

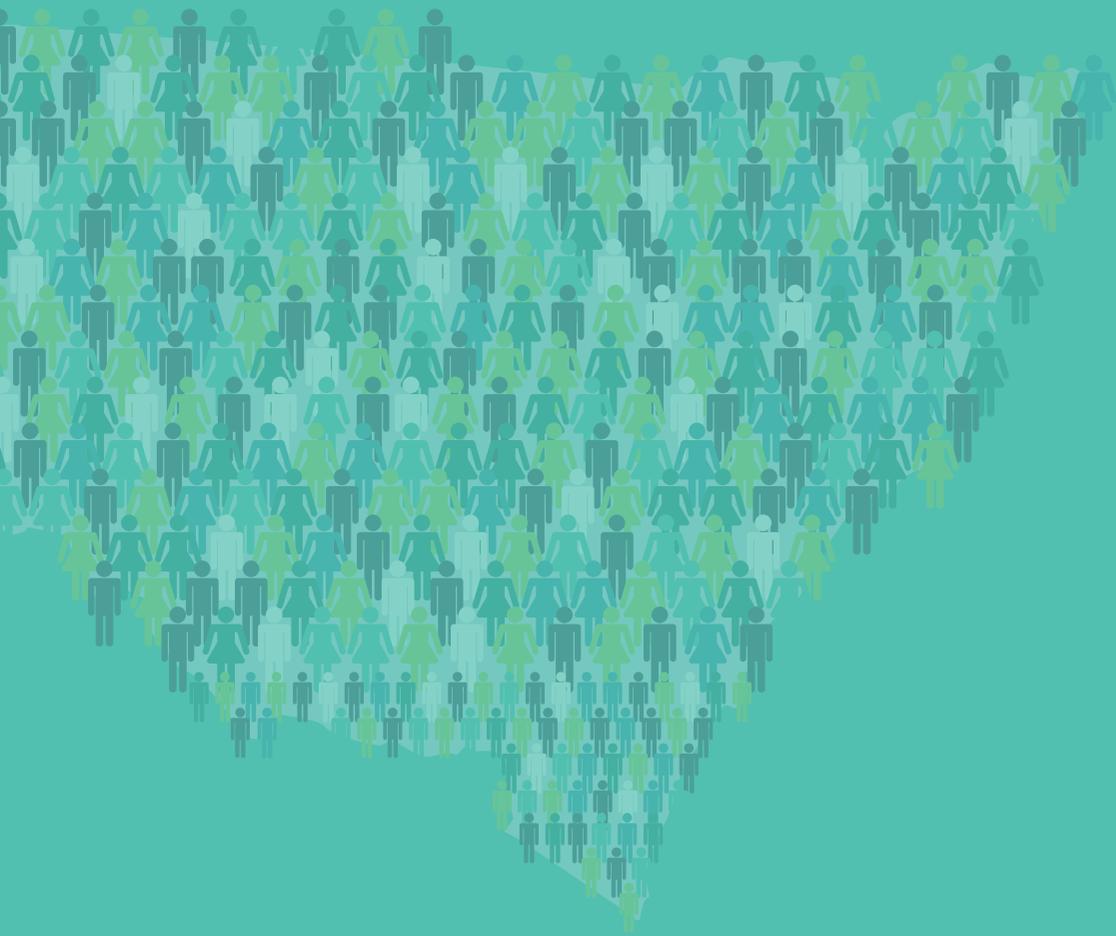
NSW DOMESTIC VIOLENCE  
DEATH REVIEW TEAM

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# REPORT

## 20152017

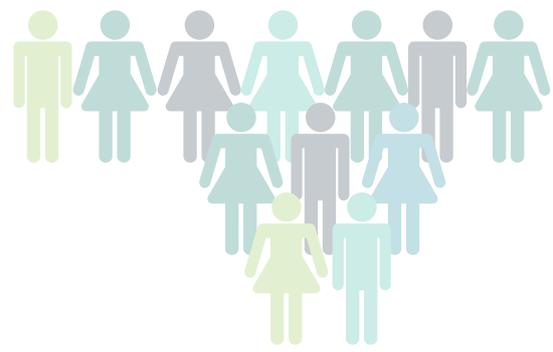




The silhouettes on the cover of this report represent the 179 women, 99 men and 65 children who lost their lives to domestic violence homicide in NSW in the period 2000-2014.

The Team honours the lives of those whose deaths are reviewed in this report and acknowledges the enduring devastation for those left behind.

The Team is privileged to undertake this work and remains steadfastly committed to ensuring that lessons are learnt and positive change affected as a result of these deaths.



**NSW DOMESTIC VIOLENCE  
DEATH REVIEW TEAM**

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# **REPORT**

2015-2017

## **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).

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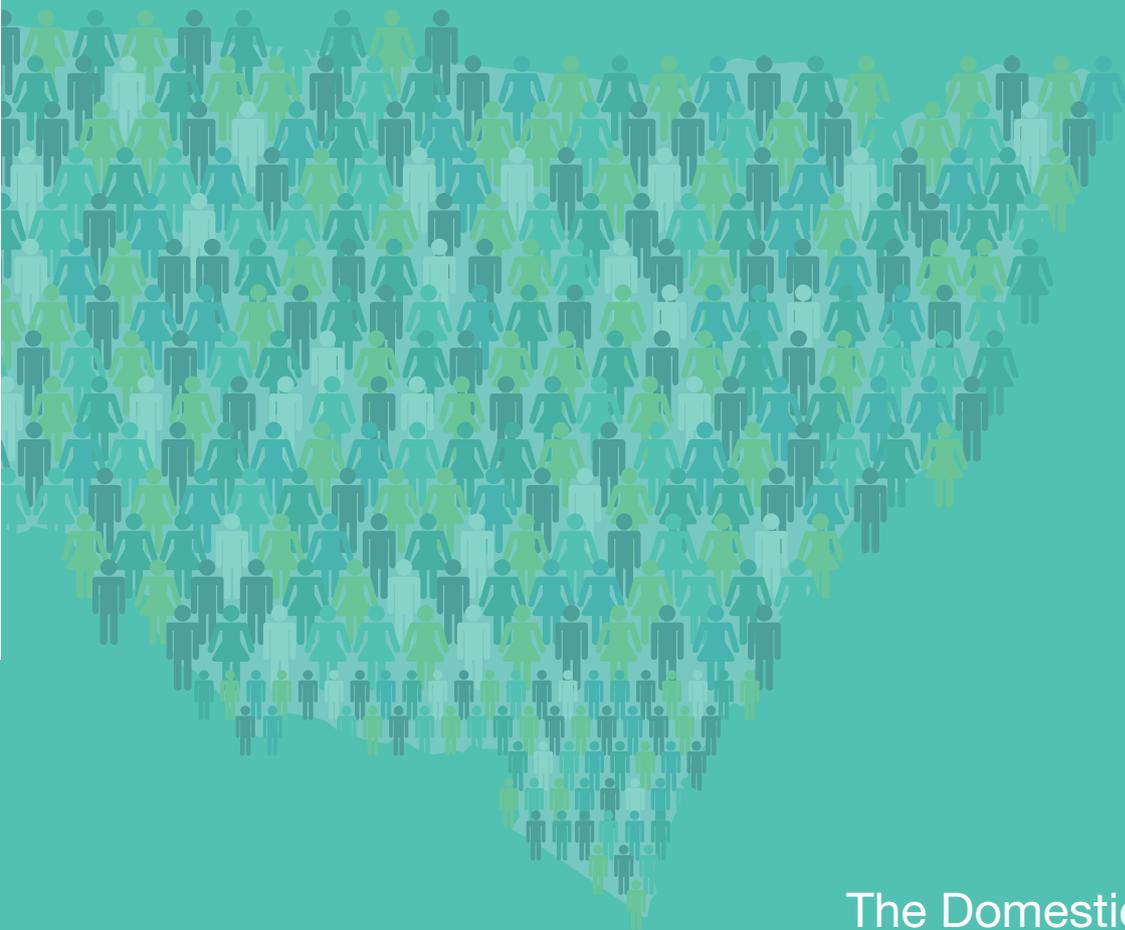
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While this publication has been formulated with due care, the Domestic Violence Death Review Team does not warrant or represent that it is free from errors or omissions, or that it is exhaustive.

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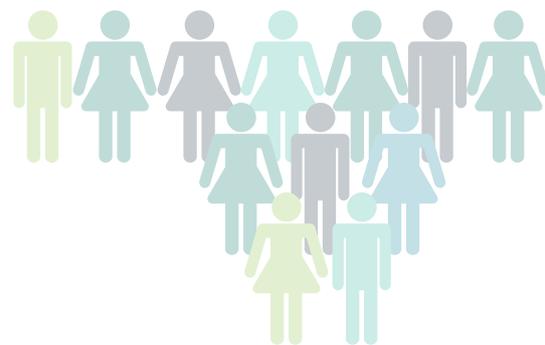
The Domestic Violence Death  
Review Team acknowledges  
the traditional owners of the land  
on which we work and live.

We pay our respects to Aboriginal  
and Torres Strait Islander Elders past,  
present and emerging; and recognise the  
strength and resilience of  
Aboriginal people in this land.

## HELP & SUPPORT

If you or someone you know is experiencing domestic violence, there are a range of services that can provide assistance and support. In an emergency, always call 000.

Service	Location	Phone	Website
<b>1800RESPECT</b>	Nationwide	1800 737 732	<a href="http://www.1800respect.org.au">www.1800respect.org.au</a>
A 24 hours a day, seven days a week helpline that provides counselling, information and support.			
<b>Domestic Violence Line</b>	Statewide	1800 656 643	<a href="http://www.domesticviolencensw.gov.au">www.domesticviolencensw.gov.au</a>
A 24 hours a day, seven days a week helpline that provides information, support and assistance.			
<b>Women's Legal Service NSW</b>	Statewide	1800 801 501	<a href="http://www.wlsnsw.org.au">www.wlsnsw.org.au</a>
A community legal centre that provides free specialised legal services, including in relation to domestic violence.			
<b>Men's Referral Service NSW</b>	NSW, VIC, TAS	1300 766 491	<a href="http://www.ntvmrs.org.au">www.ntvmrs.org.au</a>
A telephone counselling, information and referral service, operating Mon-Fri, 9am-9pm.			
<b>Immigration Advice and Rights Centre</b>	Statewide	02 8234 0799	<a href="http://www.iarc.asn.au">www.iarc.asn.au</a>
Provides free immigration advice and representation to refugees and financially disadvantaged immigrants in NSW.			
<b>Wurringa Baiya Aboriginal Women's Legal Centre</b>	Statewide	1800 686 587	<a href="http://www.wurringabaiya.org.au">www.wurringabaiya.org.au</a>
Community legal centre for Aboriginal women, children and youth with a focus on issues relating to violence, operating Mon-Fri, 9:30am-4pm (advice line closed Wed).			
<b>Elder Abuse Helpline and Resource Unit</b>	Statewide	1800 628 221	<a href="http://www.elderabusehelpline.com.au">www.elderabusehelpline.com.au</a>
Provides information, support and referrals for older people in NSW, operating Mon-Fri, 8:30am-5pm.			
<b>Kids Helpline</b>	Nationwide	1800 551 800	<a href="http://www.kidshelpline.com.au">www.kidshelpline.com.au</a>
A 24 hours a day, 7 days a week counselling service for young people aged 5-25 years.			
<b>Link2Home</b>	Statewide	1800 152 152	<a href="http://www.housing.nsw.gov.au">www.housing.nsw.gov.au</a>
A 24 hours a day, 7 days a week information and referral service for people who are homeless or at risk of becoming homeless.			
<b>Beyond Blue</b>	Nationwide	1300 224 636	<a href="http://www.beyondblue.org.au">www.beyondblue.org.au</a>
A 24 hours a day, 7 days a week counselling, information and referral service for people experiencing anxiety and depression.			



## CONVENOR'S MESSAGE

This is the fifth report of the NSW Domestic Violence Death Review Team and the fourth to contain substantive data and recommendations.

This report covers the reporting period from July 2015 – June 2017, and presents an overview of the Secretariat and Team's activities, case reviews, data and progress on recommendations made in prior reports. This is also the first report to present preliminary data and findings around domestic violence related suicide in NSW.

When an individual dies in the context of domestic violence we are afforded the opportunity to shine a light into that person's life; to investigate and critically examine their engagement with services, or conversely, why they did not engage with services. Looking at a death in this way also enables us to understand how that individual's community responded to their violence victimisation or perpetration. As such reviewing deaths provides an opportunity to view domestic violence holistically, systematically and with a view to understanding its complexity – not only in cases of homicide but as it manifests in our community more generally.

Our review process is strong, and our recommendation process is rigorous. In 2017 the Secretariat of the Team has commenced an additional function of assisting Coroners on open cases and providing specialist expertise in respect of domestic and family violence in coronial matters. The Team has also continued to build bridges with other review bodies as well as with academic institutions, and non-government organisations.

This report is the most extensive review undertaken by the Team to date. It includes an analysis of 14 years of domestic violence homicide data, the findings of which reveal important incidence, case characteristic and demographic information to inform the work of policy makers, service providers and advocates alike. The Team remains acutely aware, however, that each figure represents a life lost and enduring devastation for those left behind. For this reason, a significant proportion of this report is dedicated to telling the stories of the people behind the numbers – confronting narratives that make for extremely difficult reading but that provide invaluable insights into the lived experiences of victims of domestic violence.

Drawing together findings from its in-depth case analyses together with its data findings, the Team has developed 36 evidence-based recommendations which seek to promote and highlight the need for sustained and collaborative action.

A theme throughout this report is the importance of viewing domestic violence holistically, as episodes in a broader pattern of behaviour rather than as incidents in isolation of one another. Each case reflects the terrible scourge of domestic and family violence and teaches us something from which we can and indeed must learn. Accordingly, I would like to acknowledge the terrible loss of life in this report and extend my condolences to the families of those whose stories are contained and reflected within it.

**Magistrate Michael Barnes**

Convenor, Domestic Violence Death Review Team  
State Coroner

this report  
is the most  
extensive  
review  
undertaken  
by the Team  
to date.

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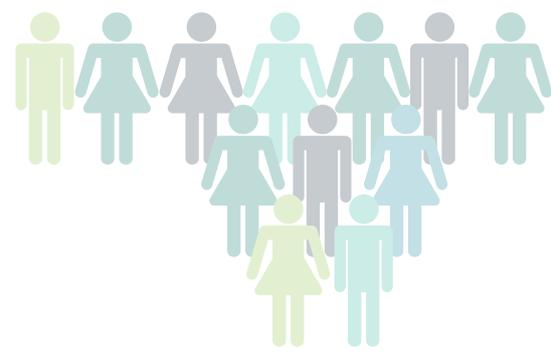
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Manager

## **Emma Buxton**

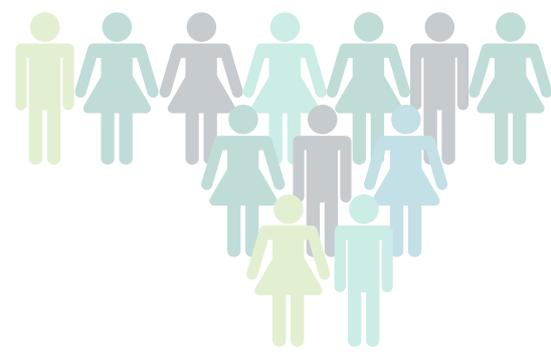
Research Analyst



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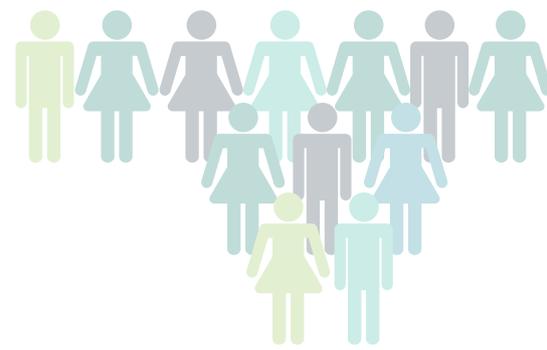


## LIST OF ABBREVIATIONS

<b>ACLO</b>	Aboriginal Community Liaison Officer (NSW Police Force)
<b>ADVO</b>	Apprehended Domestic Violence Order
<b>ANROWS</b>	Australia's National Research Organisation for Women's Safety
<b>BOCSAR</b>	NSW Bureau of Crime Statistics and Research
<b>BLUEPRINT</b>	NSW Domestic and Family Violence Blueprint for Reform 2016-2021
<b>COPS</b>	Computerised Operational Policing System (NSW Police Force)
<b>CSNSW</b>	Corrective Services NSW
<b>CTO</b>	Community Treatment Order
<b>DFV</b>	Domestic and family violence
<b>DVDRT</b>	Domestic Violence Death Review Team
<b>DVDS</b>	Domestic Violence Disclosure Scheme
<b>DVICM</b>	Domestic Violence Intervention Court Model
<b>DVJS</b>	NSW Domestic Violence Justice Strategy 2013-2017
<b>DVLO</b>	Domestic Violence Liaison Officer (NSW Police Force)
<b>DVNSW</b>	Domestic Violence NSW
<b>DVSAT</b>	Domestic Violence Safety Assessment Tool
<b>ECAV</b>	Education Centre Against Violence (NSW Health)
<b>FACS-Community Services</b>	Family and Community Services – Community Services
<b>FACS-Housing</b>	Family and Community Services – Housing
<b>FV</b>	Family violence
<b>GP</b>	General Practitioner
<b>ILGA</b>	Independent Liquor and Gaming Authority
<b>IPV</b>	Intimate partner violence
<b>MERIT</b>	Magistrate's Early Referral into Treatment Program
<b>NDIS</b>	National Disability Insurance Scheme
<b>NGMI</b>	Not guilty by reason of mental illness
<b>NSWPF</b>	NSW Police Force
<b>OPT</b>	Opioid Treatment Program
<b>PINOP</b>	Person in need of protection
<b>PWDA</b>	People with Disability Australia
<b>ROSH</b>	Risk of Serious Harm
<b>Safer Pathway</b>	It Stops Here: Safer Pathway (part of the NSW Government DFV Reforms)
<b>SAM</b>	Safety Action Meeting
<b>SOPS</b>	Standard Operating Procedures (NSW Police Force)
<b>UNA</b>	Unfit and not acquitted (following a special hearing)
<b>VIS</b>	Victim Impact Statement
<b>WDVCAS</b>	Women's Domestic Violence Court Advocacy Service

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# EXECUTIVE SUMMARY 2015-2017

The Domestic Violence Death Review Team was established in July 2010 under the *Coroners Act 2009* (NSW). The Team's overarching objective is to examine domestic violence related deaths so as to reduce the incidence of such deaths and to facilitate improvements in systems and services.

The term 'domestic violence related death' recognises that the scope of the Team's work includes examination of not only of domestic violence homicides, but also domestic violence related suicides, as well as where fatal accidents are caused by domestic violence.

The Team undertakes quantitative and qualitative analyses of domestic violence related deaths and synthesises the information derived from these review processes to develop findings and recommendations for implementation by government and non-government agencies.

Accordingly, this report outlines:

- data findings for all domestic violence homicides occurring in NSW between 1 July 2000 and 30 June 2014 (Chapter 2);
- case summaries for the 53 domestic violence related deaths that were subject to in-depth review by the Team (Chapter 3);
- recommendations and commentary derived from the Team's quantitative and qualitative review findings (Chapter 4);
- a focused data analysis of intimate partner domestic violence homicides (Chapter 5);
- the first iteration of the Team's study concerning domestic violence related suicides (Chapter 6); and
- agency updates as to the status of previous recommendations made by the Team (Chapter 7).

## DV RELATED HOMICIDE

### Quantitative review findings

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#### Complete homicide dataset – July 2000 to June 2014

---

In the data reporting period 1 July 2000 to 30 June 2014 there were 1132 homicides in NSW resulting in the deaths of 748 males, 383 females and 1 transgender person.

*Key data findings:*

- **30% of all homicides occurred in a context of domestic violence.**
- **61% of homicides with a female victim were domestic violence related.**
- **18% of homicides with a male victim were domestic violence related.**

---

#### Intimate partner homicide dataset - July 2000 to June 2014

---

In the data reporting period 1 July 2000 to 30 June 2014 there were 204 cases where a person was killed by a current or former intimate partner in a context of domestic violence (162 females and 42 males).

*Key data findings:*

- **79% of intimate partner homicide victims were women.**
- **98% of women killed by an intimate partner had been the primary domestic violence victim in the relationship.<sup>1</sup>**
- **37% of women in this dataset were killed by a former intimate partner, and almost two-thirds of these women had ended the intimate relationship with the domestic violence abuser within three months of being killed.**
- **Women killed by an intimate partner were aged between 15 and 80 years of age.**

---

<sup>1</sup> In three cases where a woman was killed by her male intimate partner, both parties had used domestic violence behaviours against each other and on the information available it was not possible to determine if there was a primary aggressor.

- 12% of women killed by an intimate partner identified as Aboriginal.
- 89% of men killed by a female intimate partner had been the primary domestic violence abuser in the relationship. All 7 men killed by a male intimate partner had been the primary domestic violence victim in the relationship.
- 31% of men killed by an intimate partner identified as Aboriginal.
- 24% of men who killed an intimate partner suicided following the murder.
- Males who killed an intimate partner were aged between 17 and 87 years of age.
- 26% of females who killed an intimate partner were acquitted at trial.
- In 14% of cases male abusers killed a female victim in breach of a current enforceable ADVO.
- 61% of domestic violence abusers had abused prior intimate partners.
- For the 78 intimate partner homicides there were at least 109 child survivors of homicide.
- In 16% of cases a child was present during the fatal assault.

---

### Relative/kin homicide dataset - July 2000 to June 2014

---

In the data reporting period there were 109 cases where a person was killed by a relative/kin in a context of domestic violence (44 adults and 65 children under the age of 18 years).

*Key data findings: child homicide victims*

- Child homicide victims in this dataset were aged between 4 weeks and 14 years of age, with 55% of children being aged less than 4 years of age.
- 42% of children were killed by their biological father acting alone and 26% were killed by their biological mother acting alone.
- 18% of children were killed by a male non-biological parent acting alone and 3% were killed by a female non-biological parent acting alone.
- 20% of child homicide victims in this dataset identified as Aboriginal.
- 31% of male homicide perpetrators in this dataset suicided after killing a child/ren compared to 10% of female homicide perpetrators.

*Key data findings: adult homicide victims*

- 59% of adult homicide victims in this dataset were men and 41% were women.
- 55% of adults in this dataset were the primary domestic violence victim in the relationship with the relative/kin who killed them.
- 48% of adult homicide victims in this dataset were killed by their son/step-son.

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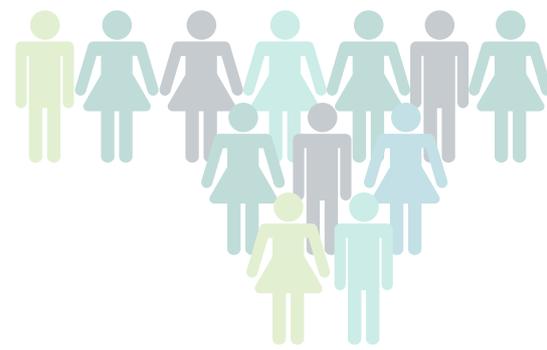
### Focused intimate partner homicide dataset – March 2008 to June 2014

---

Between 10 March 2008 and 30 June 2014 there were 78 intimate partner homicides in NSW which occurred in a context of domestic violence, resulting in the deaths of 66 women and 12 men. Each of these 78 cases has been subject to in-depth review by the Team thereby allowing for a more detailed examination of case characteristics for this dataset.

*Key data findings:*

- The majority of intimate partner homicides involved a domestic violence abuser killing a domestic violence victim (86%), but in other cases (13%) the domestic violence victim killed an abuser.
- Actual or intended separation was a characteristic in 50% of all intimate partner homicides.
- In around a quarter of all cases there were indications that the domestic violence abuser had strangled the domestic violence victim prior to the fatal assault (26%).
- Domestic violence abusers stalked victims in 39% of cases prior to the fatal assault.
- In 14% of cases there was no disclosed history of physical violence prior to the fatal assault.



- **16% of adult homicide victims in this dataset identified as Aboriginal.**
- **37% of homicide perpetrators in this dataset were found not guilty by reason of mental illness.**

## Qualitative review findings

The domestic violence system in NSW is complex. Through the case review process, however, the Team is afforded a unique opportunity to identify issues that might otherwise be obscured within this complex system.

For this report the Team undertook case reviews for the 53 domestic violence homicides in the reporting period July 2012 – June 2014.<sup>2</sup> The Team conducted in-depth analysis of each case review in a series of full day workshops to identify common themes, issues and areas for recommendation. **Chapter 3** sets out de-identified case reviews to assist readers in understanding the complex dynamics of domestic violence and the characteristics of these cases. The Team hopes that these commentaries can help readers to understand more about these tragedies, so we can learn from these deaths and prevent future losses of life.

The Team has identified a range of findings through its qualitative review function, including:

- the importance of viewing and understanding domestic violence holistically;
- the need for domestic violence responses to address multi-stratum structural inequality and disadvantage;
- the crucial role friends and family can play in assisting victims and perpetrators to access appropriate response services;
- the ongoing need to support police in responding to domestic and family violence;
- non-fatal strangulation as an important risk and vulnerability indicator for victims of domestic violence;
- the critical role of healthcare professionals in the intervention and prevention of domestic violence;

- unique barriers and vulnerabilities that may present to particular groups within the community including LGBTI victims of domestic violence, victims from culturally and linguistically diverse backgrounds, victims with impermanent visa status, older victims of violence, victims who reside in regional or remote NSW, and victims of violence with disability;
- the continued overrepresentation of Aboriginal people as victims and perpetrators of domestic violence homicides and the particular barriers faced by Aboriginal women in accessing appropriate services including the justice system;
- the availability of housing as a critical component in supporting victims of violence;
- reproductive coercion as a tool of control employed by domestic violence abusers; and
- the need to ensure that secondary victims of homicide, and in particular child survivors of homicide, are supported both in terms of their immediate needs and beyond.

## Commentary and Recommendations

A clear theme that has emerged from the Team's review is the importance of viewing and understanding domestic violence holistically and this theme is reflected throughout the Team's commentary and in many of its recommendations.

Accordingly, **Chapter 4** of this report provides commentary which covers a wide range of areas and makes recommendations that are specific and focused as well as recommendations that are broader in scope, addressing issues of prevention and intervention, as well as secondary trauma.

The complexity of the domestic violence service system is also reflected in the scope of the Team's recommendations, which anticipate reform in legislation, policies, practices and services.

The Team recognises and emphasises the importance of conceiving of domestic violence death prevention as an intergenerational and sustained effort that transects agencies, committees and issues well beyond moments of interaction between an abuser and a victim.

<sup>2</sup> This figure includes cases that closed during the reporting period (but which may pre-date the current reporting period), and excludes cases that remained open when the Team completed its case review process.

To guide and inform these efforts, the Team has developed a reform agenda, including to:

- shift cultures permissive of violence, including through the media;
- promote a holistic approach to policing of domestic violence such that this abuse is understood as a complex pattern of behaviour, including through the use of Team case studies;
- enhance the operation and effectiveness of civil protection orders;
- examine the potential to enhance and promote domestic violence specialist court practices;
- build capacity for healthcare professionals to respond to domestic and family violence;
- better support and respond to the complex needs of domestic violence victims and abusers, including where domestic violence co-occurs with alcohol/substance use and/or mental health problems;
- ensure access to interpreters for women in healthcare settings, in particular for women receiving post-natal home visits;
- better support new immigrants and individuals with impermanent visa status;
- promote and enhance access to housing for women experiencing domestic violence; and
- provide sustained support and appropriate responses to Aboriginal women experiencing domestic violence.

## DOMESTIC VIOLENCE AND SUICIDE

The impact of intimate partner violence on individuals' mental and physical health has been examined in a number of studies with findings demonstrating that intimate partner violence victimisation is a risk factor for women developing mental health issues. To date, however, relatively few studies have investigated the relationship between suicide and intimate partner violence, and of those that have, most have not examined completed suicides, but rather the prevalence of and associations between suicidal ideation and attempts, and intimate partner violence.

Accordingly, in 2016 the DVDRT's Secretariat commenced an initial 6-month whole-of-population pilot study, reviewing all completed suicides in the NSW from July to December 2013, the findings of which are set out in **Chapter 6** of this report. This review is being undertaken with a view to better understanding the relationship between suicide and domestic violence victimisation and perpetration, and uncovering opportunities for intervention and prevention in relation to this cohort.

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### Domestic violence suicide dataset – July to December 2013

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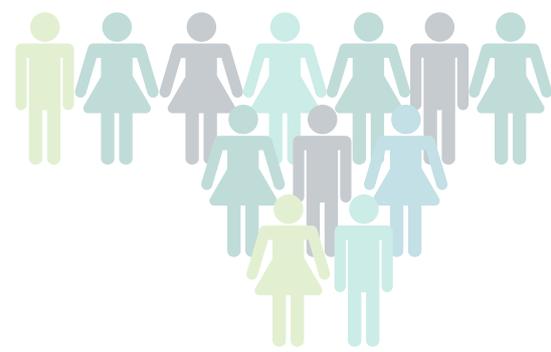
In the data reporting period 1 July to 31 December 2013 there were 330 completed suicides in NSW. Each case was examined by the DVDRT Secretariat to determine whether the deceased was known to police for domestic violence (either as a victim, an offender or both) prior to the suicide or whether domestic violence perpetration or victimisation or separation was identifiable as a proximal event from the police report of death.

*Key data findings:*

- **Of the 330 suicides, 245 (74%) people who suicided were male and 85 (26%) were female.**
- **39% of females and 38% of males were known to police in relation to domestic and family violence during their life (either as a victim, a perpetrator, or both).**
- **Of the females known to police for intimate partner violence, 69% were identified by police as victims, 6% as perpetrators, and 19% as both victims and perpetrators.<sup>3</sup>**

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<sup>3</sup> In one case a female was known to police for IPV but on the information available it was not clear whether she was a victim or perpetrator of IPV.



- 9% of females who suicided were named in a current ADVO, most as the protected person.
- Of the males known to police for intimate partner violence only, 87% were identified by police as intimate partner violence perpetrators, 5% as victims, and 8% as both perpetrators and victims.
- 7% of males who suicided were named as a defendant in a current ADVO at the time of their suicide.
- Of those known to police in relation to domestic and family violence, just over 20% of females and 10% of males who suicided were known in relation to having been exposed to domestic and family violence in their childhood.
- Review of the police report of death indicates that for 11% of females, and 13% of males, domestic violence, relationship conflict or relationship breakdown appear to be a proximal feature of the suicide.

# RECOMMENDATIONS 2015-2017

## Recommendation 1

**1.1** That the NSW Government give consideration to becoming a member of Our Watch.

**1.2** That the DVDRT Secretariat work together with Our Watch to analyse media reporting around murder suicides in New South Wales and disseminate its research findings.

## Recommendation 2

**2.1** That the NSW Police Force reviews how it captures, records and displays data on domestic violence events with a view to making appropriate changes that would support operational police to view the incident holistically and in the context of the history of the parties and relationship. This will assist police to make informed decisions as to what action to take in the context of the incident they are dealing with.

**2.2** That the DVDRT identify real life case studies which demonstrate issues/difficulties of identifying domestic violence as a complex pattern of behaviours and supply these case studies to the NSW Police Force together with relevant commentary. That the NSW Police Force incorporate these real-life case studies into the police training regime.

## Recommendation 3

That the Attorney General consider mechanisms to ensure that ADVOs are made for an appropriate duration, including:

- increasing the default length of ADVOs from 12 months to a longer duration to promote enhanced victim safety; and
- requesting that the Judicial Commission of NSW update the Local Court Bench Book or other education and training to invite judicial officers to consider factors relevant to setting an appropriate duration for an ADVO (including any period of time an offender is in custody, to ensure that the person in need of protection is protected upon the defendant's release).

## Recommendation 4

That the NSW Police Force update its Domestic Violence Standard Operating Procedures to require that where ADVO enquiries are made at the front desk of police stations, the inquirer is taken to a private interview room (except in circumstances where this would present as a security risk). The Standard Operating Procedures should also be updated to ensure that the inquirer is provided information about domestic violence and victims' safety.

## Recommendation 5

**5.1** That the Attorney General, in consultation with relevant stakeholders, review the operation of the NSW offence of strangulation (contained at s37 of the *Crimes Act 1900* (NSW)) to determine whether this offence is operating effectively.

**5.2** That the NSW Police Force update its Standard Operating Procedures to require that where a victim discloses strangulation, police advise the victim to seek urgent medical attention given the potential long-term health consequences of this form of assault.

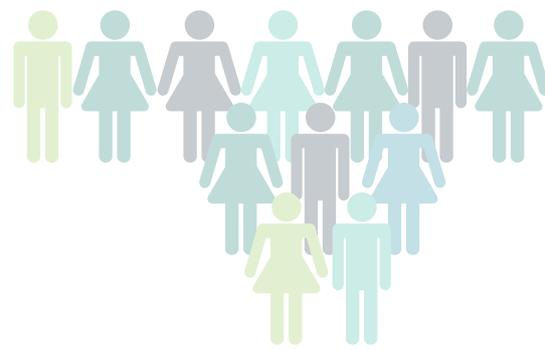
## Recommendation 6

That the NSW Attorney General review the issue of intractable domestic violence offenders – offenders who are not deterred by civil or criminal penalties for domestic and family violence – with a view to determining whether any additional strategies can be developed for this cohort.

## Recommendation 7

**7.1** That the Attorney General, in consultation with relevant stakeholders, consider how the approaches reflected in the Domestic Violence Justice Strategy, such as the application of specialist court practice in all local courts, can be further advanced.

**7.2** That the NSW Government review the support needs of victims in contested domestic violence matters, and the adequacy of current supports, with the aim of providing consistent support across NSW. This should include an examination of the specific needs of Aboriginal women, including in relation to attending court.



**7.3** That the Attorney General approach the Chief Magistrate to discuss how the expertise of judicial leaders can be harnessed to further improve responses to domestic violence in courts.

## Recommendation 8

**8.1** That the NSW Government consider the need for regulation of generalist counsellors, and/or other mechanisms to ensure generalist counsellors are operating in a way that respects and enhances the safety of victims and children in respect of domestic and family violence.

**8.2** That the NSW Government engage with the Australian Psychological Association, Australian Counselling Association, Australian Association of Social Workers and other relevant professional bodies to examine ways to improve associated professionals' awareness of and response to domestic and family violence such as through continuing professional education or registration processes.

## Recommendation 9

That NSW Health work with Primary Healthcare Networks, Royal Australian College of General Practitioners, Australian College of Rural and Remote Medicine, Aboriginal Medical Services, Women NSW, Australian Primary Healthcare Nurses Association and any other relevant agency or service as required, to support the development of strategies and materials for providing ongoing education to General Practitioners and practice nurses in relation to domestic and family violence.

Consideration should be given as to how to maximise uptake of training and whether domestic and family violence training should be required as part of Continuing Professional Development for General Practitioners.

## Recommendation 10

That the NSW Government appropriately resource NSW Health to ensure that Level 4 and above hospitals with a 24-hour emergency department are appropriately supported by 24-hour psychosocial resources to support the safety of victims.

## Recommendation 11

That the Ambulance Service of NSW work with the Ministry of Health (Health and Social Policy branch) to develop a specific domestic and family violence standard operating policy.

## Recommendation 12

**12.1** That the revised NSW Health Domestic Violence Identification and Response policy address the safety needs of victims of violence who are being discharged from mental health institutions.

**12.2** That NSW Health develop strategies to improve screening rates for women in mental health services.

## Recommendation 13

That the NSW Department of Justice work with NSW Health in relation to the redesign of MERIT to explore strategies to integrate MERIT into the current referral and information sharing framework under Safer Pathway. This redesign should include a requirement that all workers involved in the MERIT program be trained in domestic and family violence.

## Recommendation 14

That the Independent Liquor and Gaming Authority, when making determinations regarding any alcohol licensing related applications in areas identified by the NSW Bureau of Crime Statistics and Research as domestic violence 'hot spots', apply the following criteria:

- 1) For any applications pertaining to an extension of trading hours, or the development of new liquor outlets or bottle-shops in domestic violence hot spots, there should be a rebuttable presumption against granting the application;
- 2) The Authority should require applicants to prepare Community Impact Statements for their applications and these should require the applicant to consult with community members, including a Domestic Violence Liaison Officer from the relevant Local Area Command or a Safety Action Meeting Representative from the Local Coordination Point,

and applicants must respond to the concerns of these parties. Applicants should also be required to provide local alcohol sales industry data as part of their application; and

- 3) In the case that licences or applications are successful after the applicant completes the Community Impact Statements, the licence holder should be required to display domestic violence educational material within public areas of the venue, including posters by NSW Police Force or other relevant educational material concerning domestic violence.

## Recommendation 15

That NSW Health provide resources to a consumer based organisation and/or family and carers organisation who work with people who use drugs to collaborate with the DVDRT Secretariat to develop a strategy for improving awareness of, and intervention in relation to, domestic and family violence amongst people on Opioid Treatment Programs in NSW.

This strategy should aim to raise awareness and highlight the importance of this intervention point in a holistic and coordinated response to violence, highlight referral pathways available to this group of clients, increase capacity to identify and respond to domestic and family violence across the workforces administering and delivering these programs, and should be tailored to the different Opioid Treatment Program pathways currently available in NSW.

## Recommendation 16

**16.1** That NSW Health conduct a literature review and convene a working group within NSW Health to ventilate relevant issues and develop a model of practice around working with complex clients with cumulative alcohol or drug, mental health and domestic violence issues.

**16.2** That NSW Health convene an interagency forum including with relevant expertise in drug and alcohol, mental health and domestic violence, to develop strategies for improving and co-ordinating responses to people with mental health, drug and alcohol and domestic violence perpetration or victimisation issues. This may include the development of a co-ordinated plan of action, referral pathways and complex program interventions across agencies.

## Recommendation 17

That NSW Health convene an interagency working group to consider mechanisms by which to rapidly share information between NSW Health and Justice with respect to any existing Community Treatment Orders, clients who may be in breach of Community Treatment Orders when offending, or clients who may benefit from the inclusion of Community Treatment Orders as part of bail conditions.

This working group should also consider ways to monitor compliance with Community Treatment Orders for domestic and family violence offenders.

## Recommendation 18

That the NSW Police Force update its Standard Operating Procedures and adjust training material to reflect preferred practice around Elder Abuse as contained in the NSW Police Notebook Card (developed by the Elder Abuse Helpline Resource Unit).

## Recommendation 19

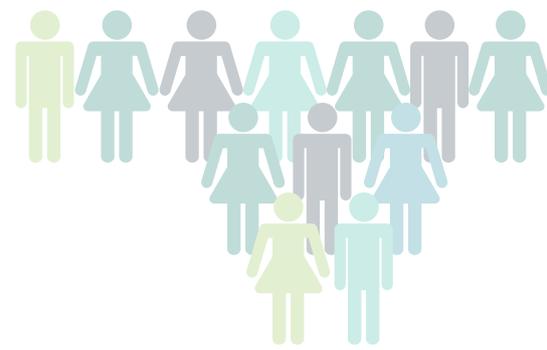
**19.1** That NSW Health give consideration to adopting a policy whereby women who do not receive antenatal screening receive postnatal screening.

**19.2** That NSW Health update its policies and practice to ensure that, where required, appropriate healthcare interpreters are made available to women in NSW receiving post-natal care in the form of home visits.

## Recommendation 20

**20.1** That the Commonwealth Government work with state governments and other relevant stakeholders to develop and fund a specific initiative to enable vulnerable individuals with impermanent visa status, or without a valid visa, to access affordable, appropriate and expedient medical care. This initiative must recognise the unique vulnerability of victims of domestic and family violence who may be precluded from accessing affordable services due to residency issues or barriers to access arising from fear of deportation.

**20.2** That the Commonwealth Government give consideration to expanding the Family Violence Provisions currently applicable to spousal visas to



ensure that victims who are applying for permanent residency under different classes of visa are supported when escaping domestic or family violence.

**20.3** That the Commonwealth Government work with the Office of the Migration Agents Registration Authority to update accredited graduate certificate courses to include a specific topic about domestic and family violence as part of the syllabus. This update should highlight the specific vulnerabilities that may arise for domestic and family violence victims by virtue of having uncertain or impermanent visa status (across categories) and issues relevant to, but not confined to, the operation of the Family Violence Provisions. That the Office of the Migration Agents Registration Authority give consideration to incorporating mandatory domestic and family violence continuing professional development into educational requirements for registered Migration Agents in Australia.

**20.4** That the Commonwealth Government work with state governments and other relevant stakeholders to identify how non-residents experiencing domestic or family violence can be better supported in respect of access to shelter accommodation, access to more permanent housing solutions and access to appropriate financial and other supports. That as part of this work, the Commonwealth Government resource the NSW Government to provide accommodation and other services for domestic and family violence victims who are non-residents.

**20.5** That the Commonwealth Government give consideration to either updating the *Life in Australia* booklet, or producing another publication to be distributed to all persons entering Australia on a provisional or permanent visa, to highlight what domestic and family violence is, and what victims can do to seek help in Australia (including referral information).

## Recommendation 21

That Women NSW engage more directly with women with disability and women living in regional and remote areas regarding their challenges in accessing domestic and family violence services with a view to developing specific actions to better support and respond to these priority groups.

## Recommendation 22

That the NSW Police Force Aboriginal Coordination Team update the Aboriginal Client Liaison Officer position description to include an additional criteria under the 'Knowledge, Skills and Experience' section, namely the 'Ability to work effectively in dealing with domestic, family and community violence in the local community, and in particular an ability to advocate for and reinforce the importance of supporting victims of domestic violence.'

## Recommendation 23

**23.1** That the NSW Department of Justice, in partnership with Aboriginal community groups, develop a pilot program aimed at supporting Aboriginal women to attend court in relation to domestic violence offences in which they are a witness or victim.

**23.2** That the NSW Government fund the pilot program anticipated in 23.1

## Recommendation 24

That the NSW Government conduct or commission research examining the forms, prevalence and impact of reproductive coercion in NSW and use this, and the international evidence base, to develop a strategy for addressing reproductive coercion in its various manifestations, including through family planning clinics, women's health clinical services, termination providers, general practice and youth health services.

## Recommendation 25

That NSW Health convene a working group to consider strategies to support the safety of family members or carers looking after or living with persons who are suffering from mental illness and concurrently using domestic and family violence (police reported or anecdotal).

The working group should consider risk assessment processes concerning the safety of family members or carers (including their risk of violence victimisation from their family member experiencing mental health issues) as part of Community Treatment Order assessments, discharge plans from mental health institutions or from

other institutions who may be providing mental health care, and outpatient management plans.

## Recommendation 26

That Corrective Services NSW approach the Chief Magistrate to discuss strategies to ensure that Corrective Services NSW has sufficient time to conduct risk assessments for offenders who are on remand prior to the offender being sentenced and released. If it is determined that change in court practices is required, consideration should be given to how best to effect such change and whether changes should be codified.

## Recommendation 27

**27.1** That NSW Health ensure that any domestic and family violence training delivered to NSW Health staff, or by NSW Health staff to healthcare service providers (such as by Education Centre Against Violence), discuss and provide referral information relevant to workers who themselves may be experiencing domestic and family violence.

**27.2** That NSW Health provide information about domestic and family violence leave to all staff by circulating a bulletin which should also include educational information about domestic and family violence. Information about supports available for workers should also be displayed on local health district intranets and other relevant intranets administered by NSW Health.

**27.3** That the Commonwealth Government require that all aged care providers deliver information to their staff about domestic and family violence, including information about how to access support.

## Recommendation 28

**28.1** That the NSW Government give consideration to amending its domestic and family violence leave guidelines to include a statutory declaration as evidence of domestic and family violence.

**28.2** That the NSW Government monitor the uptake and use of the domestic and family violence leave provisions, including to monitor how frequently and on what grounds the leave provisions are being used.

## Recommendation 29

**29.1** That the NSW Government fund FACS-Housing to expand its allocation of housing for clients escaping domestic and family violence.

**29.2** That FACS-Housing include information about the availability of temporary accommodation on its website 'Link2Home' highlighting that for victims and domestic violence such accommodation is not subject to the 28-day limit.

**29.3** That FACS-Housing continue to liaise with DVNSW and other relevant stakeholders to ensure that the Link2home processes for clients experiencing domestic or family violence remain appropriate.

## Recommendation 30

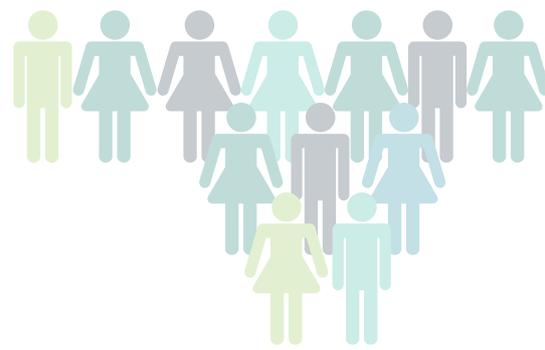
That FACS-Housing evaluate its current pilot project which provides perpetrators with temporary accommodation linked to referrals and support.

## Recommendation 31

**31.1** That FACS-Housing monitor the uptake and use of its new client information and service 'app' once launched, and consider strategies to ensure the 'app', and the broader Housing Connect Program, is accessible to clients, and in particular culturally and linguistically diverse clients and clients who are not digitally savvy.

**31.2** That FACS-Housing update its security contracts to require that subcontractors call police where they see, suspect or are informed about domestic violence episodes occurring on, or in relation to, FACS-Housing properties.

**31.3** That FACS-Housing work with the NSW Police Force to ensure the provision of timely and up to date housing information for use by officers (including in relation to the information referred to in Recommendation 29.2).



## Recommendation 32

**32.1** That Victims Services work with the NSW Police Force to formalise a policy or memorandum of understanding in relation to crime scene clean up in all cases where a crime scene is established following a homicide or serious assault from which death may result. This policy should clearly articulate each agencies role in ensuring that crime scene clean up is coordinated in a timely fashion and that families are appropriately supported in accessing financial assistance where required.

**32.2** That Victims Services and the NSW Police Force work together with homicide victims support organisations to develop or update any existing information package, such as the *Family Members of Homicide Victims* brochure, for secondary victims of homicide. This package should contain clear and plain English information about victims' immediate needs, actions required of the secondary victim, support services available and how to engage support, and next steps after a family member or loved one is killed. Agencies should develop a strategy for making this package available to all secondary victims of homicide as soon as practicable after the fatal assault.

## Recommendation 33

That Victims Services, Family and Community Services, NSW Health, the Department of Education and Communities and other relevant organisations work together to improve access to support and advocacy for young people and children who are a secondary victim to a homicide, including where carers may be reluctant to engage with services.

## Recommendation 34

That Victims Services update its online information and any material that accompanies the making of a Provisional Order for restitution to indicate that the defendant can challenge the making of an order in circumstances where the defendant has an ongoing relationship with a victim who has been granted compensation.

## Recommendation 35

That the NSW Government review legislation to allow for the making of Victim Impact Statements in circumstances where the defendant is found unfit and not acquitted, or not guilty by reason of mental illness under the *Mental Health (Forensic Provisions) Act 1990* (NSW).

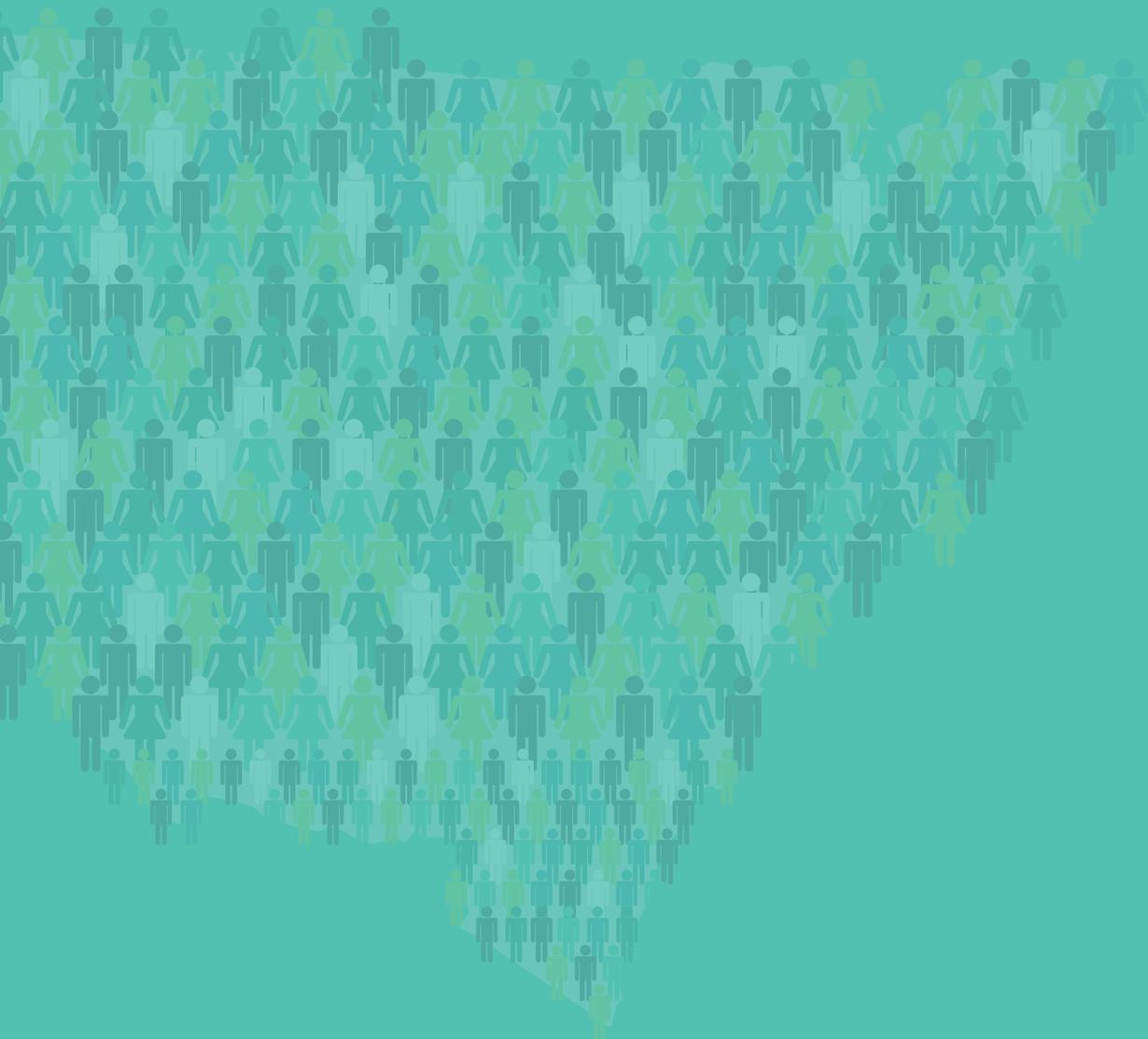
## Recommendation 36

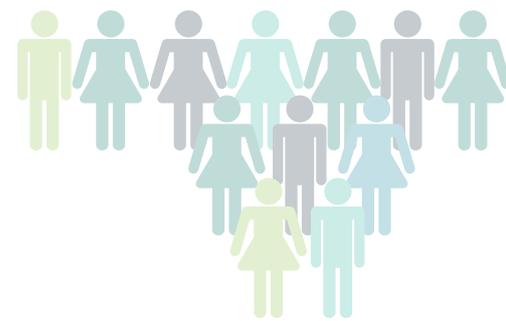
That NSW Health together with the Mental Health Commissioner review the adequacy of supports available for victims of domestic and family violence, or secondary victims of domestic violence related homicides in NSW, where the person charged has been assessed as having a mental illness or intellectual disability.

The review should consider strategies to improve the identification of domestic violence cases by mental health professionals, including the Mental Health Review Tribunal.

# Introduction

This chapter provides an overview of the underlying principles which guide the operation of domestic violence death review mechanisms and sets out the background, establishment and methodology of the NSW Domestic Violence Death Review Team.





## Why review domestic violence homicides?

‘Domestic violence’ (or ‘intimate partner violence’) is a term used to describe a pattern of behaviour whereby a 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 relationship. At the heart of this definition is the abuser’s use of coercion and control to assert and maintain power and dominance over the victim.

Manifestations of domestic violence can include:

- psychological and emotional abuse;
- physical abuse;
- sexual abuse;
- verbal abuse;
- social and economic abuse; or
- any other forms of behaviour used by the abuser to coerce or control the victim.

Domestic violence includes violence perpetrated by heterosexual and same-sex current or former intimate partners. Domestic violence includes both criminal and non-criminal behaviours.<sup>4</sup> It is acknowledged that while men can be victims of domestic violence, the vast majority of domestic violence is perpetrated by men against women.<sup>5</sup> This has led to an understanding of domestic violence as a gendered harm, invoking issues of patriarchy, and inviting the examination of social and community norms.

