTH WALES State Coroner 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.

The core legislative functions of the DVDRT are to:

- review and analyse individual closed cases of domestic violence deaths (as defined in the *Coroners Act 2009* (NSW));
- 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.

The DVDRT reports annually to the New South Wales Parliament.

Domestic and Family Violence Death Review Unit (Queensland)

The Domestic and Family Violence Death Review Unit ('DFVDRU') was established in the Office of the State Coroner in January 2011 following a review of the conduct of Coronial investigations into domestic and family violence deaths. The review identified that Coronial investigations were primarily focused on criminal prosecution and not on the history of domestic and family violence preceding the death. Accordingly, there was a lack of systemic analysis of the context in which domestic and family violence deaths occurred and a lack of investigation surrounding ways to prevent such deaths occurring in the future.

The DFVDRU operates under the direction of the State Coroner to investigate these deaths more thoroughly, analyse the context in which the death occurred and make preventive recommendations. The DFVDRU also undertakes research and gathers data in relation to domestic and family violence, which can be used to contextualise and inform Coronial findings and recommendations. An Expert Advisory Group has been established to assist and inform the review process.

The DFVDRU's definitions align with the *Domestic and Family Violence Protection Act 1989*.

Domestic and Family Violence Death Review (South Australia)

In response to election commitments made by the current South Australian Government, the Office for Women and the SA Coroner's Court have undertaken a partnership to research and investigate domestic violence related deaths. The position of Senior Research Officer (Domestic Violence) was established in January 2011 as an initiative of the South Australian *A Right to Safety* ('ARTS') reform agenda.

This position works collaboratively with the ARTS reporting and advisory structure and reports on outcomes to the Chief Executive Group (chaired by the Minister for the Status of Women) which oversees ARTS outcomes.

The position is based within the South Australian Coroner's Office and works as part of the Coronial investigation team to:

- Identify deaths with a domestic violence context in order to assist in the investigation of the adequacy of system responses and/or inter-agency approaches, which may prevent deaths occurring within that context.
- Review files, provide interim reports and have specific input into Coronial Inquests, which relate to domestic violence.
- Develop data collection systems in order to inform Coronial processes and identify demographic or service trends, gaps or improvements more broadly.
- Conduct specific retrospective research projects relevant to building a domestic violence death review evidence base.

The legislative basis for this position sits within the *Coroners Act 2003* (SA). The definition of 'domestic violence context' is aligned with the *Intervention Orders (Prevention of Abuse) Act 2009* (SA).

Victorian Systemic Review of Family Violence Deaths (Victoria)

The Victorian Systemic Review of Family Violence Deaths ('VSRFVD') was established in 2009. Positioned within the Coroners Court of Victoria and operating under the provisions of the *Coroners Act 2008* (Vic), the VSRFVD assists with open Coronial investigations of family violence-related deaths involving children and adults.

The VSRFVD has five main aims, which are to:

- examine the context in which family violence deaths occur;
- identify risk and contributory factors associated with family violence;
- identify trends or patterns in family violence-related deaths;
- consider current systemic responses to family violence; and
- provide an evidence base for coroners to support the formulation of prevention focussed recommendations aimed at reducing non-fatal and fatal forms of family violence.

The VDRFVD's definitions of 'family violence' and a 'family member' are aligned with the *Family Violence Protection Act 2008* (Vic) and the Victorian Indigenous Family Violence Taskforce Report (2003).

COMMON ELEMENTS

The following are common elements across all existing Australian domestic and family violence death review mechanisms. A comparative summary is shown in Appendix A.

- Each is underpinned by the idea that domestic and family violence-related deaths are largely preventable.
- Each operates under the auspice of state-based legislation and state determined governance structure.
- Each state clearly defines eligible relationships and behaviour that amounts to domestic and family violence.
- Each adopts review criteria which allow for the review of homicides, homicide/suicides and suicides where such deaths have occurred in a context of domestic and family violence.

PURPOSE

The overarching goals of the Network are to:

- improve knowledge regarding the context and circumstances in which domestic and family violence deaths occur in order to identify practice and system changes that may assist in reducing these types of deaths from occurring in the future;
- identify at a national level the context of, and risks associated with, domestic and family violence-related deaths;
- identify, collect, analyse and report national data on domestic and family violence-related deaths; and
- align domestic and family violence death review findings to programs at a national level.