In NSW, however, the term ‘domestic violence’ is used broadly in criminal and civil legislation to include abusive behaviours not only between intimate partners but also between family members, kin and other close relationships.<sup>6</sup>

Accordingly, this report uses the term ‘domestic violence’ to refer to both domestic violence and family violence. This report also recognises that children who witness or live with domestic violence in the home are victims of domestic violence.

Where appropriate, the report distinguishes between intimate partner violence and other kinds of family violence.

Despite changing community attitudes regarding the criminality of these behaviours, and decades of policy intervention, domestic violence remains one of the most serious social issues confronting NSW as a state and Australia as a nation.

Research has highlighted that an identifiable history of domestic violence is a common feature in a high proportion of homicides. This is particularly the case for women; a high proportion of whom are killed by a domestic violence abuser in a context of ongoing coercion and control.<sup>7</sup>

Domestic violence related homicides are considered to exhibit predictable patterns and aetiologies.<sup>8</sup> When a homicide occurs in a domestic violence context it can be characterised by a history of abusive behaviours that may have been known to service providers, friends and family prior to the homicide.

Accordingly, these deaths warrant particular attention and analysis. This has been the impetus for the establishment of domestic violence death review teams worldwide.<sup>9</sup>

4 National Council of Australian Governments, *The National Plan to Reduce Violence Against Women and their Children 2010-2022*, (Commonwealth Government, 2011) available at [https://www.dss.gov.au/sites/default/files/documents/08\\_2014/national\\_plan1.pdf](https://www.dss.gov.au/sites/default/files/documents/08_2014/national_plan1.pdf) (accessed 30 September 2017).

5 Australian Bureau of Statistics, *Personal Safety Survey Australia 2005*, ABS cat. No 4906.9, 2006, Canberra; Chan and Payne, *Homicide in Australia: 2008-09 to 2009-10 National Homicide Monitoring Program Annual Report*, (Australian Institute of Criminology, Canberra, 2013); Dobash, Dobash, Wilson and Daly, ‘The myth of sexual symmetry in marital violence’ (1992) 39(1) *Social Problems* 71; Grech and Burgess, *Trends and patterns in domestic violence assaults: 2001 to 2010*, (NSW Bureau of Crime Statistics and Research, Sydney, 2011).

6 Crimes (Domestic and Personal Violence) Act 2007 (NSW).

7 Alderidge and Browne, ‘Perpetrators of Spousal Homicide: A Review’ (2003) 4(3) *Trauma, Violence & Abuse* 265; Virueda and Payne, *Homicide in Australia: 2007-2008 National Homicide Monitoring Program Annual Report* (Australian Institute of Criminology, Canberra, 2010).

8 Websdale et al, ‘Domestic Violence Fatality Reviews: From a culture of Blame to a culture of safety’ (1999) *Juvenile and Family Court Journal* (Spring), 61; Office of the Chief Coroner for Ontario, *Domestic Violence Death Review Committee 2012 Annual Report*, 2014, available at [http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office\\_coroner/PublicationsandReports/DVDR/DVDR.html](http://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/PublicationsandReports/DVDR/DVDR.html) (accessed 30 September 2017).

9 Dawson (ed.), *Domestic Homicides and Death Reviews: An International Perspective* (London, Palgrave Macmillan, 2017).

Domestic violence death review teams are collaborative multi-agency committees which conduct in-depth analyses of domestic violence homicides. Such teams undertake a careful examination of the circumstances surrounding these homicides with a view to providing a better understanding of agencies' roles and constraints in responding to domestic violence, as well as other barriers and limitations (*qualitative analysis*).

Teams can also undertake data collection and analysis with a view to mapping trends and dynamics across domestic violence homicide cases (*quantitative analysis*).

Examining homicides which occur in a domestic violence context enables the Team to identify where systems could be improved to better address the needs of domestic violence victims and abusers, but also more generally assist us to understand the broader dynamics and issues around domestic violence in the community.

## The NSW Domestic Violence Death Review Team

### Background and establishment

Recognising the long history of death review processes operating in other jurisdictions,<sup>10</sup> from the early 2000s, advocates and various government agencies began campaigning for a domestic violence death review process to be established in NSW.<sup>11</sup>

In December 2008, the NSW Government convened the Domestic Violence Homicide Advisory Panel, which considered the merit, key elements and best practice model of any ongoing review mechanism for NSW. The panel handed down its report in mid-2009, unanimously recommending that a permanent domestic violence death review team be established and identifying its key features and functions.

In July 2010, the *Coroners Amendment (Domestic Violence Death Review Team) Act 2010* (NSW) commenced, amending the *Coroners Act 2009* (NSW) by inserting Chapter 9A and thereby establishing the Domestic Violence Death Review Team (the 'Team').

The Team's overarching objective is to examine domestic violence related deaths so as to reduce the incidence of such deaths and to facilitate improvements in systems and services.<sup>12</sup>

The Act provides that the functions of the Team are to:

- review and analyse individual closed cases of domestic violence related deaths;
- establish and maintain a database so as to identify patterns and trends relating to such deaths; and
- develop recommendations from qualitative and quantitative data and undertake research that aims to prevent or reduce the likelihood of such deaths.<sup>13</sup>

The term 'domestic violence related death' recognises that the scope of the Team's work includes examination not only of domestic violence homicides, but also domestic violence related suicides, as well as where fatal accidents are caused by domestic violence.

Since its establishment there have been a number of amendments to the Team's legislative framework to enhance and fine tune the Team's review function. Some amendments have been in response to recommendations made by the Team in prior reports<sup>14</sup> and others as a consequence of the statutory review of Chapter 9A of the *Coroners Act 2009* (NSW), the report of which was published in October 2015.<sup>15</sup>

As a result of these amendments the Team now has the benefit of additional expertise in its membership including: representation from Corrective Services NSW, Department of Premier and Cabinet, and Women NSW; the Commissioner of Victim's Rights; an addiction specialist; and a mental health specialist (although this position has remained vacant since its establishment).

10 For example, in the United States and Canada such processes have existed since the 1990s, see David, 'Exploring the Use of Domestic Violence Fatality Review Teams' (2007) 15 Australian Domestic & Family Violence Clearinghouse Issues Paper.

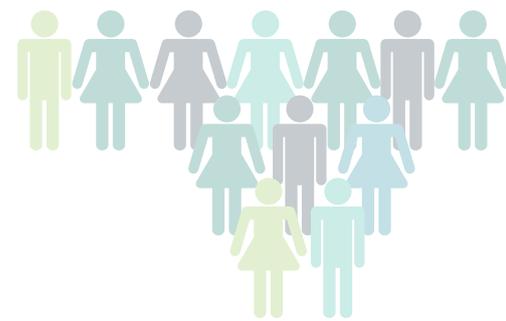
11 NSW Ombudsman, *Domestic Violence: Improving Police Practice* (NSW Ombudsman, Sydney, 2006).

12 *Coroners Act 2009* (NSW) s101A.

13 *Coroners Act 2009* (NSW) s101F(1).

14 See, for example Recommendations 1-3 in the Team's 2011/12 Report.

15 Statutory Review of Chapter 9A of the *Coroners Act 2009* – The Domestic Violence Death Review Team available at <https://www.parliament.nsw.gov.au/la/papers/>



The Team, as a consequence of legislative amendment, has also moved to reporting biennially.

In this report, the Team outlines data and case reviews regarding domestic violence related homicides, recommendations and commentary derived from these reviews and presents the first iteration of its study concerning domestic violence related suicides.

## Review and Recommendation: Understanding the function of the Team

The functions of this Team closely parallel the function of other investigative bodies and/or persons, including the recommendation function of Coroners, the investigative and reporting function of the Ombudsman, and the function of other death review bodies in Australian states and territories.

The purpose of these reviews is to investigate individual cases or groups of cases to identify issues within systems, including problems in the way systems operate, omissions or oversights within systems that affect key players in the system (or others more broadly), and to consider how systems and approaches may benefit from change.

The domestic violence 'system' in NSW is complex, dynamic and multi-stratum. By virtue of the death however, the Team is afforded a unique opportunity to identify issues that might otherwise be obscured within this complex system. The Team's review process, therefore, acts as a lens into systems and affords a critical analysis of the effectiveness of those systems, where improvements have been made, or where systems and services do not, but should, reach.

The operation of death review processes, much like Coroner inquests, is premised on the understanding that the issues arising within single, or small groups of cases can reveal inadequacies within systems and the ways in which systems do, or do not, work. Some death review processes select cases to examine based on the issues arising, conduct a review and make recommendations in relation to the ways systems are functioning based on individual cases. Other bodies produce targeted 'systemic reviews' based on individual cases only, which are published in individual reports or are available online.

The review approach adopted by this Team is to conduct reviews in relation to all cases, but derive recommendations from individual and groups of cases. This whole-of-population approach has been adopted to afford the Team the ability to review the broadest possible cross-section of cases.

The complexity of the domestic violence service system is reflected in the scope of the Team's recommendation function, which anticipates that the Team will make recommendations as to legislation, policies, practices and services, and that these recommendations will be implemented by government and non-government agencies.

## Review Methodology

The Team adopts a two tier approach to investigating and reporting on domestic violence deaths:

**Tier 1:** Development of a **complete domestic violence homicide dataset** – which provides *quantitative data analysis* in relation to all homicides occurring in a domestic violence context in NSW within the data reporting period.

For this report, quantitative data analysis is presented in relation to the 338 domestic violence homicides that occurred within the data reporting period, which for this report is 1 July 2000 – 30 June 2014.<sup>16</sup>

**Tier 2:** Analysis of **in-depth case reviews** – which provide detailed *qualitative case analysis* in relation to all homicides occurring in a domestic violence context in NSW within the case review period, which for this report is 1 July 2012 – 30 June 2014 (a 2 year period).

DBAssets/tablepaper/webAttachments/67991/Report%20on%20the%20review%20of%20Chapter%209A%20of%20the%20Coroners%20Act%20(Domestic%20Violence.pdf (accessed 30 September 2017).

<sup>16</sup> This end date is selected to ensure that the maximum number of closed cases can be included in the analysis.

From a synthesis of information derived from Tier 1 and Tier 2, the Team develops various findings and recommendations which aim to facilitate improvements in systems and services, highlight where changes have been made in the time that has elapsed between the homicide and the review, and promote better outcomes for victims of domestic violence.

## Tier 1 Methodology

To develop the complete domestic violence homicide dataset the Team identifies and examines every homicide that occurs in NSW, capturing detailed demographic information and case characteristics for every case.

This dataset is developed with a view to determining overall trends and patterns in relation to domestic violence context deaths, using a comparative dataset (where appropriate) of all non-domestic violence context deaths.<sup>17</sup>

From the total homicide dataset, each case is examined to determine the relationship between the homicide victim and the perpetrator and whether the death occurred in a domestic violence context.

To determine if a homicide occurred in domestic violence context, case material is examined to identify any evidence (reported or anecdotal) of domestic violence behaviours.

It is acknowledged that the domestic violence context may not always be identified given the limitations inherent in the evidence available to the Team. The figures presented in this report may therefore represent an undercount.

Every domestic violence homicide is categorised by the relationship between the homicide victim and the homicide perpetrator:

**Intimate partner homicide:** where a person is killed by a current or former intimate partner in a domestic violence context;

**Relative/kin homicide:** where a person is killed by a non-intimate family member in a domestic violence context; and

**‘Other’ domestic violence homicide:** where there is no intimate or familial relationship between the perpetrator and deceased, but the homicide nonetheless occurs in a domestic violence context (for example, cases where a bystander is killed intervening in domestic violence).

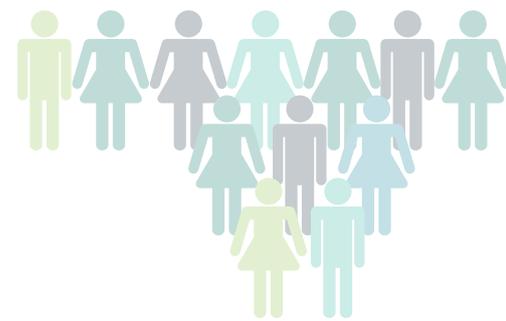
Most domestic violence homicides involve a single homicide perpetrator killing a single homicide victim and the process of categorising the homicide is straightforward.

There are, however, a number of cases where a homicide perpetrator kills multiple victims. In these circumstances, each homicide victim is taken to have a distinct relationship with the homicide perpetrator. For example, where a domestic violence abuser kills his intimate partner and child, the woman’s death will be categorised as an intimate partner homicide, and the child’s death a relative/kin homicide.

There are also a number of cases where a single homicide victim is killed by multiple perpetrators. Each perpetrator has a distinct relationship with the deceased which may mean that the death sits across categories. For example, a case where a domestic violence abuser, acting together with a friend, kills the abuser’s former partner. In these circumstances, the woman’s death is both an intimate partner homicide (with respect to her former abuser) and an ‘other’ homicide (with respect to the friend as the woman had no intimate or familial relationship with the friend but her death occurred in a context of domestic violence).

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<sup>17</sup> While this data is captured by the Team, the data analysis of non-domestic violence related homicide is not included in this report.



## Tier 2 Methodology

The Team conducts comprehensive in-depth reviews of individual domestic violence homicides which occur over a designated period considered to be sufficiently proximal to the homicides.

Examination of in-depth case reviews enables the Team to more thoroughly examine individual cases with a view to making meaningful and specific recommendations based on current practice and policy within agencies.

In-depth reviews are prepared following a comprehensive examination and analysis of all available case material, including:

- police reports to the Coroner;
- the brief of evidence (prosecutorial or coronial);
- post mortem and toxicology reports;
- remarks on sentence;
- coronial findings;
- media reports; and
- any additional information called for by the Team.<sup>18</sup>

In conducting the review, the Team's Secretariat prepares a case review report which sets out, in as much detail as possible, information including:

- deceased/homicide perpetrator profiles – including demographic information such as: age; sex; ethnicity; family history; education history; relationship status; housing status; employment history; and criminal history;
- a chronology of events – including any relevant events, both proximal and distal, to the death;
- the domestic violence 'status' of the deceased/homicide perpetrator, i.e. whether they were the domestic violence victim or domestic violence abuser in the relationship;
- relationship history – including the nature, duration and history of the relationship between the homicide victim and perpetrator;

- details of the death – as determined by the available material;
- any criminal justice outcome; 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.

Each case review report is examined by the Team in a series of workshops to identify common themes, highlight areas where policy or law has shifted, discuss arising issues and develop areas for recommendation.

Recommendations are developed by Team members in consultation with agencies to ensure that the work of the Team is informed by current practice and policies.

This report accordingly provides in-depth reviews of the 53 domestic violence homicides which occurred in NSW between 1 July 2012 and 30 June 2014.<sup>19</sup>

<sup>18</sup> Coroners Act 2009 (NSW) s101L.

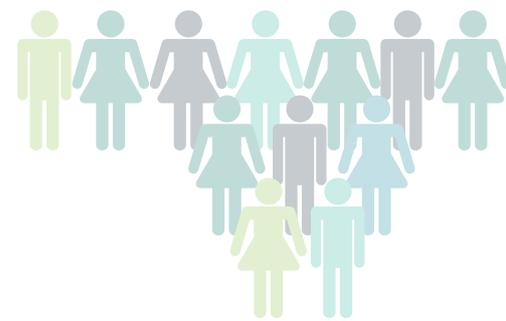
<sup>19</sup> This figure includes cases that closed during the reporting period (which may pre-date the current reporting period), and excludes cases that remained open at the conclusion of the Team's case review process.

# Complete Dataset Findings

## Domestic Violence Homicide in NSW 2000–2014

This chapter presents data analysis in relation to the Team's complete dataset - all 338 closed domestic violence homicides that occurred in NSW in the fourteen years between 1 July 2000 and 30 June 2014. The 338 domestic violence homicides are considered in three distinct groups: intimate partner homicides, relative/kin homicides, and 'other' domestic violence homicides.





## Homicide Overview

During the fourteen years between 1 July 2000 and 30 June 2014 (the 'data reporting period') there were a total of 1132 victims of homicide in NSW.<sup>20</sup>

Of the 1132 homicide victims:

- **383** were female;
- **748** were male; and
- **1** homicide victim identified as transgender.

Of the 1132 homicides, **338 (30%)** occurred in a context where there was an identifiable history of domestic violence. Of the 338 homicide victims who were killed in a domestic violence context:

- **207** were female (54% of all female homicide victims; 61% of all domestic violence homicide victims); and
- **131** were male (18% of all male homicide victims; 39% of all domestic violence homicide victims) (Fig.1).

These figures include the deaths of both domestic violence victims and domestic violence abusers (that is, cases where a domestic violence victim kills their abuser). These figures include both adult and child homicide victims.

Every homicide occurring in a domestic violence context in the reporting period has been examined, and the data is considered below in three distinct groups: intimate partner homicides; relative/kin homicides; and 'other' domestic violence homicides.<sup>21</sup>

## Intimate Partner Domestic Violence Homicide

### Incidence – all intimate partner domestic violence homicides

Of the 338 homicide victims who were killed in a domestic violence context in the data reporting period, there were 204 cases (60%) where a person was killed by their current or former intimate partner.

Of these 204 intimate partner homicide victims, the majority (N=162, 79%) were women. Men comprised slightly more than one-fifth of homicide victims in this category (N=42, 21%) (Fig.2).

The 204 intimate partner homicides were perpetrated by 203 offenders; 168 men and 35 women.<sup>22</sup>

### Intimate partner domestic violence homicide – Female victims

All 162 women killed in this category were killed by a current or former male intimate partner (Fig.3).

Almost all of the 162 women who were killed by their male intimate partner in a domestic violence context had been the primary domestic violence victim in the relationship (N=159, 98%).

In three cases where a woman was killed by her male intimate partner, both parties had used domestic violence behaviours against each other and on the information available it was not possible to determine if there was a primary aggressor.

There were no cases where a woman was a primary domestic violence aggressor who was killed by a male primary domestic violence victim (Fig.4).

<sup>20</sup> Excluding open cases.

<sup>21</sup> It is noted that there are seven cases where the death sits across categories due to the homicide being perpetrated by multiple parties (see Review Methodology for further explanation). Accordingly, the sum of the homicides across the three distinct groups gives a figure of 345.

<sup>22</sup> One man killed two male intimate partners 6 months apart.

## Intimate partner domestic violence homicide – Male victims

Of the 42 men killed in this category, 35 were killed by a current or former female intimate partner and 7 were killed by a current or former male intimate partner (Fig.5).

Almost all of the 35 men who were killed by their female intimate partner had been the primary domestic violence aggressor in the relationship (N=31, 89%).

There were no cases where a woman was a primary domestic violence aggressor who killed a male primary domestic violence victim.<sup>23</sup>

All 7 men who were killed by their male intimate partner had been victims of domestic violence in the relationship (Fig.4).

## Intimate partner domestic violence homicide – relationship characteristics

Unless stated otherwise, the information set out below describes the findings from the dataset in terms of the characteristics of the homicide victim and homicide perpetrator (not by reference to who was the domestic violence aggressor or victim in the relationship).

### Current intimate partner relationships

Of the 162 women in this category, most were killed by their current intimate partner (N=102, 63%) (Fig.6).

Of the 102 women killed by their current intimate partner, 46% (N=47) were killed by their de facto husband, 44% (N=45) were killed by their husband, and 9% (N=9) were killed by their boyfriend (Fig.5). One woman was killed by a man with whom she was having a long term covert relationship.

Although the relationships were current at the time of the woman's homicide, in over a third of these cases one or both parties had indicated an intention to end the relationship within three months of the killing (N=42,

41% of all current relationships). This meant that although the parties remained in a relationship at the time of the homicide, in a significant proportion of these cases separation was contemplated or, in some cases, imminent (Fig.6).

Of the 42 male homicide victims in this category, almost all were killed by their current intimate partner (N=36, 86%). This included three cases where one or both of the parties had indicated an intention to end the relationship within three months of the killing (but the relationship remained ongoing) (Fig.6).

### Former intimate partner relationships

Of the 162 female victims of intimate partner homicide, 60 (37%) were killed by a former partner (Fig.6). Of the 60 women killed by a former partner, this included 26 cases where a woman was killed by her former husband (43%); 23 cases where a woman was killed by her former de facto husband (38%); and 11 cases where a woman was killed by her former boyfriend (18%) (Fig.3).

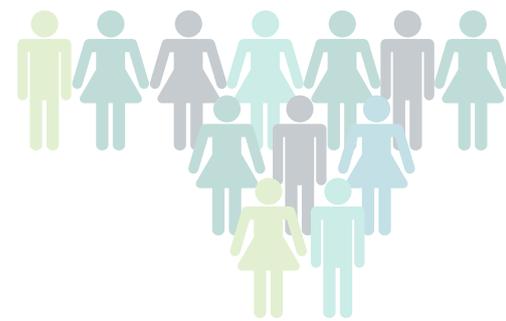
It is important to note that of the 60 women killed by their former intimate partner, almost two-thirds had ended the intimate relationship with the domestic violence aggressor within three months of the killing (N=39, 65%).

As has been noted in previous reports, the data findings for this category of domestic violence homicide continue to support evidence that the period immediately following separation may be particularly dangerous for women who leave an abusive partner<sup>24</sup> and it is critical that this information inform both system and service responses to domestic violence.

Of the 42 male intimate partner homicide victims, six were killed by a former intimate partner (Fig.6) (two former wives, two former de facto wives, one former girlfriend, and one former boyfriend) (Fig.5). Of the six men who were killed by a former partner, one man was killed within three months of the relationship ending.

23 In three cases where a man was killed by his female intimate partner, there had been domestic violence in the relationship perpetrated by both parties. In one case a female perpetrator (acting together with her abusive husband) killed a man she was having a covert intimate relationship with - accordingly, the male homicide victim was neither a domestic violence abuser nor domestic violence victim.

24 Hotton, 'Spousal Violence After Marital Separation' 21(7) Statistics Canada – Catalogue no. 85-002-XIE, 2001, available at <http://publications.gc.ca/collections/Collection-R/Statcan/85-002-XIE/0070185-002-XIE.pdf> (accessed 30 September 2017; Campbell et al, 'Risk factors for femicide in abusive relationships: results from a multisite case control study' (2003) 93(7) American Journal of Public Health 1089.



## Relationship length

Of the 162 women who were killed by an intimate partner, half were killed by an intimate partner with whom they had been in a relationship for five years or less (N=81, 50%). Approximately one quarter of these women (N=21, 26%) were killed by an intimate partner with whom they had been in a relation for less than 12 months. (Fig.7).

For a quarter of women killed by an intimate partner the relationship had been ongoing for longer than 15 years (N=40, 25%). Almost two-thirds of these 40 women (N=25) were killed by an intimate partner with whom they had been in a relationship with for more than 20 years (Fig.7).

Of the 42 men who were killed by an intimate partner, almost two-thirds were killed by an intimate partner with whom they had been in a relationship for five years or less (N=27, 64%) (Fig.7).

Of the 42 men killed by an intimate partner, in five cases the relationship had been ongoing for longer than 15 years (12%) (Fig.7).

## Intimate partner domestic violence homicide – homicide victim characteristics

### Age

Most women killed in this category were between the ages of 25 and 44 years (N=95, 59%).

Of the 162 women killed by an intimate partner, 24 (15%) were aged over 50 years.

The youngest woman killed by an intimate partner was 15 years old and the oldest was aged 80 years (Fig.8).

Most men killed in this category were between the ages of 25 and 49 years (N=27, 64%).

The youngest man killed by an intimate partner was 19 years and the oldest was aged 68 years (Fig.8).

## Region where victim ordinarily resided

Data has been collected in relation to the residential address of each intimate partner homicide victim by reference to the NSW Police Force Region in which the victim was ordinarily resident at the time they were killed (Fig.9). This information is included to assist police in determining operational requirements and priorities for particular police regions.

The highest number of women killed in this category were ordinarily resident in the Northern Region (N=36, 22%), followed by the North West Metropolitan Region (N=35, 22%) (Fig.10).

The highest number of men killed in this category were ordinarily resident in the Northern Region (N=10, 24%), followed by the Central Metropolitan (N=7, 17%) and the Southern Region (N=7, 17%) (Fig.10).

Overall, the highest number of intimate partner homicide victims were ordinarily resident in the Northern Region (N=46, 23%) (Fig.10).

### Country of birth

The rationale for collecting data in relation to country of birth accords with considerations around the availability of appropriate services for perpetrators and victims of violence from culturally and linguistically diverse backgrounds.

Most female (N=112, 69%) and most male (N=33, 79%) intimate partner homicide victims were born in Australia (including Aboriginal and Torres Strait peoples, discussed below) (Fig.11).

Other countries of birth included: New Zealand, Lebanon, India and Fiji (Fig.11).

## Aboriginal and Torres Strait Islander status

New South Wales has the largest Aboriginal and Torres Strait Islander population in Australia (approximately 216,176 permanent residents) and Aboriginal and Torres Strait peoples represent approximately 2.9% of the total New South Wales population.<sup>25</sup>

<sup>25</sup> Australian Bureau of Statistics, Census of Population and Housing 2016, cat. No. 2001.0, 27 June 2017, available at <http://www.abs.gov.au> (accessed 30 September 2017).

Of the 162 female intimate partner homicide victims, 12% identified as Aboriginal (N=20).

Of the 42 male intimate partner homicide victims, approximately one-third identified as Aboriginal (N=13, 31%).

This data demonstrates an overrepresentation of Aboriginal victims of intimate partner domestic violence homicide.

## Intimate partner domestic violence homicide – case characteristics

### Manner of death

One-third of women killed in this category died as a consequence of stab wounds (N=53, 33%). The second most common manner of death was assault (N=37, 23%), followed by shooting (N=26, 16%) and suffocation/strangulation (N=25, 15%) (Fig.12).

Most men killed in this category died as a consequence of stab wounds (N=32, 76%). The second most common manner of death was shooting (N=5, 12%), followed by assault (N=3, 7%) (Fig.12).

### Location of death

Most women in this category were killed in their home (N=127, 78%), followed by a public place (N=16, 10%) (Fig.13).

Most men killed in this category were killed in their home (N=27, 64%), 7 were killed at the homicide perpetrator's home (17%), four were killed at another residence (10%), and three were killed in a public place (7%) (Fig.13).

### Multiple Homicide Events

The term multiple homicide event is used to describe cases where two or more people are killed in an episode of violence.<sup>26</sup>

Of the 204 intimate partner homicide cases there were 10 cases where a perpetrator killed their intimate partner as well as another person/s. Of the 10 multiple homicide events, 9 were perpetrated by men and one by a woman.

Of the 10 multiple homicide events:

- **5** involved the homicide perpetrator killing their intimate partner together with one or more of their children (including step, adopted and/or foster children);
- **1** involved the homicide perpetrator killing their former wife and her new intimate partner; and
- **4** involved the homicide perpetrator killing their intimate partner and another relative/s.

In four of these cases the perpetrator suicided after committing the multiple homicide event (three male homicide perpetrators and one female homicide perpetrator).

## Intimate partner domestic violence homicide – homicide perpetrator characteristics

### Age

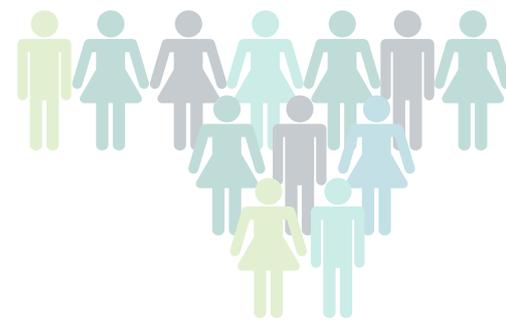
Of the 168 men who killed their intimate partner, almost half were aged between 30 and 44 years (N=80, 48%). The youngest male perpetrator was 17 years old and the oldest was aged 87 years (Fig.14).

Of the 35 women who killed their intimate partner, the highest proportion were aged between 40 and 44 years (N=8, 23%) (Fig.14). The youngest female homicide perpetrator was 20 years old and the oldest was aged 55 years.

### Country of birth

Most men (N=112, 67%) and most women (N=30, 86%) who killed their intimate partner were born in Australia (including Aboriginal Australians, discussed below) (Fig.15).

<sup>26</sup> Cases where a homicide perpetrator kills a single person and then suicides (thus resulting in a total of two deaths) are not classified by the Team as a multiple homicide event.



Other countries of birth included: New Zealand, Lebanon, India and Serbia (Fig.15).

### **Aboriginal and Torres Strait Islander status**

Of the 168 men who killed their intimate partner, approximately 10% identified as Aboriginal (N=16).

Over a quarter of the 35 women who killed their male intimate partner in a context of domestic violence identified as Aboriginal (N=10, 29%).

This demonstrates a significant overrepresentation of Aboriginal perpetrators of intimate partner homicide.

### **Intimate partner domestic violence homicide – criminal/coronial outcomes**

Of the 168 male perpetrators of intimate partner domestic violence homicide, 127 were dealt with by way of criminal proceedings and 41 were subject to coronial proceedings.

Of the 35 female perpetrators of intimate partner domestic violence homicide, 34 were dealt with by way of criminal proceedings and one was subject to coronial proceedings.

### **Criminal proceedings**

Of the 127 male perpetrators of intimate partner domestic violence homicide who were dealt with by way of criminal proceedings, a little under two-thirds were convicted of murder (N=81, 64%) (Fig.16).

The second most prevalent criminal court outcome for men who killed their intimate partners was a manslaughter conviction (including guilty pleas and guilty verdicts of manslaughter) (N=28, 22%) (Fig.16).

Of the 34 female perpetrators of intimate partner homicide who were dealt with by way of criminal proceedings, over half were convicted of manslaughter (N=18, 53%) and just over one-quarter were acquitted (N=9, 26%) (Fig.16).

### **Coronial findings (perpetrator suicide)**

Of the 42 homicide perpetrators who suicided after killing their intimate partner, 41 were male and one was female. Accordingly, almost a quarter (24%) of all male intimate partner homicide perpetrators suicided after murdering their intimate partners, and 3% of all female intimate partner homicide perpetrators suicided after murdering their intimate partners (Fig.16).

## **Relative/kin Domestic Violence Homicide**

### **Incidence – all relative/kin domestic violence homicides**

Of the 338 homicide victims who were killed in a domestic violence context in the data reporting period, there were 109 cases (32%) where a person was killed by a relative/kin in a domestic violence context.

### **Relative/Kin domestic violence homicide – Child victims**

Of the 109 homicide victims killed by relative/kin in a domestic violence context, 65 (60%) were children under the age of 18 years.

Of the 65 children killed by a relative/kin in a domestic violence context, 37 (57%) were boys and 28 (43%) were girls.

### **Relative/Kin domestic violence homicide – Adult victims**

Of the 109 homicide victims killed by relative/kin in a domestic violence context, 44 (40%) were adults over the age of 18 years.

Of the 44 adults killed by a relative/kin in a domestic violence context, 26 (59%) were men and 18 (41%) were women.

## Child relative/kin domestic violence homicide – relationship type

Of the 65 children killed by a relative/kin in a domestic violence context, the vast majority were killed by a biological or non-biological parent (N=63, 97%) and two children were killed by their grandfather (Fig.17).

Of the 63 children killed by a biological or non-biological parent, most were killed by a biological parent acting alone (N=44, 70%) (Fig.17).

Of the 44 children killed by a biological parent (acting alone), most were killed by their father (N=27, 61%). Seventeen children (39%) were killed by their biological mother acting alone (Fig.17).

Of the 63 children killed by a parent, in 14 cases (22%) the child was killed by a non-biological parent acting alone, including their step-father (N=3), de facto step-father (N=9), step-mother (N=1) and foster mother (N=1) (Fig.17).

Three children were killed by their biological mother and father acting together, and two children were killed by their biological mother and de facto step-father acting together.

## Child relative/kin domestic violence homicide – victim characteristics

### Age

The 65 child homicide victims in this category were aged between 4 weeks and 14 years of age. Over half all children killed in a domestic violence context were aged less than 4 years (N=36, 55%) (Fig.18).

Of the 36 children killed who were less than 4 years old, most were aged under 2 years (N=27, 75%) (Fig.18).

### Region where victim ordinarily resided

The highest proportion of the 65 child relative/kin homicide victims killed in a context of domestic violence were ordinarily resident in the Northern Region

(N=18, 28%), followed by the South West Metropolitan Region (N=14, 22%) and Southern Region (N=13, 20%) (Fig.19).

### Country of birth

All but one of the child homicide victims in this category were born in Australia (N=64, 98%), with the other country of birth being India (Fig.20).

### Aboriginal and Torres Strait Islander status

Of the 65 child homicide victims in this category, 20% (N=13) identified as Aboriginal.

## Child relative/kin domestic violence homicide – case characteristics

### Manner of death

Over one-third of the 65 child homicide victims in this category died as a consequence of a physical assault (N=23, 35%), followed by poisoning/noxious substance (N=10, 15%) and suffocation/strangulation (N=9, 14%) (See Fig.21 for complete data).

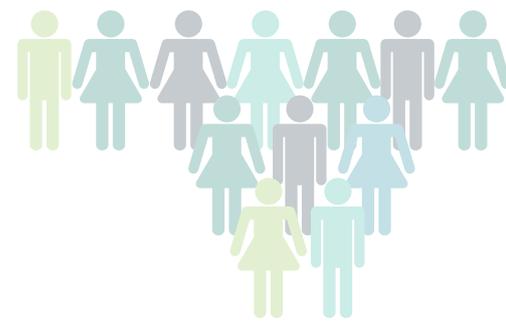
### Location of death

Over three-quarters of the 65 children killed by a relative/kin in a domestic violence context were killed in their home (N=50, 77%). Eight children were killed at the perpetrator's residence (if different from the child's residence) (12%); 5 children were killed in public/open spaces (8%) and 2 children were killed at another residence (3%) (Fig.22).

### Multiple Homicide Events

There were 10 homicide events where a perpetrator killed more than one child (resulting in the deaths of 23 children).

Of the 10 multiple child homicide events, six were perpetrated by the children's biological father, three by the children's biological mother and one by the children's biological grandfather.



## Child relative/kin domestic violence homicide – perpetrator characteristics

The 65 child homicide victims in this category were killed by 57 perpetrators; 36 men and 21 women.

### Age

The youngest male perpetrator in this category was 18 years old and the oldest was aged 69 years (Fig.23).

The youngest female perpetrator in this category was 18 years old and the oldest was aged 39 years (Fig.23).

### Country of birth

Most male (N=26, 72%) and almost all female (N=19, 90%) perpetrators who killed a child in this category were born in Australia (including Aboriginal Australians, see below) (Fig.24).

Other countries of birth included: New Zealand, Egypt, Iran, Vietnam, and the United Kingdom (Fig.24).

### Aboriginal and Torres Strait Islander status

Of the 57 homicide perpetrators who killed a child in this category, 9 (16%) identified as Aboriginal – six males (17% of all male perpetrators in this category) and three female (14% of all female perpetrators in this category).

## Child relative/kin domestic violence homicide – criminal/coronial outcomes

Of the 36 male perpetrators who killed a child in this category, 25 were dealt with by way of criminal proceedings and 11 were subject to coronial proceedings.

Of the 21 female perpetrators who killed a child in this category, 19 were dealt with by way of criminal proceedings and two were subject to coronial proceedings.

## Criminal proceedings

Of the 25 male homicide perpetrators in this category who were dealt with by way of criminal proceeding, 52% (N=13) were convicted of manslaughter; 40% (N=10) were convicted of murder; and one (4%) was found not guilty by reason of mental illness (Fig.25). In one case the homicide perpetrator died prior to trial and the matter was accordingly no-billed.

Of the 19 female homicide perpetrators in this category who were dealt with by way of criminal proceedings, 74% (N=14) were convicted of manslaughter; 21% (N=4) were convicted of murder; and one (5%) was found guilty of infanticide (Fig.25).

## Coronial findings (perpetrator suicide/death)

Almost a quarter of all homicide perpetrators who killed a child relative/kin in a domestic violence context suicided (N=13, 23%).<sup>27</sup>

This included 11 males (31% of all male perpetrators in this category) and two females (10% of all female homicide perpetrators in this category) (Fig.25).

## Adult relative/kin domestic violence homicide – relationship type

Of the 44 adults killed by a relative/kin in a domestic violence context, 26 (59%) were men and 18 (41%) were women.

Of the 26 men killed by a relative/kin in a domestic violence context, 46% (N=12) were killed by their son/step-son. In the other 14 cases the man was killed by his:

- daughter/step-daughter (N=3);
- son-in-law (N=3);
- brother (N=2);
- brother-in-law (N=2);
- father (N=1);
- mother-in-law (N=1);
- nephew (N=1); and
- son and grandson acting together (N=1, Fig.26).

<sup>27</sup> This included one perpetrator who died accidentally as a consequence of burns after he killed his intimate partner and her son.

Of the 18 women killed by a relative/kin in a domestic violence context, 50% (N=9) were killed by their son/step-son. In the remaining 9 cases the woman was killed by her:

- daughter/step-daughter (N=3);
- brother-in-law (N=1);
- nephew (N=1);
- cousin (N=1);
- extended family/kin (N=1);
- son-in-law (N=1); and
- son and daughter acting together (N=1, Fig.26).

Of the 44 adult homicide victims who were killed by a relative/kin in a domestic violence context, 24 (55%) were victims of domestic violence who were killed by a domestic violence abuser. Twelve homicide victims (27%) were domestic violence abusers who were killed by a domestic violence victim.

In five cases the homicide victim was neither a domestic violence victim or a domestic violence abuser meaning that they were killed by an abusive relative but had not ever been the direct target of that relative's abusive behaviour prior to the fatal assault. In four of these cases the abuser's primary victim/s was also killed in the fatal assault and in one case a woman was killed when she questioned her relative about his abusive behaviour towards another person.

The remaining three cases involved homicides where there had been physical and/or psychological violence perpetrated by both the homicide victim and the homicide perpetrator.

## Adult relative/kin domestic violence homicide – victim characteristics

### Age

Adult homicide victims in this category were aged between 23 and 84 years.

Most male victims were aged between 50 and 64 years (N=12, 46%) while most female victims were aged 45-49 years (N=6, 33%) (Fig.27).

## Region where victim ordinarily resided

The highest proportion of adult relative/kin homicide victims killed in a context of domestic violence were ordinarily resident in the Northern Region (N=13, 30%), followed by the South West Metropolitan Region (N=11, 25%) and North West Metropolitan Region (N=11, 25%) (Fig.28).

## Country of birth

Over half of all the adult homicide victims in this category were born in Australia (N=28, 64%). Other countries of birth included New Zealand, the United Kingdom, Italy, Romania, Iraq, Lebanon and India (Fig.29).

## Aboriginal and Torres Strait Islander status

Of the 44 adult relative/kin homicide victims killed in a domestic violence context, 16% (N=7; 2 men, 5 women) identified as Aboriginal.

Accordingly, of the 18 female homicide victims in this category, 28% identified as Aboriginal (N=5). Of the 26 male homicide victims in this category, 8% (N=2) identified as Aboriginal.

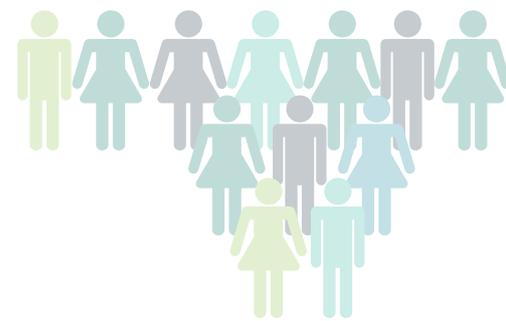
## Adult relative/kin domestic violence homicide – case characteristics

### Manner of death

Over half of all adult homicide victims killed by a relative/kin in a domestic violence context died as a consequence of stab wounds (N=23, 52%). Other manners of death for adult homicide victims in this category included:

- shooting (N=8);
- suffocation/strangulation (N=4);
- assault (N=3); and
- multiple causes (N=3).

In two cases the cause of death was unknown (Fig.30).



## Location of death

Of the 44 homicide victims in this category, almost all were killed in their home (N=38, 86%) (Fig.31).

Men were also killed in public/open places, other residences, and at the perpetrator's residence. One woman was also killed in public place (Fig.31).

## Multiple Homicide Events

There were five multiple homicide events involving a perpetrator killing an adult relative as well as another person/s, as described below:

- **1** case where a domestic violence abuser killed his father-in-law and his ex-partner;
- **1** case where a domestic violence abuser killed his brother-in-law and his wife;
- **1** case where a domestic violence abuser killed his father-in-law and his two children;
- **1** case where a domestic violence victim killed her abusive parents; and
- **1** case where a domestic violence abuser killed his father and step-mother.

## Adult relative/kin domestic violence homicide – perpetrator characteristics

The 44 adult homicides in this category were committed by 43 perpetrators, noting that in one case a man was killed by his son and grandson acting together. Of the 43 perpetrators, 36 were male and 7 were female.

## Age

The youngest male perpetrator in this category was 14 years and the oldest was aged 59 years (Fig.32).

The six female perpetrators who killed an adult in this category were aged between 13 years and 70 years (Fig.32).

## Country of birth

Of the 43 relative/kin homicide perpetrators who killed an adult victim, about two-thirds were born in Australia (67%, N=29).

Almost two-thirds of male perpetrators (64%, N=23) and almost all female perpetrators (86%, N=6) in this category were born in Australia (including Aboriginal Australians, see below).

Other countries of birth included: Lebanon, Italy, Romania, Iraq, Thailand, and the United Kingdom (Fig.33).

## Aboriginal and Torres Strait Islander status

Of the 43 relative/kin homicide perpetrators who killed an adult victim, 16% identified as Aboriginal (N=7, six males and one female).

## Adult relative/kin domestic violence homicide – criminal/coronial outcomes

Of the 36 male perpetrators who killed an adult in this category, 33 were dealt with by way of criminal proceedings and in 3 cases the matter was subject to coronial proceedings.

Of the 7 female perpetrators who killed an adult in this category, all were dealt with by way of criminal proceedings.

## Criminal proceedings

Of the 33 male homicide perpetrators who were dealt with by way of criminal proceedings, a high proportion were found not guilty by reason of mental illness (42%, N=14). For the other 19 perpetrators, 33% (N=11) were convicted of murder; 21% (N=7) were convicted of manslaughter; and one (3%) was acquitted on the basis of self-defence (Fig.34).

Of the 7 female homicide perpetrators, two (29%) were found not guilty by reason of mental illness; two (29%) were convicted of murder, two (29%) were convicted of manslaughter, and one (14%) was acquitted on the basis self-defence (Fig.34).

## Coronial findings (perpetrator suicide)

Of the 43 homicide perpetrators in this category, three (7%, all male) suicided immediately after the homicide (Fig.34).

## 'Other' domestic violence homicide

### Incidence – all 'other' domestic violence homicides

Between 1 July 2000 and 30 June 2014, there were 32 cases where the homicide victim had no direct domestic relationship with the homicide perpetrator but the circumstances of the death were such that it was determined to have occurred in a context of domestic violence.

Examples of 'other' domestic violence homicides include cases where a bystander is killed intervening in domestic violence, or where a new intimate partner is killed by a domestic violence victim's former abusive partner.

Of the 32 homicide victims in this category, 31 were men and one was a woman.

There were 33 homicide perpetrators in this category, noting that one man was killed by both the husband and son of a woman with whom he was having a covert relationship.

All but two of the homicide perpetrators in this category were men.

### 'Other' domestic violence homicide – relationship characteristics

Most homicide victims in this category were 'new intimate partners' (N=20, 63%) who were killed by their wife or girlfriend's former abusive male partner.

In a high proportion of these cases, the male homicide perpetrator's coercive and controlling behaviours against his former female partner continued after the dissolution of the relationship and the abuser's behaviour intensified after his former partner started a new relationship.

Additional relationships in this category included:

- **4** cases where the homicide perpetrator killed their current wife/girlfriend's former domestic violence abuser;
- **2** cases where the homicide victim was a bystander intervening in domestic violence between the homicide perpetrator and his female partner;
- **2** cases where the homicide victim was killed by their daughter's abusive boyfriend;
- **1** case where a domestic violence abuser was killed by a person intervening in domestic violence between the homicide victim and a family member;
- **1** case where a man was killed by his abusive flatmate;<sup>28</sup>
- **1** case where a domestic violence abuser was killed by a contract killer who was hired by the domestic violence victim; and
- **1** case where a woman was killed by an acquaintance who was acting together with her former abusive partner.

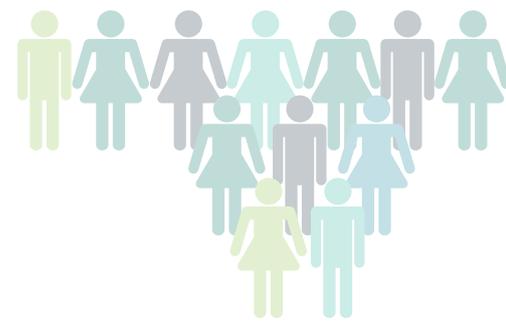
### 'Other' domestic violence homicide – victim characteristics

As noted above, all but one of the 32 homicide victims in this category were men.

#### Age

Homicide victims in this category were aged between 21 and 64 years (Fig.35).

28 In August 2016, amendments to the Coroners Act 2009 (NSW) commenced such that a flat mate would now be considered a 'domestic relationship' for the purposes of review by the Team.



### Region where victim ordinarily resided

The highest number of homicide victims in this category were ordinarily resident in the Northern Region (N=7, 22%), followed the Central Metropolitan Region, North West Metropolitan Region and Western Region, each of which had 5 homicide victims (16%) (Fig.36).

### Country of birth

Three-quarters of homicide victims in this category were born in Australia (N=24, 75%), with other countries of birth including New Zealand, India, Malaysia, the Cook Islands, Fiji, the United Kingdom, the Netherlands, and Korea (Fig.37).

### Aboriginal and Torres Strait Islander status

Two homicide victims in this category identified as Aboriginal (6%).

### 'Other' domestic violence homicide – case characteristics

#### Manner of death

Most homicide victims in this category died as a consequence of stab wounds (N=19, 59%), followed by shooting (N=10, 31%); assault (N=2, 6%); and one homicide victim died as a result of multiple causes (3%) (Fig.38).

#### Location of death

Most homicide victims in this category were killed in their own home (N=14, 43%), followed by the perpetrator's residence (N=9, 28%); other residence (N=5, 16%); and public place (N=4, 13%) (Fig.39).

### 'Other' domestic violence homicide – perpetrator characteristics

As noted above, there were 33 homicide perpetrators in this category, 31 men and two women.

### Age

Homicide perpetrators in this category were aged between 16 and 69 years (Fig.40).

### Country of birth

Over two-thirds of all the homicide perpetrators in this category were born in Australia (N=22, 68%).

Other countries of birth included: Indonesia, New Zealand, Lebanon, the Cook Islands, Fiji, United Kingdom, the Netherlands, Korea, Hungary and the Philippines (Fig.41).

### Aboriginal and Torres Strait Islander status

Three homicide perpetrators in this category identified as Aboriginal (9%).

### 'Other' domestic violence homicide – criminal/coronial outcomes

Of the 33 perpetrators in this category, 31 were dealt with by way of criminal proceedings (29 male perpetrators and two female perpetrators). In two cases the matter was finalised by way of coronial proceedings.

#### Criminal proceedings

Of the 31 perpetrators in this category who were dealt with by way of criminal proceedings, just under half were convicted of murder (N=15, 48%) and 42% (N=13) were convicted of manslaughter.

Three homicide perpetrators (10%) in this category were acquitted, one on the basis of self-defence and two on the basis of defence of another (Fig.42).

#### Coronial findings (perpetrator suicide)

Two male perpetrators in this category suicided after the homicide and accordingly the matter was finalised by way of coronial proceedings (Fig.42).

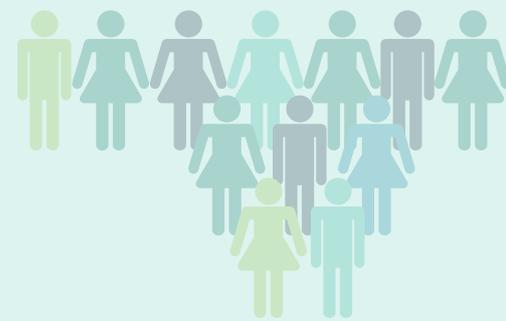
# Case Review Summaries

## Domestic Violence Homicide 2012-2014

This chapter sets out the 53 domestic violence homicides reviewed by the Team for the reporting period 1 July 2012 to 30 June 2014. Each case was subject to in-depth analysis by the Team in a series of full day workshops to identify common themes, issues and areas for recommendation.

**WARNING:** these case summaries include information that some readers may find distressing. The details in these summaries are included to assist readers in understanding the complex dynamics of domestic violence and the characteristics of these cases. The Team hopes that these commentaries can help readers to understand more about these tragedies, so we can learn from these deaths and prevent future losses of life.

Names in these cases have been changed to protect the identities of people involved and respect the privacy of surviving family and friends.



# Intimate partner domestic violence homicide

## Domestic violence victim killed by domestic violence abuser

### Case Review 3340

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This case involved the stabbing homicide of a woman, Joan, by her abusive boyfriend, Garth.

Joan grew up in a coastal town with her mother. She was sexually abused as a young child by her step-grandfather, who was charged and convicted in relation to these offences, and served a custodial sentence. In her late teens Joan moved out of home to live with her boyfriend Travis. Travis was abusive towards Joan, and police became involved on a number of occasions, including applying for an ADVO protecting Joan from Travis.

After Joan ended her relationship with Travis, she was involved in a serious car accident which left her with profound injuries, including an acquired brain injury and a physical disability. After the accident Joan suffered from depression, and started using cannabis on a daily basis. She received compensation as a consequence of the accident and used this to buy a car and house. At some point Joan started a new relationship with a man called Quentin, but after their relationship ended he started stalking and harassing her. He also assaulted her, for which she was compensated under the Victims Compensation Scheme (as it then was). Police applied for an ADVO protecting Joan from Quentin. In relation to this contact with police, the police narratives notes that Joan was aggressive and uncooperative, but that this behaviour was consistent with her having an acquired brain injury.

Some time after her relationship with Quentin ended, Joan started seeing Garth. Joan and Garth's relationship had been on foot for 7 weeks when he murdered her.

Garth was born in Sydney, and told the forensic psychiatrist (after the homicide) that he was physically and sexually abused during his childhood. He left school in year 10, and around this time he started using alcohol and drugs. His mother described that he was physically abusive and aggressive as a young person, and that these behaviours continued into his adult life.

Garth had a long history of offending against prior partners. His first partner Ruby described him as controlling, manipulative and abusive. He isolated Ruby from family and friends and would regularly kick and punch her throughout their relationship. He controlled who Ruby could see, her finances, and was physically abusive towards her pets. Garth would be violent when he was drinking, but would also use violence when he had not been drinking. He would tell her it 'wouldn't happen again' after episodes of violence, but also threatened to kill her if she ever left him. Eventually, after many years of living in fear of her life, Ruby managed to escape Garth.

Garth's next partner, Maya, described him as being controlling and abusive towards her. He would text her incessantly, and would threaten to suicide if she left him.

On one occasion police applied for an ADVO protecting Maya which Garth breached the day it was served, and continued to breach over subsequent days. He was charged in relation to these breaches, however he continued to breach the ADVO and bail conditions by contacting Maya in breach of the order, and by failing to attend his bail reporting requirements. Garth was convicted in relation to these offences and received a 12 month suspended sentence and fine.

Around the time Garth was offending against Maya, he was also in a relationship with a woman called Bridgette. Garth was verbally abusive and threatening towards Bridgette both during their relationship and after it ended. He threatened to kill her, and she reported his abusive behaviours to police who applied for an ADVO protecting her. Garth was charged with assaulting Bridgette following an episode of violence in which he punched her in

the face. He was bailed and again failed to comply with his bail conditions. When he appeared before the Local Court, Garth was referred into the MERIT program (for drug and alcohol rehabilitation).

While he was a resident at the rehabilitation facility, Garth was breaching his ADVO with Bridgette by turning up to her house (while on day release). Police charged him with breaching the ADVO, however the rehabilitation facility was unaware that he had been offending while on leave from the facility.

Garth successfully completed the MERIT program and left the facility. He started drinking within days of leaving the facility.

A few weeks before the homicide, Garth met Joan through a mutual friend and they commenced an intimate relationship. Garth moved in to Joan's house. Little is known about their relationship, other than the fact they 'argued' regularly over the short period they were together.

The day of the homicide, Garth had been drinking and he and Joan argued. Garth ferociously attacked Joan, stabbing her multiple times. The circumstances surrounding her homicide are not clear as there were no witnesses. Garth then left the premises and travelled into the city where he continued to drink. The next day he told his mother that he had killed Joan. He approached a police officer at the train station and told them he was wanted for Joan's murder. He was arrested and charged. He was initially found unfit to be tried, but in a special hearing was found guilty of manslaughter on the basis of substantial impairment and sentenced to a limiting term of just over 11 years.

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## Case Review 3492

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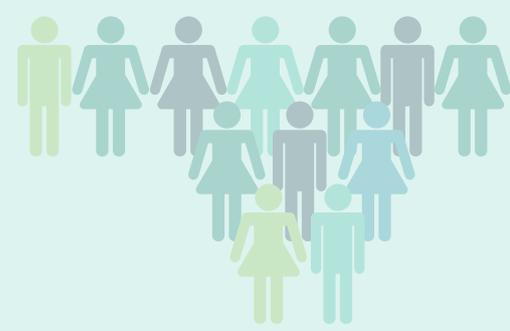
This case involved the homicide of a woman, Saya, by her abusive estranged husband Ganesh. Saya was protected under an ADVO naming Ganesh as the defendant when he killed her, and Ganesh was on bail for sexual assault offences against Saya.

Both Ganesh and Saya grew up in Fiji and were Fijian Indian. Ganesh and Saya were biological cousins and their marriage was arranged by family members. It is not clear when they moved to Australia, but after they moved to Australia they had three children.

At the time of the homicide Ganesh and Saya had been married for over 20 years and had recently separated.

From early in their relationship Ganesh was abusive towards Saya and the children described witnessing their father's violence against their mother. They described that the violence had escalated in the years prior to the homicide, and that Ganesh would regularly verbally abuse and denigrate Saya in front of them. Ganesh had also threatened to kill Saya and had held a knife to her throat. Saya had also told her eldest daughter that Ganesh regularly physically abused her. Ganesh would taunt and tease Saya, including in front of the children, and tell her he had married someone else. He also threatened Saya that he would kill her and 'chop her up' in the house. On one occasion Ganesh assaulted Saya and caused her to suffer a miscarriage.

While their relationship was on foot the police were involved on only one occasion. On this occasion Saya called the police and Ganesh disconnected the call. The police attended but the children pleaded with their mother not to speak to police. After their relationship ended, however, Saya started engaging with police more regularly. Saya and Ganesh initially continued to co-habitate after they separated and Ganesh's violence towards Saya worsened. After an assault where Ganesh chased Saya and threw water on her, she called police and police applied for an ADVO protecting Saya from Ganesh. After he was served the ADVO, Ganesh attended the police station to enquire about getting an ADVO to protect himself. When police attended to serve a provisional ADVO on Saya (protecting Ganesh), she disclosed to them his serious history of violence against her. Saya was required to attend court but it would appear that the cross ADVO did not progress. The ADVO protecting Saya from Ganesh was finalised.



Through attending court Saya became linked in with domestic violence services and court assistance and the local Domestic Violence Liaison Officer (DVLO). Saya made a report about Ganesh's violence, but the report was not completed and charges were not progressed at this stage. She engaged with police on a number of occasions over the following month, started engaging with a Family Lawyer and eventually, a few months prior to her murder, attended the police station and reported that Ganesh had attempted to sexually assault her that month, and also had historically raped her during their marriage. Saya spoke to her doctor at the time of the rape however the doctor did not take any action in respect of her disclosures.

Following Saya's reports, Ganesh was charged with sexual assault offences and was released on bail to live with relatives in an adjoining suburb. He was precluded from approaching the family home where Saya lived. Saya started working with a caseworker from Staying Home Leaving Violence around this time, and Saya told the case worker that her family were pressuring her to drop the charges against Ganesh.

Around this time Saya and the children went overseas. When they returned Saya noticed that her house had been broken into and some things had been stolen and that her tyres had been slashed. Saya told her caseworker that she had advised police that she thought Ganesh had done this however the police record in relation to the break in does not reflect this. Saya's caseworker arranged for her locks to be changed,

Over the next few weeks there were a number of contacts between Saya and the police including one in which Saya wanted her children brought home when Ganesh had not returned them after a parenting visit. Police officers attended and spoke to Saya, but did not bring the children back. Saya became extremely upset and police told her that she needed to settle down if they were to be able to help her. Saya told her caseworker that after this episode, and the break and enter, she had 'lost faith' in police, and the caseworker started to try and rebuild Saya's confidence in the system by arranging for a meeting with a DVLO in the coming weeks.

The day of the homicide, Ganesh followed Saya home from an appointment she had attended, went into the house and murdered her by suffocating her. He broke a window and took several items from the house, before returning to the relatives' house where he was bailed to live. When the children could not get back into the home, they contacted relatives and reported that their mother was missing. The following day police attended the home and found Saya deceased on the bed.

Ganesh denied any involvement but was charged with murder and the matter went to trial. Due to a number of administrative errors, Ganesh was able to remove a caveat on the family property that Saya had lodged and was able to sell the family home to fund his defence in breach the forfeiture rule.

Ganesh was found guilty of murder and sentenced to over 20 years imprisonment.

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## Case Review 3299

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This case involved the homicide of Miriam, a woman aged in her 40s, by her abusive boyfriend Tim, who was aged in his late 30s.

Miriam had grown up in Australia and by her late teens had a substance use disorder. In her early 20s she started on the Opioid Treatment Program to address her dependence issues.

Miriam had two children as a young woman, but the eldest child lived with other family members. Miriam's son Charles continued to live with her in FACS-Housing premises in a metro area, and she had lived in the same house for many years as at the time of her homicide. While Miriam disclosed that she had had abusive partners in the past, she did not have many long term relationships until she met Tim.

Tim grew up in regional NSW and was abused by his father as a child. He was diagnosed as having developmental delay at an early age as a consequence of child abuse. Tim and his sister were taken into state

care, and lived with foster carers throughout their childhood. Tim's mother died in a car crash while he was still very young. While living with foster carers Tim struggled at school and was expelled for assaulting a teacher in year 8. Around this time, he started using cannabis, and started a relationship with a school friend's mother, Yael. This relationship lasted 14 years, and throughout the relationship Tim was both physically and verbally abusive towards Yael, and was sexually abusive towards her two daughters from a previous relationship. He was later convicted of some offences relating to his offending against Yael's daughters. Tim and Yael had a son who was removed by FACS-Community Services at a young age.

Tim worked intermittently as a sex worker and during this time became drug dependant. He was admitted as an inpatient at a psychiatric unit twice in his early 20s as a result of drug induced psychosis. He had a long criminal history, including periods of imprisonment, for violent and non-violent offences, drug offences and other crimes.

After ending his relationship with Yael, Tim started a relationship with a man called Eric. Tim and Eric would use drugs together, and throughout their relationship Tim was verbally and physically abusive towards Eric. Tim threatened to kill Eric, damaged property, threatened him with a knife and after a violent attack before their relationship ended, was scheduled under the mental health legislation.

Tim met Miriam when he moved into her FACS-Housing unit complex. They soon started a relationship, and Miriam's friends noticed that her appearance deteriorated and her demeanour changed. Miriam's friend believed that Tim was a predator who 'targeted her' because of her vulnerability. The friend also saw episodes in which Tim would physically assault Miriam, grabbing her by the hair. Neighbours overheard numerous arguments and fights and made numerous reports and complaints to FACS-Housing. Police attended in relation to callouts on numerous occasions, but no charges or ADVOs were ever progressed.

In the months prior to the homicide, friends and family noticed that Miriam had visible injuries, including a broken nose, cut eye and bruising to her arms and ribs, and on one occasion Charles overheard Tim threatening Miriam with a knife. Miriam was attending her Opioid Treatment Program dispensary on a daily basis throughout this time and was presenting with these serious injuries.

The night before the homicide Miriam visited her friend who observed visible injuries around Miriam's neck and the friend believed that Miriam had been strangled. Miriam also told her friend that Tim had recently stabbed her son, and appeared upset and depressed.

The morning of the homicide Tim and Miriam were overheard arguing for around 15 minutes before a neighbour saw Miriam screaming on the balcony, covered in blood and having been stabbed. A number of residents witnessed Miriam collapse on the balcony and called police and ambulance. Tim was arrested and charged with her murder. He initially claimed it was an accident, but later pleaded guilty and was sentenced to over 15 years imprisonment.

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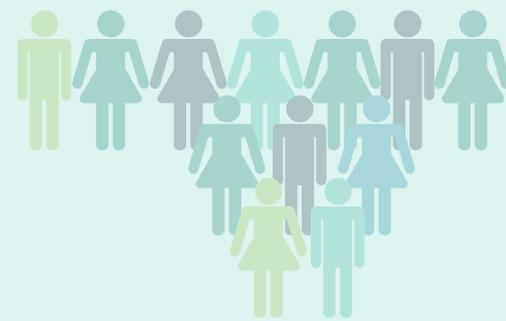
## Case Review 3691

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This case involved the murder of a woman, Sheree, by her estranged husband Roy. After murdering Sheree Roy suicided.

Roy grew up in rural NSW and lived in rural areas his whole life. He had a close relationship with his family, but struggled at school and had numeracy and literacy issues. Roy started using drugs and alcohol when he was around 18 years old and spent periods of time receiving treatment for his drug and alcohol use. Roy and Sheree met as teenagers and were in a relationship for a short period of time before Roy ended the relationship.

After he broke up with Sheree, Roy had a relationship with a woman called Tiffany. They met at a rehabilitation centre where Tiffany was employed as a health worker and Roy was a patient. They had two children together, and after their relationship ended Roy became increasingly abusive towards Tiffany. After their relationship ended



Tiffany and Roy continued to live together in the same house, and Roy resumed a relationship with Sheree, inviting her to come and live in the house with Tiffany and him. Tiffany ended up seeking refuge accommodation with her children, and she and Roy went through 'bitter' family court proceedings. In her Family Court affidavit, Tiffany noted that Roy was extremely abusive towards her, threatened to kill her and her parents, and, on one occasion, held the children hostage until she signed legal documents seeking to remove her name from the deeds to the house. He also threatened on one occasion to drive the car, with the two boys in it, off a cliff.

Little is known about Sheree's early life. After she and Roy first broke up, she commenced another relationship and had three children. After that relationship ended, Sheree reconnected with Roy and, as noted above, they started living together in the house he initially shared with Tiffany. From early in their relationship, Sheree's children witnessed episodes of violence by Roy against Sheree. Roy and Sheree would regularly fight and on occasions Roy would grab a knife and stab items of household furniture. During one of these episodes, Roy slit his own throat with a knife and almost died, but eventually recovered. Sheree's son described that Roy would get very angry and punch things.

Both Roy and Sheree had significant medical intervention in relation to their respective physical and mental health issues. Both Roy and Sheree had attended the same counselling service, and Sheree disclosed to her counsellor that Roy was verbally abusive, and her mood was low. The counsellor discussed some strategies for coping, and ways in which Sheree might be able to rebuild her self esteem. In the months after this, Roy disclosed to his counsellor that he was having 'anger management issues' and that he would take his anger out on Sheree. His counsellor discussed some strategies to help Roy manage his anger. Both Roy and Sheree continued to engage with the counsellors, but it would appear that the counsellor never recognised the violence.

A few days before the homicide Sheree ended her relationship with Roy. Sheree's daughter said that Roy did not 'take the break up well' and described him as being an 'emotional wreck.' Roy told Sheree's daughter that he wanted to kill himself, and the daughter told him not to be ridiculous. Roy left their house and went and stayed with a relative nearby. He continued to tell his relatives that he wanted to reconcile with Sheree, but he was concerned that she had a new partner. Roy and Sheree continued to text one another, and one of Sheree's friends told Roy that she had started a new relationship. Roy told family and friends that he wasn't coping and continued to make comments about suiciding.

The day before the homicide, Sheree changed her Facebook status to 'single'.

The day of the homicide, Roy went to Sheree's house and murdered her by strangling her with a rope. He then drove out into the bush and suicided.

The matter was finalised by way of inquest.

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## Case Review 3495

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This case involved the murder of a woman aged in her early 30s, Lata, by her husband Manoj who was aged in his 40s.

Lata had grown up in India and was educated to a tertiary level and worked as a beauty therapist. She had a close relationship with her family, particularly her sister Anika. Manoj was also born in India to a large family. After finishing high school, he worked in trades, and moved overseas for work.

Lata and Manoj had an arranged marriage and had a child Rajiv in India, before all three moved to Australia. After moving to Australia Lata worked as a beauty therapist and Manoj worked in trades.

From early in their relationship there are indications that Manoj was violent towards Lata. A number of years before the homicide Police attended the couple's premises after Manoj had hit Lata on the head with a pole. After being hit by Manoj, Lata grabbed a knife and threatened Manoj. Both parties had physical injuries and police applied for cross ADVOs, which were later withdrawn/dismissed at court.

At some point Lata and Manoj started sleeping in separate rooms. When Anika came to visit she noticed that Manoj would stare at her, and he would also kiss Anika and touch her in ways she believed were inappropriate. Anika also noticed that Manoj would listen in on Lata's phone conversations and would argue with her constantly. Lata started telling her sister about the way in which Manoj would control their money, and how he resented her independence and her working. Lata told her sister that Manoj would try and dominate her by not allowing her access to money and that he would constantly check her bank and email accounts.

Anika also witnessed Manoj assault Lata on one occasion, where he pulled her hair, punched her and verbally denigrated her. Police attended following this assault, but Lata and Manoj denied that anything had happened. After this assault, the couple separated and Manoj moved out. Around this time Rajiv was sent to boarding school in India.

Lata and Manoj divorced. Lata opened her own beauty salon and Manoj advised her he was going to remarry in India. Manoj travelled to India and his brother told Lata that he was married. Lata was concerned that he was going to assume custody of Rajiv in India, and arranged to get family law advice in Sydney. When Manoj returned from India, he told her that he wanted to reconcile. He moved back in to live with Lata but they continued to sleep in separate rooms.

In the months leading up to the homicide, Lata and Manoj continued to discuss reconciling, but neighbours overheard fighting and arguing on numerous occasions. In the days before the murder, Lata had told her sister that Manoj had been searching the internet about 'murder' and 'suicide', and that he had been searching 'how to burn a unit by gas leak', and 'prison sentences for murder'.

The morning of the homicide, Manoj called a relative in India and told them that he had murdered Lata. He hung up the phone and the family members tried to contact the police in Australia. A few hours later Manoj contacted police, and he told them he had murdered Lata by hitting her on the head with a metal pole and stabbing her numerous times, while she tried to defend herself. He told officers after he was arrested that Lata had come at him with a knife and he had acted in self-defence. Investigating police identified that Lata had been strangled in addition to being assaulted and stabbed. They also found that the batteries had been removed from the smoke detector in the unit and located a gas-lighter in the lounge room.

While awaiting trial, Manoj hanged himself in his cell.

The case was finalised by way of inquest.

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## Case Review 3049

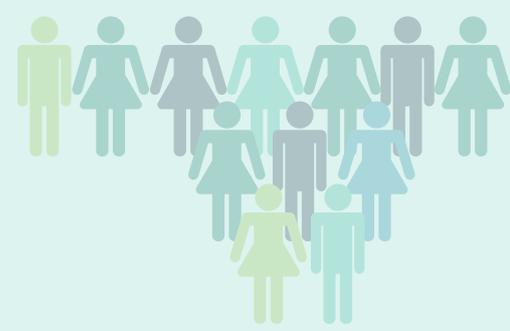
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This case involved the murder of a young woman, Matilda by her abusive boyfriend Maddox. Maddox was on parole when he murdered Matilda.

Matilda was born in metropolitan NSW and grew up primarily in the care of her mother. She left school in year 10 and completed her school studies through a university program. She worked in a corporate role at the time of her murder, and split her time living between her father, her mother and Maddox's family.

Maddox had also been born in metropolitan NSW and identified as Aboriginal. As he was growing up he witnessed his father's domestic violence against his mother and also suffered physical abuse from his father. After his mother left his father, his father stalked the family and they constantly moved to escape him. As a consequence, he had difficulty at school and he left in year 9. After leaving school he started using drugs and alcohol, and described hanging out with friends who encouraged him to use violence. Maddox had one child, Elly, from an earlier relationship, and there is evidence that he was abusive towards his former partner.

Maddox and Matilda met at a concert and from early in their relationship Maddox was violent towards Matilda. Maddox was very controlling of Matilda, and she stopped seeing many of her friends. Several months into their



relationship Maddox assaulted a stranger and was charged with assault offences (which were pending at the time of the homicide). Around this time, he was also arrested and charged with drug supply offences, and served a period of time in custody.

After Maddox was released from gaol he assaulted Matilda a number of times, including in front of his family. Friends and family observed Matilda with bruises and injuries on a number of occasions. On another occasion Matilda's mother Bess overheard Maddox swearing and yelling at Matilda on the phone, and when she got on the phone and told Maddox he needed to respect Matilda, Maddox threatened to kill Bess.

Matilda's father also overheard Maddox yelling at Matilda on the phone, and had noticed in the lead up to the homicide that Matilda was losing weight. Matilda had also told her father that she was scared of Maddox.

In the weeks prior to the homicide, Matilda came to work with a bruised eye, which she tried to cover with makeup. When questioned about her injury, Matilda told her supervisor that Maddox had caused it and further disclosed that Maddox was stalking her, and that she regularly had to change her route to and from work because she was scared of him following her. The supervisor suggested that Matilda go to the police.

A few days before the homicide Matilda's mother moved, and Matilda was living in her mother's unit alone for a few days until her brother was to move in.

The day of the homicide, Matilda was at home with a few friends when Maddox called and started abusing her over the phone. During this call Maddox threatened to kill her and her father, and Matilda said that she had enough and wanted to end their relationship. Her friends overheard the conversations.

Matilda, concerned for her father, told Maddox to come to the unit and talk to her in person. He called several more times over the next few hours and her friends, concerned about leaving her alone, offered for her to come and stay with them. She refused their offers, and they eventually left the apartment. Matilda also spoke to her mother who told her to push something heavy against the door if she was scared.

Maddox came to the unit complex and Matilda let him upstairs. Once upstairs, Maddox brutally assaulted Matilda over a prolonged period and she died of assault injuries consistent with beating, knee drops and stomping injuries. Evidence in the apartment indicated that he had dragged her around from room to room, and tried to shower her. Maddox left Matilda on the floor of the apartment and was captured on CCTV leaving the unit about half an hour after Matilda had let him in.

Maddox told his friend (who was waiting outside) to call 000 and pretend to be a neighbour, which the friend did, however he did not have the correct address. The ambulance arrived after Maddox and his friend had left, but they couldn't establish the correct unit and left.

Over the next few days friends and family tried to contact Matilda, but believed that she had turned her phone off and was just not answering calls. Her brother found her deceased in the unit several days later.

A few weeks after Matilda's murder, Maddox was charged with her murder. Maddox was ultimately found guilty of Matilda's murder and sentenced to over 30 years imprisonment.

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## Case Review 3553

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This case concerned the homicide of a man called Richard by his abusive de facto husband Troy in their shared FACS-Housing residence in metropolitan Sydney. Richard was named on the lease, and Troy was staying in the premises in breach of Richard's tenancy conditions.

Richard was born in New Zealand and had immigrated to Australia during his 20s. Richard would sometimes use the name Ricki and present as a female, however he did not identify as transgender and used the pronouns he/him. Richard had three sisters with whom he was close.

Troy was born in Sydney as one of 8 siblings. Troy described being abused by his father throughout his childhood and described being sexually abused by boarders who would stay at the family home. Troy left school in year 7 and had limited reading or writing ability.

Both Troy and Richard had long term problematic drug and alcohol use.

Troy had a long history of violence against previous partners including a number of convictions, and at the time of the homicide he was a defendant under a current enforceable ADVO protecting his ex-wife Isla. Troy's history of reported and unreported violence against former female partners did not form part of the homicide case.

Troy was violent towards Richard throughout their relationship. Troy would control Richard's money, and friends and family noticed that Richard would regularly have bruising and injuries which he told them Troy had caused, including burn marks from Troy extinguishing cigarettes on him. Richard told his family that he was scared of Troy.

At the time of the homicide Troy was in regular contact with a faith based counselling service. This organisation had provided him with support and counselling, including in relation to drug and alcohol use, over a number of years. Representatives of the organisation also provided a positive character reference for Troy when he was being sentenced for a serious physical assault against his former wife Isla.

Despite Troy's long history of violence against Richard, the only episode of police contact concerning Troy's violence towards Richard occurred less than a week prior to the homicide.

After witnessing Troy assault Richard with a piece of wood, a neighbour called the police and requested they attend. The job was not coded as a domestic violence callout as despite the neighbour being aware that Troy and Richard were in an intimate relationship, she apparently did not identify them as such on the call (noting also that the neighbour was apparently very difficult to understand). Accordingly, the matter was not given the higher response priority that it would have received as a domestic violence call out - meaning that police did not attend for 8 hours, during which time Troy and Richard remained in their apartment together. Richard asked his neighbour to call the police back and tell them not to come, because Troy 'was on a good behaviour bond' and he did not want to send him to gaol. When police eventually attended Richard did not tell them what had happened.

The day of the homicide Richard asked Troy to move out of the unit. A few hours after this, Troy called a staff member at the faith based counselling service and asked them to come to the unit. When they arrived, they found Richard deceased on the lounge, having been stabbed once in the back.

Police attended and Troy told them that he had killed Richard as he was making sexual advances. Troy was tried for Richard's murder, and although he was initially found guilty, the verdict was appealed and on retrial he was acquitted on the basis of self-defence.

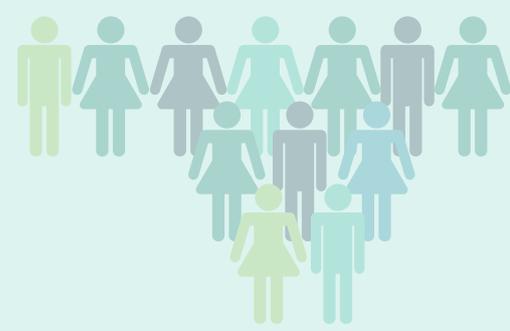
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## Case Review 3223

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This case involved the homicide of a woman aged in her late 40s, Yvonne, by her de facto husband Don, also aged in his 40s.

Don was exposed to violence between his parents while growing up, and experienced disadvantage throughout his childhood. Don started offending at a young age. He was expelled from school at 14 years of age for behavioural problems and had literacy and numeracy issues as an adult. Don had a long history of offending – including larceny offences, break and enter offences and other kinds of non-violent offending and had received numerous custodial sentences in relation to this offending. Don also had a history of convictions and custodial sentences for violence offences, including for offences against prior intimate partners. Prior to the homicide he had served 2 years in prison for a serious assault against his former intimate partner, in which he kidnapped her



from a domestic violence refuge and physically attacked her. After being released from prison for this offence, Don met Yvonne at a local shopping centre.

Yvonne left school in year 8 after developing drug and alcohol dependence issues.

She had four children, the youngest of whom had been removed and placed into state care at birth. Yvonne had been a long term victim of violence from her three intimate partners, and her family noted that she would 'fight back against horrible men', i.e. she would use retaliatory violence against her abusers. Yvonne had a criminal record and had spent a short period of time in custody. Yvonne also had a history of self-harming behaviours and mental health problems. Yvonne had been on the Opioid Treatment Program for many years prior to being killed.

After Yvonne and Don met, they started spending a lot of time together and from early in the relationship Don was abusive towards Yvonne. Don would bark at her like a dog in public, call her a dog and would denigrate her in front of mutual friends. Don was extremely manipulative, controlling and abusive towards Yvonne. From time to time, Yvonne would also use violence against Don.

Yvonne moved into Don's FACS-Housing property 6 weeks prior to the homicide. Shortly after Yvonne moved in, a neighbour reported hearing violence in the apartment. She reported hearing a woman screaming and yelling to be 'let go'. The neighbour believed that the woman was being sexually assaulted and went downstairs to the security desk to report her concerns to the security contractor. The security guard apparently ignored the neighbour and would not talk to her. She spoke to a second guard, who also did not call police or provide assistance. The neighbour returned to her unit upstairs and no further action was taken.

A month before the homicide Don told police that Yvonne had assaulted him. Police applied for a provisional ADVO protecting Don which was later dismissed/withdrawn at court.

A few days before the homicide, Yvonne called for an ambulance, reporting that she was experiencing chest pains following an argument with Don. The ambulance attended and Yvonne told the ambulance officers that she often got chest pains when she and Don fought. The ambulance took Yvonne to the hospital and Don accompanied her in the ambulance. Hospital records indicate that following an episode of violence at the hospital, including yelling and screaming, Don and Yvonne were told to leave and were removed by security.

That night neighbours heard a commotion at Don and Yvonne's unit. The following morning Yvonne went down to the security desk and she was observed to have a bruised face and was bleeding from the head. She told the security guard to call police as Don had attacked her. She appeared frightened. Ambulance and police attended and she told them that Don had assaulted her with a toilet brush. The ambulance officers took Yvonne to hospital and police spoke to Don, indicating that they would return to get a statement from him after they had spoken to Yvonne at the hospital. The police asked Don to remain at the unit. The police returned to the unit several times throughout the day but on each occasion they couldn't raise Don. He later called police, claiming that it was Yvonne who had been physically abusive towards him, not the other way around, and said that he was hiding in the bushes outside the unit as he was scared Yvonne was going to return to the unit. Police attended to investigate the call but they were not able to locate him.

At the hospital, Yvonne spoke to the social worker about the domestic violence episode. Yvonne told ambulance officers and the social worker that she had 'had it' with Don and was planning to leave him.

After being discharged from the hospital, police officers took Yvonne to the police station, where she spoke to the DVLO. Yvonne told the DVLO about the assault and said that Don had held her down on the mattress in the lounge room and refused to let her get up and go to the toilet. She urinated on the mattress and he then punched her in the face. Some time later that evening, Yvonne was in the bathroom talking to her father on the phone when Don came in and struck her on the head with the toilet brush, causing a laceration to her scalp. Yvonne also told the DVLO that a week earlier Don had attempted to strangle her, and that he had again

punched her in the face. The DVLO observed that Yvonne had a swollen cheek, marks around her neck and various injuries (including the laceration to her head) that were consistent with her disclosures.

Police applied for an urgent ADVO protecting Yvonne and the DVLO contacted the DV Line to try and secure emergency accommodation for Yvonne that night. As no accommodation was available, the DVLO suggested that Yvonne try FACS-Housing, but she refused as she had exhausted her temporary accommodation allocation.

After leaving hospital Yvonne returned to Don's unit in the afternoon. At 9pm officers arrived at Don's apartment to follow up about the assault from the night before. He told the officers that Yvonne was sleeping, but the officers soon determined that she was unconscious. Don was arrested at the scene and Yvonne died in hospital, having suffered a head injury.

Don denied that he had caused the injury and pleaded not guilty to Yvonne's murder. The jury returned a verdict of guilty to manslaughter and Don was sentenced to 8 years imprisonment.

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## Case Review 3316

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This case involved the homicide of a woman in her mid-30s, Suzy, by her de facto husband Adam, also aged in his mid-30s.

Suzy had a few boyfriends throughout her teens however Adam was her first serious relationship. Suzy worked as a nurse and was described as being strongly committed and dedicated to her nursing career. She had a close and loving relationship with her family.

Adam's parents were both heavy drinkers. They separated when Adam was young and had an 'extremely acrimonious' divorce. Adam was apparently sexually abused by a family member when he was young however it would appear that Adam did not disclose this abuse to anyone at the time. Adam drank heavily from his early 20s and this continued up to the time of the homicide. At the time of the homicide Adam was working in the mining industry.

From the outset of their relationship, Adam sought to isolate Suzy from her family and friends. He refused to attend family functions and was rude and offensive towards Suzy's friends and colleagues. When Suzy did spend time with friends and family Adam would constantly call and message her, demanding that she come home.

After being unable to conceive, Suzy and Adam commenced an IVF program and went through about 10 cycles on the program, at a cost of about \$80,000. Suzy funded this treatment from her savings and Adam refused to contribute any money towards the program.

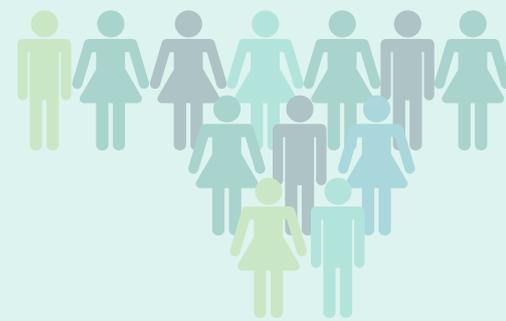
Suzy was successful in conceiving on the program but had multiple miscarriages. Adam would make derogatory and belittling comments towards Suzy for not carrying a pregnancy to full term.

Suzy tried to justify Adam's behaviour to her friends and family as being a result of problems in his childhood.

Suzy and Adam were financially secure and owned a number of properties together. However, Adam controlled all the finances in relation to the properties and the household generally. Suzy had no knowledge about Adam's income or how money was split between the properties.

Adam was sometimes physically abusive towards Suzy, including episodes where shoved, punched, kicked and bit her. Suzy's diary entries also imply that Adam was sexually abusive towards her. Over the course of their relationship, family, friends and colleagues asked Suzy whether Adam was ever physically abusive and Suzy denied that he was.

In the 12 months prior to the homicide, however, Suzy and Adam separated for a period and during this



separation Suzy did disclose Adam's physically and emotionally abusive behaviour to family and friends. During this separation both Adam and Suzy sought advice from lawyers in relation to property settlement negotiations. Adam continued to abuse Suzy throughout the separation, sending her numerous abusive text messages and threatening to kill himself. During the separation, Adam had a number of sessions with a psychologist and spent a significant proportion of these sessions blaming Suzy's family for the breakdown of his and Suzy's relationship.

Approximately 6 months before the homicide Suzy and Adam resumed their relationship. Suzy made further disclosures of abuse after she and Adam reconciled, telling a neighbour that Adam had physically assaulted her and destroyed some of her belongings. The neighbour told Suzy to contact police however Suzy indicated that she was too ashamed and embarrassed to report Adam's abusive behaviour. Suzy also told the neighbour that she did not want her family to find out that Adam was continuing to abuse her.

About a month prior to the homicide, Adam saw his GP as he was having trouble sleeping and was prescribed medication to address anxiety.

According to Adam, on the evening of the homicide he and Suzy began to argue about her family. During the course of the argument he grabbed a knife and stabbed Suzy multiple times. A neighbour heard Suzy screaming and called 000. Police and ambulance arrived a short time later however Suzy had already died as a result of her injuries. Adam was arrested at the scene.

Adam offered to plead guilty to manslaughter on the basis of substantial impairment however this was rejected by the Crown. Adam was ultimately found guilty of Suzy's murder and sentenced to over 20 years imprisonment.

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## Case Review 3224

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This case involved the homicide of a woman in her early 20s, Rita, by her husband, Kamal who was aged in his early 50s.

Both Rita and Kamal were born in Sudan.

Rita and her family moved to Australia in the mid-1990s, when Rita was in primary school. Rita lived with her family in Australia until she was in her mid-teens when she returned to live in Sudan with her aunt. Soon after returning to Sudan, Rita and Kamal were introduced and their marriage arranged. Rita had been raised a Christian and converted to Islam to marry Kamal.

In the year after their marriage, Rita and Kamal's first child was born in Sudan. Rita told her mother that she wanted to return to live in Australia, but said that Kamal kept control of her passport.

About 3 years later, soon after the birth of the couple's second child, Rita and Kamal came to Australia to live, moving in with Rita's family. Kamal spoke only limited English and gained employment in waste removal.

After moving to live in Australia, Rita's family observed that Kamal would not let Rita leave the house without his permission. When Rita did leave the house Kamal would keep track of her movements by phoning her and would 'time her' to make sure she returned directly home. Rita's family apparently argued with Kamal about the way sought to control Rita.

After a few months living with Rita's family, Kamal decided to move interstate. Kamal threatened to divorce Rita if she did not relocate with him. Rita did not want to move away from her family but was worried as Kamal had control of the children's passports and would regularly threaten to take the children back to Sudan.

Soon after moving interstate Rita told her sister that Kamal had assaulted her and had caused her to have a miscarriage. Rita told her mother that she was scared of Kamal, that he was extremely possessive, and

threatened to harm her if she ever left him. Over the next few months, Rita told family members that Kamal would rarely give her any money and that this meant that she was often unable to use her mobile phone. Kamal started accusing Rita of being unfaithful to him and began covertly recording her conversations with the children and phone conversations. Kamal continued to threaten to divorce Rita and there were a number of episodes where he would leave the home for weeks at a time, apparently in search of a new wife.

During one of these periods, Rita and the children returned to live with Rita's family. A few weeks later Kamal called Rita and told her that he had not divorced her. He told Rita that she and the children were to return to their home and they did.

After returning to live with Kamal, Rita began to disclose problems in the relationship to her GP. On one occasion Rita and Kamal attended the GP together and Kamal complained that Rita was always nervous around him. The GP gave Rita a form to take home to assess her mood and depression. In follow up appointments, Rita told the GP that Kamal was recording her conversations. The GP assessed Rita as being moderately depressed, completed a mental health plan and referred Rita to a psychologist. The GP saw Kamal soon after this, and Kamal told the GP that he did not trust Rita and had been hiding a tape recorder in the house to covertly record Rita's activities.

Around this time, Rita disclosed to family members that Kamal was refusing to tell her where her or the children's passports were. She told her family she was extremely stressed as Kamal was controlling every aspect of her life and that she was not allowed to have any freedom. Rita told her mother that Kamal had removed the lock on the bedroom door because when they would fight, she and the children would seek refuge in the bedroom and lock the door. Rita's mother arranged to travel interstate to stay with Rita and the children however Kamal contacted her and told her to delay her visit for a few weeks.

On the day of the homicide Rita found another recording device hidden in the bedroom. When Kamal returned home from work Rita confronted him about the recording device. They began to argue and according to Kamal, Rita made derogatory remarks about Kamal's masculinity and stated that he was not the father of their children, after which he grabbed a knife and stabbed her multiple times.

Kamal left the bedroom, woke and dressed the children (who had been sleeping in another bedroom) and called 000. Police attended and Kamal was arrested and charged with Rita's murder.

At trial, Kamal was found guilty of manslaughter, having successfully argued provocation, and was sentenced to 12 years imprisonment.

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## Case Review 3409

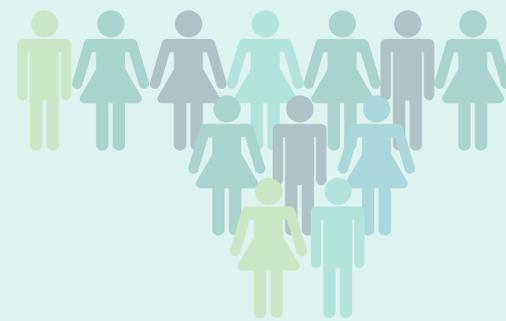
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This case involved the stabbing homicide woman aged in her mid-40s, Ema, by her husband Dev, also aged in his 40s.

Ema was born in Fiji and completed school, before becoming a healthcare worker. Ema had a daughter in Fiji, and when her daughter was young she met Dev.

Dev was born in Fiji and lived in a rural area. He struggled at school and left before completing primary school. When he finished school he started working in various labouring and other jobs.

After Ema and Dev met they soon married and had a child. Dev was abusive towards Ema from early in the relationship, and he had assaulted, threatened and abused her when they lived in Fiji. In the late 2000s, the whole family moved to Australia to live with her sister. Ema became an Australian citizen a few years later, as did Dev. Ema worked as a nurse's aid, but took time off to look after the children, and Dev worked in a factory until a few months prior to the homicide. Ema and Dev had a small social network primarily comprising of Ema's family.



Shortly after arriving in Australia, police attended the couples house after Dev assaulted Ema. She told police when they attended that Dev had also assaulted her on other occasions, and that she was scared of him. On this occasion Dev assaulted Ema after an argument over which church they were going to attend. During this assault Dev damaged property, punched Ema in the head and held a fist to her face whilst denigrating and threatening her. The assault was witnessed by their children. After escaping from Dev, Ema ran down the road to her Pastor's house, and the Pastor called police. Dev was arrested and charged with common assault and malicious damage. An ADVO was applied for and finalised for a period of 12 months, and Dev pleaded guilty to both offences and was placed on a bond.

A year and a half later, Ema and Dev had another child, and shortly after they moved into a rental property some distance away from Ema's family. Dev was made redundant from his job and Ema returned to work. About a month after Dev was made redundant, Ema disclosed to a friend that she was scared of Dev, that he was very abusive and had threatened her with a knife on a number of occasions. The friend offered for Ema and the children to come and stay with her, but Ema declined.

A few months later Ema and the family moved again back to live closer to her sister.

The day after they moved into the new house, Ema returned home from work and she and Dev argued. Dev struck Ema with a chair, before getting a knife and stabbing her multiple times. The children witnessed the homicide and ran to the neighbours to seek help.

Dev plead guilty to murder and was sentenced to over 18 years imprisonment.

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## Case Review 3374

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This case involved the homicide of a woman, Priya, who was murdered by her estranged husband, Depak.

Priya and Depak were both born and raised in Fiji and were Fijian Indians. Depak experienced violence from his father growing up and his parents separated when he was a child. Priya was close to her parents during her childhood, although they too had separated when she was young. She moved to Australia to live with her father, and met Depak in Sydney.

After they met and married Priya and Depak lived with an elderly man in a metro area, and Depak was employed as the man's carer. Priya and Depak had a son, Nik. Priya worked in aged care.

At the time of the homicide Depak was on a spouse visa. It is not clear on the material reviewed, but it would appear that Priya was on a working visa.

There is no recorded history of violence but in a number of text messages reviewed, Depak would apologise for snapping at Priya, and there were references to many arguments. Also in these messages Depak accuses Priya of killing two of their babies (it is unclear whether this is referring to terminations, miscarriages or something else). In the weeks leading up to the homicide Priya was in the process of separating from Depak. In the weeks before her death, Priya had sent her father some of her belongings and asked a friend if she could stay with them.

The night of the homicide Depak claims that he and Priya argued throughout the night, and Priya threatened to leave him and take their son Nik with her. Depak grabbed a knife and stabbed her multiple times. He called a relative who came over and found Priya deceased. The police were called and Depak was arrested and charged.

At trial, Depak argued provocation and self-defence, but was found guilty of murder and sentenced to over 20 years imprisonment.

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## Case Review 3424

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This case concerned the murder of a woman Jiao by her ex-boyfriend Hongchi.

Jiao was born in China. She was close to her family and was studious, receiving a bachelor's degree in China, before travelling to Australia to study her Masters. She had originally worked in China, but moved to Australia for work. She continued to support her family in China.

Hongchi was born in China and he had a disadvantaged childhood. He was exposed to his father's violence against his mother as a young child. He was also studious and studied at university in China, and had recently lost his professional job at the time of the homicide.

Hongchi and Jiao met in China in the years before the homicide. They started a relationship and began living together. About 6 months after they started a relationship, Jiao was offered a job in Australia and she and her father travelled to Australia and lived together in a small unit. Hongchi and Jiao remained in a long distance relationship.

Shortly after moving to Australia however, Jiao was having difficulty getting in contact with Hongchi. Later she found out that he had been taken into custody after being convicted of the offence of 'being found at a sex work premises' in China. As a consequence of the conviction he had also lost his job. After Jiao's father became unwell they travelled back to China for him to receive treatment, and Jiao returned to work in Australia. Jiao's father witnessed a number of episodes where Jiao and Hongchi would argue, usually about his offending and the time he spent in gaol.

After Jiao had returned to Australia, Hongchi told his and Jiao's family that he was planning to move to Australia to live with Jiao. Meanwhile Jiao was telling her friends in Australia that she wanted to end her relationship with Hongchi.

After returning to Australia Jiao met a man called Gui who was in Australia (from China) working. They started a relationship. Jiao told Hongchi about Gui and told him not to come to Australia, but he said he wanted to say goodbye to her in person and determined to travel to Australia.

When Hongchi arrived in Australia Jiao met him and picked him up. They spent the day together, and Jiao told him that their relationship was over. According to Hongchi's statement that evening Jiao went to visit Gui, leaving Hongchi at her apartment. Jiao told Gui that she had ended her relationship with Jiao and that she had told him he could only stay for a few days and had to leave. She parted ways from Gui and went home.

At 3 am neighbours heard screams and the sound of scraping of furniture coming from Jiao's unit. A neighbour knocked on the door before calling police. Hongchi also called 000 and told the operator that he had murdered his girlfriend Jiao.

When police arrived he told them that he had killed Jiao because she had told him she was leaving him. Hongchi pleaded guilty to murder and was sentenced to 20 years imprisonment.

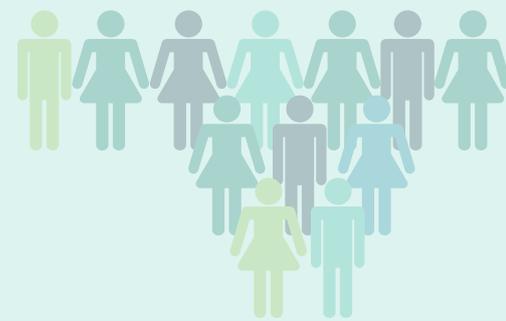
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## Case Review 3428

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This case involved the murder of a woman, Kylie, by her current intimate partner Kelvin. Both Kelvin and Kylie identified as Aboriginal.

Kelvin was born in Victoria. His parents separated when he was young and he witnessed his mother's partners using violence against her throughout his childhood. His mother and his father both used alcohol, and after the homicide Kelvin was assessed as likely having foetal alcohol spectrum disorder. Kelvin left school when he was



15 years old and had ongoing issues with literacy and numeracy as an adult. He also started using alcohol and drugs in his mid-teens.

Kelvin had a long history of police contact in Victoria and NSW, including a history of violence against former partners. Kelvin had a relationship with a woman called Cathy and they had two children together. Kelvin was extremely abusive towards Cathy, including physically, verbally, psychologically and emotionally abusing her. He assaulted her causing a miscarriage on one occasion, and would whip her with an electrical cord. On one occasion he broke her arm and tried to drown her in the bath. Just prior to meeting Kylie, Kelvin had been released from prison having served a sentence in relation to violence against Cathy.

Kelvin had also been abusive towards another partner, Leah. During their short relationship Leah described Kelvin as controlling, abusive and manipulative. Their relationship ended after he assaulted her by kicking her a number of times to the ribs. Police attended and served a provisional ADVO which was not finalised, as Leah did not know when she had to attend court. She told police that she did not want Kelvin charged as she was scared of Kelvin and did not want his relatives coming after her.

Around 6 months prior to the murder, Kelvin started a relationship with Kylie.

Kylie had also been born in Victoria and had known Kelvin her whole life. She had a close relationship with her mother, but described her father as being abusive and having alcohol issues throughout her childhood.

Kylie had one long term relationship before meeting Kelvin. Her first relationship was with an abusive man called Buddy, who was the father of her three young children. Buddy had served a period of imprisonment for offending against Kylie, and was known to police in relation to numerous episodes of offending against Kylie.

While Buddy was in gaol, Kylie and Kelvin started a relationship. From early in their relationship Kelvin was abusive towards Kylie. There were a number of episodes of police contact in Victoria during the 6 months in which Kelvin and Kylie were in a relationship. In the first episode Kelvin pulled Kylie's door off its hinges and broke a number of objects in her house. He was arrested and taken to hospital, but absconded. No further action was taken. In the next episode, Kelvin attacked Kylie on the street, dragging her by her hair and assaulting her. He was arrested, charged and bailed.

In the third episode, Kelvin pulled her out of her house and dragged her into a vehicle with other men. He also threatened to break her jaw. After this, he fled across the border, allegedly to evade police. Once in NSW Kelvin assaulted Kylie and she was taken to hospital. No social work or other assistance was apparently provided and she was kept in hospital overnight. Both NSW and Victoria police were struggling at this time to locate Kelvin, and were seeking to serve ADVOs on him (neither of which had been served at the time of the homicide).

Three days before the homicide Kylie told her mother she was planning on moving interstate with Buddy. In the days before the homicide Kelvin also told his friends that he would smash Kylie if he found her with someone else.

The night before the homicide, Kylie and Kelvin had a fight at a party they were attending, and returned to Kelvin's mother's house. During the night they had an argument, and Kelvin started assaulting Kylie. Kelvin's mother tried to intervene but Kelvin threatened her she he would also assault her if she did. Kelvin assaulted Kylie over the course of an hour and afterwards told his mother he thought that Kylie had died.

Police attended and Kelvin was arrested and charged with Kylie's murder. He pleaded guilty and was sentenced to over 20 years imprisonment.

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## Case Review 3539

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This case involved the homicide of a woman in her 60s, Cora, by her husband Anton, also in his 60s. After killing Cora, Anton suicided.

Both Cora and Anton were born in Greece where they met and married. The couple migrated to Australia in the late 1960s and had a number of children. Both Cora and Anton were retired at the time of the homicide.

Anton was controlling and emotionally abusive towards Cora throughout their relationship. Anton was also physically abusive towards Cora earlier in their relationship and one daughter, Melina, described seeing her father hit her mother on a number of occasions. Melina noted that while the physical abuse stopped many years before the homicide, Anton continued to be emotionally and verbally abusive towards Cora, constantly belittling and making derogatory comments to her.

Many years before the homicide, Cora confided in a family member that she was not happy in the marriage. The family member tried to provide emotional support to Cora but ultimately she stopped confiding in the family member and they had not discussed the issue for many years.

In the 12 months prior to the homicide Cora had become more socially isolated and saw few people outside her immediate family. Cora's GP said that she was very closed and did not disclose information about her personal life.

In the days prior to the homicide, Cora told one of her children that Anton was not well but did not elaborate on this.

On the morning of the homicide, Anton attacked Cora while she slept, inflicting multiple fatal blunt force injuries. He then went out into the back yard and hanged himself. They were discovered later that day by one of their children.

The matter was finalised by way of inquest.

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## Case Review 3541

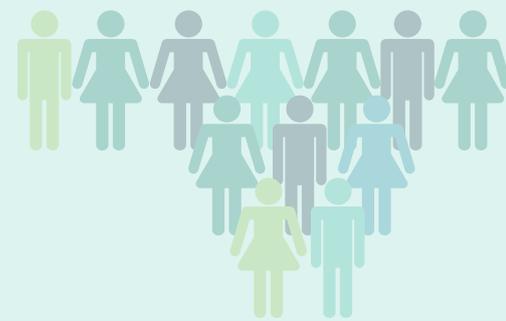
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This case involved the stabbing murder of a woman, Bryony by her ex de facto partner, Cameron. Little is known about Bryony's childhood, but when she was aged in her teens she developed drug dependence issues. She had two children, both of whom were removed by child protection services due to her drug use. At the time of her death she was having supervised contact with her children, and was on the Opioid Treatment Program.

Before meeting Cameron, Bryony had had a number of intimate partners, most of whom were violent and abusive. The NSW Police computer system reveals over 170 COPS events involving Bryony as either a victim, perpetrator or informant. She was protected under a number of historical ADVOs with former partners.

Cameron grew up in a metropolitan area in NSW and had one brother, Perry. Cameron had a history of violence against his mother (including an episode in which he grabbed her by the throat), and his father, and was named in a defendant in an ADVO protecting his brother Perry. Cameron claimed that he experienced psychosis in his late teens, after using cannabis. He started drinking when he was 16, and used cannabis daily. He was known to police as a domestic and family violence abuser.

While little detail is known about the relationship between Cameron and Bryony, it was on foot for about a year and their relationship ended some months prior to the homicide. According to Cameron the relationship was 'volatile', but little detail is known about Cameron's violence towards Bryony. After their relationship ended, Cameron was homeless and spent a period of time living in a regional area (transient) before returning to Sydney.



Around this time Cameron's mother died of a drug overdose and there is evidence that Cameron believed Bryony had killed his mother. The post mortem found that the overdose was accidental, but Cameron told police after the homicide that he believed Bryony had killed his mother.

After Bryony ended her relationship with Cameron, Bryony and Cameron's brother Perry started a relationship. Throughout their relationship Perry was very abusive towards Bryony and there were numerous episodes of police contact, and on one occasion Perry was scheduled following a domestic violence callout. Bryony was seen by friends and family with a number of injuries including a black eye, a swollen nose and strangulation marks around her throat. Two days prior to the homicide police applied for an ADVO protecting Bryony from Perry. Although it is not clear when Bryony and Perry's relationship ended, shortly after the ADVO was applied for Bryony's new partner Finn threatened Perry with a gun and told him to stay away from Bryony.

The day of the homicide Perry and Cameron met up at a pub and consumed a significant quantity of alcohol. Perry was telling Cameron that he believed Bryony had killed their mother, and that he had been ruminating over this thought for some time. Later that day Cameron returned to his unit and stabbed Bryony a number of times. Police were called.

Police conveyed Cameron into custody. He requested that his brother Perry come to the station as his support person. While waiting in the dock at the station, Cameron was electronically recorded saying to his brother 'don't forget to tell them you are hearing voices we will get a section 32.'

When Cameron was interviewed in the police station he told the police officers that he was hearing voices and that he was sick. A few months later Cameron was assessed by psychiatrists as having a schizophrenic illness. Although concerns were raised that he was faking his illness, the psychiatrists remained firm in their diagnosis.

Cameron was found not guilty by reason of mental illness.

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## Case Review 3452

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This case involved the murder of a woman, Elizabeth by her former partner Seb, who then suicided.

Elizabeth grew up in regional NSW and moved to a metropolitan area for work. She was described as outgoing and kind by friends and family and had a close and loving relationship with her family.

Little is known about Seb's upbringing, but he had one sister, Eugenia, was close to his family, and at the time of the homicide worked for the Navy.

Seb had a history of violence against former partners, including when he lived interstate. His ex-girlfriend Ash provided a statement to police following Elizabeth's murder. During their relationship (interstate) Seb was possessive towards Ash, and would regularly denigrate her male friends and try to isolate her from her friends. Ash also believed that Seb was accessing her emails. Ash described Seb as being menacing and intimidating towards her, and said he was a compulsive liar. When she broke up with him he started coming to her house and work bringing her presents unannounced and when she did not want them, and on one occasion he was violent towards her pet.

Around this time Ash also noticed that her keys kept disappearing, and her property was vandalised and damaged. In one episode Seb physically assaulted Ash at her parents' house and she passed out. When she regained consciousness she tried to escape but he chased her and threatened to kill her. He tried to strangle her, but she managed to kick him and escape. She called his family, who came and intervened. Ash was scared of Seb and changed her numbers in an attempt to escape his abuse. She attempted to apply for an ADVO, but for a number of reasons, this did not proceed.

After Seb moved back to NSW, Seb and Elizabeth met on a dating site. From early in their relationship there is evidence that Seb would lie to Elizabeth about his job, what he did for work, and where he was. He also damaged her property and allegedly stalked her. He also lied about his father having cancer, and lied about working overseas.

Elizabeth thought that Seb's behaviour was odd from early in their relationship, as did her friends who believed that Seb was hiding something, such as the fact he may have been married. Her friends also noticed that Seb was abusive towards Elizabeth, and one of Elizabeth's friends overheard a conversation on one occasion in which Seb called Elizabeth a whore and a slut. Seb also sent Elizabeth abusive text messages. Elizabeth told her friends that Seb had anger management problems, but also that he was intimidating and forceful towards her. He regularly accused her of cheating on him and would send her photos of him with other women. Elizabeth's friends did not like Seb, and tried to confront Elizabeth about his behaviour.

On one occasion after a fight Seb threatened to kill himself.

Seb continued to lie, regularly changed plans and was resistant to let Elizabeth visit his family interstate. One of Elizabeth's friends, around this time, contacted Seb's employer to enquire about whether he worked there and she was advised that he did not.

After these episodes, Elizabeth broke up with Seb. After their relationship ended, Seb begged for her to resume a relationship with him, but she refused and continued to confront him about his lies. There was evidence that Seb accessed Elizabeth's email, and he also sent her pornographic images of other women in 'compromising positions' via text message, claiming that he was sleeping with them. He alternately sent her messages attempting to 'make up' with her and 'begging' her to take him back.

In the months before the homicide Elizabeth attended the police station to enquire about an ADVO, but no ADVO was applied for. She told her mother later that she was worried Seb would lose his job or his temper would be inflamed if she were to apply for an ADVO.

Around this time Elizabeth started contacting Eugenia, Seb's sister. Through this contact Elizabeth uncovered many of Seb's lies, including his lies about work and his father's health. Around this time Elizabeth had to arrange for Seb to come and pick up some of his belongings from her flat.

In the days before Elizabeth's murder, Seb found out that Elizabeth and Eugenia had been speaking.

Although the circumstances around Elizabeth's murder are not clear, Seb murdered her in her apartment by strangling and assaulting her. He stole her phone and credit cards and started messaging her friends. He travelled interstate to spend a few days with his family, whilst continuing to message Elizabeth's friends, telling them she was not at work as she was ill. When he was interstate, after Elizabeth's murder had been discovered, he killed himself.

The case was finalised by way of inquest.