SCOPE

The network will address issues concerning, but not limited to:

- state-based review processes and how learning and outcomes from case reviews may benefit other jurisdictions. This will include comparing and reporting on findings across jurisdictions;
- defining the inclusion criteria for the compilation of national data;
- the development of a data collection and exchange mechanism to ensure appropriate and consistent recording, analysis and reporting of data across jurisdictions;
- investigative standards for domestic and family violence-related deaths; and
- the identification of domestic and family violence risk and contributory factors as observed from case reviews.

Some key areas of consideration might include:

- common risk factors and system failures in the lead-up to a death that could be prevented in the future; and
- policy development and recommendations to coroners and stakeholder agencies.

NATIONAL POLICY CONTEXT

The establishment of the Network aligns with Strategy 5.2 of the national policy agenda as detailed in *The National Plan to Reduce Violence Against Women and their Children 2010 – 2022*. This mandates States and Territories to work together to:

> ***Strategy 5.2****: Strengthen leadership across justice systems.*
>
> ***Action 2*** *- Drive continuous improvement through sharing outcomes of reviews into deaths and homicides related to domestic violence.*
>
> ***Immediate national initiatives****: Monitor domestic violence-related homicide issues to inform ongoing policy development, including the Australian Institute of Criminology's National Homicide Monitoring Program to research domestic violence-related homicides, risk factors and interventions.*

CONTACT DETAILS

The Network has a rotating Chair and for the 2012 calendar year, New South Wales is the Chair. Contact with the Network can be made via Anna Butler, Manager – Domestic Violence Death Review Team on +61 2 8584 7712 or anna_butler@agd.nsw.gov.au.

ANNEXURE C: DVDRT DICTIONARY

'Abuse of Older People' is any behaviour that causes physical, psychological, financial or social harm to an older person. The abuse can occur within any relationship where there is an expectation of trust between the older person, who has experienced abuse, and the abuser.

'Acquaintance/Friend' describes a relationship between a perpetrator and deceased where the two parties have met one another or have otherwise had contact with one another, but are not related to one another as relatives/kin and do not have an intimate partner relationship.

'ADVO' is an Apprehended Domestic Violence Order, pursuant to Part 4 of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW).

'Age (Deceased)' describes the age of the deceased at their date of death.

'Age (Perpetrator)' describes the age of the perpetrator at the date that they caused the death of the deceased.

'Assault' describes the use of assaultive force without the use of a weapon (beating/bashing/assault) and/or the use of a blunt force weapon.

'ATSI' describes the indigenous identification of a deceased or perpetrator. ATSI stands for Aboriginal and/or Torres Strait Islander.

'Boyfriend' describes a male person who has a relationship with another person, characterized by intimate and/or sexual involvement, but the parties do not regularly cohabitate.

'Case Review Period' is 10 March 2008 to 30 June 2009 (inclusive).

'Child custody issues' describes issues around contact or residency in relation to children, either in the context of an ongoing relationship or post separation. This terminology reflects common usage and is not intended to reflect existing legislative definitions set out in the *Family Law Act 1975* (Cth).

'Data Reporting Period' is 1 July 2000 to 30 June 2009 (inclusive).

'Deceased Residence' describes the deceased's primary place of residence. Where the deceased was subject to a shared parenting arrangement or had multiple places of residence, the term 'deceased residence' is used to describe the location where they spend the most time (for instance, if the deceased lived with one parent during the week and lived with the other parent on the weekends, their house during the week would be deemed their 'residence').

'De facto Relationship' describes where two persons cohabitate as an intimate couple but are not married.

'De facto Wife' describes a female who is living in a de facto relationship.

'De facto Husband' describes a male who is living in a de facto relationship.

'**Double Counting'** see 'Multiple Perpetrator Incident'.

'Domestic Relationship' is defined in s 101C(1) of the *Coroners Act 2009* (NSW).

'Ex-Boyfriend' describes a male person following the cessation of a 'boyfriend' relationship (see 'Boyfriend').

'Ex-Girlfriend' describes a female person following the cessation of a 'girlfriend' relationship (see 'Girlfriend').

'Ex-Husband (Divorced)' describes a male person who is legally divorced.

'External cause assault death' describes the death of a person caused by a perpetrator through the application of assaultive force or by criminal negligence (excluding 'vehicle manslaughter').