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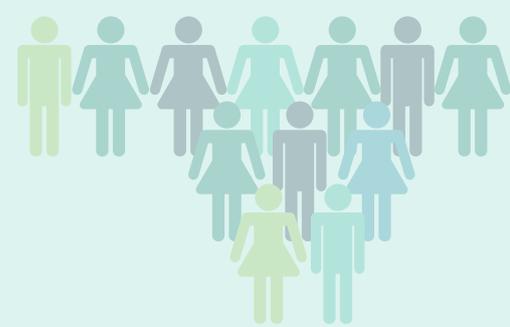
## Case Review 3692

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This case concerned the murder of a woman, Margaret, by her intimate partner, Mark, who then killed himself.

Margaret was born in Australia. She had a close relationship with her family, including her sister, who lived nearby at the time Margaret was murdered. Margaret completed high school and qualified as a nurse. She was working as a nurse when she was murdered.

Mark was born in Australia, and he had been estranged from his family since he was a young adult. He was highly intelligent and active, but had few friends and was described as being 'different'.



Mark and Margaret met through a mutual friend and started a relationship.

Mark was known to police in relation to violent confrontations with neighbours, but there was no history of police reported violence between Mark and Margaret. On one occasion Margaret had an injury and told her friend that Mark had caused it, but she never disclosed any further history of physical violence. Other friends noticed that Mark was controlling towards Margaret, denigrating her for cutting her hair, trying to force her to open a joint bank account and forcing her to wash her mouth out after drinking coffee.

In a period proximal to the murder, Margaret and Mark's relationship had ended but they continued to cohabitate, sleeping in separate rooms. Around this time Margaret disclosed to her friend that she planned to disinherit Mark from the will and that she did not want any of her money to go to him, and she did not want him to be able to contest the will. She changed her will to privilege her sisters' inheritance. Margaret and Mark started arguing more, and Margaret told her sister that they were arguing all the time. She organised to visit a solicitor to discuss property settlement.

The day of the murder Mark called Margaret's friend and cancelled a scheduled catch up. He told Margaret's sister that she was not going to be home for a few days. It is not clear when Mark murdered Margaret, but he killed her by assaulting her with a household item. A few days after killing Margaret, Mark suicided. Police discovered Margaret's body in her house after attending the house to advise her about Mark's death.

The case was finalised by way of inquest.

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## Case Review 3696

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This case involved the murder of a woman Fiona by her de facto husband, Ian who then killed himself. The couple had been in a relationship for about 16 years and were in the process of separating when Ian murdered Fiona.

Fiona was born and raised in a remote part of NSW, finished school before starting work on Ian's property. She started a relationship with Ian, which her family did not approve of as he was older than she was, and she moved out of her parents' house and started living with Ian. While she maintained a close and loving relationship with her family, Fiona's family never visited her and Ian at their home.

Ian had also grown up in a remote rural part of NSW, and his family were involved in farming. After leaving school he also became involved in farming and met Fiona. Ian had issues with alcohol use, and by the time he started a relationship with Fiona, he was drinking heavily. Ian had a history of being aggressive and abusive towards neighbours, who indicated that they were too scared to report his abuse to police.

After starting a relationship, Ian and Fiona had three children. At different times family and friends noticed that Fiona had injuries, including bruising around her neck. Fiona left Ian on a number of occasions but each time they would reconcile soon after.

On one occasion Fiona attended the police station after an episode of abuse, but did not want to progress charges against Ian. Friends and colleagues continued to notice that Fiona had injuries, and she told one colleague from the farm that Ian had assaulted her shoving her up against a wall. There was also evidence that Ian was psychologically and sexually abusive towards Fiona, and that he would abuse her in front of the children. Fiona also told her friend that Ian threatened to kill her if she left him.

Ian had a number of guns, and Fiona surrendered a number of the firearms to police during a gun amnesty.

In the 12 months leading up to the homicide, both Ian and Fiona started telling a mutual friend that their relationship was in trouble and that they were thinking of separating. When Ian would drink Fiona would sometimes take the children out of the house and stay elsewhere for the night.

In the months leading up to the homicide, Fiona arranged for the children to move schools and told her mother she was planning to leave Ian. She started engaging with solicitors, and Ian started making arrangements to sell some of his assets. Fiona started looking for work elsewhere and got a job on another farm which was to commence a few days after her murder. She started expressing concern that Ian may self-harm if she were to leave him.

In the weeks leading up to the homicide police applied for an ADVO protecting Fiona and the children after she disclosed to the local police officer that she was ending her relationship with Ian. In regards to the ADVO Fiona told them she didn't want it as she believed it would make things worse. Police applied for an ADVO, and explained to Ian that they had applied for this as they were concerned about Fiona and the children's safety. Final orders were made for a period of 6 months just a few days before the homicide. The police had seized Ian's guns, but Fiona expressed concerns that Ian would still be able to access firearms due to living in the country.

The day of the homicide Fiona texted a friend and asked them to get police to attend as Ian had a gun. Ian shot and killed Fiona, before turning the gun on himself in front of police.

The case was finalised by way of inquest.

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### **Case Review 3546**

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This case involved the shooting homicide of woman, Jenna, by her husband Paul, who then shot and killed himself.

Little is known about Jenna and Paul's individual histories, but at the time of the homicide they had been married for over 40 years and had three adult children and a number of grandchildren. Jenna was popular in the regional community in which they lived, and was known to be kind and generous. Paul was known in the community as a hardworking man.

In the year prior to the homicide Jenna met a man called Gray, and they started a relationship. Jenna's relationship with Paul was breaking down at the time. Jenna regularly holidayed alone and on one occasion while Jenna was away on a holiday, Paul wrote to Jenna's doctor to tell him to 'take her off' her medication as he believed it was making her 'sexually promiscuous'. He later presented to Jenna's doctor to express his concerns that he was worried about their relationship ending as her medication was making her 'sexually promiscuous'. The doctor's notes indicated that she believed there were longstanding issues in their relationship. Paul had a number of health issues including sexual health issues.

As the year was drawing to a close Jenna was planning to leave Paul and take a holiday with Gray. The night of the murder, Paul shot her in the head and then killed himself.

The case was finalised by way of inquest.

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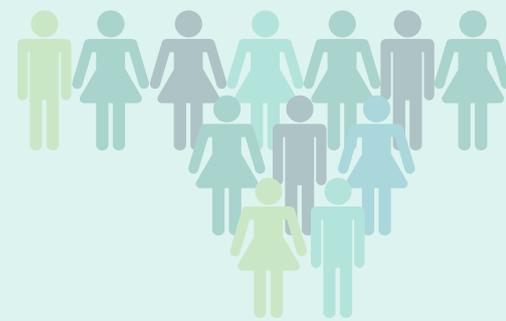
### **Case Review 3472**

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This case involved the murder of a woman Indira by her husband Samar.

Indira and Samar grew up in India and had an arranged marriage in the late 2000s. After marrying they travelled to Australia on student visas and worked a few jobs over the next few years. They had few family or friends in Australia.

Whilst living in Australia, Indira gave birth to the couple's only son, Gudu. Around this time Indira lodged an application for permanent residency. After travelling back to India for a short time, Indira and Samar returned to Australia but left Gudu in the care of Samar's family. The permanent residency application was later cancelled, and Indira applied for a sponsored working visa.



Samar and Indira continued to work a number of jobs, one of which was as a night time cleaner. They lived in an overcrowded apartment in a metropolitan area. There continued to be issues around Indira's immigration status, and in the months prior to her murder her sponsorship was withdrawn. Indira had also told her employer that she and Samar would argue about the parenting arrangements for Gudu. They continued to have few family and friends with whom they were engaging with, and few statements were included on the brief of evidence. There is little evidence of any violence.

The night of the murder Samar was planning on leaving to visit his mother who was unwell in India. There is some indication that Indira did not want Samar to go. After going to bed Samar got up in the early hours of the morning and he and Indira decided to go to work early. They travelled to work together and while they were at the premises, Samar murdered Indira by strangling her and occluding her airways. He then tried to strangle himself with his jumper. Police attended and he was arrested. He told police that he did not know what had come over him, but that he was the dominant person in the relationship, as was 'their culture'.

While in custody, Samar suicided by hanging.

The case was finalised by way of inquest.

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## Case Review 3429

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This case involved the homicide of a young Aboriginal woman, Kim by her abusive ex-de facto partner, Damian.

Damian grew up in regional NSW and described himself as an average student. After finishing school Damian worked in a number of different industries, including the mining industry. He had a short criminal history which included a violence offence against a prior partner, Sonia. In this offence Damian threatened Sonia with a knife after he found out she had a termination, and tried to smother her with a pillow. During the course of this assault Sonia managed to escape, and police apprehended Damian for this, and other offences.

After Sonia ended her relationship with Damian, he lived with his parents until he met Kim.

Kim had grown up in a regional NSW area and described having a close relationship with her family. She was known to FACS-Community Services as a child, including as a consequence of being exposed to domestic violence. When she was around 17 she had her first child, and had another child two years later. During this time Kim had a number of abusive partners, and was PINOP under a number of ADVOs. One of her partners was investigated for sexual abuse allegations against her daughter, as was another one of her partners. Her children were known to FACS-Community Services in NSW.

Kim and Damian met at a nightclub and started a relationship 3 months before Kim's murder. When Kim and Damian met her children were staying with her father in another jurisdiction, and the children were taken into the care due to concerns that they were not being cared for appropriately by Kim's father. Kim travelled interstate and had her children restored to her care and the children, Kim and Damian all moved in to live with Damian's family in NSW.

Damian was controlling towards Kim throughout their relationship and Kim's brother noticed that they argued every day and whenever Kim said she wanted to visit her family, Damian told her she was 'not allowed to'. The brother also described seeing Damian threaten Kim by 'raising his hand', and Kim had told him that Damian would assault her.

After living together for a while Damian proposed to Kim. Damian's family started asking for Damian and Kim to move out of the house, and Kim and Damian and the children spent several short periods of time camping in the backyard and the shed of Damian's parents' house. Around this time there was an episode in which Damian and Kim argued and separated and reconciled. They continued to try and find permanent accommodation for the children and themselves.

A few days before the homicide, Kim told her ex-boyfriend that she was unhappy with Damian and he was forcing her to 'do stuff' that she didn't want to do. She told her ex-boyfriend that she wanted to leave Damian.

The day of the homicide Kim and Damian went camping with the children and Kim's step sister. There was an argument over a minor matter and Damian became angry and packed up the camping gear and they drove home. When they got home Kim and Damian ended their relationship and Kim changed her relationships status on Facebook to 'single'. Later that night, Damian and Kim met up in a public place to discuss their relationship and Damian murdered Kim by strangling her. There was also evidence that Damian had had either consensual or non-consensual intercourse with Kim (it could not be determined which). Damian left Kim in a public place, and she was found the following morning.

Damien ultimately entered a plea of guilty to murder and was sentenced to over 19 years in prison.

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### Case Review 3453

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This case involved the homicide of man in his late 40s, Malcolm, by his boyfriend Craig, a man in his early 30s. Although there was significant evidence that Malcolm and Craig had an on/off intimate relationship for a number of years, at trial Craig denied that they had ever been in a relationship and was ultimately found not guilty on the basis of self-defence.

Malcolm was born in NSW and as an infant he and his siblings were removed from their parents care and placed in a faith based care home. While living in the care home Malcolm was sexually abused, and in the weeks prior to his death Malcolm received a significant compensation payment from the church.

Malcolm engaged in problematic drug and alcohol use from his early 20s and by the time of his death had a lengthy criminal record primarily in relation to stealing, public disorder and drug offences.

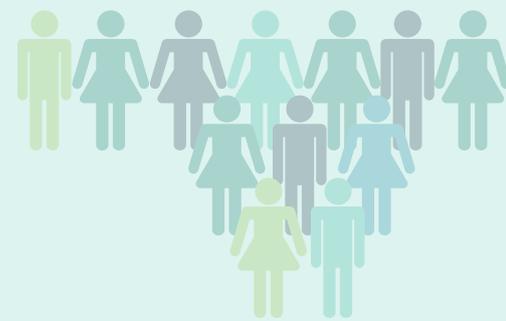
Craig was born in New Zealand and began drinking alcohol and getting in trouble at school in his mid-teens. By the time he was 18 Craig was drinking heavily and was homeless. One of Craig's siblings said that Craig was abusive towards their mother and step-father and, on one occasion, had threatened his mother by holding a knife to her throat. Craig had a number of different girlfriends in New Zealand and was abusive towards these partners.

Craig moved to Australia with his mother and a number of siblings when he was in his early 20s. After arriving in Australia Craig commenced a relationship with a woman called Donna. Craig was extremely abusive towards Donna and served a number of prison sentences in relation to serious physical assaults against her. In addition to the convictions for assaulting Donna, Craig had a significant criminal history in NSW for other violence, stealing, public disorder and drug related offences.

At some time in the mid-2000s Craig and Malcolm met and commenced an on/off relationship. Malcolm told his sister that Craig was very controlling in the relationship. Malcolm told a number of friends that Craig was 'guarded' about his sexuality.

A number of years before the homicide Malcolm began seeing a counsellor. Malcolm told the counsellor that Craig 'blamed him' for his sexuality.

Two years prior to the homicide Malcolm secured FACS-Housing premises. Malcolm regularly hosted noisy parties and loud music often disturbed the other residents in the block of units. When confronted by neighbours about the noise, Malcolm would often become verbally abusive towards them. Neighbours made numerous complaints to the housing provider and the Ombudsman in relation to Malcolm's disruptive and abusive behaviour. Police were called to the unit complex on a number of occasions and when police made inquiries with the housing provider they were advised that they were looking to relocate Malcolm to another property.



About a month before the homicide Malcolm told a friend that he and Craig had broken up. Malcolm told his friend that he and Craig had argued and Craig had punched him in the face, smashing his glasses. Malcolm told his friend that Craig had pulled a knife on him in the past and that Craig was aggressive when he was drinking.

In the weeks before the homicide, Malcolm received a significant compensation payment in relation to the sexual abuse he had suffered as a child. Craig told his mother that Malcolm had promised to give him some of the money.

In the days before the homicide one of Malcolm's neighbours noticed that he had lost a lot of weight and he told her that he had been using a lot of amphetamines.

The day before the homicide Malcolm, Craig and a number of friends were socialising at Malcolm's unit. One of the friends noticed that Malcolm had a plank of wood against the door which he said he used to barricade himself in to the unit. The group drank and used drugs throughout the day and into the night. The other residents noticed that there was a lot of loud noise coming from Malcolm's unit. A number of neighbours knocked on the door to complain about the noise and Malcolm became verbally abusive.

By the morning the friends had left leaving only Malcolm and Craig in the unit. Malcolm and Craig began to argue and Craig hit Malcolm repeatedly with the length of wood being used to barricade the door. After the attack, Craig left the unit and travelled to his family home.

Craig told a number of family members that he and Malcolm had fought because Malcolm had made a sexual advance towards him. He claimed that Malcolm had then tried to hit him with a plank of wood. He said that he got the wood from Malcolm and then hit him with it before leaving the apartment.

A day later a neighbour called police and asked them to conduct a welfare check on Malcolm as they had not seen him for a number of days. Police attended Malcolm's apartment and found Malcolm deceased.

Police spoke to Craig who maintained the version of events he had told his family.

Craig was charged with Malcolm's murder and it is noted that the police narrative relating to the charge event indicates that Malcolm and Craig were 'involved in a non-cohabiting eight year domestic relationship' and Craig was charged under the Murder (DV) law part code.

At trial, Craig denied that he and Malcolm had ever been in a relationship and successfully argued that he assaulted Malcolm after he made a sexual advance towards him and had tried to attack him with the wood. Craig was acquitted of Malcolm's murder on the basis of self-defence.

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## Case Review 3035

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This case involved the homicide of woman in her 30s, Kristen, by her former de facto husband, Glen who was aged in his mid-60s. Kristen and Glen had been separated for approximately 6 months at the time of the homicide and Kristen had commenced a new relationship.

As a child Glen, his mother and his siblings experienced physical and verbal abuse from his father. Glen left school in his early teens and was charged with a number of break and enter offences after which he was thrown out of home and went to live in a 'home for boys'.

When he was in his 20s Glen married a woman called Cherie. Glen was abusive towards Cherie and threatened to shoot her if she ever left him. The marriage ended when Glen was charged and convicted of sexually assaulting Cherie's daughter. Glen had other intimate relationships and was physically, verbally and emotionally abusive towards his partners.

In the early 1990s, Glen started working with Kristen's father and commenced a relationship with Kristen, who was aged in her mid-teens.

Kristen and Glen moved interstate and in the early 2000s Kristen and Glen's daughter was born. The couple returned to NSW near Kristen's family. A number of family members described observing Glen physically and verbally abusing Kristen, including grabbing her by the throat and threatening to kill her if she ever left him.

Kristen and Glen moved to a rural property some distance from Kristen's family. Neighbours described regularly seeing Kristen with injuries and suspected that Glen was physically abusing her. When neighbours asked her about her injuries, Kristen would make excuses as to how she had sustained the injuries but they did not believe that she was telling the truth.

Glen had regular contact with his GP in relation to a number of medical conditions and in the late 2000s referred Glen to a psychologist for depression. Glen had a number of sessions but did not disclose anything about himself to the psychologist. After this he was prescribed antidepressants by his GP.

Kristen formed a friendship with one of her neighbours, Harry. This friendship developed into a covert intimate relationship and Harry tried to convince Kristen to leave Glen. Kristen told Harry that she could never leave Glen as he would find her no matter where she went. Kristen told Harry that she had hidden Glen's firearm that he used to keep under the bed.

Approximately 6 months before the homicide, Kristen ended the relationship with Glen and moved out of the rural property closer to town. After Kristen moved out, Glen would regularly tell neighbours and friends that he was going to harm or kill Kristen and their daughter but no one took these threats seriously.

On the morning of the homicide Kristen and Glen spoke on the phone. They argued as Kristen did not want Glen to come and collect their daughter for a visit as he had a history of drink driving with the daughter in the car. Kristen offered to drive their daughter out to the property but Glen became verbally abusive and hung up on her.

That afternoon Glen drove to Kristen's house and shot her. Glen and Kristen's young daughter was present in the house and when she heard and saw what had happened, ran to neighbours for help. Glen returned to his property and called 000, making disclosures about having killed Kristen.

Glen was arrested and charged with Kristen's murder. Glen was found unfit to stand trial and the matter was referred to the Mental Health Review Tribunal. Ultimately the matter was dealt with in a special hearing and Glen was found guilty of manslaughter on the basis of substantial impairment and a limiting term of 7 years was imposed.

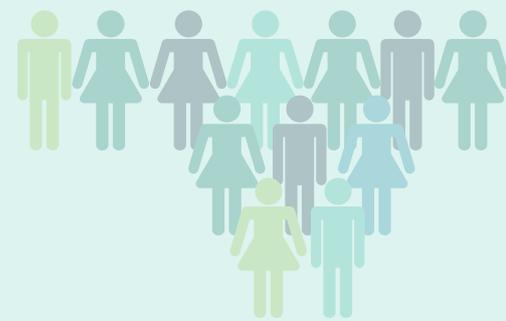
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## Case Review 3596

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This case involved the death of a woman Cathy aged in her early 30s, who was fatally assaulted by her partner Andrew (aged in his mid-30s). Both Cathy and Andrew identified as Aboriginal. At the time of the fatal assault, Andrew had recently been released from custody where he had been serving time for a prior assault against Cathy.

Cathy was born in regional NSW and lived in the same house on an Aboriginal mission her whole life. During her childhood Cathy was exposed to domestic violence by her father against her mother, and experienced child abuse. Throughout her adult life Cathy experienced family violence from her sisters and brothers. Cathy had experienced significant domestic violence from her first partner Fred, who had assaulted her many times (including to grab her by the throat and strangle her, and to break her jaw). Police were involved with Cathy in relation to Fred's violence on a number of occasions. When Cathy was pregnant with her and Fred's child Maeve, Fred died as a consequence of a heart attack.



When Maeve was young, Cathy met Andrew and they started a relationship. Andrew had grown up in the same area as Cathy. While little is known about Andrew's childhood, it was suspected that Andrew's father had an alcohol dependence disorder when Andrew was growing up and his father's criminal record highlights that Andrew's father had a long history of violence against women. Andrew started offending during his childhood, including offences of assaulting other children (once with a screwdriver), break and enter, breaching community service orders, throwing fire bombs and other assault offences. Andrew also had a history of violence against women, including his former partner Gabby, with whom he had two children. Andrew served a short period in custody for assault offences against Gabby, and over the years of their relationship she was protected under a number of short ADVOs (12 months each) which Andrew would habitually breach. Gabby ended her relationship with Andrew after a serious assault in which he grabbed her, dragged her across the front lawn and stomped on her. In relation to this assault he was sentenced to 18 months imprisonment, and a 12 month ADVO was issued protecting Gabby (set to expire while Andrew was in custody). After he was released from custody, Andrew met Cathy.

At the time of her death, Cathy had been in a de facto relationship with Andrew for a number of years and they had three children together. When she was heavily pregnant with their first child, Andrew assaulted Cathy by punching her a number of times. While police were involved at this episode, no charges were progressed. A week after their first child was born, Andrew punched Cathy in the back of the head after forcing his way into her car. Andrew also tried to snatch the pram with the new baby in it, but a local Elder intervened and told Andrew he had to leave. Police attended and applied for an ADVO protecting Cathy, and charged Andrew with common assault. The common assault charge did not progress as Cathy did not attend court. Andrew breached this ADVO by again assaulting Cathy and trying to grab their second baby from the pram. While he was charged with common assault and breach ADVO, both charges were dismissed as Cathy did not attend court to give evidence.

A few months later Andrew seriously assaulted Cathy by punching, kicking and stomping on her, before absconding and moving to the South Coast. It took a substantial period of time for police to locate Andrew and serve him with his court attendance notice for the assault ABH and the final ADVO. For these offences he served a period of imprisonment. In the interim while living on the South Coast, Andrew had also been offending against another new partner, Olivia.

A short time after he was released from custody, Andrew recommenced living with Cathy. The night of her death, friends and family noticed that Andrew and Cathy were arguing, at a party where everybody was socialising and drinking. At some point in the evening Cathy was dancing, and Andrew started punching her, jumping on her head and stomach and kicking her. The assault was witnessed by a friend, and during the assault the children also woke up and saw their mother laying on the floor and their aunt hitting Andrew with a household item. As Cathy was laying on the floor, her sister went to the local phone booth and called 000. She told the operator that Cathy had been assaulted and requested that police attend. Cathy's sister attempted to call numerous further times, and became frustrated with the operator who continued to ask her the same questions. In total Cathy's sister called four times within 35 minutes in an attempt to urgently raise police and ambulance to the mission.

Within the hour ambulance and police came out to the mission and drove around, listening for music or yelling. Police apparently made several enquiries with various people at the mission but were 'unable to locate any of the parties' so they left and closed the job.

In the early hours of the morning, Andrew called 000 and said that he needed an ambulance because Cathy was 'stiff' and no longer breathing. Police and ambulance attended and Andrew was arrested. Cathy died in hospital. That morning, Cathy's family – including her young niece – cleaned up the crime scene after it was released by forensic services.

Due to Cathy's blood alcohol concentration, the cause of death was uncertain and was attributable to both her

injuries and her intoxication. As a consequence of her complex manner of death, charges in relation to Cathy's death did not progress and Andrew was convicted of assaulting her and causing actual bodily harm, for which he was imprisoned for 12 months.

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## Case Review 3540

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This case concerned the murder of a woman, Dee, aged in her 40s, by her abusive de facto husband, Logan, aged in his 50s, in Western Sydney. At the time of her death, Dee was protected under an ADVO in which Logan was the defendant.

Dee was the youngest of three children and she identified as Aboriginal. Dee started using drugs and alcohol from an early age, and commenced on the Opioid Treatment Program when she was aged in her early 20s. Dee left school in year 10 and was qualified as a hairdresser. Dee had a significant criminal history primarily for stealing and shoplifting offences when she was killed.

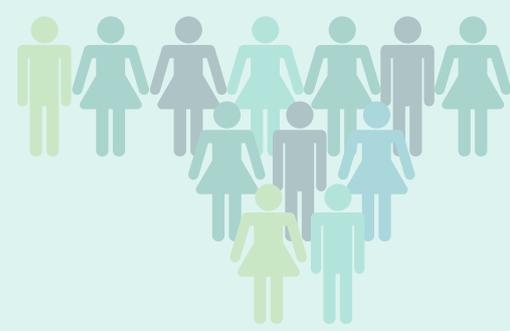
During the 1990s Dee had her first serious relationship and gave birth to her first child. Dee and her partner's relationship ended when her son was around 3 years old and he lived full time with his father at the time of the homicide. Dee's second serious relationship was with an abusive man called Ike, and they had two children together. Ike used domestic violence against Dee throughout their relationship, and she would also fight back against his violence from time to time. Ike spent periods of time in custody in relation to episodes of violence against Dee, and during one of these periods Dee's two children were removed from her care and placed with family members pursuant to formal arrangements with Community Services.

While Ike was serving an 18 month custodial sentence for a serious assault against Dee, she started a relationship with Logan. Logan had a long history of drug and alcohol dependence disorders, and at the time of the homicide, Logan had an extensive criminal record, having spent over 17 years in gaol in relation to armed robbery, violence, domestic violence against former partners, stealing and drug offences. Logan also had an extremely long history of severe violence against former partners and would use violence against women in private and even, on several occasions, in front of police. Logan was an intractable offender, and his violence was not limited by police presence or the consequences of breaching an ADVO.

From early in their relationship Logan was abusive towards Dee. During one period in which Logan was in prison for shoplifting offences, Dee told her friend that Logan had beaten and stabbed her early in their relationship. After he was released from gaol, they continued their relationship and Logan continued to abuse Dee. A few months prior to her murder, Dee presented at a hospital Emergency Department with serious assault injuries, and told medical staff that she had been assaulted with a pole. She did not tell them that Logan had assaulted her. Neither Dee nor the hospital staff reported the assault to police and despite Dee presenting for follow up some time later, Logan's assault was never reported to police. Dee also continued to seek medical assistance through her GP and other healthcare professionals due to her developing epilepsy as an adult.

In a period proximal to the homicide Logan seriously assaulted Dee. In this episode police were called to a public place after a number of people witnessed the assault. Police attended the public place and witnesses told police that they had seen the assailant drag the female up the road and into the unit complex just up the street. Police entered the unit block and followed a trail of blood the unit where Logan and Dee were staying. Unable to raise anyone by knocking, police kicked in the door and heard a woman screaming from the bedroom. Police approached the bedroom and saw Logan sitting on the bed and Dee bleeding from numerous assault injuries on the floor, having also urinated.

Police spoke to Dee and Logan separately, but Dee refused to tell police what had happened. Dee signed one of the officer's notebooks to indicate that she 'did not wish to provide any information'. Police called an ambulance but Dee said that she did not want to go to hospital. Logan told police, 'It's normal, she's been pressing me for days and I couldn't take it anymore, I fucked up, I'm sorry.'



The police event recorded that police held ‘extreme fears for the victim’ and noted that because of the ‘unwillingness of the victim to provide police a version or statement that the victim is placing herself in a very vulnerable situation’.

Police arrested (but did not remove) the abuser and served him with a provisional ADVO. Police left the scene and applied for an urgent ADVO protecting Dee from Logan and sought access to the station’s CCTV, noting on the COPS system that if ‘more information comes to light, police will certainly lay charges against the POI.’ The CCTV footage was reviewed and charges were laid after Dee was murdered. The ADVO was finalised with the additional order that Logan not approach Dee when he was drinking alcohol. There was no associated provision that would enable Logan, with his alcohol dependence, to realistically meet this condition.

On the morning of the homicide, Dee attended her Opioid Treatment Program dispensary and she and Logan spent the day together drinking at a licensed premises before returning to the unit they were sharing with a friend. During the night Logan murdered Dee by stabbing her to death. The following day Logan told the flatmate that he had killed Dee and that evening the flatmate called police. Police attended and Logan was arrested and charged with Dee’s murder. He pleaded guilty and was sentenced to over 20 years in prison.

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### Case Review 3393

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This case concerned the murder of Vera, aged in her 40s, by her de facto husband Tucker, also aged in his 40s. At the time of her murder, Vera was protected under an interim ADVO naming Tucker as the defendant and Tucker was on bail for domestic violence offences against Vera and her son.

Vera was born and raised Sydney and she was very close with her family. Vera met her first husband, Thomas when she was working in a coastal town, and they married and had a child, Justyn. After some years, Thomas and Vera ended their relationship amicably and shared parental responsibility for Justyn, pursuant to informal arrangements. Around this time Vera also started working in an office and was well liked by colleagues.

A number of years before the homicide Vera’s mother passed away and Vera became depressed. She started using alcohol to cope, and around this time she also started a relationship with a man called Henry, who had an alcohol dependence disorder and would use drugs. Henry was abusive towards Vera throughout their relationship and police became involved on a number of occasions due to episodes of violence against Vera, and allegations that Henry was neglectful and abusive towards Vera’s son Justyn and his own biological son Timothy. Vera met Tucker through Henry, and after her relationship with Henry ended, Vera and Tucker started a relationship.

Tucker was born in Sydney and was exposed to domestic violence by his father against his mother during his childhood. Tucker left school after year 10 and worked in various apprenticeships. Tucker had two significant relationships prior to his relationship with Vera, and in both of these relationships he was abusive towards his partners. His patterns of violence included physical assaults and strangulation, threats to kill and psychological abuse and control. His ongoing pattern of violence included an episode where he attacked his partner during an argument and threatened to electrocute her using a hairdryer in the shower, while holding a knife to her throat. At the time of the homicide, Tucker had a criminal record which included a number of convictions for serious domestic violence offences, but his record also indicated that he had assaulted his partners on a number of occasions and charges had never been laid, or had been dropped.

When Tucker and Vera started their relationship, Vera and Justyn moved in to live with Tucker in his house. A number of Vera’s friends told police after the homicide that for the first few months Vera was ‘very happy’ with Tucker. After a while, however, Vera began to disclose to her friends that Tucker was abusive and was using alcohol excessively. Neighbours also noticed loud regular arguments coming from the house. Vera also told her friends that Justyn and Tucker would argue and fight all the time. Colleagues noticed that Vera started coming to

work with bruises and would make up excuses when colleagues asked her about her injuries. Vera eventually quit her job at the office.

Police were involved with Tucker in relation to domestic violence against Vera and Justyn on a number of occasions. In one episode, police attended the house in the early hours of the morning after being called by a neighbour. When police arrived Tucker told them that they had been arguing as he wanted Vera to leave the house. The COPS event notes that 'the police were unable to let her stay at the location because she was not on the lease'. The event further notes that Vera and Justyn spent the night sleeping in Vera's car. Although there were a number of further contacts, Tucker was charged with offences against Vera in the weeks prior to the homicide. In this episode, Tucker seriously assaulted Vera and Justyn. Police attended and arrested Tucker. Despite telling police about her fears that Tucker would get back at her if she made a statement about the assault, Vera attended the police station and made a statement. Police applied for a provisional ADVO including the condition that Tucker not approach the house. Tucker was charged with assaulting both Justyn and Vera and was released on bail the following day with conditions mirroring that of the ADVO.

A few weeks later, police attended Tucker and Vera's house to conduct a 'random domestic violence related bail and ADVO check'. When they arrived Police found Tucker and Vera sitting in the lounge room together. Police charged Tucker with breach ADVO and breach bail. After these charges were laid, Tucker moved in permanently to live with Vera again and Justyn moved to his grandmas. Tucker continued to abuse Vera, and would access her phone and harass her work colleagues.

In the lead up to the homicide, Vera asked one of her work colleagues whether she could stay with him as Tucker was 'going off'. The colleague was concerned about his safety, and told her that she could not stay. She returned home and that night a neighbour heard a loud argument followed by loud music. That night Tucker murdered Vera, fatally strangling her, assaulting her and burning her. The following day, suspicious that Tucker may have killed Vera, Tucker's friend called police.

Despite initially denying that he had killed her, Tucker ultimately pleaded guilty to Vera's murder and was sentenced to over 16 years imprisonment.

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## Case Review 3575

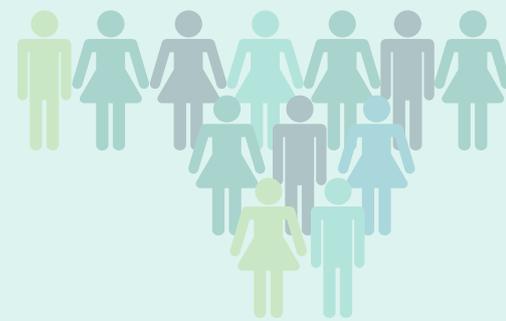
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This case concerned the murder of a woman, Alana, aged in her 30s, by her abusive and controlling husband Lionel, also aged in his 30s. After her murdered Alana, Lionel suicided. At the time of the murder, Alana and Lionel were separating but still living together.

Little is known about Alana and Lionel's early lives, although they commenced a relationship when they were in high school, married in the early 2000s and at the time of Alana's murder, they had three young children. Both Alana and Lionel worked in the NSW Public Service.

According to Alana's brother, Ronald, although Alana and Lionel's relationship was 'good', they had had gone through a 'rocky patch' and Alana had separated from Lionel and moved out about 12 months prior to her murder. Before they first separated Alana and Lionel had been living together with Lionel's family in a shared unit. Alana moved out and took her possessions to her parent's home. She appeared to be crying and upset and had lost weight and seemed distant. Alana's mother told police after her daughter's murder that Alana had disclosed to her that Lionel had assaulted her before they separated and that this is why she had moved out of their home. Alana also told her mother that Lionel was very controlling and 'wouldn't let her live her own life'. Alana also told her mother that she didn't trust Lionel.

Another family member indicated that they had seen Lionel verbally abuse Alana, put her down and 'damage her confidence', and on one occasion after she had gone to bed, Lionel went into their bedroom and dragged Alana out of bed and made her wash the dishes.



After moving back to her parent's home during the separation, Alana told her father that she wanted to divorce Lionel because he treated her so badly. Alana's father told her not to get a divorce and to think about the kids, as it would be too hard on them if their parents got divorced. Alana's father called Lionel and invited him to the house to discuss their relationship. The family all sat down and Alana's mother and father convinced Lionel and Alana to stay together as a divorce would be too hard on the children. Alana's mother told Lionel that if he was having issues with Alana, he should speak to them first rather than assault her.

While Alana was separated from Lionel she commenced a relationship with a work colleague, Aaron. Lionel found out about this relationship by accessing Alana's emails using spyware he had installed on Alana's computer to track her movements online. After some time Aaron and Alana ended their relationship and agreed to remain friends.

Alana and Lionel started living together again around 5 or 6 months prior to the homicide. Lionel continued to monitor Alana's emails. Around 1 month prior to the homicide Lionel told his friend that Alana was having an affair. He told his friend that he had been using the keylogger software on Alana's computer to track her movement, online activity and credit card expenditure. He told his friend that he was thinking of divorcing Alana.

In a period proximal to the murder, Lionel applied and was approved for a handgun permit. In the days prior to the homicide Lionel told his father that Alana wanted to divorce him but Lionel's father told him he should keep the family together. Several days prior to the homicide Lionel resigned from his long term employment, and the day before the homicide he purchased a gun. The evening of the homicide Lionel posted a status update on social media outlining details of Alana's relationship with Aaron, and indicating that he and Alana would soon be deceased. Lionel then murdered Alana by shooting her, before shooting himself. Having seen Lionel's social media update, friends came to the apartment where they found Alana and Lionel deceased.

On the table at the scene of the murder were printed copies of emails between Aaron and Alana, a number of photos and records, and a copy of a letter from a gynaecology centre. This letter indicated that Alana had attended a gynaecology clinic some weeks earlier to terminate a pregnancy. Lionel had written on the letter that he believed Alana had been pregnant with someone else's child.

Also on the table was a photocopy of text messages wherein Alana purportedly threatened to kill the children if Lionel were to reveal details of her relationship with Aaron. These messages apparently had come from Alana's phone, but it is not clear whether they had been written by Alana. There was no other evidence that Alana had ever threatened or hurt her children.

Lionel also left a letter for police on the table indicating that he was killing Alana in order to 'protect' their three children.

This case was finalised by way of inquest.

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## Case Review 3693

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This case concerned the murder of a woman, Shae, aged in her 40s, by her husband Derek, aged in his late 30s. Both Shae and Derek identified as Aboriginal. Shae and Derek lived together in an urban coastal area of NSW, but were separated and living under one roof at the time of Shae's murder.

Shae grew up on an Aboriginal mission in NSW. She was raised by her grandmother and disclosed as an adult that she had been abused as a child (although it is unclear by whom). When she was about 16 years old, Shae moved to Sydney to attend school where she met Derek. When Shae was 17 she left school after her mother died, and when she was 18 she and Derek started a relationship.

Derek was born in regional NSW and he was exposed to his father's domestic violence against his mother during his childhood, and suffered physical abuse by his father. In the months prior to the homicide Derek also disclosed

that he had been sexually assaulted by a relative during his childhood. Derek left school when he was around 14 and worked and played professional sport throughout his late teens and 20s.

Early in their relationship, Shae and Derek moved up the coast. Shae worked as a healthcare worker and while Derek initially played football, at the time of the homicide he was working as a truck driver.

At the time of the homicide, Derek's criminal record consisted of one conviction for a drink driving offence, and Shae had no criminal record.

Derek and Shae married and had two daughters during their relationship. Derek was extremely abusive towards Shae throughout their relationship and threatened to kill her on numerous occasions. Derek accused Shae of having affairs and would listen in on her phone calls. Shae told one of her friends that Derek also forced her to have sex with him, and indicated that while she wanted to end her relationship with Derek, she felt community pressure to stay with him.

In the late 2000s, Shae ended her relationship with Derek and he started seeing a psychotherapist. After having a consultation with Derek, the psychotherapist asked to see Shae, who told her about Derek's violence and abuse. The psychotherapist told Shae that she should consider getting help from police, but continued to see Derek regularly in relation to his 'anger management' issues.

On one occasion after they had separated Derek punched Shae, and the children intervened and called police. Shae told police that this assault was one of many and that she had been too scared to engage with them previously. A final ADVO was put in place and Derek was charged with common assault and bailed. Derek continued to abuse and harass Shae while on bail, and was charged with breaching the ADVO. This charge, and the common assault charge for which he was originally on bail, were later dismissed after Derek pleaded not guilty.

During his final session with his psychotherapist, Derek told her that he wanted to kill Shae. The psychotherapist contacted Derek's mother and told her that Derek needed to urgently see a psychiatrist and she called Shae and told her about what Derek had said. She reiterated that Shae should seek help. A few months later, Shae started seeing an Aboriginal counsellor through the Staying Home Leaving Violence program who worked with Shae until the homicide.

In the period prior to the homicide Shae and Derek engaged solicitors in relation to their property settlement, and Shae's solicitor advised her to not leave the house because it would give Derek 'more rights' over the house when they divorced.

On the day of the homicide Derek told his mother that he suspected Shae was having 'an affair' and during the evening texted a family member to indicate that he couldn't live without Shae. The family member went to the house and found that Derek had murdered Shae by strangling her, and had suicided himself with an unregistered firearm.

The case was finalised by way of inquest.

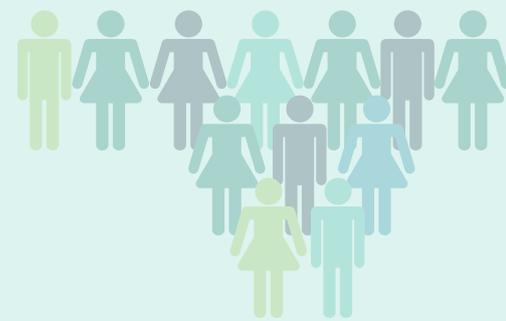
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## Case Review 3312

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This case involved the homicide of a woman, Alisha aged in her 30s, by her de facto husband Thomas, also aged in his 30s.

Alisha had grown up in North America and moved to Australia when she was aged in her 20s, where she started studying hairdressing. She was on a skilled visa at the time of her death and had lodged an application for permanent residency.



Thomas was born and raised in Sydney. He had trained overseas with a view to becoming a religious leader, but returned to Australia where he eventually worked in sales. While Thomas had a criminal record for other offences, and had served a number of sentences in periodic detention, he had never been convicted of any domestic violence offences. However, his police record highlights that Thomas had previously threatened and stalked a number of his former partners, and had threatened to release sensitive footage of a prior girlfriend, and information about a prior termination she had had. No charges had been progressed in relation to these episodes.

Thomas and Alisha commenced a relationship in early 2010 and from an early stage in their relationship Alisha disclosed to friends and family members that Thomas was abusive towards her, although throughout their relationship she disclosed very little in the way of physical violence. Alisha received mixed responses to her disclosures from friends and family, with at least one friend believing that Alisha was exaggerating her experiences for attention. Alisha told other friends and family members about Thomas' controlling behaviours and that he would stalk and psychologically abuse her. On occasion's friends and family also witnessed episodes of abuse, overhearing Thomas abusing Alisha on the telephone, questioning her about where she was, and calling constantly. Alisha's family noticed a change in Alisha's appearance. Thomas also stopped Alisha from going out and socialising with friends. Thomas would also threaten to have Alisha's visa withdrawn and that he could have her deported. Throughout the relationship Alisha's mother constantly tried to get Alisha to return home and to get away from Thomas.

In few months prior to her murder, Alisha started seeing a psychologist and told her about Thomas' abusive behaviours. Despite Alisha clearly indicating that she was a victim of severe and escalating domestic violence, the psychologist recommended that Alisha and Thomas go to couple's therapy. Also around this time Thomas installed spyware monitoring software on Alisha's computer and on Alisha's phone.

In the weeks prior to the homicide, Alisha started seeing a personal trainer, Olivia, who – after hearing about Alisha's issues with eating- suggested Alisha contact her friend Tansie, who was a life coach. A week before her death Alisha had her first appointment with Tansie. Alisha spoke to Tansie about her eating disorder and described becoming emotionally shut down due to Thomas' abuse. Over subsequent sessions, Alisha told Tansie more about Thomas' abuse and Alisha also told Tansie that she was scared and suspicious of the way in which Thomas always seemed to know what she said in conversations with her mother, and would repeat things she had said on the phone. Tansie told Alisha that she could consider putting some belongings in storage so that she could access them if she needed to in an emergency. Alisha also told Tansie she had already packed a bag with her passport in it.

A few days prior to Alisha's homicide, Alisha asked Olivia whether she would mind taking some of her clothes as she was planning to leave Thomas. Olivia agreed and took some bags to her car. After Olivia had left, Thomas found out about the bags. Thomas called Tansie and started abusing her over the phone, and after she hung up she received a text message which told her to drop Alisha's bags back. Tansie told Olivia to return the bags, which Olivia did the following morning. Later that morning Tansie received a text message from Alisha's phone accusing Tansie of ruining her life, but Tansie did not respond to this message and she believed Thomas had sent it.

Around this time Alisha also asked her mother to come and get her. She searched for airline tickets online to bring her mother to Australia, but later called her mother and told her that Thomas had found out about the searches, and that she had worked out he was using surveillance on the computer and her phone. Alisha told her mother that she was going to find a way to leave and said that if anything happened to her to contact Tansie. That same day, Alisha called her migration agent and asked him what would be the risk to her application for permanent residency if she travelled to North America without a Bridging B visa. The agent advised her that her Bridging A visa would cease, that the travel would not cancel the application for permanent residency but she would need to return to Australia on another visa, such as a tourist visa, in order to access the application again.

The night before her death, Thomas turned off the surveillance cameras he had had installed in the apartment. The next morning a neighbour heard screaming and yelling in the hallway of the apartment block and CCTV captured footage of Alisha attempting to leave the apartment. A few moments later Thomas murdered Alisha.

Thomas denied he was responsible for Alisha's death but was found guilty of murder at trial and sentenced to over 25 years imprisonment.

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## Case Review 3481

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This case involved the murder of a woman in her late 40s, Penny, by her estranged husband, Ray, aged in his 50s. After he murdered Penny, Ray killed himself. Penny and Ray had been in a relationship for about 4 years and had been separated for about 5 months at the time of the homicide.

Penny was born in Sydney and after leaving school Penny worked as a secretary. She had two prior partners both of whom were abusive, and she had two children from a prior relationship. In around 2008, Penny started experiencing financial difficulties and depression after her father died. Around this time Penny met Ray.

Ray was born in Sydney and he had a history of criminal offending which begun when he was a young teenager. At the time of the homicide Ray was working as a truck driver. Ray had a long history of violence against prior partners, and his abuse would worsen once the relationship ended. Ray had a pattern of stalking, assaulting, and threatening his prior partners, and had been known to police in relation to violence against women (including several convictions).

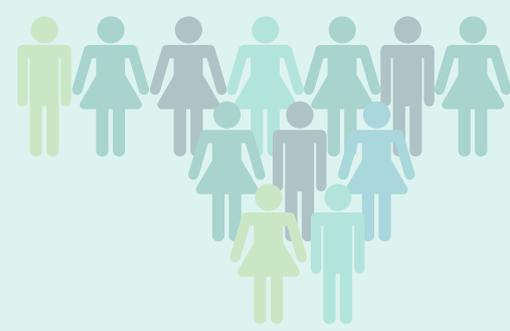
When Penny met Ray, they soon started living together in Ray's house. Penny's son Harry could not stand living with Ray due to Ray's overbearing and controlling personality and moved out soon after. Penny and Ray married later that year.

Penny's son Harry described that during the relationship Ray would become 'jealous' of Penny spending time with her children. On one occasion after he had moved out Harry visited Penny and Ray but Ray would not let him stay in the house. Penny and Ray argued and Ray kicked Penny and Harry out of the house. Penny tried later to pick up some clothes from the house but Ray would not let her in. Harry called the police who attended and helped Penny collect her belongings. Ray continued to control Penny and harass her while the relationship was on foot, and while Penny and Ray reconciled and broke up on a few occasions, they ultimately separated about 5 months prior to the homicide.

After the relationship ended, Ray constantly harassed Penny via phone and text, and requested that his solicitor remove Penny from his will. Ray stalked Penny, including to follow her home from work to find out where she was living, and to indicate to her that he knew where she lived. Over the next few months, Ray was commenced on anti-depressants by his GP after telling the doctor that he was having issues with his relationship and at work. Ray and Penny's solicitors continued to trade property settlement offers, none of which were accepted. Ray also allegedly spiked Penny's drink at the local club, which was written up in the club notebook but not reported to police. On one occasion Ray sent Penny a text message which threatened that he was going to suicide. Ray continuously pressured Penny to reconcile with him, but she refused.

A few weeks before the homicide Penny's house was broken into and she was robbed. Police examined the house and took a full report of items that had been taken. A short time later this happened again and she again reported it to police. Ray contacted police and told them that Penny was making fraudulent claims and had faked the robberies.

Ray started telling Penny that he was planning on leaving the state. Penny kept trying to arrange to pick up items from Ray's house, but he would constantly change plans at the last minute.



On the day of the homicide Penny went to pick up the rest of her belongings from Ray's house. A neighbour saw Ray and Penny arguing as they walked into the house, and about an hour and a half later Ray called his sister and told her to ring police as Penny had had an accident. Ray's sister called 000. Another of Ray's relatives went to Ray's house and found Penny had been shot in the driveway. Police attended and found Ray had suicided by hanging and shooting himself with an unregistered firearm.

The case was finalised by way of inquest.

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## Case Review 3352

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This case involved the homicide of a Vietnamese woman called Li by her husband Dung. Dung killed Li in the context of their relationship breaking down.

Li was born in South Vietnam and moved to Australia in the late 1970s with her then husband Ngoc. Li and Ngoc had three daughters during their relationship, all of whom were born in Australia, Peony, Jane and Sang. Li owned a successful small business and had many friends and acquaintances from the Vietnamese community.

In the early 2000s Ngoc had a stroke and, after a few years of receiving care at home, had to go into full time nursing care. Li visited Ngoc regularly, brought him food and would take him out about once per week. Li met Dung online in around 2005, and Li and her children kept Dung a secret from Ngoc. After meeting Dung, Li's mood improved considerably – as she had been very sad since Ngoc's stroke and subsequent illness. At some point, Li and Ngoc divorced and Li and Dung apparently married overseas.

Dung was born in North Vietnam and he had two children from a prior marriage. He left Vietnam as a refugee following the Vietnam war and lived in America. As a consequence of being held as a POW during the Vietnam war, he suffered brain damage. At the time of the homicide Dung had only basic English skills.

While Dung was living in America, he and Li met online and started talking regularly on the phone. They visited one another on several occasions over the following years travelling between the US and Australia. Dung moved to Australia permanently in around 2011.

After Dung moved in with the family Li's children regularly saw Li and Dung arguing, and noted that there was 'tension in their relationship'. They would argue about Dung speaking to other women on the internet and Dung told Sang that Li 'would not let him have other friends in Australia'. Sometimes when they would fight, Li would drive home from her office and leave Dung to walk home.

Following the homicide members of the Vietnamese community had approached Sang and told her that Li was unhappy in her relationship with Dung.

At some point in the months prior to the homicide, Li and Dung started sleeping in separate rooms. Li started to complain about Dung to her children. According to Peony's statement, Li would accuse Dung of being lazy, and would call him a 'stupid dog' in Vietnamese. Around this time Li also told her friend that Dung refused to sign a pre-nuptial agreement with her, and that she was worried about her money and assets.

A few months before the homicide Dung told Sang that while everyone was out he had been 'mucking around' on the stairs with Li, and he had 'pushed her down the stairs and she fell'. After Dung told her this, Sang checked on her mother who complained of abdominal pain, but said she was fine.

Around a week prior to the homicide Dung told Sang that he and Li had been 'mucking around' on the stairs again and that Li had 'fallen down' again. Sang went upstairs to see her mother, who was in bed, and noticed that Li 'looked scared' and noticed that she glanced quickly at Dung, before looking back at her and saying 'it's nothing, I'm fine'. Sang became frustrated as her mother would not tell her anything further about what happened.

Around this time, Li called her brother and said she was unhappy with Dung. Li's brother thought at the time that 'something bigger' was going on.

All three of Li's children described that in the weeks leading up to the homicide, Li would ask them whether they thought 'Dung was Ok' and would ask them what they thought of him. The girls all thought this was strange.

The day of the homicide Dung murdered Li in the family home by assaulting and strangling her. Sang returned home from work, and after a few hours, found her mother's body in the house. After finding her mother, Sang called 000 and police and ambulance soon arrived. Dung was not at home at the time.

The day after Li died, Dung attempted to kill himself. Li's children found him and Dung was rushed to hospital in a serious condition and was admitted to intensive care. After further police interviews, Dung was arrested for Li's murder. He pleaded not guilty and was convicted of murder and sentenced to over 20 years imprisonment.

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## Case Review 3571

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This case involved the murder of a woman, Janis, by her abusive husband Joseph.

Janis was born in Lebanon and moved to Australia in the 1960s. On a trip to Lebanon in the 1990s she met Joseph. Joseph had also been born in Lebanon and came from a large family. He described being physically abused by his father as a child, and left school when he was about 11 years old. After meeting Janis in Lebanon, they married and moved to Australia.

After settling in Australia, Janis and Joseph had two children – Peter and Summer. Throughout their relationship Joseph was abusive towards Janis. The children noticed that their father would 'overpower' their mother during arguments, and would criticise and denigrate her. Neither Summer nor Peter were close to their father, and Peter described his father as being jealous and manipulative towards his mother. Peter witnessed his father hit his mother on occasions and had confronted him in the past about this. He also noticed also that his father would control Janis' relationships with her friends. In the early years of their relationship the police became involved on a number of occasions in relation to verbal arguments, but no further action was ever taken due to no offences having been committed. On one occasion, when Joseph was seeking a firearms licence, Janis told police that Joseph had threatened to kill her and burn down the house. While police applied for an ADVO to protect her, Joseph forced her to drop the application.

After a few years Janis and Joseph started sleeping in separate beds.

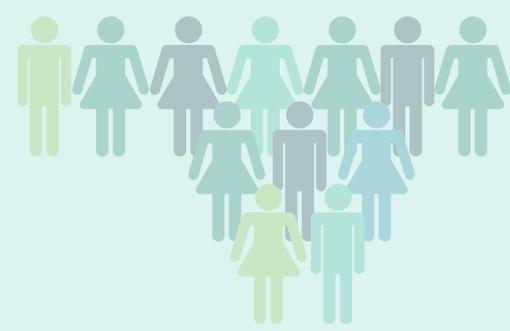
The year prior to the murder Joseph was diagnosed with depression and was prescribed anti-depressants. Around this time Joseph also started accusing Janis of having a relationship with his cousin, and continued to threaten to kill her. He continued to question her constantly about where she was going and who she was with, even when she went to visit her mother. Joseph also punctured her tyres on one occasion.

Eventually, in light of these behaviours, Janis went to the police station to get some advice about what to do about Joseph. She told the officers about Joseph's behaviours. She told them that she wanted to leave him but was concerned about what might happen. She also told them that she was concerned about her children, and felt like a prisoner in her own home. Police applied for an ADVO which proceeded to final orders.

Around this time Peter asked his mother why she didn't 'just divorce' Joseph. Janis told Peter that she was waiting until the children finished school, and she didn't have the money to support them both on her own.

In the months prior to the homicide Joseph continued to accuse Janis of having an affair, this time with a neighbour, and continued to denigrate and control her.

The night of the homicide, Joseph and Janis were at home alone when Janis told Joseph that she wanted a divorce. Joseph grabbed a household item and hit her a number of times over the head. Janis was badly injured



but alive, and Joseph called 000. Later that night Janis died from her injuries. Joseph was arrested and charged with her murder.

Joseph was found not guilty by reason of mental illness, having been diagnosed (post homicide) as suffering from a delusional disorder, namely morbid jealousy.

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## Case Review 3528

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This case involved the murder of a woman, Wendy, by her abusive husband, Homer. Wendy and the children were protected under a current ADVO at the time they were murdered.

Wendy was born in the early 1970s, but other than this, little information is known about her childhood from the material reviewed. Wendy was apparently estranged from her family and no family members were interviewed by police in the construction of the brief.

Homer was born in Sydney. During his childhood he was abused by his father and also exposed to his father's violence against his mother. When Homer was still young his father died of a heart attack. After his father's death, through his first years of high school, Homer started smoking cannabis and using alcohol. He started truanting from school and engaging in anti-social behaviour. Homer had significant mental health problems and had numerous admissions to mental health facilities throughout his life.

Wendy and Homer started a relationship in their late teens, and between the early 1990s and late 2000s they had 7 children. From early in the relationship Homer was abusive towards Wendy, including when she was pregnant. While he had a number of criminal convictions prior to their relationship, the majority of Homer's criminal record related to assaults he had perpetrated against Wendy. This included a period of time he spent in custody for an assault against Wendy.

The children described seeing Homer abuse their mother Wendy regularly throughout their childhood. Throughout Homer and Wendy's relationship, Wendy would escape Homer's violence with the children from time to time, often staying in a domestic violence refuge.

On several occasions police applied for ADVOs protecting Wendy. Family members regularly saw Wendy with injuries and bruises, and she would tell them that Homer had hit her. Other family members witnessed Homer verbally abusing and denigrating Wendy, including in front of the children. On one occasion, when Wendy was 8 months pregnant, Homer was verbally abusing her and she ended up getting stomach pains and heading to hospital before the police arrived at the callout.

In the most significant assault known to police Homer assaulted Wendy in front of police by hitting and kicking her while she lay on the ground. As a consequence of this assault Homer was charged with assault ABH and breaching the ADVO and sentenced to 12 months imprisonment. Around this time Homer was diagnosed with schizophrenia. The ADVO was revoked before Homer was released from custody.

Homer continued to offend against Wendy and the children over the next few years, and his abusive behaviour would often worsen when he was non-compliant with medication.

In the years prior to her murder Wendy disclosed to a neighbour that she was struggling financially and finding it difficult with Homer's illness. The neighbour often heard them arguing and yelling, and could hear the children crying and upset during these fights. Wendy also told the neighbour that she was very isolated as she did not have a close relationship with family or friends.

In the months prior to the homicide, Homer stopped taking his medication and became increasingly irritable and aggressive. Homer reconnected with one of his family members and started telling them that he thought

Wendy had been having an affair and that he didn't think the children were his. He said that she was having orgies while he was in custody. Family members tried to counsel Homer and Wendy about their marriage, but in the two months prior to the homicide Wendy told Homer that she wanted to end the relationship with him. They separated and Wendy lived in the house with the children, while Homer lived elsewhere.

After their relationship ended, Homer and Wendy continued to argue and on one occasion Homer seriously assaulted one of their children. In this assault Homer grabbed his son by the neck and strangled him after becoming angry he was picking his nose. Wendy witnessed this assault and called 000. When police attended they applied for an ADVO and charged Homer with assault. Homer was bailed to live with his mother.

While on bail, Homer's delusional beliefs worsened. When he would visit the children Homer started questioning them about what they and their mother had been doing and what men had been in the house. There was also an occasion where Wendy suspected that Homer had broken into the house and removed all her religious paraphernalia.

In the week prior to the homicide Homer went to his GP and was commenced on a new medication regime for his mental illness.

The day of the homicide Homer came to Wendy's house to visit the children and take them to the park. Once inside Homer stabbed Wendy multiple times while she tried to escape by crawling out the door. One of the children called 000 and police attended. Police subdued and handcuffed Homer, meanwhile Wendy died as a consequence of her injuries.

Homer was interviewed and was determined to be suffering from a delusional condition. He was charged with Wendy's murder but was found not guilty by reason of mental illness. The judgment does not mention any of Homer's history of violence against Wendy, and describes their relationship as 'good' in the period leading up to the homicide.

## Intimate partner and relative/kin domestic violence homicide

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### Case Review 3455

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This case concerned the homicide of two women, Mimi (aged in her 20s) and her mother Heyran (aged in her late 40s) by Mimi's estranged husband Chung (aged in her 20s). Accordingly, this case is both an intimate partner homicide and a relative/kin homicide.

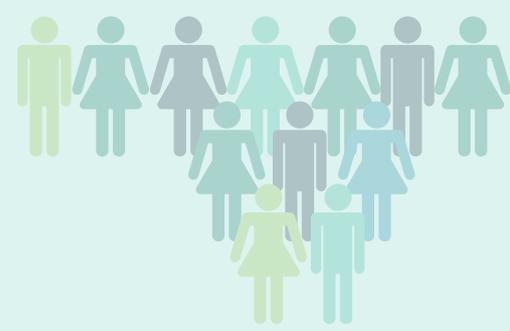
After murdering Mimi and Heyran, Chung suicided.

Mimi and Chung both grew up in China, and in the late 2000s Mimi moved to Australia. Her mother Heyran had moved to Australia a few years earlier after separating from Mimi's father Bolin.

Shortly after moving to Australia, Mimi married Chung, whom she had met online, and a few years later Mimi's father Bolin moved over to live with Chung and Mimi in their apartment in the city. Mimi described having a good relationship with both Heyran and Bolin, and although they had divorced, they remained very close.

In Australia Mimi worked as a healthcare worker, but Chung had no job. According to Bolin, Mimi and Chung argued constantly about Chung's inability to hold down work. Their relationship deteriorated and Mimi told her friend that she believed Chung was suffering from depression. She also said she was unhappy in their relationship and that they were suffering from 'marital problems'.

On a holiday to China, Mimi and Chung decided to divorce. When they returned they started sleeping separately, and according to Bolin, Chung told him that he wanted to reconcile, but Mimi did not want to. Chung started



entering Mimi's bedroom at night, but Mimi told him to get out. Mimi told Chung he should leave and go back to China, but he refused to leave and stayed at the house. The family tried to get him to leave, but he would refuse.

In the days before the homicide, Mimi told her mother Heyran that Chung had been violent towards her previously, and was accusing her of being a lesbian. Heyran, Mimi and Bolin confronted Chung and told him that he needed to leave. Bolin tried to purchase a ticket to China for Chung, but Chung grabbed his passport back.

The next morning, Bolin went to the train station, leaving Heyran, Mimi and Chung at the house. During the day Bolin tried to call his wife, but Chung answered and told Bolin that they were at the lawyer's office. Bolin thought this was strange. Bolin returned from work but Heyran did not pick him up at the station. He tried to get in touch with Heyran unsuccessfully, and upon walking home and breaking into the house, he located Heyran and Mimi murdered in the lounge room.

Two days later Chung's body was located after he jumped in front of a train.

The case was finalised by way of inquest.

## Domestic violence abuser killed by domestic violence victim

### Case Review 3378

This case concerned the stabbing homicide of a man, Bobby, by his de facto wife, Tara.

Bobby grew up in a coastal town and his parents separated when he was a young teenager. He left school in year 10 and worked in a range of different roles.

Bobby had previously been in a relationship with a woman called Simone. Bobby had two children with Simone, and Simone was known to police in relation to verbal arguments against Bobby (in which she was named as the primary aggressor). After their relationship ended, Bobby sought full time care of the children and at the time of the homicide, the two children lived with he and Tara.

Tara grew up in a coastal town and after her father had an accident when she was young, she experienced financial difficulties and her father started using alcohol. Tara was exposed to domestic violence by her father. After leaving school in year 10 Tara worked in retail.

Tara also had a former partner Harrison. They had two children during their relationship. Harrison was physically abusive towards Tara, however this was never reported to police.

Tara and Bobby met at a party and started a relationship. A few months later they all moved in together, and Bobby spent weekends and some weeks living with Tara in her FACS-Housing unit. A few months after they started living together Tara became pregnant.

From early in the relationship Tara and Bobby regularly argued, including in relation to parenting, disciplining the children and other issues. Tara told her friends and family that sometimes Bobby would physically assault her when they were arguing and that on one occasion she had sought medical attention from her GP after Bobby assaulted her. She told her sister that Bobby had stomped on her back when she was pregnant. Tara's sister had also witnessed Bobby assault Tara on a number of occasions, and had heard Bobby verbally abusing Tara, calling her denigrating names.

Tara's daughter told police after the homicide that when Bobby consumed alcohol he would become more abusive towards Tara, and would also start punching himself in the head. Tara's younger daughter also described seeing her mother with bruises on her neck. The children were exposed to Bobby's violence against Tara.

Bobby's mother reported that Tara would also injure Bobby, and that she would evict him from the house. No other evidence was available about this.

The night of the homicide there was a gathering at Tara's unit to watch a sports game. After the game Tara started preparing dinner for the children, and there was an accident involving the children. After the accident Bobby grabbed his son by the neck, smacked him and threw him on the couch and kicked Tara's daughter as she walked by. Tara intervened and told Bobby not to touch her kids. He said she should discipline her kids properly. Another guest overheard Tara threatening to stab Bobby. Bobby left and walked to the bottle shop. When he returned he and Tara argued, Bobby started hitting himself and started goading Tara to punch him. She was holding a knife in her hand and stabbed him. Tara yelled for someone to call the ambulance. The children were present at the scene. Bobby died as a consequence of the stab wound.

Tara told police when they attended that she had stabbed Bobby and she was arrested and charged with his murder. She pleaded guilty to manslaughter and was sentenced to over 6 years in prison. Tara gave birth to their child in custody, and had her daughters returned to her care when she was released from custody.

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## Case Review 3423

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This case concerned the homicide of a man in his early 30s, Chad, by his de facto wife Luana, who was also aged in her early 30s.

Chad was born in North America. His father was extremely abusive and violent towards both Chad and Chad's mother. Chad's parents separated when he was in his mid-teens. After finishing school Chad joined the military but was discharged for stealing offences. After this he completed an engineering degree.

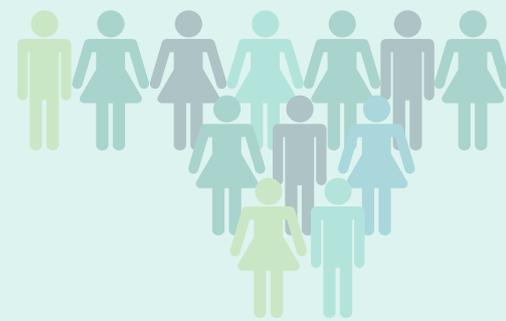
For a number of years in his 20s, Chad was in a relationship with a woman called Brooke. Chad was abusive and physically violent towards Brooke and this behaviour apparently escalated when Chad consumed alcohol. Brooke described various episodes of violence including Chad dragging her across the house by her hair, locking her out of the house when she wasn't dressed, and derogatory verbal abuse.

In the mid-2000s Chad travelled to Australia on a skilled migrant visa. For a short time Chad and Brooke maintained a long distance relationship however Brooke refused to join Chad in Australia and ended the relationship.

Luana was born and raised in Sydney and had a close and loving relationship with her family. In her late teens she married a man called Christopher and their first child, Julian, was born soon after. A few years later Luana and Christopher's second child, Carla, was born after which the couple divorced. Luana and Christopher shared custody of the two children pursuant to informal parenting arrangements.

Approximately 12 months after their divorce, Luana attended her local police station and told police that Christopher had verbally abused and pushed her when she was collecting the children from his house and that she was afraid of Christopher as he was becoming increasingly aggressive towards her during the exchange of the children. Police applied for an ADVO protecting Luana from Christopher and there were no further recorded episodes of domestic violence by Christopher towards Luana.

Chad and Luana met in a bar and began going out a few months later. About 6 months later Chad moved into Luana's apartment where she lived with her children. After Chad moved in, Luana became concerned about how much Chad drank however when she tried to talk to him about his drinking he would become verbally abusive. After moving in with Luana, Chad also became physically abusive, and would grab Luana by her hair and push her against walls when they argued. Luana did not tell family or friends about Chad's abusive behaviour as she felt ashamed.



Some time after Chad moved in, Luana and Chad became engaged.

Over the next three years there were numerous episodes of violence by Chad, some of which were reported to police. On one occasion Chad and Luana began arguing about Chad's excessively rough 'play' with Julian. Luana told Chad she was leaving and Chad grabbed her around the throat and held her until she thought she was going to black out. Luana broke away and called the police. Chad was arrested and taken to the local police station where he gave a conflicting account of the episode, stating that Luana was acting erratically and he held her until she calmed down. Police did not pursue charges on the basis that there were conflicting accounts and neither party had visible injuries. The police applied for an interim ADVO which was subsequently withdrawn/dismitted.

Luana described various episodes of violence that she did not report to police including Chad throwing beer bottles at her, Chad damaging and destroying property and further episodes of strangulation.

Chad blamed Luana for his abusive behaviour, telling family members that Luana was too opinionated and aggravated him on purpose. Luana was in regular contact with some of Chad's family and they told her to stay away from him when he was drinking.

On another occasion Luana called police when Chad, who had been drinking heavily, became verbally abusive and she feared that he was going to physically assault her. Police attended by which time Chad had left the house. Luana denied having any fears for her or the children's safety and there was no further action.

Chad told friends that Luana was possessive and jealous and that she was lying to her family and friends about being a victim of domestic violence to try and turn people against him. On one occasion, in the early hours of the morning, Chad and Luana began to argue as he refused to turn the volume of the television down and she was worried it would wake the children. Chad called police and claimed that Luana had punched him in the face. Police attended and observed that Chad was clearly affected by alcohol and had no apparent injuries. Luana told police that Chad drank every day and said she was scared of him when he was drunk. Police applied for an ADVO protecting Luana with the additional condition that Chad not approach Luana within 12 hours of drinking alcohol. The police conducted a follow up phone call with Luana a few days later to check on her wellbeing and Luana advised police that Chad had moved out. The ADVO was listed at the local court a few weeks later and was 'withdrawn/dismitted'. It is not clear why the ADVO was withdrawn/dismitted.

Chad was also abusive towards Luana's children, and in particular to Julian. A few days before the homicide Chad became angry and Julian and began verbally denigrating him. Chad started grabbing at his belt as if he was going to hit Julian and Luana intervened. Chad screamed that he was going to teach Julian 'a lesson'. Luana told Julian to lock himself in the bedroom and stopped Chad when he tried to push past her to get to Julian. Chad then stormed out of the house.

A few days later Luana and Chad were arguing about money and Chad began abusing Luana for not earning enough money. Chad had been pressuring Luana to ask her parents for a substantial loan so he could start his own business and she told him that she was not going to ask them for the money. He began screaming at her and she told him that she did not want to marry him.

Chad came up behind Luana and placed his hands around her throat, choking her. Luana was unable to scream and tried to get Chad off her by kicking and scratching at him. Luana eventually broke free and ran to the kitchen and grabbed a knife. Chad followed her and she told him to stay away from her. Chad lunged towards Luana and she stabbed him in the chest. Luana immediately called 000 and attempted to render Chad first aid.

Luana was charged with murder and at trial the jury were directed to return a verdict of not guilty to the murder charge. The jury ultimately returned a not guilty verdict to the manslaughter charge on the basis of self-defence.

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## Case Review 3544

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This case concerned the homicide of a man Henry, who was killed by his wife Lucy. Both Lucy and Henry identified as Aboriginal.

Lucy was born in regional NSW and she witnessed and experienced violence during her childhood. It would appear that Lucy was removed from her parents by child protection services and placed with family members at a young age. Lucy left school when she was around 12 years old, and when she was 14 years old she ran away from home and lived in a hostel, before living for a short time with her mother in Sydney.

Lucy started using alcohol at 16, and had her first child when she was 17 with her then partner Ralph. While she was in a relationship with Ralph, she had two other children. After her relationship with Ralph ended, Lucy had a number of abusive partners, and while in a relationship with an abusive man called Todrick, she had her children removed by child protection services. Todrick used serious physical, sexual and emotional violence against Lucy during their relationship, and police were involved on several occasions. After she separated from Todrick, Lucy had a number of further partners, many of whom were abusive towards her, before she met Henry in the mid-2000s. At the time of the homicide, she had an extensive criminal record for violent and non-violent offences, and was known to police as a victim of intimate partner violence and family violence.

Also around the time, Lucy's grandchildren – who she was looking after at the time – were removed by child protection services. Around this time Lucy was suffering from an undiagnosed alcohol dependence disorder, and was struggling emotionally given the recent deaths of both of her parents.

This is when Lucy commenced a relationship with Henry.

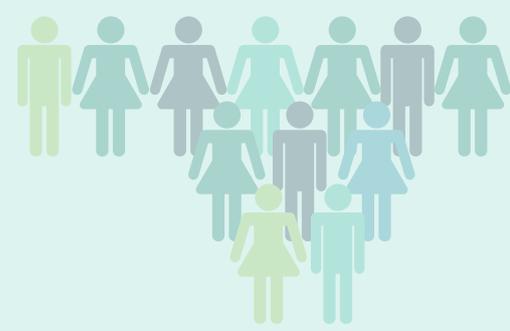
Henry was born and grew up in regional NSW and when he was a young teenager he accidentally shot and killed his father in a hunting accident. After this, Henry started consuming significant quantities of alcohol and experiencing mental health issues, and he described feeling ashamed after his father's death. Before he met Lucy he had a number of partners. Review of police records highlighted that Henry had been both an intimate partner violence abuser and, at times a victim. Henry had an alcohol dependence disorder which was undiagnosed at the time of his death. At the time of his death, Henry also had a long criminal record for both violent and non-violent offences, which included several short periods of imprisonment.

After Lucy and Henry started a relationship, they soon started living together. Around this time Lucy was taking antidepressants following the removal of her grandchildren, and Henry continued to experience bouts of mental illness, depression and self-harm. From early in the relationship Lucy and Henry both used violence against one another, and on an occasion in the mid 2000s she stabbed him in the hand during the course of an argument. After this episode police charged Lucy with assault offences and applied for an ADVO protecting Henry which included an order that Lucy not approach Henry within 12 hours of consuming alcohol. This condition was mirrored in the bail conditions. Within a short time of this condition being set Lucy breached bail as she and Henry were living together and consuming alcohol in contravention of the orders. This was because both Henry and Lucy had undiagnosed alcohol dependence disorders.

Over the next few years police were regularly involved in relation to arguments and violence between Lucy and Henry. Lucy would regularly call police and request their assistance in relation to domestic violence she was using, or experiencing, from Henry.

On a number of occasions Lucy was scheduled after self-harming. On one occasion, Lucy was also convicted of assaulting Henry with a knife and sentenced to 12 months imprisonment, with a non-parole period of 2 months. Shortly after this conviction she stabbed herself in the stomach with a knife and was again scheduled.

Lucy and Henry married and continued to engage with Police regularly in relation to Lucy's violence against Henry, and Henry's violence against Lucy. In particular Lucy would regularly call the Aboriginal Community Liaison



Officer (ACLO) to talk about her experiences, and this officer remained a close point of contact for Lucy in the years leading up to the homicide.

The day of the homicide, Lucy and Henry had been drinking together. That evening, Lucy called police and told the operator that she wanted to see police before she 'killed someone'. She cried and told the operator that she couldn't go back to gaol. She requested police attend, but due to her intoxication the police were not dispatched. Lucy called the Aboriginal Community Liaison Officer, who thought that she did not sound right or normal when speaking to him on the phone. An hour later, she told a neighbour that she had stabbed Henry. The neighbour called the police, and police arrested Lucy at the scene while an ambulance conveyed Henry to hospital. Lucy initially told police that Henry had self-harmed, but she later admitted to having stabbed Henry once in the chest.

Lucy offered a guilty plea to manslaughter but this was rejected and the matter went to trial. Lucy was convicted of manslaughter and sentenced to over 7 years imprisonment.

## Relative/kin domestic violence homicide

### Child homicide victims

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#### Case Review 3341

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This case involved the death of a young toddler, James, who died as a consequence of assault injuries caused by person/s unknown. James' mother, Juliette, was convicted of manslaughter on the basis of failing to seek medical treatment in relation to the assault injuries he had sustained.

Juliette grew up in regional NSW with her stepfather and mother, and she identified as Aboriginal. For over 10 years, from the age of 9, Juliette's stepfather Andrew sexually abused her and raped her almost daily. Andrew also controlled everything she did, prevented her from going out of the house and threatened to hurt her if she told anyone about his abuse. As a consequence of Andrew's abuse, Juliette developed an eating disorder and started self-harming from around the age of 10.

When she was 13 years old Juliette first became pregnant as a consequence of Andrew's rape. She had a termination, but quickly became pregnant again as a consequence of further rapes, and had another termination. Juliette made a report to child protection services about the abuse and as a consequence she was placed in foster care. However, Juliette missed her mother terribly and soon returned to the family home, where Andrew started abusing her again. Juliette became pregnant again as a consequence of rape and just prior to her 16<sup>th</sup> birthday, Juliette left school and gave birth to her first son, Matthew. Soon after giving birth, Juliette again became pregnant as a consequence of Andrew raping her, and she gave birth to another son, Douglas.

When she was 19 years old Juliette started a relationship with a man called Marcus. They had three children during their relationship, Saul, Taylor and James (the deceased). Juliette's eldest children, Matthew and Douglas, lived with the family from time to time, but also spent time living with Juliette's mother. Throughout their relationship, Marcus regularly used violence against Juliette, and threatened to kill himself if she ever left him. This relationship lasted many years, but eventually Juliette and Marcus ended their relationship.

After ending the relationship with Marcus, Juliette started a relationship with a man called Carlos in the months prior to James' death. Carlos had a long history of criminal offending, including domestic and family violence against his mother and a long history of offending against multiple intimate partners. Carlos would use violence both during relationships and after they ended. Carlos had been charged on multiple occasions in relation to offences of violence against women, and from early in the relationship he started controlling and denigrating Juliette.

In the period prior to James's death, Juliette reported Andrew's historical sexual abuse against her to police and Juliette started seeing a sexual assault counsellor. During this period Juliette became retraumatized and was also experiencing pressure from her family to drop the charges against Andrew.

Not long after reporting the sexual assaults to police Juliette self-harmed by stabbing herself in the stomach with a knife. Prior to this episode, Juliette was becoming increasingly anxious, and concerned that Carlos was being unfaithful to her. Before she stabbed herself, Carlos had locked Juliette out of the house while they were having a fight. After being conveyed to hospital Juliette was scheduled under mental health legislation and Marcus looked after the children. While staying with Marcus, day care staff reported that James had new bruises and made a report to Community Services. The children were known to Community Services already in relation to bruising and unexplained injuries, but these reports did not progress. The children also spent some time with Carlos while Juliette was in hospital. When Juliette left hospital she noticed that James had bruising and was behaving as though he had the flu. The following afternoon James was still unwell and she bathed him and put him to bed with some children's pain medicine.

Over the next few days, James continued to present with flu like symptoms, and when Juliette attended the doctor to have her stitches removed, she booked him in to see the doctor in a few days time. Juliette had taken James to the doctor on many occasions during his young life. While Juliette was at the doctor's herself, she left the children – including James – with Marcus. While the children were with Marcus, a neighbour heard loud banging and the sounds of a toddler screaming. This evidence did not come to light until several weeks before the trial.

After her trip to the doctor, Juliette and Carlos then picked up James who still appeared to be unwell. His flu-like symptoms continued into the next day, and when Juliette went to wake up James from his afternoon nap, she found he was unresponsive and called 000. James was conveyed to hospital, and a short time after arriving James was pronounced dead. The autopsy determined that James died as a consequence of multiple injuries, including blunt force head injury. He had both old, and new, injuries.

After conducting enquiries into James' death, police charged Juliette with James' murder. After Marcus' neighbour's evidence came to light, the crown adjusted its strategy and pursued the case as one of manslaughter (failure to protect). Juliette was found guilty of manslaughter by a jury and sentenced to over 4 years imprisonment. It was never determined who had caused James' fatal injuries.

Juliette's stepfather Andrew was convicted of historical child sex offences against her and was sentenced to a lengthy period in custody.

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## Case Review 3543

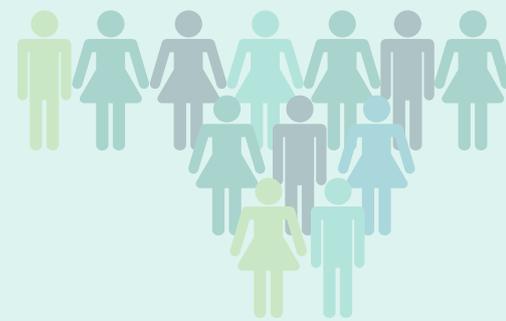
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This case involved the homicide of a 7 month old child, Jonathon, who was killed by his father, Vincent.

Jonathon's mother Penelope, a young Maori woman, had been in a relationship with Vincent for around 18 months and Vincent had been abusive towards both Penelope and Jonathon (and Jonathon's brother Kel) during the relationship.

Penelope grew up in New Zealand. She experienced sexual abuse during her childhood from a family member, but otherwise little is known about her childhood. As a young woman she had a brief relationship and became pregnant with a child called Kel. Penelope met Vincent shortly after giving birth to Kel.

Vincent also grew up in New Zealand and both his parents were from the Cook Islands. He was removed from his family and placed in the care of the state for a period of time during his childhood, and he also spent some periods of time living in the Cook Islands. After leaving school at the age of 14, Vincent worked in various labouring type roles and became involved in gang activities. He had been using alcohol since he was around 9



or 10 years old and had alcohol dependence issues and an alleged acquired brain injury due to being assaulted with a hammer during his adolescence. After the homicide he was also diagnosed with a mild intellectual disability.

Prior to forming a relationship with Penelope, Vincent had a relationship with a woman called Yara in New Zealand, and they had a child, Hope. Family members had seen Vincent physically assault Yara during their relationship, and Vincent also had a criminal history in New Zealand for vehicle theft, property damage, shoplifting and other minor offences.

After starting a relationship with Vincent shortly after Kel was born, became pregnant again. Early in her pregnancy Penelope and Vincent talked about travelling to Australia and a few months later they travelled to Australia on temporary visas with some family members. It is not clear whether Penelope knew she was pregnant at this time. Penelope smoked throughout her pregnancy and had poor antenatal attendance in Australia.

Not long before Jonathon was born, Vincent and Penelope had an argument and Vincent travelled to Sydney while Penelope remained in Melbourne. Penelope gave birth to Jonathon in Melbourne. Vincent convinced her to move to Sydney with him and his family, and she reluctantly agreed.

When they moved to coastal NSW, Penelope, Vincent and the two children lived with Vincent's brother and his family in an overcrowded house. After moving in, family observed that Vincent would use alcohol and become aggressive towards Penelope and other people. A neighbour overheard Vincent yelling and swearing at Jonathon when he wouldn't stop crying. Around this time Penelope told her family that she wanted to come home to New Zealand as she was unhappy living there. Penelope also told one of Vincent's family members that Vincent wouldn't let her leave her room. They also argued constantly.

About 6 months before the homicide, Penelope contacted the domestic violence helpline and she and her older son Kel left and went to stay at a refuge in Sydney. Vincent refused to let Penelope take Jonathon, but a short time later Vincent's sister took him to the refuge. Penelope and the children stayed at the refuge for over a month and she remained in contact with Vincent. While in the refuge Penelope made enquiries about getting Jonathon an Australian passport, but she was advised that he was not eligible, as both her and Vincent were New Zealand citizens. After Penelope had been in the refuge for a month and a half, the refuge determined that Penelope had reunited with Vincent, and a decision was made that she could no longer stay at the refuge. Penelope left the refuge and attended FACS-Housing offices seeking emergency accommodation. She was advised she was ineligible for assistance as she was not a citizen, and the office advised her to go to Centrelink in the morning and try and find a hotel to stay in that night. She told the office that she had nowhere to go and she and the children would be homeless. Penelope and the children eventually went and stayed with a friend Penelope had met at the refuge.

A report was made to child protection services in relation to Penelope's disclosures about her and the children being homeless, but the report was assessed and it was determined that there was not enough evidence that the family was homeless, and the matter was closed as there was no previous child protection history, and the family couldn't be located. Around this time, however, another child protection services report was made regarding concerns about Penelope's parenting and the fact that she may possibly have had a developmental delay. The matter was not screened in, but the record notes that the family was referred for case management. This referral did not progress as the unit could not locate Penelope or the children.

At some stage Vincent moved in with Penelope and the children at Penelope's friend's place. Shortly after he moved in there was an episode where Penelope and Vincent had an argument and Vincent grabbed Jonathon in a pram and stormed off. Penelope called police and told them that her ex-partner had kidnapped her child. Vincent returned before police arrived, and when the attended and spoke to Penelope she told them that they had just had a verbal argument, and Vincent said he had taken Jonathon for a walk to cool down. No further action was taken.

Shortly after this time Penelope took Kel back to New Zealand to enquire about getting Jonathon a passport, leaving Jonathon in Vincent's care. When she arrived in New Zealand Penelope disclosed Vincent's violence to family members and told them that he was often 'rough' with the children. Vincent and Jonathon moved back into the house with his family on the coast, where they slept together on a mattress on the floor.

The morning before the homicide, Vincent took Jonathon to the doctor for his vaccinations. Upon returning home Jonathon was unsettled and family noticed that Vincent was having difficulty settling him. Vincent tried to feed him a bottle but Jonathon would not take it and Vincent started swearing at the baby and shaking him. Vincent put him down on the bed. The next morning, family members noticed that Jonathon appeared to be in pain, and later Vincent called Penelope and told her that Jonathon had stopped breathing. Jonathon was rushed to hospital but later died.

Vincent was initially charged with grievous bodily harm, and charges were upgraded to manslaughter when Jonathon died. The Crown accepted a guilty plea and Vincent was sentenced to over 5 years imprisonment.

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## Case Review 3040

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This case involved the murder of a 2 year old girl, Esther, and the attempted murder of her mother, Yasmin, by Esther's father (Yasmin's husband) Arash.

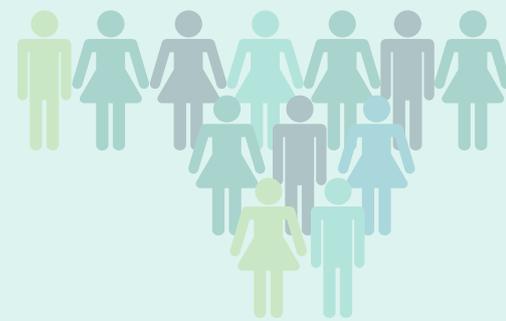
Arash was born in the Middle East and he described having a normal childhood. He attended university for a year but claimed he was captured by the Taliban who held him in a Taliban gaol for a number of years and subjected him to torture. His wife, Yasmin, later said that she did not believe his story as it was inconsistent with his family's stories during this time. He claimed that he escaped the gaol and fled to a neighbouring country where he met Yasmin who he later married in an arranged marriage.

Arash travelled to Australia on a humanitarian visa, before applying to sponsor Yasmin to join him in Australia. Arash applied for permanent residency. Arash was receiving treatment through a torture focused organisation and other refugee health organisations around this time.

From early in their relationship Arash was extremely abusive and controlling towards Yasmin. He would not let Yasmin leave the house, and would not let her develop any friendships in their community. Arash spoke good English but Yasmin spoke only limited English, and he would speak on her behalf whenever anyone would try to talk to her. Around 20 days after she arrived in the country Arash was pressuring Yasmin to have sex with him and when she refused Arash and his mother threatened to have Yasmin deported. Later that night Yasmin self-harmed, cutting herself with a knife. Arash grabbed the knife off Yasmin and stabbed himself whilst threatening her. The ambulance attended and Arash was taken to hospital where he remained for several weeks. No further action was taken.

After this time Yasmin discovered she was pregnant. Each time she visited the doctor Arash would attend with her and would speak on her behalf. While Yasmin was pregnant, Arash continued to assault her, and threatened her that if she told the doctor about the violence he would kill her. After Esther was born, Yasmin presented at the doctors after Arash had hit her in the face. The GP recorded the assault disclosure in their notes, but took no further action.

There were a number of further contacts with police one of which resulted in police applying for an ADVO protecting Yasmin from Arash. This was granted with final orders for a period of 6 months. Around this time both Arash and his mother wrote to the Department of Immigration seeking to have Yasmin's spousal visa withdrawn. Around this time Arash and Yasmin travelled back to Afghanistan for a while, and while they were there Arash took Yasmin's passport. When they returned, Arash became more controlling and abusive. Arash raped and threatened Yasmin regularly. On one occasion Yasmin had a miscarriage and Arash told her he believed she had done this on purpose.



The day of the homicide, Yasmin and Arash argued and Arash started attacking Yasmin after locking the door to the unit. Yasmin, terrified, tried to run out of the building while Arash was attacking her. A neighbour intervened and another neighbour called the police. Arash then went back upstairs to the unit and murdered Esther.

Police attended, and after extensive Mental Health assessment, Arash was determined not to be suffering from a mental illness.

Arash eventually pleaded guilty to Esther's murder and to grievous bodily harm offences against Yasmin and was sentenced to over 25 years imprisonment.

## Adult homicide victims

### Case Review 3517

This case involved the homicide of a woman, Isabella, by her daughter Samantha, in regional NSW. Samantha was 30 years old and she identified as Aboriginal. Isabella was non-Indigenous, and aged in her late 50s. Both Isabella and Samantha lived separately, but would visit one another regularly.

Samantha grew up in regional NSW and was exposed to domestic violence by her father against her mother throughout her childhood. She started using cannabis at the age of 11 and left school in year 10. When she was 18 or 19 she started experiencing mental health issues, and was scheduled on a number of occasions for acute psychosis over the following years. In the mid 2000s Samantha was placed on a Community Treatment Order which was in force when she killed her mother. Samantha had two brothers, one of whom died of a heroin overdose in the years prior to the homicide. Review of police records highlight that her brothers were abusive towards her and her mother both throughout her childhood and into her adulthood.

A few years prior to the homicide, Samantha became pregnant. She terminated the pregnancy, and experienced significant mental health issues which lead to her being scheduled. A few years later Samantha again became pregnant, and she spent part of her pregnancy as an in-patient at a psychiatric hospital. She gave birth to a daughter – Marigold – who was removed by Community Services after birth and placed in foster care. Marigold's removal devastated Samantha, who applied through Children's Court to have Marigold restored to her care, citing her compliance with medication and wellness (both of which she had been working on to have Marigold returned). Her proceedings were unsuccessful, and Samantha's mental health deteriorated significantly as a result.

At the time of the homicide, Samantha had a minor criminal record, but she was recorded as a party in over 60 events, mostly comprising episodes where she was arguing with Isabella (Samantha as aggressor), or her brothers were abusing her (Samantha as victim). The system also highlights that Samantha had made several police reports alleging historical sexual assaults when she was a teenager (by her brother and other people). Police recorded in their systems that these reports were 'extremely doubtful' about the truth of these claims as Samantha would 'change her story while retelling it', and was 'adding detail' that the police did not believe.

In the lead up to the homicide there were a number of events in which Isabella called the police to have Samantha removed from her property after an argument or episode of violence. Across these events, police inconsistently record the 'history of violence' between Samantha and Isabella, at times noting that there was 'NIL' history, and at other times that there was an 'extensive' history. In each episode, Isabella would call police who would attend and either remove Samantha or, if Samantha had already left, would seek a statement from Isabella. On each occasions Isabella refused to give a statement and, when it was offered, would also usually refuse referral and support information.

The most recent police callout, where Isabella wanted Samantha to be removed from the property, was dated 5 days prior to the homicide. Police attended and asked Samantha to leave. Samantha told police she was abused

as a child and she left the property saying to her mother 'I'm gonna take you for the house it's my house'. Isabella did not make any further disclosures to police and they left.

In the days leading up to the homicide Samantha became increasingly mentally unwell. She was scheduled and released, and after returning home neighbours noticed she was acting strangely. The night before the homicide she called her mental health worker and arranged to meet her the following day.

The next morning, Samantha travelled to Isabella's house before a scheduled supervised visit with Marigold. However Samantha missed the train and couldn't make it to the appointment. Samantha returned to her mother's house and Samantha and Isabella argued over Marigold. During this argument, Samantha picked up a pillow and smothered Isabella. After a short time Samantha called an ambulance and performed CPR on her mother. Samantha was arrested and conveyed to the police station. During her police interview, Samantha was delusional and after she was charged with murder, she was scheduled for mental health treatment.

Samantha was found not guilty by reason of mental illness in a judge alone trial.

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## Case Review 3430

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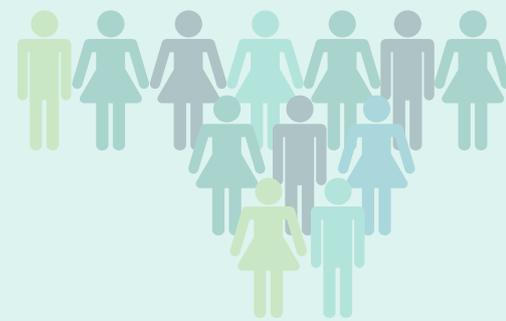
This case involved the murder of a man called Bruce and his partner (the perpetrator's stepmother), Daisy by Bruce's adult son Ewen.

Ewen was born in regional NSW to his mother Ivy and his father Bruce. Bruce was abusive towards Ivy throughout Ewen's childhood and Bruce was also abusive towards Ewen and his sister. After an episode in which Bruce assaulted Ewen, Ivy separated from Bruce and took both the children to live elsewhere. Later, Ewen said that he always blamed himself for the end of his parents' marriage. Ewen and his sister spent every second weekend with Bruce, but lived most of the time with their mother. From an early age Ewen started engaging in some anti-social behaviour, but was described as a good student without problems at school until year 10. In year 10 Ewen started being bullied, and at the school formal he punched another student and was convicted of a serious assault offence, for which he was sentenced to a good behaviour bond. Around this time Ewen started using drugs and alcohol. Ewen was abusive towards his sister and would denigrate her and tell her to kill herself. As a consequence of Ewen's abusive behaviours, she left home and became estranged from Ewen.

After Bruce and Ivy divorced Bruce started a new relationship with Daisy. From early in their relationship Bruce was abusive towards Daisy, including on one occasion strangling her. Bruce and Daisy had a son, Ulrich. After Ulrich was born, Bruce continued to abuse Daisy, and on one occasion she escaped to a refuge with the baby. They separated and eventually reconciled after Ivy had had another child, Sofi, and Bruce started seeking help for his alcohol dependence and gambling issues. Throughout high-school Ewen continued to visit his father and Daisy every second weekend.

After finishing high school, Ewen moved in to live with his grandparents for a short time. Around this time the grandparents described episodes in which Ewen would become 'angry' and say that he was going to kill Bruce. Ewen moved around a few times before moving in with Bruce and Daisy. Ewen was working, at this time, as a security contractor, but lost his licence due to assaulting a patron. He continued throughout this period to behave strangely, including telling his mother that he was planning on 'committing murder.' She encouraged him to seek help and he visited a hypnotherapist and healer.

A few years prior to the homicide Ewen started a relationship with a woman called Benita who had two children. They moved in together a short time later. Benita told police after the homicide that throughout his period Ewen regularly threatened to murder Bruce and Daisy. Ewen sought medical help and was diagnosed with depression and anger management and his GP prescribed him antidepressants. Around this time however, Ewen assaulted Benita by strangling her and pinning her up against the wall. After strangling her, Ewen told Benita again that he was going to kill his father.



The day of the homicide Ewen and Benita had an argument during a party at their house. Ewen grabbed Benita by the hair and threatened that he was going to go and kill her mother. Ewen then grabbed a knife and started walking down the street. He tried to break into a car, and then tried to attack a woman who was driving a car, causing her to crash. He stabbed another man through the window of his car, before continuing to walk along the road, stealing a bicycle and cycling to a nearby store. He tried to break into someone's house along the way by pretending that he worked for a charity.

When Ewen arrived at the store, Benita and her friends (who had been driving around searching for him) tried to intervene. Ewen punched Benita and tried to attack the owner of the store. Ewen texted Benita's mother threatening to kill her, before car-jacking a man who had pulled up near the front of the store and driving away. After Ewen left, police attended the store and Benita told them she thought he may be going to her mother's house, or to his stepmother and father's house.

Ewen drove to his grandparents' house, intending to kill his grandparents and then his father. Ewen's grandparents were not at the house and when Ewen saw his grandparents' neighbour pull up, he car-jacked them and drove to his friend's house with the plan of obtaining a shotgun. When he arrived at the friend's house he forced his friend to open the gun safe. He grabbed a rifle and left to drive to his father's house.

When he arrived at his father and stepmother's house, Ewen bashed in the panel of the front door with the butt of the rifle and he walked up to his father Bruce before stabbing him repeatedly. Ulrich came out of his room to see what was happening, and ran to a neighbour's to seek help. Daisy, aware of what was happening, tried to hide, but Ewen found her and repeatedly stabbed her in front of her daughter Sofi. Ewen walked out of the house, and drove away.

Police located his car and chased him both in the car, and on foot, before apprehending him. He told them that he was on his way to kill his mum next. Ewen was charged with over 20 offences including two counts of murder. He pleaded guilty to all offences and was sentenced to over 40 years imprisonment.

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## Case Review 3345

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This case concerned the stabbing homicide of a woman in her late 50s, Jasmine, by her son, Christopher who was aged in his 20s.

Jasmine grew up in the Philippines before moving to Australia where she met Christopher's father Dwight. After they married, Jasmine and Dwight had three boys including Christopher. When Christopher was about 9 years old he was sexually abused by a neighbour, who was charged and convicted in relation to the assault.

Christopher was also diagnosed at a young age with a condition which caused lesions to grow on his brain; a condition which ultimately resulted in him suffering from epilepsy and regular seizures. Christopher struggled at school and left school in year 9.

As a young man Christopher came to the attention of police for minor public order offences and started using drugs and alcohol. When Christopher was around 16 years old his father Dwight called police as Christopher was refusing to go to work and he couldn't deal with Christopher's behavioural problems. Shortly after this time, Christopher was arrested for break and enter and trespass offences, and subsequently robbery offences.

As a young man Christopher also started using violence against family members. He was arrested for threatening his brother with a knife, and an ADVO was applied for but not finalised. At the time of this offender, Jasmine and Dwight told police that they didn't want Christopher to return home. Christopher moved out of home for a period and lived on the streets, but returned home a few weeks later.

Meanwhile there were a number of episodes of police contact between Jasmine and Dwight in relation to Dwight using alcohol and violence against Jasmine. Police attended on a number of occasions but no charges were progressed against Dwight in relation to alleged assaults. An interim ADVO was applied for protecting Jasmine from Dwight but this was withdrawn/dismissed.

On a number of occasions while Christopher was living with his parents he was taken into hospital, aggressive and agitated after having a seizure. Christopher's treating psychiatrist discussed the possibility of putting Christopher on Seroquel, but this did not progress and after each episode Christopher would be discharged into Jasmine's care. His medical notes highlight that Christopher had a long history of being aggressive and abusive towards family members, and noted that he had previously broken his father's hip and his brothers' nose during episodes of violence. Christopher continued to convey delusions, including around aliens visiting, but was still only managed by his GP and taking seizure medication.

In the lead up to the homicide, Christopher had a consult with his doctor and he and Jasmine were observed to be 'quarrelling' during the consult. He was referred to a psychiatrist, whose report highlighted that Christopher was hostile towards his brothers and father, but Jasmine said that he was never hostile towards her. Christopher was referred to a psychologist, but continued to live with Jasmine and Dwight.

A few months prior to the homicide, Dwight called the police to report that Christopher was throwing things in the house, and that they were arguing. Police attended and Jasmine told them she would 'make sure' Christopher and Dwight were separated for the rest of the night.

The night of the homicide Christopher was at home with his parents and brother. Christopher came into the lounge room where his parents were watching television and started screaming at them, acting erratically. Christopher ran into his bedroom and grabbed an ornamental sword, and his parents ran and tried to hide in a laundry. Christopher stabbed his mother with the sword several times. Dwight sustained a number of injuries whilst disarming Christopher, but Jasmine died at the scene.

Christopher was charged with Jasmine's murder and was found not guilty by reason of mental illness.

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## Case Review 3418

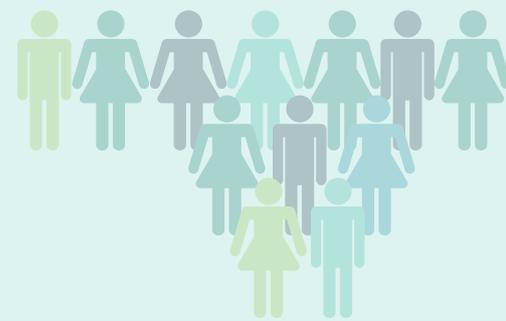
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This case concerned the homicide of Abdul, a man aged in his late 60s, by his son Ali, aged in his 40s. Abdul was born in Lebanon, and he and his wife Marie moved to Australia as young adults. They had 7 children altogether, including four who were born in Lebanon (including Ali, who was aged 5 when the family moved to Australia) and three who were born in Australia. When they left Lebanon the country was in conflict, and Ali has strong recollections of being exposed to violence and conflict during his childhood. Ali was also exposed to violence by his father against his mother, as throughout their relationship Abdul had been abusive towards Marie, and Ali was also directly abused by his father, who physically and emotionally abused him throughout his childhood.

Ali was bullied during school and left school in year 10. Around this time he started drinking, and he and his parents would often argue about his behaviour. Ali left home, met a woman called Greta and they married. Ali was initially using cannabis, but after Greta and he had two children, he started using different kinds of drugs and family members began to suspect that he was suffering mental illness.

Ali started criminally offending around this time. He was convicted of a number of drug offences and shoplifting. While he was in custody Ali was assessed as suffering from schizophrenia, and was commenced on medication for this. After being released from custody he started using heroin and soon became dependant on that drug. His relationship with Greta ended and she moved interstate with their children.

Ali continued to offend over the next few years, and served numerous short custodial sentences for assault



offences (non-domestic), larceny and other forms of armed robbery. He once tried to hang himself in a local park and was scheduled and commenced on anti-psychotic medication. He was diagnosed with psychosis, but upon taking medication he appeared to improve, and he was discharged. After being discharged, he appeared before the court in relation to a number of armed robberies and was sentenced to a significant custodial sentence.

Upon release Ali moved in with his partner Stefanie and commenced on the Opioid Treatment Program. Ali was abusive towards Stefanie from early in their relationship and although she separated from Ali a few years later due to his violence, they continued to have ongoing contact. Over the next few years Ali went through periods of being well, and then would discontinue his medication and his mental health would decline. During periods of decline he would experience psychotic episodes and persecutory beliefs. He was scheduled two further times over the coming years. He also had ongoing contact with community health providers, and was noted to be behaving strangely and holding strange beliefs regularly, and particularly while he was non-compliant with medication.

About a year prior to the homicide Ali seriously assaulted Stefanie. He punched her in the face while she was in his car, and further assaulted her after they went inside his house. He dragged her around the house and strangled her, whilst accusing her of being 'unfaithful'. He then threatened her with a knife and turned the gas on in the house. She fell asleep. The next morning he continued to assault her and then she took him to collect his opioid treatment dose. When they arrived at the hospital she ran from his car, inside the hospital, to seek help. Ali was charged with assault offences and strangulation offences, and police applied for an ADVO. Ali was bailed. Despite breaching bail a number of times by failing to appear, and being found by police in possession of a knife, he was again released on bail.

He continued to seek mental health treatment intermittently over the next few months, but by the month prior to the homicide, he was non-compliant with medication. He started making comments threatening the family, but family members did not believe he was serious. He also threatened to kill his brother and held a knife up to him, but his brother did not take it seriously. These behaviours continued up until the night of the homicide.

The night of the homicide, Ali stayed at his parents' house. They noticed he was acting strangely and during the night Ali smoked cannabis and was shouting and singing in his room. Early the next morning, when Marie got up to do her morning prayers he pushed her down the stairs whilst calling her a devil, and then he punched her in the face, before turning on his father Abdul, whom he hit with a brick before stabbing him. He inflicted severing injuries to his neck and head. One of his brothers called 000, and officers attended and arrested Ali.

Ali was tried for his father's murder and found not guilty by reason of mental illness.

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## Case Review 3494

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This case concerned the homicide of a man in his late 60s, Donald, by his step-son James, who was aged in his 20s.

James was born in the Philippines where he lived with his parents and a number of siblings. James' father was abusive towards his mother, Nida, and James' father regularly physically assaulted him. When James was in his teens his parents separated and Nida travelled to Australia on a tourist visa. She worked as a carer for a number of years by which time she had overstayed her visa and was in Australia illegally.

In the mid-2000s Donald and Nida were introduced by a common acquaintance after Donald had told the acquaintance he was looking for a 'Filipino wife'. They commenced a relationship and a short time later Nida and Donald made an application for a spousal visa. Nida returned to the Philippines for a period while her visa status was determined. Nida was granted a dependant spouse visa and returned to live with Donald in Australia. A short time later, James and his younger sister Kay travelled to Australia on temporary visas and moved in to live with Nida and Donald.

Prior to his relationship with Nida, Donald had been married to a woman called Shar and was known to police as a domestic violence abuser following an episode where he assaulted Shar. Donald was convicted of the assault and was made subject to an ADVO. Many years earlier Donald had also serviced a sentence of imprisonment in relation to a serious sex offence. Notwithstanding this criminal record, Donald was employed as a carer for people with disability.

From the time James and Kay moved in, Donald was physically and verbally abusive towards James, constantly belittling and making derogatory remarks to him. Donald was also sexually abusive towards James, touching him on his genitals and trying to force him to look at pornographic material. James wanted to return to live in the Philippines but did not want to leave his mother and sister with Donald. James began to see his local GP complaining of stress, insomnia, and panic attacks, and was commenced on anti-depressants.

Some time before the homicide Donald was arrested and charged for covertly filming a number of children playing in a private yard. Donald was convicted of a number of offences and imprisoned. While Donald was in gaol, James returned to the Philippines however he returned to live in Australia as his migration lawyer told him that he needed to return to safeguard his residency application.

A few months prior to the homicide Donald was released from gaol and his abusive behaviour towards James escalated.

On the morning of the homicide Donald began to harass James and shoved him against a wall in the kitchen. James grabbed a knife and stabbed Donald a number of times and also inflicted a number of blunt force injuries to Donald. James then attempted suicide by taking a box of medication with a bottle of alcohol and passed out. Later that evening Nida returned home from work and found Donald deceased and James unconscious. Nida called 000.

James was arrested and charged with Donald's murder. At trial James was found guilty of manslaughter on the basis of substantial impairment and was sentenced to over 7 years imprisonment.

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## Case Review 3735

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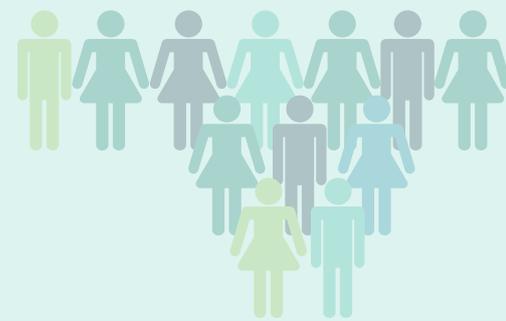
This case concerned the death of a woman in her 80s, Malia, who died as a consequence of fatal neglect by her son, Keanu.

Malia was born in Fiji, and gave birth to her son Keanu in Fiji. In the 1980s Malia travelled to Australia on a tourist visa. She overstayed her visa and remained in Australia until her death. Throughout her time in Australia she had been visiting the same GP and paying for consults, when she moved in with Keanu, she stopped attending her GP.

Keanu grew up in Fiji and met and married a Fijian woman there, having one son. In the late 1980s he also travelled to Australia on a tourist visa. He also overstayed his visa, but later successfully applied for permanent residency in Australia. He continued to work in Australia and sent money back to his wife and child in Fiji.

In the mid-2000s Malia and Keanu started living together. Around this time the doctor's notes indicate that Malia was beginning to suffer from dementia and was becoming paranoid and reclusive. Following an episode in which Malia sustained an injury to her foot she was treated in hospital and her son Keanu acted as her interpreter during her consultations with the specialist. As she required follow up care which she couldn't afford, her doctors attempted to work out a solution to get Malia the treatment she required in relation to her possible dementia. Malia never received the follow up attention required for her possible dementia.