'Extramarital' describes any relationship which operates as a further intimate relationship additional to a current intimate relationship between two parties (for instance, a woman who is having an extramarital affair with a man who is married to another woman). This definition captures not only relationships that are additional to marriages, but also relationships additional to boyfriend/girlfriend relationships, de facto relationships and other intimate partner relationships.

'Ex-wife (Divorced)' describes a female person who is legally divorced.

'Fatal Injury' describes the assaultive injuries that lead to the death of the deceased, including negligence and starvation.

'Fire/Heat-Related' describes where the manner of death is caused by fire or heat, including, for example, burns, smoke inhalation, scalding or heat exhaustion/dehydration/hyperthermia.

'Former de facto relationship' describes where two persons formerly cohabitated as a couple but were not married (also *Former de facto wife, Former de facto husband*).

'Girlfriend' describes a female person who has a relationship with another person characterized by romantic and/or sexual involvement, but the parties do not regularly cohabitate.

'Hotel/Motel' describes where the location of fatal injury is the rooms of a temporary residence that employs a 'per night' tariff system. This location excludes the 'public areas' of any hotel/motel establishment (such as the bar, or restaurant) which are coded Road/Park/Public Space.

'Husband' describes a male person who is legally married to a female person (a wife), with that marriage being legally recognized or capable of being legally recognized in Australia.

'Husband (Estranged)' describes a male person who is legally married to a female person (a wife), but the intimate relationship has ceased with the parties being separated or alienated. This is notwithstanding the fact that the parties may continue to cohabitate, or that one party wishes the relationship to continue.

'Incident' describes the discreet course of conduct which results in an external causes assault death. This may capture multiple deaths where the discreet course of conduct results in multiple proximal deaths (see 'Multiple Fatality Incident').

'Intimate Partner' is described in s101(C)(1)(a)-(c) of the *Coroners Act 2009* (NSW).

'Location of Fatal Injury (leading to death)' describes the location where the deceased sustained the injuries that resulting in their death. If the deceased was assaulted in their residence, but died in hospital, the 'Location of Fatal Injury (leading to death)' would be recorded as their residence.

'Marriage' describes a registered marriage in Australia or a marriage that is legally recognized in Australia.

'Married' describes where two persons are subject to a Marriage in Australia, or subject to a Marriage that is legally recognized in Australia (see 'Marriage').

'Manner of Death' describes the nature of the assaultive/injurious force perpetrated against the deceased which resulted in their death. For instance, where the deceased was shot with a rifle and the shooting resulted in the fatal injury which led to their death, the manner of death is recorded as 'shooting'. This information is ascertained from post-mortem reports and briefs of evidence. Where a manner of death is attributed to multiple causes in the post-mortem report, and the evidence indicates multiple kinds of assaultive or injurious force perpetrated against the deceased (for instance, 'shooting' and 'fire/heat-related', the manner of death is recorded as 'Multiple Causes').

'Matter No Billed' describes cases where an order of 'no bill' is recorded in the relevant outcomes database (for instance, Justicelink). This describes cases where after a perpetrator is committed for trial, an order is granted resulting in the trial being discontinued.

'Multiple Causes' see 'Manner of Death'.

'Multiple Fatality Incident' describes cases where two or more deaths occur in the context of an incident (excluding perpetrator suicides or unintentional perpetrator deaths).

'Multiple Perpetrator Incident' describes cases where one deceased is killed by multiple perpetrators acting together. For instance, during the data reporting period one female deceased was killed by her husband, and her two children, acting together. All three perpetrators were found not guilty by reason of mental illness. Cases of multiple perpetrators lead to 'double counting', meaning that a deceased may be counted in multiple categories due to multiple relationships between the deceased and the perpetrators. For the case described, the deceased is counted as a deceased in Category 1A (as she was killed by her intimate partner) and is also counted in Category 2A (as she was killed by both her son and her daughter). This may mean that the individual deaths recorded in each Category will record the same deceased multiple times and where deceaseds sit across multiple categories, they will be counted as a Category relationship in each Category (for instance, 1A and 2A). As a consequence, the individual deaths recorded in each Category may not necessarily add up to the total number of deceaseds (and adding the Categories together may result in a greater number of deaths being recorded). This counting methodology is corrected in the raw numbers, to ensure that no deceased is counted more than once for the purpose of generating relevant statistics around deceased and perpetrator numbers (see section 2.4.1).