Over the next few years Malia continued to seek medical assistance irregularly, and all doctors noted that Keanu was his mother's primary carer. Keanu continued to act as her interpreter during these consults.



There was one episode of police contact in which police attended the house following reports from a neighbour that a woman was screaming and yelling. When police attended they found Malia on the floor in a distressed state and the house in a state of squalor. Keanu told police that mother had dementia and that they had argued when he was trying to bathe her. The call, which had initially been coded as a domestic violence call out, was written up as a mental health event and police took no further action.

In the year before Malia's death, neighbours began to hear an elderly female yelling and screaming and apparently singing from the unit at various hours of the day and night. Some neighbours, in statements made to police after Malia's death, reported that it sounded like someone in pain while others stated that it sounded like someone who was 'mentally ill'. One neighbour was concerned about the woman's well-being and suggested to her partner that they call police. However he said that it was 'not their business' and 'not to worry about it'.

The day of Malia's death, Keanu called police and told them that his mother was not breathing. Police attended and found Malia sitting in a chair in an upright position against the wall, deceased. Keanu told the police that she was regularly seeking medical attention and that the death was unexpected. There were initially no suspicions about the death. However, once the body had been conveyed to the morgue, a preliminary examination by the pathologist revealed that Malia was suffering from severe pressure ulcers which were indicative of neglect.

After an extensive investigation Keanu was charged and tried for negligent manslaughter. Keanu was found guilty and sentenced to 3 years imprisonment.

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## Case Review 3592

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This case concerned the stabbing homicide of a man Christopher by his adult son Oscar in the family home.

Christopher was born in Australia and married his wife Renata during the 1970s. The couple had four sons including Oscar. At the time of the homicide Oscar and one of his brothers were still living at home with Christopher and Renata.

Oscar was educated in school until year 10, and started drinking when he was around 13 years old. He started using drugs at 13 or 14 and was regularly using cannabis at the time of the homicide. Oscar claims that he was sexually abused during his childhood, but no further detail is known about this. When he was 15 years old he was convicted of assaulting a school friend, and he had a number of drink driving offences (for which he had been convicted and sentenced) at the time of the homicide.

By his late teens, Oscar was becoming increasingly verbally and physically abusive towards his parents. He would often damage property within the family home. As he started using drugs such as methamphetamine, his abusive behaviours escalated, and there were a number of police callouts in relation to Oscar's violence against his parents. He was scheduled on a number of occasions over the years prior to the homicide.

Over a number of years Oscar was taken into mental health treatment on a number of occasions and was diagnosed with schizophrenia. He often presented with paranoid delusions, disordered thoughts and paranoia, and he was regularly discharged to live with his family. He was abusive towards his family both when he was using drugs, and when he was not using drugs. He was often non-compliant with his medication and while his family regularly pushed for Oscar to be placed on a Community Treatment Order (CTO), they were never successful at getting him placed on such an order.

In the months leading up to the homicide, Oscar became increasingly unwell and abusive towards his parents. His parents started contacting Oscar's mental health team and told them that he was expressing delusions and concerns that his neighbours were trying to kill him. His father also told the health team that Oscar was becoming increasingly abusive and threatening towards him. Oscar was admitted to hospital, and was found to be non-compliant with his medication. Although it was recommended that Oscar be placed on a Community Treatment Order, this was not put in place and Oscar continued to be non-compliant when he was discharged.

A few months later, Christopher again contacted Oscar's health workers and told them that he was 'sick of the abuse' and 'felt like killing Oscar' himself. Police attended and spoke to Christopher and Oscar. Christopher told police that he wanted Oscar out of the home but that Oscar was refusing to leave. Oscar was taken to the hospital for assessment and later discharged to live back with his parents.

Oscar continued to threaten and harass his parents in the house over the next few weeks. Christopher continued to press Oscar's mental health team for a CTO, but none was progressed. Around this time Oscar was discharged from his mental health service as he was not engaging with them, leaving him non-compliant with medication and without a treatment team.

In the weeks prior to the homicide Oscar's abusive behaviours towards his parents escalated.

The night of the homicide, Oscar was affected by alcohol and was being abusive towards his parents when Christopher told Oscar that he had to leave and find somewhere else to live. Oscar went to the kitchen and grabbed a knife and stabbed his father. Oscar left and police and ambulance attended, but Christopher died in hospital.

Oscar was arrested and charged with Christopher's murder but was found not guilty by reason of mental illness.

## 'Other' domestic violence homicides

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### Case Review 3420

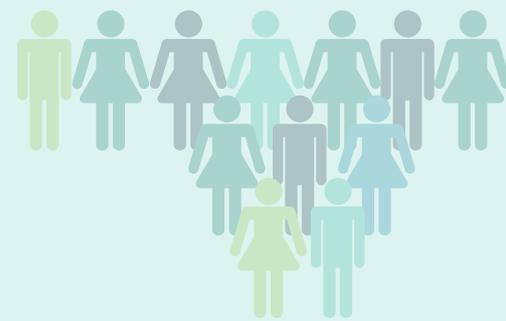
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This case involved the homicide of a young Aboriginal man, Toby, by his de facto brother in law, another Aboriginal man called Jakob.

Jakob had a difficult upbringing in regional NSW and moved around a lot as a child, living in an overcrowded house in poverty during his childhood. He experienced abuse as a child (although the precise details of this are unclear), started using alcohol as a young teenager after leaving school at 13, and first came to the attention of police when he was around 15 years old. At the time of this murder, Jakob had a long history of offending against prior partners, and had spent the majority of his adult life in prison for murdering his former partner Jane. While awaiting trial for this murder, Jakob also perpetrated a serious sexual assault against another inmate in relation to which he was imprisoned for a further two years. All up, Jakob served over 10 years in prison for these offences and was released on parole in the late 2000s.

While in prison he continued to offend against his former partners including by harassing and threatening them over the phone. While in custody he completed anger management/violence management and drug and alcohol counselling, but after being released on parole, he soon breached parole by assaulting a former partner. He was taken back into custody to serve the remainder of his sentence. After he was released from custody, Jakob continued to offend against intimate partners.

At the time of the homicide, Toby was in a relationship with Jakob's sister Nina, and Jakob was in a relationship with Toby's sister Ruby. At the time of his murder, Toby and Nina had a young family with two daughters. Toby had a significant criminal record which had commenced when he was 11 years old, and involved street offences, weapons offences, break and enter, drug offences, assault offences and truancy. As an adult, Toby had a long history of offending against Nina, including episodes where he punched her repeatedly in the face, chased her and beat her repeatedly with a television aerial. For some of these offences Toby was known to police, but other episodes were never reported or finalised by way of conviction. Searches of police systems revealed that Toby's father had been brutally murdered by a member of another family, and there are indications from both the police systems and the brief of evidence that this rivalry continued until Toby's murder.



In this case, the night prior to the homicide, Ruby and Jakob went to a party. The night of the party Jakob punched Ruby in the face and threw a beer can at her. The following morning community members attended a funeral, and after the funeral, Ruby and Jakob had people over to their house to mourn their friend's death. Around midnight Jakob became 'agitated' and assaulted Ruby by throwing a chair at her. He also had an argument with Nina, and swore at Nina, telling her to get out of his house. At this point Toby stepped in to defend Nina and Jakob and Toby started to argue. During the argument Jakob retrieved a knife, before stabbing Toby in the chest. Toby died in hospital, and Jakob was arrested and charged with his murder.

Jakob attempted to plead guilty to manslaughter, but this was rejected and he was found guilty of murder. He was sentenced to over 16 years imprisonment.

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## Case Review 2299

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This case involved the homicide of a man aged in his late 40s, Lee, by a man aged in his 50s, Tai. Lee and Tai's wife Mara were having a covert relationship, and Tai killed Lee after he waited and ambushed them in he and Mara's home.

Lee was born in Korea. He travelled to Australia during the 1990s and married a woman called Diana.

Tai was also born in Korea and experienced a disadvantaged upbringing. Tai attended high school until the equivalent of year 11 and in the 1980s he moved to Australia and where he met and married Mara. They had two children.

Mara met Lee through a social association and a few years later they started a covert relationship. Within a few months on their relationship beginning, Lee's wife Diana began accusing Lee of having a relationship with Mara, which he initially denied. Diana confronted Mara about the relationship but she also denied it. A few months prior to the homicide when Tai returned from a work trip Mara began to suspect that Diana may have told Tai about her and Lee's relationship, and Mara and Tai decided that they would sleep in separate rooms. Around this time, however, Tai started demanding that Mara have sex with him every day.

One morning about a month before the homicide, Tai left for work at about 6:00AM. Lee arrived at the house a few hours later as he was doing renovations on Mara and Tai's home. Later that morning, Tai returned to the house unannounced – without calling Mara to tell her he was coming home. Mara thought this was unusual. Tai said that he was experiencing chest pains and went to the GP. Tai told his GP that he suspected that his wife was having an affair. He gave a history of tightness in his chest, shortness of breath and heart palpitations. The GP prescribed Tai antidepressants.

Around this time, Tai also started talking to Mara in ways that she interpreted as veiled threats. For instance, he talked about the ways in which good people could be 'pushed to do terrible things' in certain circumstances.

On the morning of the homicide, Tai left home and arrived at work at about 6:00AM. At about 8:00AM, Tai told a colleague that he was experiencing chest pains, and he left work and headed home. Meanwhile Mara had taken the children to school and when she returned found Lee in the kitchen cleaning the benches. She told Lee she believed that Tai knew about their relationship.

Lee and Mara went upstairs to one of the bedrooms, and Tai arrived home and parked his car around the corner (rather than in the garage as he usually did). He entered the house and found Lee and Mara in bed together. He grabbed a knife from the kitchen and returned and stabbed and killed Lee. Tai called police, and then went outside and moved his car into the garage before they arrived.

Police attended a short time later, arrested Tai and charging him with Lee's murder.

At trial Tai successfully argued the partial defence of provocation and was found guilty of manslaughter on that basis, receiving a sentence of 7 years imprisonment.

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## Case Review 2319

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This case concerned the homicide of a man called Daniel by another man Sean who was acting together with his son Amirul. At the time of his murder, Daniel was having a secondary covert relationship with Sean's wife, Irdina.

Irdina and Sean were both born in Indonesia and were practicing Muslims. Sean left school in year 11 and worked in various odd jobs, and Irdina undertook tertiary education in Indonesia. Irdina's family arranged her marriage to Sean after her father passed away. After Irdina and Sean were married, they moved to Australia where Irdina undertook further education and started working as an accountant. Sean continued to work in various unskilled roles. Irdina and Sean had a son, Amirul, during the 1990s.

Sean was extremely controlling and abusive towards Irdina throughout their relationship. Irdina told psychologists after the homicide that the only reason she stayed with Sean was because of their son Amirul and disclosed in one of her assessments after the homicide that Sean had hit her and spat on her during their marriage. Amirul also told psychologists after the homicide that he witnessed fighting and violence between his parents. Around the time Irdina met Daniel, her and Sean had started sleeping separately.

Irdina met Daniel at work. Daniel was also Indonesian, was a practicing Muslim, and had moved to Australia during the 1990s. Daniel had a history of violence against his prior partner in Australia, and at the time of the homicide was living alone, having separated from his wife.

Irdina and Daniel soon became close friends and started spending time together at work over the next few years. Irdina asked Sean for a divorce but he refused. The psychologist after the homicide noted that Irdina was very scared that Sean would not grant a divorce even after he had killed Daniel. It is not clear when Sean became aware about Irdina's relationship with Daniel.

In the lead up to the homicide Sean and Amirul started tracking Daniel's movements and hired a car to follow him. The evening of the homicide they left home with weapons and attacked and killed Daniel. When he was assaulted, Irdina was on the phone with Daniel and overheard the assault taking place. A number of bystanders witnessed the assault (which occurred on a public street) and called emergency services. Sean and Amirul left the scene and returned home.

The following day Amirul told a friend what had happened. Irdina contacted a friend to arrange for Amirul to leave the country, she claims out of concern that he would find out about the relationship she had with Daniel.

Sean and Amirul were charged and in separate trials each was found guilty of Daniel's murder. Sean received a sentence of over 20 years imprisonment and Amirul over 25 years imprisonment.

Irdina was charged with being an accessory after murder and she was found guilty. She received a sentence of almost 2 years but the sentence was suspended.

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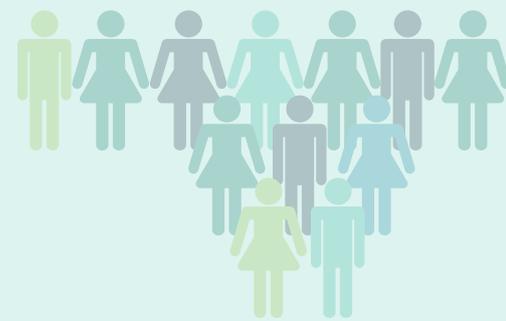
## Case Review 3371

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This case involved the homicide of a man called Walter by another man called Scott, who then suicided. Scott's wife Briana and Walter were in a covert intimate relationship when Scott murdered Walter.

Briana grew up in England, and moved to Australia as a young adult. She had two children from a prior relationship (with Scott's brother), and then started a relationship with Scott. At the time of the homicide, Briana and Scott had been in a relationship for over 20 years, and had two children, Keera and Martin.

Scott grew up in Africa, and moved to Australia as an adult. He was largely estranged from his family at the time of the homicide. He worked as a truck driver at the time of the homicide. At the time of the homicide, Scott was suffering from a terminal illness.



According to Briana, throughout her relationship with Scott he was abusive, threatening and denigrating towards her, describing her as 'fat' and saying that he 'preferred her skinny.' In the months prior to the murder, Briana and Scott had been arguing more, and she wanted to leave Scott, but was scared of what he would do if she left him. Scott would also regularly binge drink, and Briana was concerned about how he would cope if she left. Scott was also physically abusive within their relationship and on one occasion hit Briana and held a knife to her throat. This assault was witnessed by a friend who intervened to protect Briana. Briana was very short, and Scott would stand over her and yell at her when he was angry with her. Briana also noted that Scott was 'tough on the children', particularly Martin when he was in trouble at school.

Briana met Walter through work. When Briana was sick with a serious illness, Walter contributed some money to her treatment and was very kind to Briana. After separating from his wife, Walter and Briana started a covert relationship around 12 months prior to the homicide.

At some point during their relationship, Scott found out about Briana and Walter and started stalking Briana. One evening Scott and the children were going through Briana's phone to find evidence about her relationship, and when Briana found out about this she told Scott their relationship was over and said she was going to move out. Scott continued to co-opt his children into helping him stalk Briana and catch her over the next few days, and when Briana went to New Zealand on a planned trip to visit her family, Scott and the children stalked Walter, and went through many of Briana's possessions to find evidence of her relationship with him.

During this period Scott's mental health was in decline and he was suffering from depression. His children started sleeping in the lounge room with him, and Keera stopped attending high school. Around this time Scott also told one of his friends that he had only 2 months left to live.

While Briana was in New Zealand, Scott and his daughter Keera went to a meeting at Keera's school with the head teacher of welfare. At this meeting, Scott disclosed to the teacher that he suspected his wife had a new relationship, told the teacher that he and the children had been following Briana and Walter around, and disclosed that neither he nor Keera were sleeping properly. Scott told the teacher that he wanted to reconcile with Briana. They agreed that the school would send home information about counselling for both Scott and Keera.

In the week prior to the homicide, Scott rapidly lost weight and was constantly crying. He had been overheard talking about killing Walter, but his children did not believe he was serious. Scott had asked Keera to sketch out the inside of Walter's house (as she had been there previously) and she had given this sketch to him. When Briana returned from New Zealand, she and Scott worked out parenting arrangements, finances and Briana packed up her remaining things with a view to moving out a few days later.

The morning of the homicide Scott told his son Martin that he was planning on killing Walter. Martin tried to talk him out of it, but he couldn't. Briana told Scott she was going to the gym. When she left the house, Scott grabbed a rifle and followed Briana to Walter's home. He stormed in and shot Walter, and when Briana tried to get the gun from him, Scott stabbed Walter a number of times with a knife he had taken with him. After murdering Walter, Scott told Briana that this was her fault, before suiciding by shooting himself.

The case was finalised by way of inquest.

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## Case Review 3449

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This case involved the stabbing homicide of a man in his 60s, Edgar, by his former partner Ursula's current girlfriend Anyka, a woman aged in her 20s.

Edgar had grown up in Australia. He had suffered a brain injury due to a car accident when he was younger, and had a long history of violence and criminal offending. He had a lack of inhibition, had been diagnosed with having a lack of mental stability and poor judgement.

Anyka had grown up in regional NSW and she had a significant trauma history. She was abused by her mother and her father, and suffered physical and sexual abuse from her stepfather and older brother. Her family moved around a lot as a child and she had disrupted schooling. She had also been raped by a neighbour and a cousin and had reported both assaults to police, but neither had progressed to charges.

As a young teenager she began self-harming and developed an eating disorder. She started using drugs and alcohol and was removed from her family and placed in state care. When she was 14 she was hospitalised following a drug overdose, and the following year attempted suicide after suffering a miscarriage. Around this time Anyka left school, and became known to police in relation to break and enter offences and violence. At the time of the homicide she had a significant criminal record. She had been through the MERIT program and rehabilitation on a number of occasions.

Edgar met Ursula in the 1990s. Ursula had alcohol dependence and gambling issues, and Edgar would give her money in exchange for sex. Edgar was physically abusive towards Ursula, including strangling her on a number of occasions. He would also rape her. Police had attended on a number of occasions and Ursula had been previously protected under an ADVO naming Edgar as the defendant.

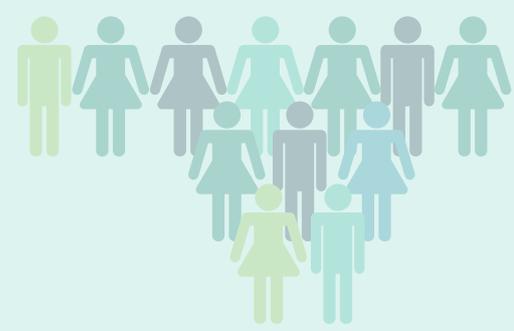
When Anyka was 18 she met Ursula (who was aged in her 40s) and they started a relationship. Edgar continued to give Ursula money, but it is not clear whether he continued to sexually assault her during this time. Anyka and Ursula travelled around Australia and while they were interstate, Anyka started experiencing delusional behaviours. Anyka and Ursula travelled back to NSW where they started staying with Edgar. The first night they were there Edgar brought out a number of sex toys and threatened Anyka with a knife and told her to have sex with him. She refused.

A few nights later, he again brought out the sex toys and attacked Ursula. Edgar locked Anyka out of the house and as she was trying to get back in, she injured her hand and Edgar called police. Anyka was conveyed to hospital for treatment.

A few weeks prior to the homicide Ursula was taken into custody for breach of parole, and Anyka continued to live in the house with Edgar. Edgar continued to pressure Anyka to have sex with him. Anyka, around this time, started experiencing delusions and was hearing voices. She attended a psychiatric hospital in the weeks prior to the homicide, and was put on antipsychotic medication and discharged.

Although the precise date of the homicide is not known, the day of the homicide Anyka and Edgar were drinking and using drugs. In the afternoon Edgar came behind Anyka and told her that she owed him. She claims that she thought he was going to rape her, and she broke free from his grasp and stabbed him. Anyka escaped and went to a relatives' house, and she told the relative what had happened. The relative reported the matter to police, but the police made no formal record of the report.

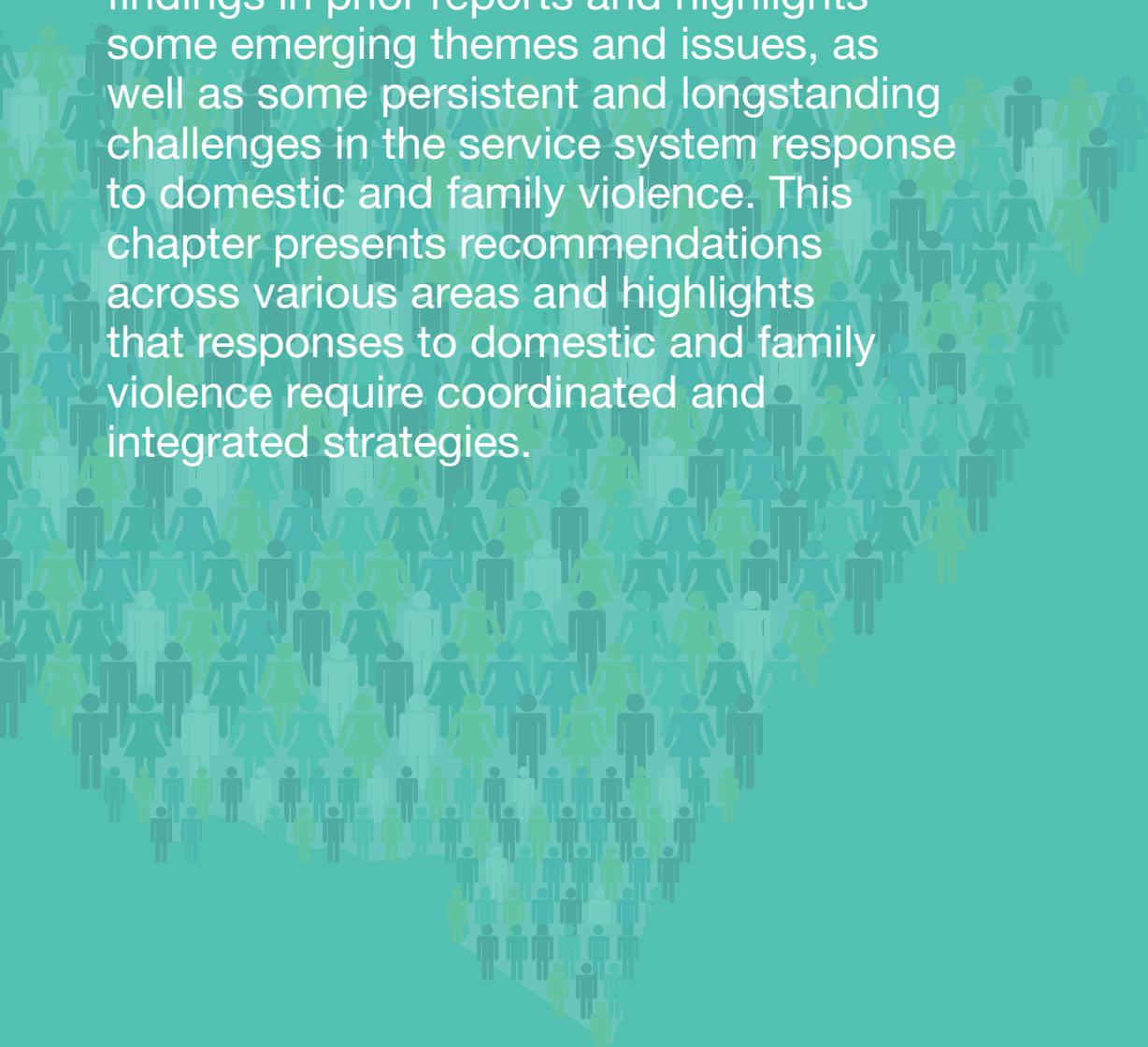
Two months later, following a call to Crimestoppers, police attended Edgar's house and found Edgar deceased. Anyka was located and arrested. Anyka was diagnosed as having a schizoaffective disorder. She pleaded guilty to manslaughter and was sentenced to over 5 years imprisonment.

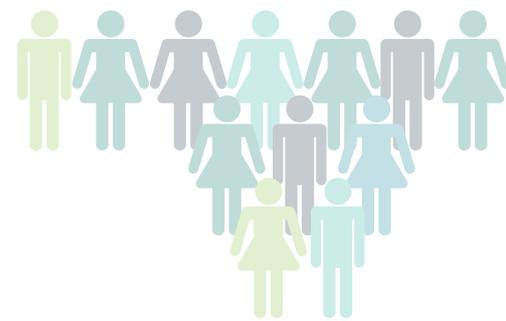


# Commentary & Recommendations

## An Integrated Analysis

This chapter outlines findings and recommendations derived from cases and data considered within this review period. This chapter builds on the Team's findings in prior reports and highlights some emerging themes and issues, as well as some persistent and longstanding challenges in the service system response to domestic and family violence. This chapter presents recommendations across various areas and highlights that responses to domestic and family violence require coordinated and integrated strategies.





## Introduction

In this reporting period a clear theme that has emerged from the Team's review is the importance of viewing and understanding domestic violence holistically. This theme is reflected throughout the Team's commentary and in many of its recommendations.

Accordingly, this report covers a wide range of areas and makes recommendations that are specific and focused, as well as recommendations that are broad in scope, addressing issues of prevention and intervention, as well as secondary trauma.

By virtue of its methodology the Team gains a unique insight into the complexity of domestic violence and, as a consequence, its findings and recommendations reflect the need for sustained, co-ordinated and holistic interventions centring on the experiences of victims, abusers and communities, and addressing social norms and attitudes supportive of violence.

This chapter highlights the importance of conceiving of domestic violence death prevention as an intergenerational and sustained effort that transects agencies, committees and issues well beyond moments of interaction between an abuser and a victim.

## Shifting cultures permissive of violence

Preventing and addressing domestic violence requires governments and policymakers to develop strategies and initiatives to shift cultures permissive of violence.<sup>29</sup> While domestic violence is often attributed, at its core, to patriarchal attitudes and gender inequality, domestic and family violence is often perpetrated and experienced at the intersection of various axes of oppression, including sexism, ageism, racism, drug and alcohol dependence, and poverty.<sup>30</sup> Accordingly, holistic responses to violence require the government to address multi-stratum structural inequality and disadvantage, and to promote shifts in public attitudes across intersecting axes. Such responses also involve coordination across governments, including investment in consistent approaches and the development of coordinated initiatives across states and territories.<sup>31</sup>

## Addressing media representations of violence

The Team has identified that media reporting around domestic and family violence, and in particular domestic and family violence related homicides and murders followed by a perpetrator suicide,<sup>32</sup> is a critical area in which mutualising and dismissive narratives of violence remain pervasive.<sup>33</sup> In this and prior reporting periods, the Team has consistently identified the media as a key site in which language and narratives around domestic violence diminish perpetrator accountability, inappropriately blame victims, and reinforce problematic stereotypes around violence.

29 World Health Organisation, *Changing cultural social norms supportive of violent behaviour*, World Health Organisation, 2009, available at [http://www.who.int/violence\\_injury\\_prevention/violence/norms.pdf](http://www.who.int/violence_injury_prevention/violence/norms.pdf) (accessed 30 September 2017); National Council of Australian Governments, *The National Plan to Reduce Violence Against Women and their Children 2010-2022* (Commonwealth Government, 2011) available at [https://www.dss.gov.au/sites/default/files/documents/08\\_2014/national\\_plan1.pdf](https://www.dss.gov.au/sites/default/files/documents/08_2014/national_plan1.pdf), (accessed 30 September 2017).

30 Sokoloff and Dupont, 'Domestic violence at the intersections of race, class, and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities' (2005) 11(1) *Violence against women* 38.

31 Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS) and VicHealth, *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia*, Our Watch, 2015, available at <https://www.ourwatch.org.au/getmedia/0aa0109b-6b03-43f2-85fe-a9f5e-c92ae4e/Change-the-story-framework-prevent-violence-women-children-AA-new.pdf.aspx> (accessed 30 September 2017); National Council of Australian Governments, *The National Plan to Reduce Violence Against Women and their Children 2010-2022* (Commonwealth Government, 2011) available at [https://www.dss.gov.au/sites/default/files/documents/08\\_2014/national\\_plan1.pdf](https://www.dss.gov.au/sites/default/files/documents/08_2014/national_plan1.pdf), (accessed 30 September 2017).

32 This is evident from a number of case reviews including Case Review 3693 and 3621.

33 Berns, *Framing the victim: Domestic violence, media, and social problems* (Routledge, 2017).

In some instances this language simply replicates problematic statements and narratives used within court processes,<sup>34</sup> but at other times journalists and news outlets adopt sensational, misogynistic, mutualising or stereotypical language in the period immediately following a homicide, often in circumstances where they are operating with few facts or insights about the nature of the case.

For instance, the day following the alleged murder of a woman by her husband, a prominent Australian newspaper published an article which included the headline that the murderer ‘suspected affair and trawled wife’s phone before fatal stabbing’. The article described how the husband searched his wife’s phone, and that ‘an argument ensued escalating to the allegedly fatal point where [the perpetrator] is accused of grabbing a kitchen knife and stabbing [the victim] in the chest.’ The article proceeded to quote statements from the perpetrator’s legal representative, namely that ‘the deceased was having an affair, he found out about it and the relationship came to a tragic end.’

While it is acknowledged that murders are a crime of particular social interest, when an individual is murdered their voice ceases to be heard, and the perpetrator’s voice often becomes the only account of the crime until the case is ventilated in court, or through reports such as those of this Team. The Team acknowledges that journalists are placed in a difficult position of having to report stories of public interest quickly, on limited facts, and have other challenges which may arise for them in the context of reporting about this violence.<sup>35</sup> However, the Team is of the perspective that framing stories in this way reduces perpetrator accountability and blames the victim for their death. Further, it is inappropriate to passively describe such a case as ‘coming to a tragic end’ when a victim was killed by a perpetrator.

This relates to another key issue the Team has identified with the media, namely the issue of reporting around victims who may use drugs and alcohol; may be struggling with various forms of dependence; victims who fight back or use retaliatory violence; victims who have secondary covert relationships; or victims who are sex workers. These factors are often drawn upon to explain or excuse the predominantly male perpetrator’s violence. Such an approach can be used against female victims to discredit their experiences of victimisation, when they do not meet patriarchal assumptions about how victims should behave as women. The media should take the lead to proactively hold perpetrators accountable and reflect and engage with the reality of victimisation for many women.

Further, the Team has identified that while journalists will often include Lifeline and Mensline referral numbers on suicide reporting, including where an abuser has murdered a partner or family member and then killed himself, it is uncommon to see the number for 1800 RESPECT or other domestic violence services included at the bottom of an article concerning a domestic violence related homicide. This is despite clear guidance from organisations such as Our Watch around standards for media reporting<sup>36</sup> (discussed below) and initiatives designed to improve media reporting, including the Eliminating Violence Against Women Media Awards.<sup>37</sup>

A high proportion of the media reporting around the cases considered by the Team highlight inadequacies in journalists’ understandings of domestic violence, and inadequacies in the way in which domestic violence deaths are reported. The influence of this media reporting on community attitudes and perspectives on violence cannot be overstated, and media reporting often both reflects, and shapes, community attitudes.

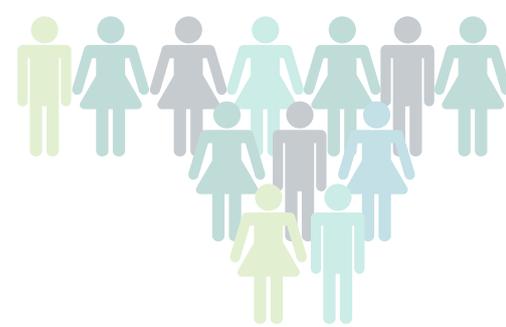
It is the Team’s perspective that journalists should seize opportunities to create a dialogue around domestic and family violence that holds perpetrators accountable, highlights the value of victims’ lives and refrains from mutualising violence – appropriately attributing violent actions to actors, rather than to a ‘relationship’. Too frequently, however, these opportunities are missed.

34 See for instance, Case Review 3558 in the Team’s 2013/15 Report.

35 Our Watch, *Reporting on Domestic Violence*, Our Watch, 2014, available at [https://www.ourwatch.org.au/MediaLibraries/OurWatch/Images/ourwatch\\_reporting\\_on\\_domestic\\_violence\\_aa\\_v1.pdf](https://www.ourwatch.org.au/MediaLibraries/OurWatch/Images/ourwatch_reporting_on_domestic_violence_aa_v1.pdf) (accessed 30 September 2017).

36 Ibid 3.

37 See <http://www.evas.org.au> (accessed 30 September 2017).



For instance, in Case Review 3693 in this reporting period, an abuser murdered his estranged wife after decades of subjecting her to extreme domestic violence. After murdering her he killed himself. The coronial finding described the case as a 'great human tragedy', which was a phrase subsequently reflected in media reporting around the case. Other media reports concerning this case did not attribute the murder to the perpetrator, rather talking about the victim having 'died', or being 'dead', without acknowledging that the perpetrator had strangled his victim before shooting himself. Articles also described the 'relationship' between the homicide perpetrator and victim as being 'marred by domestic violence' – mutualising the violence when the facts clearly indicate that the homicide perpetrator had been the primary domestic violence aggressor throughout the relationship.

In another case during this reporting period (Case Review 3571) an abuser murdered his wife, fatally assaulting her with a weapon. The murder followed years of the perpetrator's violence against the woman, and in the wake of her death her family spoke publically about their devastation and anger, but also of the woman's strength and character. While some media outlets chose to report the family's important story - both detailing the woman's history of victimisation as well as celebrating her life and resilience - most media reporting simply sensationalised the homicide and focused on the brutal manner in which the perpetrator killed her. In one article, the journalist noted that the perpetrator had threatened to kill the victim in the past, and described the murder as him having 'made good' on his 'deadly promise'. The article proceeded to describe the victim as the 'slain woman', before ironically closing with a quote from a relative, which stated that Australia had a 'long way to go' in recognising that violence against women is wrong.

Media reporting is a national, not state concern, and ending violence against women requires co-ordination between states, territories and the Commonwealth Government. In 2013, as an initiative under the *National Plan to Reduce Violence against Women and their Children 2010-2022* (the National Plan), the

Commonwealth Government established Australia's National Research Organisation for Women's Safety (ANROWS).<sup>38</sup> ANROWS is an independent, not-for-profit organisation, whose mandate is to 'deliver relevant and translatable research evidence which drives policy and practice leading to a reduction in the levels of violence against women and their children'.<sup>39</sup> Later in 2013, as a further initiative under the National Plan and to complement to the work of ANROWS, Our Watch was established to 'drive nationwide change in the culture, behaviours and power imbalances that lead to violence against women and their children'.<sup>40</sup>

Since its establishment, a key focus for Our Watch has been the way in which violence against women and their children is depicted in the media, and in 2014 it commenced the National Media Engagement Project (NME Project). The aim of the NME Project is to engage with the media and other stakeholders to improve the quality of reporting of violence against women and their children and to enhance awareness and understanding of the impacts of gender stereotyping and inequality. As part of the NME Project, Our Watch is working with peak journalism bodies to develop curriculum content for journalism students and has developed various resources for practicing journalists including a comprehensive guide to reporting on domestic violence.<sup>41</sup>

To support the NME Project, Our Watch is developing a national framework for engaging the media in the prevention of violence against women and in partnership with ANROWS is conducting a research into the way news and information media portray violence against women.

Our Watch has also developed a national awards scheme to recognise and celebrate domestic violence reporting that is appropriate, ethical and holistic and thereby contributes to an enhanced understanding of violence against women.<sup>42</sup>

While the NSW Government has provided funding to ANROWS and the Australian Institute of Health and Welfare in relation to violence prevention research,

38 National Council of Australian Governments, *The National Plan to Reduce Violence Against Women and their Children 2010-2022*, (Commonwealth Government, 2011) 33, available at [https://www.dss.gov.au/sites/default/files/documents/08\\_2014/national\\_plan1.pdf](https://www.dss.gov.au/sites/default/files/documents/08_2014/national_plan1.pdf) (accessed 30 September 2017).

39 ANROWS, available at <https://anrows.org.au/about/who-we-are> (accessed 30 September 2017).

40 Our Watch, *2013-14 Annual Report*, Our Watch, 2014, available at <https://www.ourwatch.org.au/MediaLibraries/OurWatch/our-publications/OurWatch-AnnualReport-2013-2014.pdf> (accessed 30 September 2017).

41 Our Watch, available at <https://www.ourwatch.org.au/What-We-Do/National-Media-Engagement-Project> (accessed 30 September 2017).

42 Our Watch, available at <https://www.ourwatch.org.au/What-We-Do/Our-Watch-Awards> (accessed 30 September 2017).

NSW remains the only state in Australia that is not a member of Our Watch. With a view to improving media practice, producing research and further exploring these issues in collaboration with Our Watch, and improving coordination within the violence prevention space more generally, the Team recommends:

## Recommendation 1

**1.1** That the NSW Government give consideration to becoming a member of Our Watch.

**1.2** That the DVDRT Secretariat work together with Our Watch to analyse media reporting around murder suicides in New South Wales and disseminate its research findings.

## Institutional cultures

Institutions are positioned to reinforce or reject damaging attitudes and beliefs within their hierarchy and amongst their members. The role of religious institutions in particular has formed part of the Team's earlier recommendations,<sup>43</sup> and remains an ongoing area of interest for the Team. This review period has seen the Team turn its scrutiny to the role of military institutions, and in particular the Royal Australian Navy (Navy).

In recent years in Australia there have been significant moves to respond to domestic and family violence within military organisations,<sup>44</sup> including recent initiatives within Navy.<sup>45</sup> In one case in this reporting period (Case Review 3452) the homicide perpetrator murdered his former partner several days prior to killing himself. The perpetrator was the key suspect in the victim's murder, and he suicided as police were attempting to apprehend him. Notwithstanding the perpetrator dying in these circumstances, he was given a military funeral following his suicide, resulting in significant negative press for Navy. The Chief of Navy publically apologised and ceremonial policies within the broader Australian Defence Force Pay and Conditions Manual have since been reviewed.

The Team has been advised that this revision has led to the relevant guidelines now clearly stipulating that an officer will not be afforded a funeral at Commonwealth expense in the event that they are away without leave when they die (as was the situation in Case Review 3452). Although the Team acknowledges that the change in policy means that the perpetrator would now not receive a military funeral, the Team is of the perspective that this does not adequately address the issue identified by the Team – that being that at the time he died, the perpetrator was the only suspect in a fatal assault against his former partner.

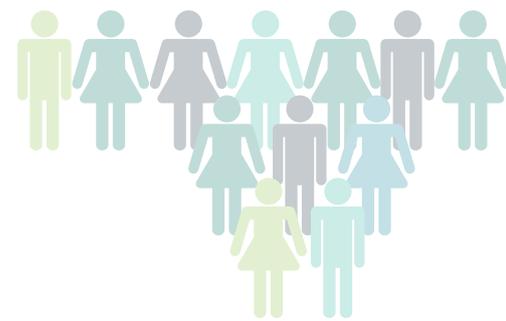
While this case presents an unusual and highly specific set of circumstances, the Team was of the perspective that the shift in policy illustrated a limited approach to understanding and addressing violence against women within the military setting. It is acknowledged that Navy has since received accreditation through White Ribbon Australia and launched a domestic and family violence strategy. Navy has advised the Team that it has a zero tolerance approach to violence against women and has cited policy initiatives and documents in support of this.

The Team seeks to promote further engagement with military organisations in this area, including in relation to the apparent narrow shift in policy in respect of military funerals. Accordingly, rather than making a recommendation, the Secretariat of the Team has undertaken to engage further with the Department of Defence in relation to issues the Team has identified around attitudes to women, and narrower concerns it has in relation to the revised funeral policy.

43 See Recommendation 12 of the Team's 2011/12 Report and Recommendation 13 of the Team's 2013/15 Report.

44 Department of Defence, *Defence Family and Domestic Violence Strategy 2017-2022* (2017) available at <http://www.defence.gov.au/Publications/Docs/DefenceFamilyDomesticViolenceStrategy2017.pdf> (accessed September 2017); *Defence strategy to address family and domestic violence*, 2017, available at <https://www.minister.defence.gov.au/minister/marise-payne/media-releases/defence-strategy-address-family-and-domestic-violence> (accessed 30 September 2017).

45 Tufrey, 'Chief of Navy launches Family and Domestic Violence Strategy', *Navy Daily*, 7 October 2016, available at <http://news.navy.gov.au/en/Oct2016/Events/3259/Chief-of-Navy-launches-Family-and-Domestic-Violence-Strategy.htm#.WZz0sFXvO70> (accessed 30 September 2017).



## Supporting informal network members

Central to the issue of shifting cultures and attitudes about domestic and family violence, in this review period the Team has also discussed how to best support bystanders, or informal network members, in relation to domestic and family violence prevention and intervention. In cases in this, as well as previous review periods, friends and family are often aware of violence in circumstances where police or service agencies have not become involved with either the victim or perpetrator. In these circumstances, friends and family can play a crucial role in assisting victims and perpetrators to access appropriate response and support services. During this review period, and in light of this issue, the Research Analyst of the Team applied for and was granted a fellowship through the University of Sydney to conduct research into informal social networks and domestic violence. The Team eagerly awaits the findings of this research.

The Team continues to monitor prior recommendations in relation to bystanders and informal helping networks, and welcomes action under the *NSW Domestic and Family Violence Blueprint for Reform 2016-2021: Safer lives for women, men and children* (the Blueprint), which incorporates several of the Team's earlier recommendations in this respect.

Addressing domestic and family violence is complex, and requires coordinated efforts that look to attitudes and beliefs, as well as effective interventions and responding to trauma post-violence, or post-homicide. Violence is a vicious cycle, and interrupting this cycle requires a holistic, sustained response addressing structural and personal inequalities, across the individual, family and community levels.

While this section has sought to outline some aspects relevant to changing attitudes, the next sections highlight the interrelationship between different elements of the response to domestic and family violence.

## Intervention through holistic, comprehensive and effective systems

### Justice system responses to domestic and family violence

The justice system response to domestic and family violence continues to be a critical point of focus for the Team, including examination of police responses to domestic violence, the operation of civil protection orders, criminal law processes and punishment, the effectiveness of targeted perpetrator interventions, and the adequacy of support processes for domestic violence survivors. In prior reporting periods the Team has identified a range of issues in the justice system response and made numerous recommendations addressing the ways in which this response can be improved. This section accordingly seeks to build on those findings and includes further commentary and recommendations related to the justice response.

In this review period the Team considered the tensions that arise between the incident-focused operation of the justice system and the repeated patterns of behaviour characteristic of domestic and family violence. Under a criminal law model each episode of violence is examined in isolation and this can result in patterns of domestic violence being misconstrued or inadequately addressed. This fragmentation has a flow on effect in terms of reliable and consistent responses to victims, perpetrator accountability, and also shapes community attitudes about violence more generally.

### Supporting police in responding to domestic and family violence

In relation to policing, a common issue identified in the Team's cases is that police attend individual domestic callouts without sufficient knowledge of the perpetrator or victim's histories of violence (including with prior partners, and prior police callouts that did not result in the arrest or charge of any party). The practice of not accessing or reviewing histories in advance of callouts can result in the attending officers approaching each callout as an isolated or 'one-off' episode, unrelated to a broader pattern of violence, coercion and control.

The Team has been advised that some of these practice limitations are due to the limited functionality of the NSW Police Force Computerised Operational Policing System (COPS). COPS is an operational database used by NSW police to record information relevant to all victims, offenders and incidents that require police action (including to create a record of an event only). COPS is designed to facilitate the logging of criminal incidents, intelligence gathering, and the issuance of charges. All information must be manually entered onto COPS by police officers and there are no auto-populate functions. The Team has been advised that this can make the system unintuitive for officers to navigate. While some changes have been made over time to try and improve its functionality, the Team was of the perspective that further technical changes may be required to enhance this system and its usability for officers in this respect.

Other more challenging issues include that police are often under significant time pressure when responding to callouts and this can make it difficult for officers to equip themselves with relevant information quickly and easily.

More broadly, the Team acknowledges that the operation of the criminal justice system as a whole promotes an incident-based focus. However, the Team is of the perspective that victim support and safety and perpetrator accountability is best promoted through interventions that recognise domestic violence as a repeated pattern of unacceptable social behaviours.

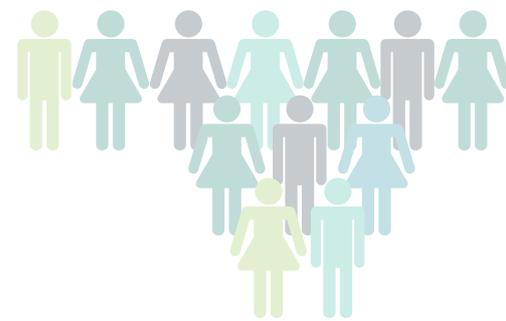
The negative effect of the incident-based approach to domestic violence is evident in a number of cases in this reporting period, including in Case Review 3492. In this case, the victim was estranged from her husband, the perpetrator, and was living separately to him when he murdered her. Several months prior to her death, while the perpetrator was on bail for sexual assault offences against her, the victim's house was broken into. She told her case worker that she informed police investigating the break-and-enter offence that she believed her estranged husband had perpetrated the break in. The victim's belief that her estranged husband was responsible for the break in was not reflected on the COPS system. After her murder, evidence came to light that her husband had broken into the property. Committing the break-and-enter would have constituted a breach of his bail conditions.

Another related issue arises in a number of cases where police records concerning histories of violence are inconsistent. In some cases, despite histories of violence between the parties being captured within the police system, individual event narratives may record that there is 'no history' of violence under the section concerning domestic violence history. Thus, even if officers were to check event records in advance of a callout, the information would not necessarily provide an accurate account of the violence history. The Team has been advised that issues such as this could be rectified via technical changes to the COPS computer system, which are considered further below.

However, aside from issues of functionality and approach, and taking a step back from specific technical limitations, the Team is of the perspective that as the criminal justice system is incident focused, understanding and conceiving of domestic violence holistically as a repeated pattern of behaviour can be a challenging fit for actors working within those systems. Accordingly, reframing approaches to domestic violence, and promoting more holistic understandings of such violence, requires practice as well as systems change.

The Team is of the perspective that moving towards more complex understandings of violence within the context of policing requires some adjustment to the police training regime, however this issue also goes beyond police and implicates other actors within the system – as will be discussed below. However, for police, drawing upon the Team's case studies will highlight the complexity of domestic violence and illustrate the various challenges facing criminal justice actors at all levels of the system. Accordingly, the work of this Team could be used to effectively educate police about the complexities and challenges associated with responding to domestic and family violence.

Accordingly, to promote holistic police practice, the Team recommends:



## Recommendation 2

**2.1** That the NSW Police Force reviews how it captures, records and displays data on domestic violence events with a view to making appropriate changes that would support operational police to view the incident holistically and in the context of the history of the parties and relationship. This will assist police to make informed decisions as to what action to take in the context of the incident they are dealing with.

**2.2** That the DVDRT identify real life case studies which demonstrate issues/difficulties of identifying domestic violence as a complex pattern of behaviours and supply these case studies to the NSW Police Force together with relevant commentary. That the NSW Police Force incorporate these real-life case studies into the police training regime.

## The role of legal professionals

In this and prior reports, the Team has continued to highlight the important role of legal professionals in relation to domestic and family violence. Examining the role of legal professionals is relevant to understanding and addressing social responses and norms around violence in a number of ways. Legal professionals may directly respond to domestic and family violence in their role as advocates within the course of criminal processes, or may otherwise, in the course of ordinary practice, become aware that a client is using, or experiencing violence. These roles are separate but related.

A key challenge for legal professionals in the context of criminal justice proceedings arises in the trial context – as the adversarial trial is, in many circumstances, antithetical to addressing problematic stereotypes and domestic violence myths, or promoting a complex understanding of violence. This challenge can arise as defence lawyers possess duties to their clients and the court – a situation that can, including in homicide cases, lead to lawyers victim blaming and operationalizing negative stereotypes in defence of a client.

Issues around trial processes and appropriately responding to domestic violence are well recognised in the literature,<sup>46</sup> and as is highlighted in the first section of this chapter, this can have a flow on effect in respect of media reporting and social narratives of violence.

In cases considered by the Team in this review period the tension between the lawyer's duty to their client and the effect of utilising damaging myths and stereotypes in service of their trial objectives, is punctuated. This has a flow on effect in terms of the Agreed Statement of Facts, even shaping the prosecution language and narrative, the language of the trial and eventually, the judge's sentencing remarks. The Team has historically made recommendations in this space<sup>47</sup> and the Secretariat has recently published an article in respect of the issue of judicial language and sentencing remarks.<sup>48</sup> It must be recognised, however, that some of the primary challenges that arise in respect of speaking about violence effectively, and combatting myths and stereotypes, vest much earlier in the legal process – particularly in the early stages of the criminal process where lawyers face conflicting roles vis-a-vis their duties.

These issues can be illustrated by way of examples from the Team's cases. For instance, in Case Review 3423, where the victim of violence killed her abuser, the Crown's opening statement in her trial put to the jury that the victim's experiences of abuse were not serious due to the fact that her abuser only used limited physical violence against her. This statement draws upon a damaging stereotype of domestic violence; namely the problematic assumption that non-physical violence is not 'real' violence. In this case there was a clear pattern of the abuser using coercive and controlling behaviours against the victim of violence before she killed him. In addition to this he had previously physically assaulted her and strangled her prior to the fatal episode. The Team was of the perspective that the Crown's comments in this case were highly problematic.

In another case (Case Review 3035), the primary victim of violence was killed by her abuser and accordingly the abuser was on trial for her murder. In describing the fatal episode of violence however, the prosecution (not

46 Hartley, 'He Said, She Said. The Defense Attack of Credibility in Domestic Violence Felony Trials' (2001) 7(5) *Violence Against Women* 510; Bennett, Goodman and Dutton, 'Systematic obstacles to the criminal prosecution of a battering partner: A victim perspective' (1999) 14 *Journal of Interpersonal Violence* 761.

47 Recommendation 1 from the Team's 2013/15 Report.

48 Buxton-Namisyk and Butler, 'What's language got to do with it? Learning from discourse, language and stereotyping in domestic violence homicide cases' (2017) 29(6) *Judicial Officers' Bulletin* 49.

the defence) submitted that the catalyst for the verbal argument that preceded the murder was the woman's attempts to impose restrictions on the abuser's access to their child. This casting of the victim's behaviour decontextualized the circumstances around the murder, which included evidence from the child that the offender habitually would drink and drive with her in the car. Further, when considered against the subsequent actions - the offender shooting the victim in front of their child - framing the victim's actions in this way inappropriately attributed responsibility to the victim for her own death.

These cases, amongst others in this, and prior, reporting periods, highlight the challenge of casting the adversarial trial as a process in which domestic and family violence can be discussed and appropriately condemned. The adversarial trial is a key component of the societal response to violence, however it remains a process through which narratives and discourses often perpetuate, rather than challenge, damaging myths about domestic violence. Accordingly, these cases also highlight the need to further examine potential avenues through which to encourage change, including by working with lawyers at every stage of their education, and in the course of their practice.

These cases have also caused the Team to consider the use of domestic violence expert witnesses in relevant cases.<sup>49</sup> While the Team has not considered the issue of expert witnesses in-depth in the course of this report, this is an area of interest for the Team and may be pursued in its future work.

The Team's cases in this period also highlight that lawyers have an important role in respect of clients who disclose that they are using, or experiencing violence, but that at the same time lawyers often lack the skills to respond effectively. While some initiatives, such as Family Law Doors,<sup>50</sup> have sought to equip family lawyers with skills in respect of risk identification and management for violence victims, in this report the Team has been more concerned with capacity building in relation to all practicing lawyers. While in the course of their legal education, lawyers learn about legal responses to violence and are equipped with the requisite skills to participate in the adversarial trial, most

legal professionals are not equipped with the skills to provide appropriate support and referral to their clients who are experiencing violence.

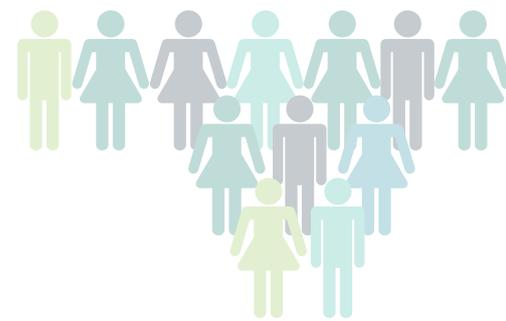
While it is acknowledged that lawyers are not social workers or domestic violence experts, cases in this review period reveal that lawyers may give clients advice that may endanger their safety. In a number of cases in this review period, lawyers dispensed poor advice that, in some cases, directly contributed to circumstances surrounding their client's death. Given the nature of the work in which lawyers are engaged, this is particularly relevant to family lawyers.

This was evident in Case Review 3696, where the victim of violence separated from her abusive husband following a long standing relationship, and she engaged the services of a solicitor in relation to family law. In the course of advising his client about property division, the lawyer told the victim of violence that she should remain in the house with the abuser and their children until the property division was complete as this would be advantageous to her settlement. Accordingly, the victim and abuser continued to live together after the relationship had ended. It was not clear whether the lawyer was aware of the violence his client had experienced both during and after their relationship had ended. In any event, it would appear that the lawyer did not give consideration to the victim's safety. Within two months of receiving this advice the woman was murdered by the perpetrator.

A similar issue arose in Case Review 3693. In this case the victim and abuser had separated after living together for around 25 years. After separating from the abuser the victim sought advice from a generalist solicitor (not a family law specialist). After meeting the lawyer, the victim told her daughter that the solicitor had advised her not to move out of the house because it would give the abuser 'more rights' over the property when they divorced. Again, it is not clear whether the lawyer was aware of the violence the abuser used against the victim during their relationship. While friends and relatives offered the victim a place to stay the victim observed her lawyer's advice and accordingly remained in the home in a separate room to the abuser.

49 Eastale, 'Translating Women's Experiences: the Need for Expert Witnesses in the Court' (Australian Institute of Criminology, 1993) available at [http://www.aic.gov.au/media\\_library/conferences/medicine/peasteal.pdf](http://www.aic.gov.au/media_library/conferences/medicine/peasteal.pdf) (accessed 30 September 2017); Rogers, 'Prosecutorial Use of Expert Testimony in Domestic Violence Cases: From Recantation to Refusal to Testify' (1998) 8 *Columbia Journal of Gender and Law* 67; Lemon, 'A Transformative Process: Working as a Domestic Violence Expert Witness' (2009) 24 *Berkeley Journal of Gender, Law & Justice* 208.

50 As discussed in the Team's 2012/13 Report, see also <http://www.familylawdoors.com.au> (accessed 30 September 2017).



Two days after receiving this advice, the victim was murdered by the abuser in their home.

These practice issues, as well as the more holistic issues identified earlier in this section, highlighted to the Team that lawyers retain significant authority and their advice to their clients must prioritise the safety of victims of violence who seek advice, including in the context of family law proceedings.

In the Team's 2013/15 Report it recommended:

*That the NSW Domestic Violence Death Review Team work collaboratively with the Office of the Director of Public Prosecutions (NSW), the NSW Bar Association, the Law Society of NSW and the NSW Public Defenders' Office to develop appropriate strategies to better support lawyers in recognising and responding to domestic violence.*

As a consequence of this recommendation the nominated parties have been working together with the Secretariat of the Team including to convene a working group to discuss strategies to address the multi-stratum issues relevant to lawyers. This work is ongoing, and concerns raised from cases in this report will be considered in subsequent meetings, including specific concerns arising in the context of family law.

In this review period the Team has also considered issues within the family law system more broadly in respect of family violence. On 16 March 2017, a Committee of the Australian Parliament commenced an inquiry examining family violence within the family law system, aiming to make recommendations for systems improvement. Terms of reference and other information relevant to the inquiry are available online at <http://www.aph.gov.au/fvlawreform>. The Team eagerly awaits the findings of this inquiry.

## Addressing specific issues within the justice system

During this review period the Team identified a number of inadequacies in the current justice response to domestic violence, including in relation to the operation of Apprehended Domestic Violence Orders (ADVOs) and the offence of strangulation in NSW, each of which is considered below. Other issues identified by the Team were not resolved by way of recommendation but

the Team was satisfied with out of session discussion and investigation conducted into these issues. This included issues around inter-jurisdictional policing and ADVO recognition, which is the subject of the National Domestic Violence Order Scheme (coming into effect later in 2017).

## The effectiveness of Apprehended Domestic Violence Orders

ADVOs are a feature in many of the cases considered by the Team in this, and prior, reporting periods. While in some cases ADVOs are in place at the time of the homicide (for example, Case Reviews 3393, 3492 and 3540), in many more cases there is a history of ADVOs between the abuser and the victim and these ADVOs have expired at the time of the homicide (for example, Case Reviews 3693, 3409, 3571 and 3428). ADVO expiry can highlight that the orders are often of insufficient length to protect the victim's safety. In other cases, ADVOs expire while the abuser is in custody, meaning that when the abuser is released to the community the victim is unprotected. As ADVOs are civil orders their purpose should be viewed as a mechanism by which to emphasise and enhance victim safety. They should not be viewed as punitive orders against the abuser/defendant.

In a number of cases during this review period the Team expressed concerns over the length of ADVOs and queried the sufficiency of short ADVOs (of 6 or 12 months in length) in cases involving significant histories of violence. The Team noted that while magistrates retain discretion to make longer (and shorter) orders, the majority of ADVOs examined by the Team are enforceable for a period of 12 months only. The Team questioned the sufficiency of this length for protecting victims' safety, and identified that this is a practice standard that may be subject to change. The Team remains concerned that lawyers and prosecutors are not requesting orders that are long enough to protect the safety of victims of violence, and considers that this is an issue to be raised in the course of discussions with legal professionals as above. In other jurisdictions, different practices in respect of ADVOs are observed in many respects including length and provisions of sunset clauses.<sup>51</sup>

<sup>51</sup> Taylor et al, *Domestic and family violence protection orders in Australia: An investigation of information sharing and enforcement* (ANROWS, 2015) available at [https://d2c0ikyv46o3b1.cloudfront.net/anrows.org.au/s3fs-public/16\\_4.1%20Legal%20WEB\\_FINAL\\_0.pdf](https://d2c0ikyv46o3b1.cloudfront.net/anrows.org.au/s3fs-public/16_4.1%20Legal%20WEB_FINAL_0.pdf) (accessed 30 September 2017).

While the rationale for retaining shorter ADVOs may be that there will be fewer contested orders, the consequence of shorter ADVOs may be that victims' safety will not be prioritised, and in many cases the risk of violence will continue after the order has expired. While the functionality and resourcing of court systems is a pressing consideration, the safety of victims is key and the Team was of the perspective that practice change was warranted in this area.

Accordingly the Team recommends:

### Recommendation 3

That the Attorney General consider mechanisms to ensure that ADVOs are made for an appropriate duration, including:

- increasing the default length of ADVOs from 12 months to a longer duration to promote enhanced victim safety; and
- requesting that the Judicial Commission of NSW update the Local Court Bench Book or other education and training to invite judicial officers to consider factors relevant to setting an appropriate duration for an ADVO (including any period of time an offender is in custody to ensure that the person in need of protection is protected upon the defendant's release).

A related issue, but one bearing upon the police response to domestic and family violence, is the issue of supporting victims who make enquiries about ADVOs at police stations. In Case Review 3452, the victim attended a police station after her relationship with the abuser ended as she had concerns about his ongoing stalking behaviour, including following and constantly text messaging her. The victim spoke to an officer at the counter enquiring about ADVOs but did not disclose any details about the abuser's behaviour. Ultimately the victim did not apply for an ADVO and a short time after she had made these enquiries she was murdered by the abuser.

Given that the victim had decided not to proceed with an ADVO in this case, and accordingly was not protected under any order when she was murdered,

the Team considered how this case might have been different under the current system, and whether new initiatives such as the Domestic Violence Disclosure Scheme (DVDS)<sup>52</sup> or the Domestic Violence Safety Assessment Tool (DVSAT), may have resulted in the victim being responded to differently.

The NSW Government has recently piloted the DVDS which has been developed to help people who may be at risk of domestic violence to find out from police whether their current or former partner has a history of violent criminal offences. The stated purpose of this scheme is to assist victims to make 'informed choices' about their relationships, but its limitations are acknowledged in the literature concerning the scheme which highlights that as domestic violence is underreported, some matters are withdrawn prior to court, and, ultimately, the absence of information to disclose may not mean that the victim is safe from their current or former partner.

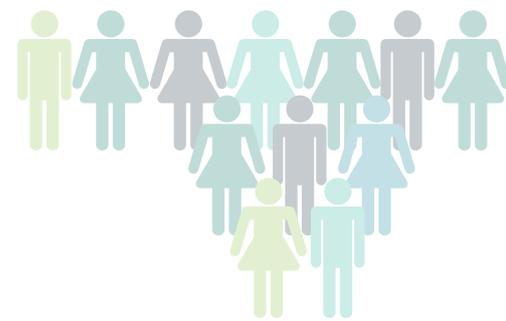
In the Team's case, even if the DVDS was in place in the Local Area Command where the victim presented, she would not have received any report of historical abuse as while the perpetrator had a profound and concerning history of violence against a former partner, he had never been charged with in any.

The Team also considered whether the victim would be subject to a safety assessment at the police station under the It Stops Here: Safer Pathway reforms (Safer Pathway).<sup>53</sup> As the victim was not presenting in relation to a specific episode of violence, the Team was advised that she would have not been subject to a safety assessment. NSW Police Force further highlighted that undertaking such assessment for these types of enquiries would be inappropriate, as it may dissuade victims from presenting at police stations to make enquiries as part of their help seeking in relation to violence.

In considering this case therefore, the Team ultimately examined how officers may most effectively support victims who present at police stations, including ensuring that victims feel safe and supported to disclose if they decide to. A clear way of supporting victims is to increase capacity within the workforce, including with the provision of additional Domestic

<sup>52</sup> See <http://www.domesticviolence.nsw.gov.au/dvds> (accessed 30 September 2017).

<sup>53</sup> NSW Department of Justice, *It Stops Here: Safer Pathway Overview* (2014) available at [http://www.domesticviolence.nsw.gov.au/\\_data/assets/file/0013/301180/Overview\\_Safer-Pathway.pdf](http://www.domesticviolence.nsw.gov.au/_data/assets/file/0013/301180/Overview_Safer-Pathway.pdf) (accessed 30 September 2017). See also [https://www.women.nsw.gov.au/violence\\_prevention/It\\_Stops\\_Here\\_Safer\\_Pathway](https://www.women.nsw.gov.au/violence_prevention/It_Stops_Here_Safer_Pathway) (accessed 30 September 2017);



Violence Liaison Officer (DVLO) roles – specialist positions with NSW Police Force in the area of domestic and family violence. In relation to this issue, the Team was advised that in the absence of an identified and highlighted gap in the current service provision of DVLOs, it is unlikely to gain traction in respect of recommending the creation of additional specialist roles. The Team has accordingly not made a recommendation in this area but will continue to monitor issues around DVLOs.

The Team examined the NSW Police Force Domestic Violence Standard Operating Procedures and noted that while these provide for officers to talk with enquirers where possible in private, the Team was of the perspective that a relatively minor amendment – requiring officers to take enquirers to a private room – may enhance the likelihood that enquirers will feel secure and confident to disclose their experiences of violence. This must be balanced, of course, with any security risk posed – such as the risk of leaving the police station’s front desk unattended. Additionally, the Team considered whether officers should provide safety information to victims informed by the information contained within the DVSAT, and determined that this would be a valuable addition.

Accordingly the Team recommends:

#### Recommendation 4

That the NSW Police Force update its Domestic Violence Standard Operating Procedures to require that where ADVO enquiries are made at the front desk of police stations, the inquirer is taken to a private interview room (except in circumstances where this would present as a security risk). The Standard Operating Procedures should also be updated to ensure that the inquirer is provided information about domestic violence and victims’ safety.

#### Strangulation

The issue of non-fatal strangulation, including the charging practices and convictions related to this offence in NSW, have been considered by the Team in this reporting period. Strangulation is a serious domestic violence offence and presents unique risks to victims, including risks of future injury that may not be visible at the time of the assault.<sup>54</sup> The literature also demonstrates a link between strangulation and domestic homicide, highlighting the importance of responding effectively to this particular form of violence.<sup>55</sup> Further, the Team’s focused intimate partner dataset reveals that in over a quarter of intimate partner homicides, the domestic violence abuser had strangled the domestic violence victim prior to the fatal assault (see Chapter 5).

In a number of cases, (including Case Reviews 3423 and 3452) the Team identified that strangulation offences were not being charged under the NSW offence of strangulation, but rather were being charged as common assault or assault occasioning actual bodily harm offences. This raised questions about the current form of the strangulation offence in NSW and whether difficulty in proving the elements of the offence has resulted in perpetrators being charged with lesser offence where strangulation has been alleged to have occurred.

In 2014, a new offence of ‘Choking, suffocation and strangulation’ was introduced by way of amendment to s37 of the *Crimes Act 1900* (NSW). This section provides that a person is guilty of an offence if that person:

- (1)(a) intentionally chokes, suffocates or strangles another person so as to render the other person unconscious, insensible or incapable of resistance, and
- (b) is reckless as to rendering the other person unconscious, insensible or incapable of resistance.

Maximum penalty: imprisonment for 10 years.

(2) A person is guilty of an offence if the person:

chokes, suffocates or strangles another person so

<sup>54</sup> Faungo et al, ‘Strangulation forensic examination: Best practice for health care providers’, (2013) 35(4) *Advanced Emergency Nursing Journal* 314.

<sup>55</sup> Douglas and Fitzgerald, ‘Strangulation, Domestic Violence and the Legal Response’, (2014) 36(2) *Sydney Law Review* 231.

as to render the other person unconscious, insensible or incapable of resistance, and

(b) does so with the intention of enabling himself or herself to commit, or assisting any other person to commit, another indictable offence.

Maximum penalty: imprisonment for 25 years.

(3) In this section:

“another indictable offence” means an indictable offence other than an offence against this section.’

The new offence replaced the ‘Attempts to choke etc (garrotting)’ offence which could only be proved if the act of choking was accompanied by an intent to commit another indictable offence.

In the second reading speech, the then Attorney General Mr Brad Hazzard noted that part of the rationale for the legislative change was that under the former section, 70% of domestic violence assaults involving strangulation in NSW were being charged as common assault. Accordingly, the amendments were made to facilitate enhanced charging and improve the conviction rate for strangulation offences, particularly those in a domestic violence context, although the legislative amendment itself did not refer to domestic violence or a domestic relationship.<sup>56</sup>

In considering this issue the Team examined recent data collected by NSW Police Force in relation to strangulation, which highlights that limitations persist around charging and conviction under the new offence. Although this is preliminary data, it suggests that the 2014 amendments have had limited effect on the issues they sought to address. Further enquiry is likely required to definitively assess the impact of the amendments, and review of the statutory provision should evaluate whether the amended legislation is meeting its objectives.

Other jurisdictions have conducted similar review of legislation and adopted offences specifically related to non-fatal strangulation, including some jurisdictions which have developed specific offences related to

strangulation in a domestic violence context. For instance, following recommendations of the Special Taskforce on Domestic Violence in its report *Not Now, Not Ever: Putting an End to Domestic Violence in Queensland*,<sup>57</sup> the Queensland Government created a specific offence of strangulation in a domestic violence context. This offence became operational in Queensland in 2016 and there is anecdotal evidence to suggest that the adoption of the new offence has led to a significant number of charges. However the new offence is yet to be formally evaluated in terms of its conviction rates and other relevant considerations to its operation. The Queensland offence is in different form to the NSW offence and specifically relates to offences committed in the context of domestic violence or in domestic relationships, with lower penalties but fewer elements to prove.

The Queensland legislation, contained at 315A of the *Criminal Code 1899*, provides that:

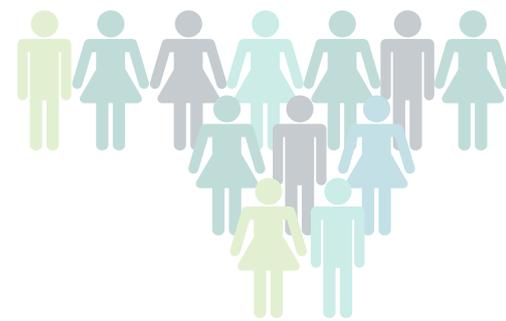
- (1) A person commits a crime if—
  - (a) the person unlawfully chokes, suffocates or strangles another person, without the other person's consent; and
  - (b) either —
    - (i) the person is in a domestic relationship with the other person; or
    - (ii) the choking, suffocation or strangulation is associated domestic violence under the Domestic and Family Violence Protection Act 2012.

Maximum penalty—7 years imprisonment

As noted, the Queensland legislation became operational relatively recently and is yet to be formally evaluated. However the Team was of the perspective that, in form, this legislation was promising and may overcome some of the challenges that persist in prosecuting the NSW offence.

<sup>56</sup> See <https://www.parliament.nsw.gov.au/bills/Pages/Profiles/ Crimes-amendment-strangulation-bill-2014.aspx> (accessed 30 September 2017).

<sup>57</sup> Special Taskforce on Domestic and Family Violence In Queensland, *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* (2015) available at <https://www.communities.qld.gov.au/resources/gateway/campaigns/end-violence/about/special-taskforce/dfv-report-vol-one.pdf> (accessed 30 September 2017).



The second related issue the Team discussed were the short and long term health complications that may specifically arise where a victim is non-fatally strangled. While strangulation may not leave many, if any, visible injuries on a victim, its potential long term health consequences are recognised in the literature, and specific medical examinations may be important for not only proving an offence, but to protect the victim's long term health.<sup>58</sup>

The Team was of the perspective that effectively promoting the health and wellbeing victims of non-fatal strangulation as well as successfully securing convictions requires further action by police as first responders in ensuring victims seek appropriate medical care.

Accordingly the Team recommends:

## Recommendation 5

**5.1** That the Attorney General, in consultation with relevant stakeholders, review the operation of the NSW offence of strangulation (contained at s37 of the *Crimes Act 1900* (NSW)) to determine whether this offence is operating effectively.

**5.2** That the NSW Police Force update its Standard Operating Procedures to require that where a victim discloses strangulation, police advise the victim to seek urgent medical attention given the potential long-term health consequences of this form of assault.

### Managing intractable offenders: promoting accountability and protecting victims

Another issue identified by the Team in this, and prior, reporting periods in relation to the justice system is the issue of intractable offenders; offenders that are not dissuaded from offending by civil orders (ADVOs), punishment, or even police being present at an episode of violence.

Many offenders in this review period had long histories of abusing women, and some had served significant periods of time in custody in relation to violent assaults. In one case (Case Review 3540) police attended a domestic violence call out and while they were present,

the offender arrived at the property, pushed past police holding an iron bar and told the officers he intended to use the weapon to assault his former girlfriend. Despite being apprehended by police during this and multiple other episodes of violence and despite serving multiple sentences in relation to violence, the abuser ultimately murdered his intimate partner.

In another case, in a prior review period (Case Review 2593), the abuser was in prison for an assault against his former partner and told Corrective Services NSW (CSNSW) staff that he was planning to kill her upon his release. Notwithstanding this disclosure it was determined that the offender should be released on parole, thereby enabling CSNSW supervision (the alternative being that he would complete his sentence and leave without supervision). Only a few days after he was released on parole, the abuser murdered his former partner's new boyfriend.

The Team acknowledged that some offenders are unlikely to be dissuaded by civil or criminal orders, and that these offenders pose a consistent challenge to the assumptions and practices underpinning the operation of the justice system and broader social norms.

The Team notes that the NSW Government has established the 12 Premier's Priorities which include Priority 3 – to reduce domestic violence reoffending – with a target of reducing domestic violence reoffending by 25% by 2019. The Team has been advised that a range of strategies are being implemented to meet this target, which may be relevant to this cohort of offenders. These strategies focus on intervening earlier through strategies targeted at ADVO defendants and offenders on bail and remand; increasing convictions through improved evidence collection and victim support; and changing offender behaviour – with a significant increase in behaviour change interventions with offenders in custody and under community supervision

The Team has also been advised that the NSW Government has announced a range of sentencing reforms which will be relevant for this cohort of offenders. The reforms provide that courts will be required to take the victim's safety into account in determining an appropriate sentence, and that there will be a presumption that anyone convicted of a domestic violence offence will be required to be

<sup>58</sup> Faungo et al, 'Strangulation forensic examination: Best practice for health care providers', (2013) 35(4) *Advanced Emergency Nursing Journal* 314.

supervised by CSNSW, thereby promoting access to rehabilitation programs. The Team has been advised that domestic violence offenders will not be eligible for an Intensive Correction Order with a home detention condition if they will be living with the domestic violence victim. And finally, the Team has been advised that the State Parole Authority will have the power to revoke parole when it has concerns about community safety, regardless of whether a breach has actually been committed.

The Team acknowledges the breadth of these reforms but given the disturbing persistence of some offenders in its cases, it is the Team's perspective that there should be a continued focus on this cohort, to determine where new strategies can be developed.

Accordingly the Team recommends:

### Recommendation 6

That the NSW Attorney General review the issue of intractable domestic violence offenders – offenders who are not deterred by civil or criminal penalties for domestic and family violence – with a view to determining whether any additional strategies can be developed for this cohort.

### Specialising the legal response: Nudging the system and trialling new approaches

Responding to domestic violence holistically is a key theme in this report. This section has raised several key issues in relation to the justice response to violence, from ADVOs, through to increasing the effectiveness of particular criminal offences. However, while it remains important to take an individualised approach to addressing particular issues, focusing too narrowly on addressing small components of an overarching system can obscure the bigger picture. Similarly, while looking at issues individually and within particular cases can highlight broader issues within the system, it remains important to bear in mind the way the system, as a whole, operates, and how its operation may be improved. Accordingly, this section considers the case for enhancing specialisation within the justice response.

The Team notes that the 2010 Australian Law Reform Commission (ALRC) Report *Family Violence – A National Legal Response*<sup>59</sup> made significant recommendations for improving criminal justice responses to domestic violence. This report highlighted that specialisation within individuals and institutions is key when coordinating responses to violence, but emphasised that there are pressing arguments both for, and against, specialisation.<sup>60</sup> The report highlights that specialisation can improve the knowledge of service providers within the system, and the establishment of specialised courts may improve systems as a whole – promoting attitudinal change and skill specialisation within broader systems. Specialisation can also improve consistency and efficiency in court processes, and may – in the long run – save money.

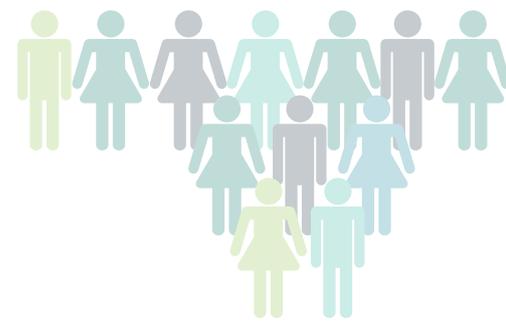
Taken together these benefits provide a strong case for specialisation, but – as the report highlights – specialisation also has several key challenges. The first key challenge is accessibility – specialised courts by nature may geographically or otherwise be inaccessible to individuals who will benefit from these mechanisms. Another issue may be personnel related, and it can be difficult to find experts to staff specialised courts, to recruit staff who can cope with the difficulty of some of the work handled by such courts, and incentivising the work can also pose difficulties. Noting these challenges however, the report also suggests that 'given the cost of family violence to the Australian community, both specialisation and greater resourcing of the system generally represent achievable best practice benchmarks.'<sup>61</sup> This report proceeds to recommend that state and territory governments should, in consultation with relevant stakeholders, establish or further develop specialised family violence courts within existing courts in their jurisdiction.<sup>62</sup>

59 Australian Law Reform Commission, *Family Violence – A National Legal Response: Report 114* (2010), available at [https://www.alrc.gov.au/sites/default/files/pdfs/publications/ALRC114\\_WholeReport.pdf](https://www.alrc.gov.au/sites/default/files/pdfs/publications/ALRC114_WholeReport.pdf) (accessed 30 September 2017).

60 Ibid 1486-1488.

61 Ibid 1486.

62 Ibid 1505.



Similar considerations and recommendations can be found in the *Not Now, Not Ever* report of the Special Taskforce on Domestic and Family Violence in Queensland, which recommended the establishment of specialist domestic and family violence courts, but also noted that the court system needs better trained magistrates, court staff and lawyers to more appropriately understand and address domestic violence across the justice system.<sup>63</sup> As a consequence of this report, Queensland adopted the Southport Specialist Domestic and Family Violence Court model on 1 September 2015 and this became a permanent court in 2017 following interim and final evaluations of its processes and outcomes. Specialist family violence courts are currently being rolled out in other areas of Queensland following the success of the Southport model.

The interim evaluation identified that the project was tracking well, and highlighted that a critical component of the success of the court was having the right personnel, including specialist magistrates experienced in the complexity of domestic and family violence.<sup>64</sup> The final evaluation highlighted some areas for improvement, but noted that the specialist approach was feasible and needed to be adapted to local needs in the rollout of further courts.<sup>65</sup> The final evaluation recommended that the court should continue, but also recommended the further development of a client focused support framework pre, during, and after court, and roll out of tiered specialisation approaches across the state.

The Team notes that while NSW currently practices listing domestic and family violence matters together and has services such as the Women's Domestic Violence Court Advocacy Service (WDVCAS) engaged in most courts in the state to support victims, NSW

currently does not have a specialised approach to managing domestic and family violence civil and criminal matters, and much like Queensland pre 2014, has inconsistent and ad hoc arrangements.<sup>66</sup>

The Team notes that in 2005 the Domestic Violence Intervention Court Model (DVICM) was established in Wagga Wagga and Campbelltown. The objectives of the DVICM were to improve the quality and efficiency of the justice response to domestic violence in NSW by prioritising victims' safety and well-being, promoting perpetrator accountability, and addressing offending behaviour. Evaluations of the DVICM determined that while the model increased access to victim support, the pilot did not perform on evaluation measures including finalising cases by way of early plea, withdrawing prosecutions, finalisation periods or penalties.<sup>67</sup> According to the ALRC *Family Violence – A National Legal Response* report, stakeholders cited limited resources, training, coordination and information sharing as persistent challenges to the DVICM model.<sup>68</sup>

In 2011 the NSW Department of Justice and Attorney General (as it then was) completed a strategic review of the DVICM model, and determined that specialist domestic violence courts would concentrate knowledge and resources in a few locations and would therefore not deliver consistent, improved practice that would be accessible to all victims across NSW. The review did recommend, however, that features of specialist courts should be embedded into the practice of all local courts, and into the criminal justice processes for domestic violence matters. The findings of the review were largely mirrored in subsequent recommendations made by the NSW Parliament's Standing Committee on Social Issues Inquiry into domestic violence issues and trends.<sup>69</sup>

63 Special Taskforce on Domestic and Family Violence In Queensland, *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* (2015) 13-14, available at <https://www.communities.qld.gov.au/resources/gateway/campaigns/end-violence/about/special-taskforce/dfv-report-vol-one.pdf> (accessed 30 September 2017).

64 Department of Justice and Attorney-General (Qld), *Interim evaluation of the trial specialist domestic and family violence court in Southport* (2016) 3, available at [http://www.courts.qld.gov.au/\\_\\_data/assets/pdf\\_file/0006/511737/report-on-the-interim-evaluation-of-the-domesticand-family-violence-court-in-southport.pdf](http://www.courts.qld.gov.au/__data/assets/pdf_file/0006/511737/report-on-the-interim-evaluation-of-the-domesticand-family-violence-court-in-southport.pdf) (accessed 30 September 2017).

65 Bond et al, *Domestic and Family Violence Court Trial in Southport. Summary and Final Reports* (Griffith Criminology Institute, 2017) ii, available at [http://www.courts.qld.gov.au/\\_\\_data/assets/pdf\\_file/0007/515428/dfv-rpt-evaluation-dfv-court-southport-summary-and-final.pdf](http://www.courts.qld.gov.au/__data/assets/pdf_file/0007/515428/dfv-rpt-evaluation-dfv-court-southport-summary-and-final.pdf) (accessed 30 September 2017).

66 Special Taskforce on Domestic and Family Violence In Queensland, *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* (2015) 279-280, available at <https://www.communities.qld.gov.au/resources/gateway/campaigns/end-violence/about/special-taskforce/dfv-report-vol-one.pdf> (accessed 30 September 2017).

67 Rodwell and Smith, *An evaluation of the NSW Domestic Violence Intervention Court Model* (NSW Bureau of Crime Statistics and Research, 2008) available at <http://www.bocsar.nsw.gov.au/Documents/r58.pdf> (accessed 30 September 2017); Birdsey and Smith, *The Domestic Violence Intervention Court Model: A follow-up study* (NSW Bureau of Crime Statistics and Research, 2012) available at [http://www.justice.nsw.gov.au/Documents/Media%20Releases/2012/060312\\_BOCSAR\\_CJB155.pdf](http://www.justice.nsw.gov.au/Documents/Media%20Releases/2012/060312_BOCSAR_CJB155.pdf) (accessed 30 September 2017).

68 Australian Law Reform Commission, *Family Violence – A National Legal Response: Report 114* (2010) 1498, available at [https://www.alrc.gov.au/sites/default/files/pdfs/publications/ALRC114\\_WholeReport.pdf](https://www.alrc.gov.au/sites/default/files/pdfs/publications/ALRC114_WholeReport.pdf) (accessed 30 September 2017).

69 Standing Committee on Social Issues, *Domestic violence trends and issues in NSW*, (NSW Parliament, 2012) available at <https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/ReportAcrobat/5173/120827%20Final%20report.pdf> (accessed 30 September 2017).

A number of members of this Team were of the perspective that the issue of specialised court processes warranted revisiting in light of the success of the Queensland model and in light of the many and varied challenges in terms of the justice response to domestic and family violence (some of which have been discussed in this section, others of which are detailed later in this report).

The Team supports the view that specialist practices should be applied in all local courts and has been advised that this approach is reflected in the NSW Domestic Violence Justice Strategy 2013-2017 (DVJS). The DVJS sets out 28 standards of service that address consistent police responses, universal victim referral, interagency risk assessment and management, support before and during court, specialist prosecution, specialist court listing and processes, judicial education, adherence to the Charter of Victims' Rights, and behaviour change interventions for perpetrators.<sup>70</sup> The Team has been advised, however, that important aspects of the DVJS, such as hearing support and case management, have not been implemented at full scale due to insufficient funding.

Accordingly, and notwithstanding the gains made under the DVJS and the focus on reducing domestic violence reoffending under the Premier's Priorities, the Team is of the view that there remain opportunities to further improve elements of the criminal justice response to domestic violence, particularly support for victims with complex needs and those in contested matters, and for Aboriginal victims who face particular challenges as they engage with the justice system.

In a complex system consideration must be given to developing innovative solutions and trialling new approaches when responding to domestic and family violence. While NSW has, in recent years, adopted a range of new and innovative responses to domestic and family violence, consideration should be given to how to promote holistic and wholesale change within the justice system, and how to help victims and hold perpetrators accountable.

Accordingly the Team recommends:

## Recommendation 7

**7.1** That the Attorney General, in consultation with relevant stakeholders, consider how the approaches reflected in the Domestic Violence Justice Strategy, such as the application of specialist court practice in all local courts, can be further advanced.

**7.2** That the NSW Government review the support needs of victims in contested domestic violence matters, and the adequacy of current supports, with the aim of providing consistent support across NSW. This should include an examination of the specific needs of Aboriginal women, including in relation to attending court.

**7.3** That the Attorney General approach the Chief Magistrate to discuss how the expertise of judicial leaders can be harnessed to further improve responses to domestic violence in courts.

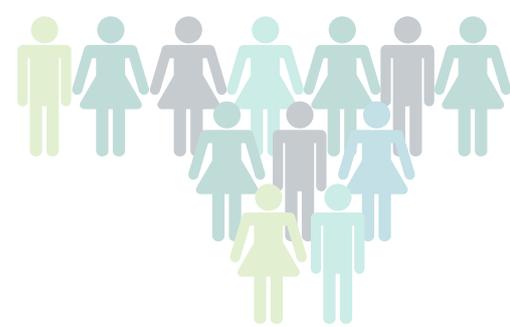
## Building capacity across healthcare contexts

### Counsellors and Psychologists

Another key area identified by the Team in this case review period was the limited capability of counsellors working with victims or perpetrators of domestic and family violence. This was evident amongst generalist counselling services, including those working within faith-based, non-government and government services, and practicing psychologists. In a number of the Team's cases in this review period both victims of violence and abusers were accessing services, and case review records illustrated that counsellors had varying knowledge, capacity and expertise around domestic and family violence.

For instance, in Case Review 3691 the victim and abuser had both, at various times, been clients of a clinical psychology practice. During consultations both the victim and abuser disclosed aspects of the abuser's domestic violence, including the abuser describing

<sup>70</sup> Attorney General and Justice, *The NSW Domestic Violence Justice Strategy: Improving the NSW Criminal Justice System's Response to Domestic Violence 2013-2017* (2012) available at [http://www.crimeprevention.nsw.gov.au/domesticviolence/Documents/domestic-violence/jag2391\\_dv\\_strategy\\_book\\_online.pdf](http://www.crimeprevention.nsw.gov.au/domesticviolence/Documents/domestic-violence/jag2391_dv_strategy_book_online.pdf) (accessed 30 September 2017).



himself as having ‘anger management’ issues which he would ‘direct’ towards the victim. The abuser had a long history of using violence against both the victim and his former intimate partners, and had previously attempted suicide in the context of his domestic abuse. As neither the victim nor perpetrator used the language of ‘domestic violence’ to describe the abuser’s behaviours, the treating psychologist proceeded to assist the abuser with anger management issues and the victim received no advice or support relevant to her safety and well-being. Ultimately, following years of separate consultations at the practice, the abuser killed the victim.

In another case (Case Review 3693) the abuser began seeing a psychotherapist after he separated from the victim, and in the course of his consultations started disclosing that he was ‘angry’ about their separation. He did not initially mention to his psychotherapist that during their relationship he had been extremely abusive towards the victim, and that police had been involved. After his disclosures of ‘anger’, the psychotherapist requested to see the victim in a separate consultation. In the first session with the psychotherapist the victim disclosed the long history of abuse she had suffered from the abuser, and the psychotherapist advised the victim to go to the police. The psychotherapist continued to see the abuser as a client over the following months and in the final session with the psychotherapist the abuser disclosed that he wanted to kill the victim. The psychotherapist made the abuser promise not to kill the victim because it would ‘ruin the children’s’ lives’. The psychotherapist contacted the victim to advise her about the abuser’s disclosure and told her to ‘make a safety plan’. The psychotherapist did not contact police. She also contacted the abuser’s mother and told her that she would no longer see the abuser as his behaviour was beyond her capabilities. The psychotherapist did not make any referrals for the abuser, or for the victim, although the victim did end up engaging with a very capable Aboriginal counsellor through Staying Home Leaving Violence. Several months after the final session with the psychotherapist the abuser murdered the victim.

In another case (Case Review 3312) the victim visited a psychologist and disclosed significant detail about the abuser’s violence towards her. After the victim made these disclosures the psychologist suggested that the couple seek marriage counselling. This illustrated to the Team a lack of awareness about the suitability

of marriage counselling in the context of a significant asymmetry of power and domestic violence.

In another case (Case Review 3553) the abuser was engaged with generalist counsellors through a faith-based development agency including in relation to drug and alcohol use issues. Whilst engaged with this agency the abuser was charged with assaulting his partner by dragging her by the hair. The agency provided a character reference for the abuser to the Magistrate at sentencing which described the abuser and his partner as engaging in ‘manipulating game-play’ and attributed the violence to both the abuser and his partner’s ‘past issues’. The abuser later assaulted his partner downstairs from a meeting at the agency by driving his car towards her in a menacing way.

When the Team contacted the agency to query about its domestic and family violence policy, the agency described that it did not see itself as a ‘first intervener’ in domestic and family violence, and its responses demonstrated that it took a narrow view of its role in the space – highlighting that clients may bring up past traumas (which may presumably include domestic violence) and that these would be dealt with by counsellors, sometimes over many months.

The counselling agency’s lack of awareness of the abuser’s domestic violence behaviours and the description of these behaviours as ‘manipulating game play’ highlighted to the Team a lack of awareness about the dynamics of domestic and family violence. Construing domestic violence in this way limits perpetrator accountability and understandings of violence and this has an undeniable impact on the quality of the counselling response provided to the abuser.

Counsellors in NSW are not governed by a single framework but rather different kinds of counsellors, or individuals occupying a counselling role, may have different qualifications, educational requirements and be governed by different regulatory bodies. For instance, in one case in this review period (Case Review 3312) the victim was engaged with a life coach, and life coaches in NSW are not subject to regulation of any kind. This can be compared to psychologists, for instance, who throughout their educational and professional lives are regulated at multiple levels by oversight agencies.

Given the plurality of individuals implicated in this area the Team considered a range of different options for engaging with these cohorts. The Blueprint highlights that delivering quality services in NSW requires service providers to be adequately supported and competent, and operating with adequate service quality standards in respect of clients experiencing and using domestic and family violence.<sup>71</sup> The Team is of the perspective that the challenges associated with increasing competency in this pluralised sector must be approached holistically and through frameworks such as the Blueprint.

Accordingly the Team recommends:

## Recommendation 8

**8.1** That the NSW Government consider the need for regulation of generalist counsellors, and/or other mechanisms to ensure generalist counsellors are operating in a way that respects and enhances the safety of victims and children in respect of domestic and family violence.

**8.2** That the NSW Government engage with the Australian Psychological Association, Australian Counselling Association, Australian Association of Social Workers and other relevant professional bodies to examine ways to improve associated professionals' awareness of and response to domestic and family violence such as through continuing professional education or registration processes.

## General Practitioners

A related issue is the role of healthcare professionals, and in particular General Practitioners (GPs), in respect of domestic and family violence. In a number of cases in this, and prior, review periods, victims and abusers have been engaged with healthcare services while concurrently experiencing or using violence, often in the absence of engagement with police or specialist domestic violence services (for example, Case Review 3539)

The Team has long recognised that healthcare services may operate as soft entry points into the domestic and family violence system, according with findings in the broader academic literature, which highlight that over 1 in 5 women make their first disclosure of domestic violence to their GP.<sup>72</sup> Despite the recognised importance of this entry point for victims and abusers however, a number of cases during this period illustrate some profound and persistent inadequacies in GP responses to victims who disclose violence. This highlights that these entry points may not be working effectively to support victims or hold perpetrators accountable, and may instead normalise violence experiences or behaviours amongst patients.

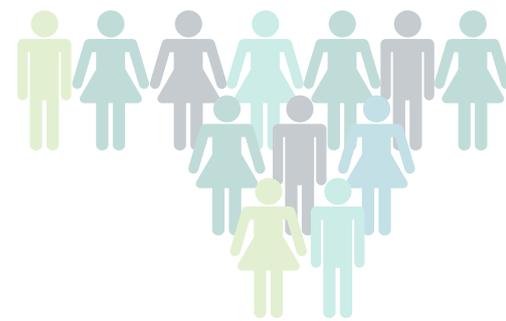
This was evident in Case Review 3492, where the domestic violence victim attended her GP after she had been sexually assaulted by her abusive husband. The GP's consultation notes record that the victim disclosed her husband's sexual assault, and was also seeking treatment for headaches she had been having. The notes indicate that the GP prescribed the victim headache medication, but had no apparent response to the disclosure of sexual assault. The abuser ultimately murdered the victim while he was awaiting trial in respect of sexual assaults against her.

In another case (Case Review 3040) the victim, who was a recent immigrant to Australia and spoke limited English, told her GP she had been assaulted by her husband, and the doctor spoke to the victim and her abuser together about her injury. The doctor provided no referral for the victim in relation to her domestic violence, and never spoke to her without the abuser present. The abuser ultimately attempted to murder the victim, and murdered their young daughter.

Similarly, in Case Review 3224 the abuser and the victim attended the GP together and the abuser told the doctor that his wife was scared of him. The GP responded by giving the victim a mental health assessment, but did not provide any referral or other information in relation to domestic violence. Later, in a one-on-one consultation with the abuser, the abuser told the doctor he had been secretly recording his wife's phone conversations with a handheld recorder. The GP made notes of this but provided no referrals,

<sup>71</sup> Women NSW, *NSW Domestic and Family Violence Blueprint for Reform 2016-2021* (2016) 8, available at [http://www.domesticviolence.nsw.gov.au/\\_\\_data/assets/pdf\\_file/0004/379849/dfv-blueprint-for-reform.pdf](http://www.domesticviolence.nsw.gov.au/__data/assets/pdf_file/0004/379849/dfv-blueprint-for-reform.pdf) (accessed 30 September 2017).

<sup>72</sup> Spangaro and Zwi, *After the Questions: Impact of Routine Screening for Domestic Violence in NSW Health Services* (School of Public Health and Community Medicine, The University of New South Wales, 18 August 2010).



and did not speak further to the victim about the abuser's disclosure. In another case (Case Review 3481) a woman presented at her GP and told the GP she and her husband, the abuser, had been having 'domestic disputes'. The GP prescribed the victim antidepressants, but did not provide any referral in relation to domestic violence; medicalising her victimisation and providing no response to the abuser. The abuser ultimately murdered the victim before killing himself.

These are but a few examples of issues identified with GP's responses to domestic and family violence. While victims may present at their GPs with physical injuries, this Team's cases highlight that domestic violence presentations may be unaccompanied by physical injury. Further, victims or abusers may present with different medical issues, but in the course of consultation may disclose domestic or family violence. These cases highlight that despite many victims and abusers attending and disclosing their experiences of violence to GPs, practitioners are currently ill-equipped to manage these disclosures.

Early in 2017 it was announced that under the Safer Pathway reforms GPs could now refer patients who are victims of domestic and family violence through their nearest Local Coordination Points via use of the DVSAT (including referrals without patient consent).<sup>73</sup> While this new process recognises the centrality of healthcare services in holistic and coordinated responses to domestic violence, GPs are not required to undertake training in relation to domestic and family violence as part of their medical degrees and are not required to undertake further training in relation to domestic violence as part of their continuing professional development.

Promising initiatives such as the *GP Toolkit* produced by Women's Legal Services,<sup>74</sup> recent research concerning GP readiness to identify and respond to intimate partner abuse,<sup>75</sup> and the Australian Medical Association training video also examine barriers to effective GP interventions, and attempt to equip these professionals with the skills and information to respond effectively. However, the challenge remains that being trained in respect of domestic and family violence is not mandatory, and accordingly only those

practitioners with an interest in these issues are likely to undertake training in this area. The Team also raised further concern about the accessibility and suitability of training for GPs working in rural and remote communities, the adequacy of training accompanying the rollout of the DVSAT as a tool for use by GPs, and issues facing practice nurses.

Accordingly to address this pressing issue, the Team recommends:

### Recommendation 9

That NSW Health work with Primary Healthcare Networks, Royal Australian College of General Practitioners, Australian College of Rural and Remote Medicine, Aboriginal Medical Services, Women NSW, Australian Primary Healthcare Nurses Association and any other relevant agency or service as required, to support the development of strategies and materials for providing ongoing education to General Practitioners and practice nurses in relation to domestic and family violence.

Consideration should be given as to how to maximise uptake of training and whether domestic and family violence training should be required as part of Continuing Professional Development for General Practitioners.

### Emergency departments

Further to the issue of effective healthcare responses to violence and increasing capacity within the sector, the Team has recognised that for many victims of violence in particular, emergency healthcare settings represent an important and underutilised intervention point in responding to domestic and family violence.

In its 2012/13 report the Team recommended that NSW Health coordinate the development and implementation of a systemic domestic violence identification and referral strategy, including for NSW Emergency Departments to refer through Safer Pathway. This recommendation was supported and has underpinned changes in NSW Health policy (as outlined in the monitoring table).

<sup>73</sup> See <https://www.nsw.gov.au/news-and-events/news/gps-to-refer-patients-to-domestic-violence-support> (accessed 30 September 2017).

<sup>74</sup> See <http://itstimetotalk.net.au/gp-toolkit/> (accessed 30 September 2017).

<sup>75</sup> Leung et al, 'GPs' perceived readiness to identify and respond to intimate partner abuse: development and preliminary validation of a multidimensional scale' (2017) 41(5) *Australian and New Zealand Journal of Public Health* 512.

Further, in May 2017 NSW Health commenced the Innovation in Care: Evaluating the Implementation of Domestic Violence Screening and Response in NSW Emergency Departments Project. This project will be conducted over a 6 month data collection period and will be evaluated at the end of the period. The project uses the four-item screening instrument, the HITS tool (Hitting or physical hurting, Insults, Threats, Screaming or Swearing) with women aged 16-45 years. Nurses refer women whose answers score over a set threshold to a social worker/psychosocial worker to provide a timely local response. The Team is advised that the establishment of each pilot site has been accompanied by implementation of a 24/7 psychosocial response and safety assessment in response to disclosures of domestic violence.

The Team welcomes these initiatives, however notes that cases in this period continue to raise concerns about the adequacy of social work services for victims attending NSW hospitals, and in particular, victims presenting at emergency departments that are not subject to the screening pilot. Further the Team has highlighted that given the range of domestic violence behaviours that can be used by abusers prior to a homicide, and the lack of clear 'escalation' in some of the Team's cases, confining social work responses to 'higher risk cases' may unduly dilute this intervention point for women who are otherwise not presenting at services. Accordingly, in progressing work in this area the Team recommends that:

### **Recommendation 10**

That the NSW Government appropriately resource NSW Health to ensure that Level 4 and above hospitals with a 24-hour emergency department are appropriately supported by 24-hour psychosocial resources to support the safety of victims.

### **Ambulance services**

Another healthcare intervention point considered by the Team in this reporting period is ambulance services. In previous recommendations,<sup>76</sup> the Team identified the importance of information sharing between ambulance services and emergency departments following a case in which a woman was conveyed by ambulance to

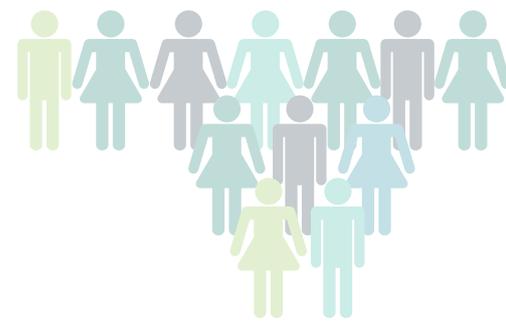
hospital after being assaulted by her husband with a rock (Case Review 3018). However, over the course of her admission to hospital, information gradually dissipated leading to her discharge notes identifying that she had been 'hit by rock'. The Team identified that in this case there was a lack of continuity in information sharing across NSW Health and specifically between the ambulance service and the emergency department as well as within the emergency department.

While the Team is advised that information sharing concerns are forming part of the current review of NSW Health's domestic violence policy, a particular case in the current review period highlights that the Ambulance Service of NSW requires specific policy guidance in promoting safe practice in respect of domestic violence victims and abusers.

In Case Review 3223 the victim contacted 000 seeking an ambulance as she was experiencing chest pains. When the ambulance attended, she told the ambulance officers that the chest pains were a consequence of an argument with her partner, the abuser, and said that this often happened to her when they fought. Despite the victim's disclosures, the ambulance conveyed the victim and abuser to the hospital together. When they arrived at the hospital the victim and abuser had an argument and security asked them to leave by security at the hospital. Five days later, after further assaults and police and healthcare contact, the abuser killed the victim.

The Team was of the perspective that while ambulance officers have a difficult job in respect of these cases, and often have to make rapid decisions based clearly on presenting health issues, the decision to convey the victim and abuser together in this context was inappropriate. While it is acknowledged that the victim did not specifically advise officers that the abuser had used 'domestic violence' against her, as the victim had disclosed to ambulance officers that they regularly argued, and had argued prior to her experiencing chest pains in this episode, the conveyance was unsafe.

76 See Recommendation 10 of the Team's 2012/13 Report.



The Team made further enquires in relation to this issue and were advised that the Ambulance Service of NSW do not have a specific operational policy in respect of domestic and family violence including in relation to their practices around transporting and conveying patients. Accordingly, to support the work of the Ambulance Service of NSW, and highlight the importance of safe and effective responses to violence in this context, the Team recommends:

### Recommendation 11

That the Ambulance Service of NSW work with the Ministry of Health (Health and Social Policy branch) to develop a specific domestic and family violence standard operating policy.

### Mental health discharge

Another concern for the Team in this period was the unique vulnerability of victims of domestic violence who were treated in mental health facilities - as either voluntary or involuntary patients - after episodes of violence, and then were discharged to return to their abusers without appropriate safety plans or referrals addressing the violence.

This was an issue identified by the Team in a number of cases, including in Case Review 3691, in which a woman self-harmed in the context of an argument with her abusive partner before being scheduled under the *Mental Health Act 2007* (NSW). It would appear that the victim was not screened in relation to domestic violence (contrary to NSW Health policy), and when she was discharged the abuser picked her up from the facility and conveyed her home. Despite the fact that the victim was scheduled following a police callout, as there were no police charges and no injuries caused by an abuser (the incident was one of self-harm), there was no police follow up in relation to domestic violence.

As to the issue of screening, under the NSW Health Policy and Procedures for Identifying and Responding to Domestic Violence (PD2006\_084), domestic violence screening must be undertaken in the four target programs as part of routine assessment:

- all women attending antenatal services
- all women attending child and family health services
- women aged 16 years and over who attend mental health services
- women aged 16 and over who attend alcohol and other drugs services

However, in the most recent publically available snapshot report (2015) it is noted that only 51.5% of women who attended mental health services were screened for domestic violence in the reporting period.<sup>77</sup>

The Team has been advised that NSW Health is currently revising its *Domestic Violence Identification and Response* policy, and accordingly, to ensure consistency and clarity in screening, referral and support processes for vulnerable victims in mental healthcare settings, the Team recommends:

### Recommendation 12

**12.1** That the revised NSW Health Domestic Violence Identification and Response policy address the safety needs of victims of violence who are being discharged from mental health institutions,

**12.2** That NSW Health develop strategies to improve screening rates for women in mental health services.

<sup>77</sup> NSW Health, Domestic Violence Routine Screening November 2015 Snapshot 13 (2016) available at <http://www.health.nsw.gov.au/kidsfamilies/protection/Documents/dvrs-snapshot-report-13-2015.pdf> (accessed 30 September 2017).

## Effective interventions and the co-occurrence of drug and/or alcohol use, mental health and domestic violence

Another issue in this, and prior reporting periods - that goes to the issue of responding effectively to domestic violence and approaching violence prevention and intervention holistically - is responding effectively to problematic drug and/or alcohol use when one or both co-occur with domestic violence behaviours.

While the Team's cases highlight that domestic violence and drug and/or alcohol use may co-occur, they also highlight that these behaviours must be understood as having a complex reinforcing, but not necessarily causal relationship. The correlation between alcohol use and domestic violence is clear from the literature, but the direction of the effect (i.e. causation) is not clear from existing studies as significant methodological challenges arise due to the complexity of explaining domestic violence.<sup>78</sup> Accordingly while it is inappropriate to identify alcohol as causing domestic and family violence, it remains important to highlight the complex interrelationship between these harms. While addressing issues of drug and alcohol use in isolation is likely insufficient to solve domestic violence, addressing these intersecting issues must form part of holistic, sustained and complex interventions in relation to such violence.

The literature suggests that reducing alcohol use in the community is likely to have a positive effect on reducing rates of domestic and family violence.<sup>79</sup> Reducing alcohol use and availability can form part of broader public health strategies around reducing alcohol related harm – including reducing trading hours, reducing availability and limiting product advertising – and these initiatives are likely to have a positive health effect at a population level. However responses can also encompass narrower, more targeted, initiatives.

A particular area of consideration in this report has been to examine drug and alcohol use and its connection with domestic violence in a number of case studies during this period, with a focus on domestic violence offences and ADVO conditions.

## Alcohol and/or drug use and effective justice interventions

Alcohol and drug use and concurrent offending is a feature in a number of the Team's cases, and highlights the complex trauma, behaviours and coping mechanisms adopted by both domestic violence abusers and victims. While not all domestic violence abusers use drugs and alcohol, for those who do, addressing complex issues around alcohol and drug dependence is a necessary component of an effective domestic violence intervention. For domestic violence victims, effective responses to domestic violence need to take into account complex issues including drug and alcohol use, and substance use disorders, so as to avoid marginalising or blaming victims within this context.

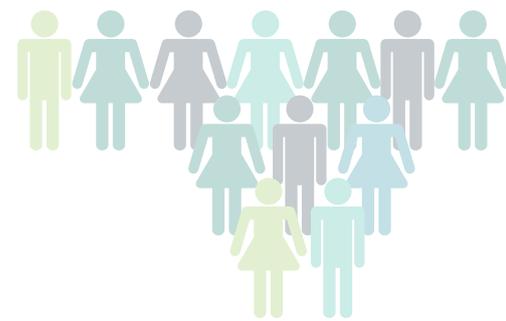
The decoupling of alcohol and drug use and domestic violence behaviours, or the lack of a sustained and committed response to these cumulative issues, is evident from some of the Team's cases in this review period.

For instance, in Case Review 3340, the abuser (who had a long history of perpetrating violence against intimate partners) was charged with a serious assault against a partner and was referred by the Magistrate into the MERIT program; an early referral pre-sentence treatment program focused on offenders who use drug and alcohol. The abuser entered a residential rehabilitation centre on this program, and his treatment focused solely on his drug and alcohol use, with no concurrent intervention addressing his domestic violence behaviours and no engagement with domestic violence service providers or police in relation to the ongoing potential risk he posed to his intimate partner.

The abuser perpetrated domestic violence both when he was using drugs and alcohol and when he wasn't. Accordingly framing his offending as being caused by his drug and alcohol use did not effectively reflect or address the complexity of his offending behaviours – behaviours which, unbeknownst to the treatment centre staff, continued while the abuser was resident in the treatment centre (during periods of day leave). One month after leaving the facility, the abuser killed his new intimate partner.