'Other (Manner of Death)' describes a manner of death not included in specified categories (for instance, malnutrition or electrocution).

'Other (Relationship Type)' describes a relationship type not included in specified relationship categories (for instance, an extended relationship between a paid sex-worker and a client).

'Other Residence' describes a private residence that is neither the ordinary residence of the perpetrator, nor the ordinary residence of the deceased.

'Outcomes' describes the judicial or Coronial outcomes of particular cases.

'Perpetrator' describes the individual who caused the external causes assault death of the deceased using assaultive force.

'Perpetrator Residence' describes the ordinary residence of the perpetrator.

'Poisoning/Noxious Substance' describes a manner of death caused by the administration of poisons, or the use of other noxious substances which result in the fatal injury leading to the death of the deceased (for example, drugs, toxic substances, toxic fumes or gases or other injurious substances).

'Relationship Type' describes the relationship of the perpetrator to the deceased. E.g. if a perpetrator kills his wife, the relationship type (perpetrator to deceased) is 'husband'.

'Relative/Kin' is described in s101(C) of the *Coroners Act 2009* (NSW).

'Relative/Kin Residence' describes where the location of fatal injury is a residence which is regularly occupied by a Relative/Kin of either the perpetrator or the deceased (see 'Relative/Kin').

'Residence' describes a location where an individual resides. It can include locations such as boarding houses, caravans/removable homes and private homes. It does not include temporary residences such as hotels/motels, unless the deceased or perpetrator was living at the hotel/motel as if it were a home. (see 'Hotel/Motel').

'Road/Park/Public Space' describes a location of death which is in a public space (such as a park, restaurant, bar, street or other area that is not used as a private residence, workplace or other).

'Shooting' describes a manner of death caused by being shot with a projectile/bullet, discharged from a power charged rifle/shotgun/handgun.

'Stab wounds' describes wounds caused by any implement/ object having a sharp edge (such as a knife, an axe or broken glass) including stab wounds, slash wounds, incised wounds and chop wounds.

'Stranger' describes a relationship between a perpetrator and deceased where the parties have not met or had contact with one another. For instance, where the deceased is a suspected extramarital partner of the perpetrator.

'Suffocation/Strangulation' describes where the manner of death results from mechanical threat to breathing, caused by manual or ligature strangulation, neck compression or asphyxia.

'Suicide <24 hours' describes where the perpetrator commits suicide within 24 hours of causing fatal injury to the deceased.

'Suicide > 24 hours' describes where the perpetrator commits suicide in a period longer than 24 hours after causing fatal injury to the deceased.

'Unintentional Perpetrator Death' (from Suicide/Death) describes the unintended or accidental death of the perpetrator, which occurs as a consequence of the course of conduct which leads to the death of the deceased. For instance, during the data reporting period one perpetrator lit a house fire which resulted in the death of a deceased. As a consequence of lighting the fire, the perpetrator accidentally sustained extensive burns which resulted in his death. This amounted to an unintentional perpetrator death, as the death of the perpetrator occurred in the context of the conduct leading to the death of the deceased, and had the unintended consequence of resulting in the death of the perpetrator.

'Vehicle' describes where the location of fatal injury is within any transport vehicle, including a road vehicle (for instance, private car, truck) or other vehicle (for instance, airplanes, boats). This applies unless the vehicle is being used in the course of work duties, at which time the location of fatal injury is coded 'workplace', or if the vehicle is located on the property of a residence at the time of the fatal injury, the location of fatal injury will be coded as having occurred at a residence.

'Wife' describes a female person who is legally married to a male person (a husband), with that marriage being legally recognized or capable of being legally recognized in Australia.

'Wife (Estranged)' describes a female person who is legally married to a male person (a husband), but the intimate relationship has ceased with the parties being separated or alienated. This is notwithstanding the fact that the parties may continue to co-habitate, or that one party wishes the relationship to continue.

'Workplace' describes where the location of fatal injury is the place where the deceased regularly undertakes paid or unpaid employment. For example, if the deceased is a nurse, and sustains fatal injuries at the hospital at which she is working, the location of fatal injury (leading to death) will be coded as the deceased's 'workplace'.

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