<sup>78</sup> Devries et al, 'Intimate partner violence victimization and alcohol consumption in women: a systematic review and meta analysis' (2014) 109(3) *Addiction* 379; Wilson et al, 'Alcohol interventions, alcohol policy and intimate partner violence: a systematic review', (2014) 14(1) *BMC Public Health* 881; Gil-Gonzalez et al, 'Alcohol and intimate partner violence: do we have enough information to act?' (2006) 16(3) *The European Journal of Public Health* 278.

<sup>79</sup> Snowden, 'Alcohol outlet density and intimate partner violence in a nonmetropolitan college town: accounting for neighborhood characteristics and alcohol outlet types' (2016) 31(1) *Violence and Victims* 111.



Other cases illustrate that the criminal justice system does not effectively engage with appropriate social work and other support services, or otherwise can inadequately manage an offender or victims drug and alcohol use issues. This is particularly clear when considering bail and ADVO conditions some of which specify that abusers cannot approach victims within a certain period of time after consuming alcohol. For some abusers, where a limitation around drugs and alcohol is not coupled with an effective social work response or effective oversight, this can fail to address issues underlying behaviours and can expose the victim to further danger.

This was evident in Case Review 3596, where a court ordered ADVO precluded the abuser from using alcohol, despite the abuser having long term alcohol dependence. As these orders were not coupled with an appropriate referral response, including into drug and alcohol rehabilitation programs, or any housing response which could ensure the abuser would have a safe place to go when he was using drugs and alcohol, the victim continued to have the abuser residing with them in breach of the ADVO and in circumstances which exposed the victim to significant danger.

Similarly, in a case from a prior review period (Case Review 3508) an ADVO condition was ordered in respect of alcohol use and the abuser assaulted the victim in breach of the ADVO. The victim called police who attended and they asked her why she had been 'allowing' the abuser to drink with her in breach of the ADVO conditions.

It was the Team's perspective that orders precluding abusers from using alcohol or drugs, when decoupled from any effective or appropriate treatment in relation to their drug or alcohol disorders, sets up orders to fail, reduces perpetrator accountability and exposes victims to further danger. This was particularly an issue for Aboriginal female victims who lived with abusers, where a lack of available and appropriate referral strategies, and co-ordinated housing responses, resulted in abusers continuing to live with victims in breach of orders. This creates further barriers for Aboriginal women accessing police and criminal justice solutions for fear of being persecuted or judged for 'allowing' abusers to breach inappropriate or unworkable court orders.

While it was noted that plain English ADVOs go some way to ensuring victims and abusers understand ADVO conditions, in circumstances where an abuser has an alcohol or drug dependence, understanding alone will be insufficient to prevent breach and victims will continue to be put in danger.

In discussing this issue the Team questioned the siloed approach to drug and alcohol issues adopted in pre-sentence rehabilitative programs such as MERIT, particularly when the entry offences for the program include domestic violence offences. The Team has been advised that work is currently being undertaken in relation to the MERIT program through CSNSW with a view to redesigning and enhancing aspects of this program. It is acknowledged, however, that due to the short duration of such programs, it is challenging for these initiatives to address the complexities of perpetrator's behaviours. Nonetheless, perpetrator accountability is not fostered by addressing drug and alcohol issues in isolation of offending behaviours, and addressing violence holistically and appropriately accordingly requires attention to the multi-stratum issues that can affect both victims and abusers.

Similarly, the Team also questioned the appropriateness of court orders – for instance ADVO and bail conditions – decoupling or failing to adequately address the co-occurrence of domestic violence and drug and alcohol use, in particular when an offender has a substance use disorder.

The Team has been advised that in the United States programs such as 'HOPE' in Hawaii, and '24/7 Sobriety' have been employed with some success in respect of reducing alcohol consumption related with other offending.<sup>80</sup> The development of these 'swift, certain and fair' programs has led jurisdictions such as Victoria, following the Royal Commission into Family Violence, to invite the Victorian Sentencing Advisory Council to consider the feasibility of similar programs in relation to family violence offenders in Victoria, including corrections imposed programs, court imposed programs, court imposed sentencing orders, enhanced judicial monitoring or enhanced alcohol exclusion orders.

Swift, certain and fair approaches aim to increase compliance with conditions of sentence and punish

<sup>80</sup> See for example, Hawken and Kleiman, *Managing Drug Involved Probationers with Swift and Certain Sanctions: Evaluating Hawaii's HOPE* (National Institute of Justice, 2009) available at <https://www.ncjrs.gov/pdffiles1/nij/grants/229023.pdf> (accessed 30 September 2017); Larkin Jnr, 'Swift, Certain and Fair Punishment: 24/7 Sobriety and HOPE: Creative approaches to alcohol and illicit drug-using offenders' (2016) 105(1) *The Journal of Criminal Law and Criminology* 39.

breaches quickly, and are designed, amongst other outcomes, to decrease reoffending. The Victorian Sentencing Council is expected to report to the Attorney General in August 2017 with findings from its study; findings that the Team eagerly awaits.

The Team has been advised that in NSW a number of strategies have been developed and are currently being trialled to ensure greater support to those at high risk of reoffending, particularly those with complex needs including addiction. These include a trial of Local Coordinated Multiagency (LCM) offender management, which involves local police, justice and social service agencies working together to manage individuals residing in the community who have a history of persistent reoffending or domestic violence offences and are at a high risk of reoffending. The trial aims to provide coordinated and intensive interventions and services tailored to the needs of individual offenders. Additionally, Extra Offender Management Service (EOMS) is being trialled. The model focuses on the underlying causes of offending through assessment, voluntary case management and service coordination – delivered jointly by non-government organisations and CSNSW - available to persistent offenders and repeat offenders charged with a domestic violence offence. Where appropriate, EOMS and LCM participants will have access to CSNSW addiction programs in the community.

All interim and evaluation reports regarding these initiatives will be reviewed by the Team and taken into account in future reports.

In summary, while there have been some advances and recent initiatives in the response to offenders with addiction and other complex needs, the Team remains concerned that domestic violence and drug and alcohol programs are not well integrated.

As noted above, the MERIT program is currently undergoing a reengineering process and the Team has identified the need to ensure that drug and alcohol issues are dealt with alongside domestic violence. This includes, for instance, the need to ensure that when ADVO or bail conditions specify abstinence from drug and alcohol use, the abuser should be referred

to a program that can address their addiction, and the matter should be referred to Safer Pathway so that relevant agencies can work together to provide a response to both the victim and the offender.

Accordingly, and so as to ensure that the issues identified by the Team are considered in this reengineering, the Team recommends:

### Recommendation 13

That the NSW Department of Justice work with NSW Health in relation to the redesign of MERIT to explore strategies to integrate MERIT into the current referral and information sharing framework under Safer Pathway. This redesign should include a requirement that all workers involved in the MERIT program be trained in domestic and family violence.

### Population level strategies and domestic violence hot spots

While the examination of alcohol and domestic violence in this report has been relatively narrow and focused on the offender population, alcohol use is facilitated by the wide availability of alcohol through bottle-shops, sales outlets and licensed venues.

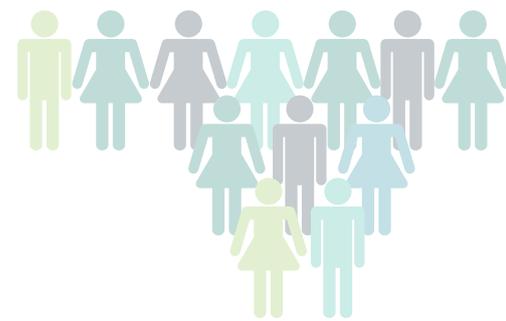
In NSW the Department of Industry (NSW Government) auspices the Independent Liquor and Gaming Authority (ILGA) whose role includes oversight of decisions around liquor outlet licencing related issues, including extended trading hours, new licences, transfers and extensions. While the ILGA publically acknowledges the links between violence and alcohol use<sup>81</sup>, media reports<sup>82</sup> and the ILGA's annual reports, reveal that a high number of licences are being applied for and granted, but few are being refused.<sup>83</sup>

Decisions of interest in relation to the issuing of licences are now published on the ILGA's website. Some decisions highlight Bureau of Crime Statistics and Research (BOCSAR) data, including around domestic violence, where it has been put to the authority by the applicant or in an objection lodged by police. As the

81 Independent Liquor and Gaming Authority, *Annual Report 2014-2015* (2015) 1, available at <http://www.liquorandgaming.nsw.gov.au/Documents/ilga/annual-report/ILGA-2014-15-Annual-Report.pdf> (accessed 30 September 2017).

82 See <http://www.abc.net.au/news/2016-11-19/one-liquor-licence-rejected-in-six-months-in-nsw-analysis-shows/8038664> (accessed 30 September 2017).

83 NSW Department of Justice, *2015-16 Annual Report* (2016) 436, available at <http://www.justice.nsw.gov.au/Documents/Annual%20Reports/JusticeAnnualReport2015-16.pdf> (accessed 30 September 2017).



literature indicates that domestic violence and alcohol use are positively correlated,<sup>84</sup> approvals of licensing arrangements must take into account domestic violence rates within each Local Government Area as reported by BOCSAR when assessing applications for liquor sales outlets. Accordingly, for applications being determined in areas identified by BOCSAR as domestic violence hotspots, the Team is of the perspective that the ILGA should be required to consider several additional criteria when making determinations.

Accordingly the Team recommends:

### Recommendation 14

That the Independent Liquor and Gaming Authority, when making determinations regarding any alcohol licensing related applications in areas identified by the NSW Bureau of Crime Statistics and Research as domestic violence 'hot spots', apply the following criteria:

- 1) For any applications pertaining to an extension of trading hours, or the development of new liquor outlets or bottle-shops in domestic violence hot spots, there should be a rebuttable presumption against granting the application;
- 2) The Authority should require applicants to prepare Community Impact Statements for their applications and these should require the applicant to consult with community members, including a Domestic Violence Liaison Officer from the relevant Local Area Command or a Safety Action Meeting Representative from the Local Coordination Point, and applicants must respond to the concerns of these parties. Applicants should also be required to provide local alcohol sales industry data as part of their application; and
- 3) In the case that licences or applications are successful after the applicant completes the Community Impact Statements, the licence holder should be required to display domestic violence educational material within public areas of the venue, including posters by NSW Police Force or other relevant educational material concerning domestic violence.

### Targeting supportive interventions: Opioid Treatment Program

Another consideration in this review period relates to outreach for vulnerable clients, and the Team considered how best to lever from existing intervention points in responding to domestic and family violence affecting vulnerable populations.

One such intervention point considered in this period was the Opioid Treatment Program (OTP). The OTP aims to reduce the social, economic and health harms associated with opioid use and accordingly delivers pharmacotherapy and related services to opioid dependent patients in the NSW Health system.<sup>85</sup> The Program has complex administration and multi-site delivery (including public and private clinics and pharmacies), but is administered at a high level by the NSW Ministry of Health.

While victims and abusers often access a range of different services in the course of their lives, the Team considered the OTP a particularly important intervention site given that clients attend their dosing sites regularly and often come into contact with the same service providers. The repeated nature of this engagement, in addition to the potential vulnerability of patients on the program, focused the Team's attention on how to best engage with and utilise this site.

In a number of cases in this review period victims and abusers were patients on the OTP while they were concurrently using, or experiencing domestic violence (for example Case Reviews 3223, 3299, 3540).

In one case (Case Review 3223) the homicide victim (and victim of violence in the relationship) was on the OTP when she was killed, and was attending a local pharmacy in a nearby suburb several times per week. The day she was killed the victim attended the dispensary after leaving the police station where she had reported a serious domestic violence assault. In other cases both the abuser and victim were on the program at the time of the homicide. In Case Reviews 3223 and 3299 the victim was presenting at the program with injuries, including facial injuries which would have been evident to program staff.

84 See for example, Miller et al, *Alcohol/Drug-Involved Family Violence in Australia. Key Findings* (National Drug Law Enforcement Research Fund, 2016) available at <https://aifs.gov.au/cfca/2017/01/31/report-alcohol-drug-involved-family-violence-australia-key-findings> (accessed 30 September 2017). See also, Devries et al, 'Intimate partner violence victimization and alcohol consumption in women: a systematic review and meta analysis' (2014) 109(3) *Addiction* 379; Wilson et al, 'Alcohol interventions, alcohol policy and intimate partner violence: a systematic review', (2014) 14(1) *BMC Public Health* 881; Gil-Gonzalez et al, 'Alcohol and intimate partner violence: do we have enough information to act?' (2006) 16(3) *The European Journal of Public Health* 278.

85 See <http://www.health.nsw.gov.au/pharmaceutical/doctors/Pages/otp-medical-practitioners.aspx> (accessed 30 September 2017).

Through its investigations the Team identified that there are limited attempts to use this program as a lever into intervention or referral points. Any use of the OTP as a lever for domestic and family violence intervention would need to avoid stigmatising the patient population, and would need to be tailored and sustained. To achieve this, and to maximise the effectiveness of this recommendation, the Team was of the perspective that specialist collaboration was required. Accordingly the Team recommends:

### Recommendation 15

That NSW Health provide resources to a consumer based organisation and/or family and carers organisation who work with people who use drugs to collaborate with the DVDRT Secretariat to develop a strategy for improving awareness of, and intervention in relation to, domestic and family violence amongst people on Opioid Treatment Programs in NSW.

This strategy should aim to raise awareness and highlight the importance of this intervention point in a holistic and coordinated response to violence, highlight referral pathways available to this group of clients, increase capacity to identify and respond to domestic and family violence across the workforces administering and delivering these programs, and should be tailored to the different Opioid Treatment Program pathways currently available in NSW.

### Alcohol and/or drug use, mental health issues and domestic violence: Responding to complexity

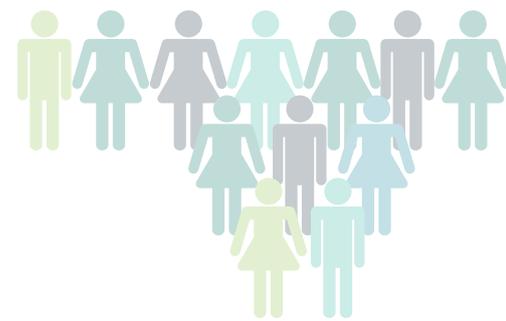
Taking a broader look at systems and services and the ways in which clients with complex needs navigate these systems, the Team - from both its case reviews and further enquiry - has identified challenges arising around the service response to clients who use drugs and/or alcohol, experience mental health issues and use or experience domestic violence, in any, or all, combinations. In some of the cases examined during this reporting period, victims and perpetrators with cumulative social issues can receive ad hoc or uncoordinated responses across the service system, including through health services, criminal justice systems, specialist drug and alcohol services, and domestic violence services. For many of these victims

and abusers addressing one component of a complex problem is insufficient for overcoming entrenched disadvantage and cumulative social issues, and sporadic or ad hoc interventions can exacerbate, rather than solve, their complex problems.

For instance, in Case Review 3528 the abuser spent periods of time in mental health treatment and was consistently using violence against his intimate partner both when he was well, and when he was unwell. On one occasion the abuser absconded from hospital (where he was scheduled under the *Mental Health Act 2007* (NSW)) and returned home. The victim was scared and took her children to her Pastor's house. The Pastor contacted police and the abuser was returned to hospital, where he resumed medication and improved over subsequent days. He was later discharged from the hospital and returned home to live with his wife and children. The intervention or discharge plan did not include any consideration of the abuser's domestic violence offending or the safety of his partner whom he was returning to live with, along with their 5 young children. It was not even clear that the hospital was aware of the abuser's domestic violence history which included convictions for assault ABH, and convictions for contravening a prior ADVO protecting the victim. The Team was of the perspective that this illustrated a lack of co-ordination or wraparound care responding to the complex needs of, in this case, the perpetrator, as well as the safety of the victim and their children.

While health services can be a primary site where the intersection of mental health problems, problematic substance use and domestic violence can be addressed, other cases highlight that people who come into contact with criminal justice and other agencies may similarly lack comprehensive referral pathways or consistent intervention at the intersection of these various issues.

For instance, in Case Review 3340, the abuser had a long history of severe drug and alcohol disorders, a long history of diagnosed and treated mental health disorders, and a very long history of using intimate partner violence against current and former partners. On one occasion the abuser presented to the police and he disclosed that he had breached an enforceable ADVO with his former partner. At the same presentation disclosed to officers that he was considering self-harm.



The abuser was conveyed to hospital where he was assessed as having mental health issues, and alcohol dependence. He was later discharged apparently without a co-ordinated response to his mental health problems, substance use disorder and his violent offending. In relation to the breach ADVO charge and another assault charge, he was referred into the MERIT program a few weeks later and entered a residential rehabilitation program. While on this program he told staff he was considering self-harming and harming his former partner. In response to these disclosures, the abuser was prescribed anti-depressants, but no attempt was made to address the threats of harm he had made to his partner.

While on day release from the MERIT program, the abuser continued to offend against his former partner and came to the attention of police, but nonetheless the residential facility where he was completing MERIT was apparently unaware of his offending and in any event there was no mechanism within the program for addressing the abuser's domestic violence.

While in this case the issue could be construed as one of information sharing, this is an inadequate construction of the problem this case highlights. The MERIT program was aware of the nature of the abuser's offending but there was no mechanism within the system or referral approach for managing the abuser's concurrent domestic violence behaviours and his substance use. Although this highlights a specific issue in the operation of pre-sentence programs such as MERIT (leading to the development of Recommendation 13 above), it also highlights limitations within some current systems more generally, and exposes the need for sustained, complex and comprehensive interventions for this cohort of offenders.

Other cases highlight challenges within existing justice approaches, such as Case Review 3508 from the Team's 2013/15 Report. In this case the domestic violence abuser had long histories of drug and alcohol use disorders, and was concurrently using violence against partners. However interventions concerning his behaviours focused on either addressing drug and/or alcohol dependence through programmatic interventions, or on punishing criminal behaviours through justice systems with a lack of consistency and crossover between these two approaches. It is the Team's perspective that singular interventions are

unlikely to achieve sustainable rehabilitative change for people suffering from, and using, complex behaviours.

This was also evident in Case Review 3592, where the abuser was being managed through criminal justice systems for drink driving offences, and completed the Sober Driver Program (delivered by CSNSW) twice. The abuser was concurrently using violence against his parents and had significant drug and alcohol issues, but the response to these behaviours was lacking.

The Team was of the perspective that these cases highlighted some of the challenges in responding to this cohort, and the need for further strategic co-ordination and interventions designed to respond to domestic violence abusers or victims with complex issues. As much of the expertise around managing drug and alcohol issues and mental health vests with NSW Health, the Team accordingly recommends:

## Recommendation 16

**16.1** That NSW Health conduct a literature review and convene a working group within NSW Health to ventilate relevant issues and develop a model of practice around working with complex clients with cumulative alcohol or drug, mental health and domestic violence issues.

**16.2** That NSW Health convene an interagency forum including with relevant expertise in drug and alcohol, mental health and domestic violence, to develop strategies for improving and co-ordinating responses to people with mental health, drug and alcohol and domestic violence perpetration or victimisation issues. This may include the development of a co-ordinated plan of action, referral pathways and complex program interventions across agencies.

As is evident from the prior section, in this case review period the Team has identified challenges around responding to victims and perpetrators with complex needs, including victims and perpetrators who are experiencing mental health problems, drug and/or alcohol dependence, and concurrently using or experiencing domestic violence.

In this, and prior reporting periods, the Team has expressed concern about the ways in which services interact, information-share and collaborate around

issues of mental health, drug and alcohol use, and domestic and family violence victimisation or perpetration. The persistent siloes across services become clear from cases such as Case Review 3340 discussed above in relation to drug and/or alcohol use, mental health issues and domestic violence, highlighting that often these cumulative social issues are decoupled through siloed service response systems. However, in this report the Team has also identified that managing complex presenting issues presents a challenge in the context of criminal justice responses to domestic and family violence, in particular in respect of Community Treatment Orders (CTOs) and bail.

In one case during this review period (Case Review 3418) the offender perpetrated an extremely serious domestic violence assault against his intimate partner. He was granted bail despite the fact he had a lengthy criminal record, including a 7 year custodial sentence, and a history of mental health problems and non-compliance with medication. The facts of this case led the Team to consider the interaction of bail decisions and CTOs, including making CTO compliance a condition of bail, and monitoring CTO breaches both when on bail, and more generally. As the issues arising in this, and other cases, were highly technical, the Team conducted further inquiry and sought input from NSW Health, and more generally in relation to CTO breaches and bail conditions.

It was acknowledged by NSW Health that this is an extremely complex issue that requires a considered and collaborative response from a range of stakeholders. Accordingly the Team recommends:

### **Recommendation 17**

That NSW Health convene an interagency working group to consider mechanisms by which to rapidly share information between NSW Health and Justice with respect to any existing Community Treatment Orders, clients who may be in breach of Community Treatment Orders when offending, or clients who may benefit from the inclusion of Community Treatment Orders as part of bail conditions.

This working group should also consider ways to monitor compliance with Community Treatment Orders for domestic and family violence offenders.

## **Improving responses and supporting victims**

While many of the initiatives and discussions outlined in this report so far are relevant to supporting victims and holding perpetrators to account, the next few sections specifically examine ways in which current systems and services may be improved to achieve effective interventions and support for domestic violence victims. These sections accordingly consider a range of issues relevant to the experiences of victims, including those victims who experience discrimination and disadvantage at the intersection of racism, sexism and heterosexism, ageism, ableism, impermanency in visa status, and poverty.

### **Responding to vulnerability: Vulnerable groups**

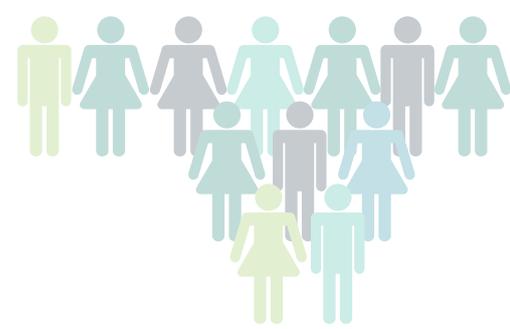
#### **LGBTI victims**

In this reporting period, the Team's cases highlight the complexity of victims' experiences in relation to domestic and family violence, including their direct experiences of victimisation, their engagement or non-engagement with services and the adequacy and variety of service responses to different victims.

While domestic and family violence is gendered, universal narratives of domestic violence as a gendered crime can produce consequences for individuals who do not fit heteronormative relationship or gender binary categories, including individuals who identify as LGBTI.

According to ACON,<sup>86</sup> drawing upon international research, LGBTI people experience high rates of domestic and family violence, and in ways that are different to non-LGBTI people. However LGBTI people are less likely to receive appropriate or comprehensive support in relation to their experiences of violence. LGBTI people experience domestic and family violence differently, and their abusers may use their sexual, gender, HIV or intersex status against them, may threaten to 'out' them, may control their access to healthcare, or may otherwise use their sexuality or gender identity as a means to control and abuse the victim. In accessing services, LGBTI people may also encounter barriers, including fear of a lack of understanding or fear of experiencing discrimination or disbelief from police and service providers, as well actual discrimination and inadequacy in service delivery.

86 See <http://www.acon.org.au/what-we-are-here-for/domestic-family-violence/#domestic-family-violence> (accessed 30 September 2017).



In this review period, two cases highlighted the particular barriers experienced by LGBTI people in relation to domestic violence, and ultimately domestic violence homicide. Case Reviews 3553 and 3453 highlight cases where victims experience profound histories of abuse from an LGBTI partner. In both cases the abusers claimed that they killed the victims to defend themselves against the victim's sexual advances and denied that they had been in a relationship with the victim. In both cases the abusers killed a long term victim of violence, and in both cases the abusers had a long history of domestic and family violence against other people, including female partners. However, in both cases the abusers were acquitted on the basis of self-defence. The Team was of the perspective that these cases highlight challenges in the justice response to violence, particularly violence against LGBTI people.

The Team also considered the police response in these cases. In Case Review 3553 a police callout in relation to a domestic assault by the abuser against the victim did not record that the abuser and victim were in an intimate relationship but rather identified them as friends – a coding that resulted in a lower priority rating being accorded to the event and significant time elapsing between the episode of violence and the callout (during which the victim and abuser remained together in their apartment). When police attended the victim denied that he had been assaulted by the abuser, and in the interim he had told his neighbour (who had called police) that he was planning to change his story and lie to police.

The Team has been advised that the original call for assistance was made by a neighbour who was aware that the victim and abuser were in an intimate relationship but apparently did not identify them as such on the call (noting also that the neighbour was apparently very difficult to understand).

This case led the Team to consider issues around coding of relationship status given the bearing this has on the police response, and broader issues still around police education and training in relation to domestic and family violence for LGBTI people. Despite noting concerns with the age of the research apparently underpinning police policy, the Team was advised that core domestic and family violence training for officers sufficiently covers the specific issues facing LGBTI people, and that no additional training, or adjustment

to generalist training, is required within the NSW Police Force. Following the NSW Police Force appraisal of the existing regime, the Team was of the perspective that it was not in a position to make recommendations in this area, although it acknowledges the need for continued attention, in this and other forums, to the specific vulnerabilities of LGBTI victims.

### Older victims

Another vulnerable group the Team discussed in this period was older victims, including older victims experiencing domestic violence by an intimate partner, and older victims experiencing elder abuse. The Team seeks to reinforce in this report that elder abuse and domestic violence are not necessarily the same thing, and may not have a synonymous meaning to members of the general population (for many older women, domestic violence may continue, rather than commence, when they are older). Accordingly in this section, the Team considers both domestic violence and elder abuse separately to highlight challenges around responding to the violence experiences of older victims.

Regarding domestic violence, this Team has long acknowledged that older women experiencing domestic violence from an intimate partner may experience particular barriers to seeking or accessing services due to their age. These barriers may present as physical barriers, for instance shelters being ill-equipped to manage the health needs of older victims who wish to leave an abuser, or may present as other barriers – including that the victim may have been in a relationship with the abuser for the majority of their lives, or may believe that as the abuser ages he will become less dangerous. In one case in this period (Case Review 3539) the abuser had been physically abusive towards the victim early in their relationship but as he aged, while the physical abuse decreased, the abuser continued to emotionally and psychologically abuse, denigrate and control the victim until he eventually murdered her. The victim never had contact with police but was engaged with a GP, who never asked about whether she was experiencing violence or engaged with the victim in respect of her safety.

Other cases highlight that particular barriers may arise due to the abuser's own vulnerability or illness, and the victim's role as carer for their abuser. In some cases in this and prior review periods, the abuser's

health may present as a barrier to a victim leaving a relationship, or seeking or receiving help in relation to violence. For instance, in Case Review 2985 from a prior reporting period, the abuser had a disability which confined him to a wheelchair and although the abuser had threatened to murder the victim, who was also his primary carer, none of the services who were engaged with the family appreciated the threat he posed until he murdered the victim.

Older people may also experience elder abuse from family members, carers or others. This abuse may take various forms including physical, emotional, financial, psychological abuse, coercion and control (including forcing an older person to remain in the home), confinement and other forms of abuse and violence.

In one case during this period (Case Review 3735) the victim was fatally neglected by her son, who was not only abusive towards her, but also experiencing mental illness. As will be discussed later in this section, the victim was living in Australia without valid residency status due to her visa having expired decades earlier, and as such access to healthcare remained an issue until her death, compounding her vulnerability. In this case, prior to the victim's death, police officers had attended the victim and abuser's home in response to a domestic violence callout (a neighbour had heard the woman screaming). When police arrived they found the older victim distressed and lying in the middle of the lounge-room floor, screaming and yelling. Notes from the callout indicate that the house smelled putrid and officers indicated that they had to 'take turns' going outside for fresh air. Despite the condition in which they had found the victim, the police did not take any action and there was no apparent follow up. The victim remained in the home with the abuser until she died from fatal neglect 18 months later.

Due to the unique vulnerability of older Australians there have been a number of enquiries examining the issue of elder abuse. In NSW, the Elder Abuse in NSW Inquiry (Portfolio Committee Number 2) was established on 1 September 2015 to inquire into and report on elder abuse in New South Wales. The

Committee tabled its report on 24 June 2016<sup>87</sup> and the NSW Government responded to this inquiry in January 2017.<sup>88</sup> Further, on 14 June 2017 the ALRC published its report *Elder Abuse – A National Legal Response*<sup>89</sup> and also in June 2017 the Human Rights Commission called for action in relation to recognising the rights of older people and ending abuse and neglect.<sup>90</sup>

While the Team has not made recommendations in this report in relation to elder abuse and national safeguarding, the Team wishes to lend its support to the findings of these inquiries and will continue to monitor the response to violence and neglect of older people in Australia in its subsequent reports.

The police response in Case Review 3735 did, however, lead the Team to conduct further enquiry around elder abuse and policing, and the Team identified that while police had been issued an 'elder abuse help card' by FACS, practice directions in relation to this card have not yet been incorporated into the SOPS. This card outlines some actions that would have been appropriate for police to engage in when responding to the issues in Case Review 3735 and would have helped promote the safety and wellbeing of the victim in this case. Accordingly, and to ensure competency amongst police in this area, the Team recommends:

### Recommendation 18

That the NSW Police Force update its Standard Operating Procedures and adjust training material to reflect preferred practice around Elder Abuse as contained in the NSW Police Notebook Card (developed by the Elder Abuse Helpline Resource Unit).

### Victims from culturally and linguistically diverse communities and women with young children

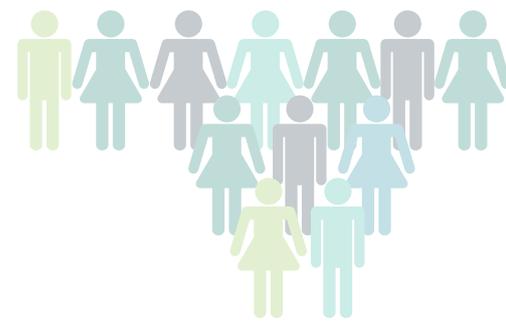
Another group of victims the Team considered in this period was victims from culturally and linguistically diverse communities or backgrounds. This group, in many ways, are unified often only in their diversity,

87 General Purpose Standing Committee No. 2, *Elder abuse in New South Wales* (NSW Parliament, 2016) available at <https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2387> (accessed 30 September 2017).

88 Family and Community Services, *Whole of government response to the Inquiry into Elder Abuse in NSW* (2017) available at <https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/GovernmentResponse/6063/Government%20Response%20-%20Elder%20Abuse%20in%20NSW.pdf> (accessed September 2017).

89 Australian Law Reform Commission, *Elder Abuse – A National Legal Response: Report 131* (2017) available at <https://www.alrc.gov.au/publications/elder-abuse-report> (accessed 30 September 2017).

90 See <https://www.humanrights.gov.au/news/media-releases/call-action-end-elder-abuse> (accessed 30 September 2017).



and accordingly meaningful engagements with these communities must recognise the significant differences across the plural identities encompassed therein.

Responding to the particular barriers experienced by this cohort in relation to domestic and family violence requires a holistic approach that takes into account language, cultural, gender and other issues that may bear upon different individuals and groups differently, and may affect some individuals, including within groups, disproportionately. The particular barriers affecting immigrant and refugee women in particular has been the subject of research by ANROWS since 2015, and the Team welcomes this research and its findings in progressing its work in this space.<sup>91</sup>

A key issue in respect of culturally and linguistically diverse communities is access to justice for victims of violence who may not speak English, and this was a particular focus in this case review period.

In one case during this review period (Case Review 3040) shortly after arriving in Australia, police attended a callout following an episode of violence by the abuser against the victim. As the victim did not speak English, at this callout the police did not seek an interpreter and accordingly only spoke to the abuser, who assured police that nothing had happened and that they were loudly mourning a family member who had recently passed. In discussing this case, NSW Police agreed that this callout did not accord with policies or practice standards in force at this time, and accordingly has agreed to use this case to inform its training regime.

In this case the victim experienced further discrimination in the context of healthcare, as after giving birth to her child, the victim was receiving post-natal care by way of home visit without an interpreter. At this time the victim was wholly isolated in her house with her young baby, and only had contact with the abuser. The abuser was extremely abusive towards the victim before, during and after her pregnancy. Further, the abuser also prevented the victim from leaving the house without him.

The Team recognises that NSW Health provides universal health services, including antenatal and

postnatal care, and interpreter services are frequently used, including during home visitations. The NSW Health Maternal & Child Health Primary Health Care Policy (PD2010\_017)<sup>92</sup> clearly articulates the importance of using an interpreter service with individuals who have limited understanding of English and is not clear why an interpreter was not used in Case Review 3040. NSW Health has advised the Team that it may have been due to reasons including the lack of an appropriate interpreter and/or limitations relating to staff training around this policy. The Team identified that this was an area requiring recommendation so as to support the rights and interests of women who do not speak English, and in recognition of the challenges and barriers women may face when caring for a newborn child.

Although not related to women who did not speak English, a further challenge the Team identified in this period regarding women's healthcare was poor record keeping around antenatal domestic violence screening. While the Team regularly requests healthcare records for victims and abusers (and relevant parties) from NSW Health in the context of its investigations, it has identified persistent challenges in accessing health records due to a lack of central record-keeping and the complex structure of NSW Health. Challenges also arise in respect of information sharing between siloes within NSW Health. This was evident in Case Review 3528, where the victim had 7 children, but healthcare records were only available in relation to two children, and not in relation to antenatal care for either child. The Team made two separate attempts to gain access to records, but no relevant records related to any screening could be located within NSW Health. While this is not a challenge confined simply to record keeping around domestic violence screening, the Team has raised concerns about the broader loss of knowledge and informed practice that may result from non-contiguous record keeping.

In further investigating the practice and policy underpinning this issue the Team further identified that in NSW Health if a woman does not have antenatal care she will not receive routine domestic violence screening (as this is done at antenatal intake). While some exceptions may arise, particularly where issues

91 See for example, Vaughan et al, *Promoting community-led responses to violence against immigrant and refugee women in metropolitan and regional Australia: The ASPIRE Project* (ANROWS, 2015) available at [https://d2c0iky46o3b1.cloudfront.net/anrows.org.au/s3fs-public/12\\_1.2%20Landscapes%20ASPIRE%20web.pdf](https://d2c0iky46o3b1.cloudfront.net/anrows.org.au/s3fs-public/12_1.2%20Landscapes%20ASPIRE%20web.pdf) (accessed 30 September 2017).

92 NSW Health, Maternal & Child Health Primary Health Care Policy (2010), available at [http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010\\_017.pdf](http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010_017.pdf) (accessed 30 September 2017).

are identified at the birth, the current policy has the flow on effect that women who do not receive antenatal care through NSW Health are not screened for domestic and family violence during their pregnancy.

The Team was of the perspective that this group is particularly vulnerable, and accordingly consideration should be given to expanding domestic violence screening to women who give birth at NSW Health facilities who have not received antenatal care.

Accordingly the Team recommends:

## Recommendation 19

**19.1** That NSW Health give consideration to adopting a policy whereby women who do not receive antenatal screening receive postnatal screening.

**19.2** That NSW Health update its policies and practices to ensure that, where required, appropriate healthcare interpreters are made available to women in NSW receiving post-natal care in the form of home visits.

### New immigrants and persons with vulnerable visa status

Another relevant consideration in this review period related to, but not necessarily synonymous with, barriers facing women from culturally and linguistically diverse backgrounds, is the issue of vulnerability arising from impermanent visa status or no valid visa.

In a number of cases during this review period victims were precluded from accessing services, or escaping violence, due to challenges arising in respect of their visa status. This included limitations arising from their visa class, or in other cases the absence of a valid visa.

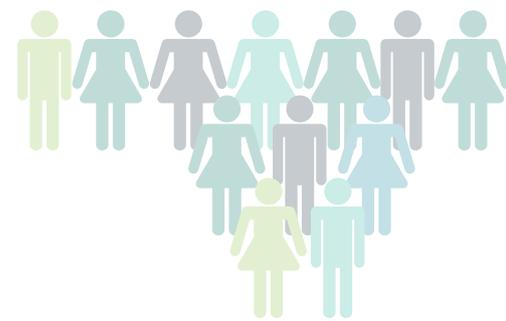
For instance, in Case Review 3312 the victim was in Australia on a working visa but wished to return home for a period to her family in North America to escape the abuser's violence. The woman was advised by her migration agent (who was unaware of the abuser's violence) that leaving the country again would jeopardise her permanent residency application. The day after she received this advice the victim was murdered.

In another case (Case Review 3735) the victim had overstayed her visa by several decades and accordingly was unable to seek access to affordable medical care for her numerous health issues due to her ineligibility for Medicare. The victim was ultimately killed due to fatal neglect, and her son was convicted of manslaughter for failing to seek medical treatment.

These cases highlighted some particular challenges facing victims when they have impermanent visa status or no valid visa.

While the Team has previously considered the Commonwealth family violence provisions and the particular vulnerabilities of victims of violence who are dependent on a spouse for visa sponsorship and support, these family violence provisions are limited to particular visa classes and would not have applied in Case Review 3312 in which the victim was on a working visa. Similarly, the Team considered that the victim in Case Review 3735 was particularly vulnerable due to her age, risk of deportation and reliance on her abusive son for her care and support. While the victim had been seeking GP care with waived cost (by the practitioner), she stopped seeking healthcare as she could not afford the further treatment she required for her health issues. The Team considered how to promote access to healthcare for victims in this situation, and how to overcome some of the particular vulnerabilities arising, in this case, from the compounding challenges of age and not having valid residency.

Related to this issue, in Case Review 3312 the victim attended her migration agent the day before she was murdered to enquire about her options in respect of her visa and permanent residency application. While the victim did not disclose her reasons for wanting to leave Australia, the agent advised the victim that if she left the country she would endanger her permanent residency application. In this case, this appeared to act as a barrier to the victim seeking help. The Team considered the role the Migration Agent could have played in this case, and seeks to highlight the important role these individuals may play in respect of vulnerable clients (much like the issues discussed in relation to lawyers above).



Another issue arising in this, and prior case review periods, has been the limited availability for non-residents in Australia who are seeking shelter or other accommodation to facilitate escaping domestic violence. For instance, in a prior reporting period (Case Review 2969), the victim was on a spousal visa which was sponsored by her abusive husband. The victim and her child attempted to leave the abuser and were advised that they were ineligible for shelter accommodation unless they had money to pay for it. There were also ineligible for any financial assistance and as the abuser had control over any money the victim could access, the victim had no choice but for her and her child to return to live with the abuser. Three months later the abuser murdered the woman and her child.

For many victims of violence the abuser controls the finances in an attempt to control the movement and agency of the victim. In this period, the Team considered the importance of economic empowerment for victims of violence and wish to highlight some of the important work being undertaken by Domestic Violence NSW (DVNSW) in this space. While a lack of economic independence from an abuser can present as a serious barrier for all victims, for victims who have vulnerable immigration status or no visa, this situation can be insurmountable. Accordingly the Team seeks to emphasise the importance of respecting victims' rights to safety in the context of access to shelter accommodation and more permanent accommodation and finance options, and has made recommendations in respect of this issue below.

More broadly, the Team also considered the particular vulnerability and barriers facing new immigrants, including in becoming aware of the supports available in relation to domestic and family violence in Australia. In a number of cases (Case Reviews 3472, 3495, 3040), victims or perpetrators were born overseas and migrated to Australia, some historically, and others in a period more proximal to the homicide. Accordingly, in determining strategies for reaching out to victims within this cohort the Team considered the feasibility of recommending that the Commonwealth Government disseminate information about domestic and family violence, including referral information, to new immigrants entering Australia.

The Team noted that Victims Services is currently working with Diversity Services (NSW Department of Justice) to disseminate relevant information to new immigrants, and Diversity Services is currently undertaking community consultation in progressing work around awareness of intervention responses to domestic and family violence and victim's compensation. However the Team was of the perspective that these initiatives could be strengthened through the broad provision of information to all immigrants through the development of either a new publication or update of an existing publication at Commonwealth level.

The Team's enquiries highlighted that any person who is applying for a provisional or permanent visa needs to read a particular booklet, *Life in Australia. Australian Values and Principles*, before signing an Australian Values Statement. While noting that Australia is not tolerant of violence, and respects equality between men and women, the booklet does not discuss family or domestic violence, nor provide any guidance around seeking help in relation to such violence in Australia.<sup>93</sup>

Accordingly to address this lack of information, and the other issues identified in this section, the Team recommends:

<sup>93</sup> Department of Immigration and Border Protection, *Life in Australia. Australian Values and Principles* (Commonwealth of Australia, 2016) available at [https://www.border.gov.au/LifeinAustralia/Documents/lia\\_english\\_full.pdf](https://www.border.gov.au/LifeinAustralia/Documents/lia_english_full.pdf) (accessed 30 September 2017).

## Recommendation 20

**20.1** That the Commonwealth Government work with state governments and other relevant stakeholders to develop and fund a specific initiative to enable vulnerable individuals with impermanent visa status, or without a valid visa, to access affordable, appropriate and expedient medical care. This initiative must recognise the unique vulnerability of victims of domestic and family violence who may be precluded from accessing affordable services due to residency issues or barriers to access arising from fear of deportation.

**20.2** That the Commonwealth Government give consideration to expanding the Family Violence Provisions currently applicable to spousal visas to ensure that victims who are applying for permanent residency under different classes of visa are supported when escaping domestic or family violence.

**20.3** That the Commonwealth Government work with the Office of the Migration Agents Registration Authority to update accredited graduate certificate courses to include a specific topic about domestic and family violence as part of the syllabus. This update should highlight the specific vulnerabilities that may arise for domestic and family violence victims by virtue of having uncertain or impermanent visa status (across categories) and issues relevant to, but not confined to, the operation of the Family Violence Provisions. That the Office of the Migration Agents Registration Authority give consideration to incorporating mandatory domestic and family violence continuing professional development into educational requirements for registered Migration Agents in Australia.

**20.4** That the Commonwealth Government work with state governments and other relevant stakeholders to identify how non-residents experiencing domestic or family violence can be better supported in respect of access to shelter accommodation, access to more permanent housing solutions and access to appropriate financial and other supports. That as part of this work, the Commonwealth Government resource the NSW Government to provide accommodation and other services for domestic and family violence victims who are non-residents.

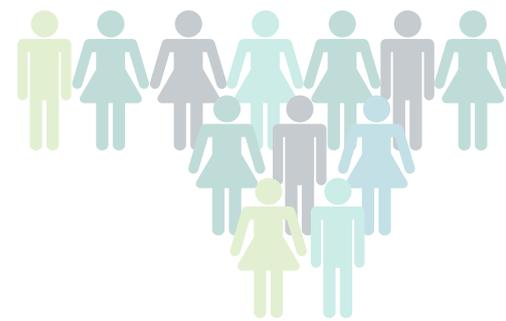
**20.5** That the Commonwealth Government give consideration to either updating the *Life in Australia* booklet, or producing another publication to be distributed to all persons entering Australia on a provisional or permanent visa, to highlight what domestic and family violence is, and what victims can do to seek help in Australia (including referral information).

### Victims of violence with disability

Another vulnerable group of victims for whom additional barriers may limit access to justice and rights to safety are victims with disability.

While the Team has considered a number of cases in this and prior reporting periods where disability may create an additional axis of vulnerability for victims experiencing domestic and family violence, it has not, to date, made any specific recommendations in respect of this group. Again, while there is significant plurality and difference in the experiences of victims with disability, focus on the unique vulnerabilities of this cohort of victims is important to ensuring victims' access to justice and safety.

The additional vulnerabilities of victims with disability arose in Case Review 3340 during this period. In this case the victim had sustained an acquired brain injury as a result of a car accident a number of years prior to meeting and being killed by her abusive partner. The victim also had a prior abusive partner (post-accident), and when she contacted police in relation to his abuse, police described her as being aggressive and uncooperative, which referred to her personality changes as a result of her acquired brain injury. While



the police applied for an ADVO protecting the victim, this case highlighted some challenges facing women with disability in interacting with mainstream services.

In Case Review 3434 (from the Team's 2013/15 report), the victim was confined to a wheelchair due to a physical disability and was murdered by her abusive boyfriend who had been using violence against her for a number of years. The victim, in this case, was largely confined to her house and was receiving in-home nursing support. While the nursing support staff would see the victim daily, including with injuries, staff never provided support in relation to the victim's experiences of violence and no other services ever became engaged with the victim prior to her death. This case highlighted, in particular, the vulnerability of women with disability experiencing domestic and family violence from an abuser, and the limitations facing victims who may be unable to access mainstream services due to a range of different factors.

In another case (Case Review 3019 from the Team's 2012/13 Report) the victim had a physical disability which confined her to a wheelchair, and was living in a small regional town. Her abusive nephew was bailed to live with her after he was charged with criminal offences pertaining to stealing her medication and while on bail, the abusive nephew murdered her.

Given the limited expertise on the Team in relation to this specific issue, in order to progress its work in this area the Team engaged with DVNSW and People with Disability Australia (PWDA), who provided input as to important policy initiatives and work currently being undertaken in this space.

In February 2016 PWDA made a submission to the NSW Government in the development of the *Blueprint* which highlighted a number of factors to be taken into consideration in respect of domestic and family violence affecting people with disability. In the publically available *Blueprint* documents the NSW Government undertakes to develop competency training opportunities for service providers to ensure that they can respond appropriately to vulnerable communities including people with disability,<sup>94</sup> but in relation to many of the recommendations made in the PWDA submission the *Blueprint* appears silent.

Accordingly, to facilitate open discussion around current issues and inform the rollout of the *Blueprint* and associated initiatives over coming years, the Team recommends that Women NSW enhance its work with victims of violence with disability to develop a platform of action for this group (see Recommendation 21 below).

By way of commentary, it must be noted that in one of the Team's cases in this review period (Case Review 3494) the abuser was working as a carer for a person with disability in 2010 after he had served a period in gaol for sexual and indecent assaults. The Team was of the perspective that the abuser's employment in this role presented a serious safety risk and highlighted an issue in recruitment and criminal record checks processes. However, the Team has been advised that as a result of the rollout of the National Disability Insurance Scheme (NDIS) and the development of the *NDIS Quality and Safeguarding Framework*<sup>95</sup>, recruitment and worker screening has since changed and this issue would be unlikely to arise under future processes. The Team will continue to monitor the implementation of this framework and this issue.

### Victims of violence from rural and remote areas

The Team's cases in this reporting period also highlight the unique vulnerabilities of victims who live in rural or remote areas (including Case Reviews 3696, 3035, 3691).

Victims of domestic and family violence living in rural and remote areas may experience particular barriers in respect of access to services including police, healthcare and other intervention points to address domestic and family violence. Victims may be geographically isolated or living on remote, large properties, and this may further contribute to a victim's social isolation, including from friends, family or services. Victims may also experience financial issues due to having limited access to money (as money may be tied up in the property), and victims may also experience additional difficulties leaving an abuser, should they wish to do so, due to a lack of refuge or other accommodation, including when victims may have children or animals they may not be able to take with them.

<sup>94</sup> Women NSW, *NSW Domestic and Family Violence Blueprint for Reform 2016-2021* (2016) available at [http://www.domesticviolence.nsw.gov.au/\\_data/assets/pdf\\_file/0004/379849/dfv-blueprint-for-reform.pdf](http://www.domesticviolence.nsw.gov.au/_data/assets/pdf_file/0004/379849/dfv-blueprint-for-reform.pdf) (accessed 30 September 2017).

<sup>95</sup> Department of Social Services, *NDIS Quality and Safeguarding Framework* (2016) available at [https://www.dss.gov.au/sites/default/files/documents/04\\_2017/ndis\\_quality\\_and\\_safeguarding\\_framework\\_final.pdf](https://www.dss.gov.au/sites/default/files/documents/04_2017/ndis_quality_and_safeguarding_framework_final.pdf) (accessed 30 September 2017).

For victims, living in rural and remote areas may compound other axes of discrimination and contribute to reduced access to justice and reduced safety.

In NSW initiatives such as Safer Pathway and the Domestic Violence Regional Strategy Group continue to engage with the particular needs of victims of violence living in rural or remote areas. However, the Team was of the view that to highlight issues around this vulnerable population and develop a strategy informed by the Team's cases, a recommendation was needed. Accordingly the Team recommends:

### Recommendation 21

That Women NSW engage more directly with women with disability and women living in regional and remote areas regarding their challenges in accessing domestic and family violence services with a view to developing specific actions to better support and respond to these priority groups.

#### Aboriginal women

Another particularly vulnerable group that the Team has considered in this, and other, periods is Aboriginal women who are experiencing domestic or family violence. Aboriginal women are overrepresented as victims of homicide (see Chapters 2 and 5), and domestic and family violence more broadly,<sup>96</sup> and continue to suffer barriers to accessing available and appropriate services at the axis of various forms of discrimination.

In a number of cases during this reporting period it is evident that Aboriginal women suffer from compounding disadvantage arising from sexism, racism, poverty, disadvantage, trauma and other factors. In one case (Case Review 3540) the victim had children removed by child protection services, suffered from poly-substance use disorder, had been the repeat victim of violence and was ultimately murdered by her abusive intimate partner. In this case, in a period proximal to the homicide, the victim was assaulted by her partner in an episode that was captured on CCTV. Police were called to attend by a number of witnesses who had seen the assault. Police spoke to the victim, who had serious injuries and was significantly affected

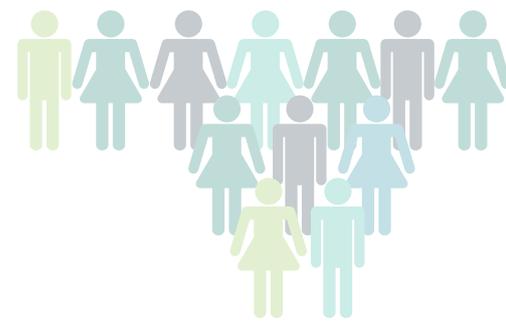
by alcohol and/or drugs. The victim refused to provide a statement and refused to let police photograph her injuries. Police arrested (but did not remove) the abuser and served him with a provisional ADVO, with a view to accessing the CCTV footage and potentially laying charges. There was in the Team's view an unacceptable delay in police reviewing the CCTV footage which was not viewed until the day the victim was killed.

In another case (Case Review 3596) the victim had disclosed a sexual assault as a teenager, but police records highlight that no action was taken in response to her disclosures as when the victim was interviewed by police (in the company of her mother and a sexual assault worker) she 'declined to supply a statement and was extremely difficult to interview'. For this same victim, the night she was killed she was assaulted over a period of time by her intimate partner in the home they shared on a remote Aboriginal mission (where the victim had lived all her life). A family member called police multiple times over a period of about 40 minutes, giving the name of both the victim and the abuser, and becoming increasingly urgent, frustrated and verbally abusive with each call. Police and ambulance attended about 20 minutes after the last call and apparently made several enquiries with a number of people but were unable to locate any of the parties. Several hours later the victim was found deceased.

In a number of cases, the Team also identified that police officers did not progress charges or inquiries due to the victim, abuser or witnesses intoxication at the time of an offence (for example, Case Reviews 3540, 3596 and 3544).

In another case (Case Review 3517) the victim was murdered by her daughter, who had profound mental illness and trauma due to alleged historical sexual assaults, having her child removed from her care, and for whom our enquiries highlighted significant violence and criminal offending within the family.

<sup>96</sup> Department of Social Services, *Second Action Plan 2013-2016 – Moving Ahead – of the National Plan to Reduce Violence against Women and their Children 2010-2022* (2014) available at [https://www.dss.gov.au/sites/default/files/documents/09\\_2014/dss012\\_14\\_book\\_tagged\\_reduced.pdf](https://www.dss.gov.au/sites/default/files/documents/09_2014/dss012_14_book_tagged_reduced.pdf); Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: Key Indicators 2011* (Productivity Commission, 2011) available at <https://www.pc.gov.au/research/ongoing/overcoming-indigenous-disadvantage/2011/key-indicators-2011-overview-booklet.pdf> (accessed 30 September 2017).



The Team's case reviews (for example, Case Review 3341), provide an insight into the vulnerability of Aboriginal girls who grow up bearing profound intergenerational and personal trauma and, as they age, become further isolated through systems and services that do not adequately address the complexity of their trauma and disadvantage.

Other cases highlight that in circumstances where support interventions are needed – for instance for a pregnant woman who is using alcohol – the service system response is to notify child protection services, rather than commence a sustained and trauma informed intervention to manage the causes underlying damaging behaviours (Case Review 3596).

While Aboriginal women's experiences of violence are complex and require sustained and holistic interventions, a particular issue the Team considered in this review period was the way in which police interact with Aboriginal women in relation to their experiences of domestic and family violence. Understanding the complexity of episodes of engagement requires understanding of relationships between the police, Aboriginal communities and structural violence more broadly, but also requires specific attention to be made to the rights and interests of Aboriginal women.

In one case during this review period (Case Review 3544), the homicide perpetrator had a close relationship with the local ACLO who had previously worked in child protection and knew the homicide perpetrator in the context of that work. The homicide perpetrator would regularly call the ACLO for support in relation to domestic and family violence. Observing this important support and how this engagement worked in this case, highlighted that ACLOs are importantly positioned to build a bridge between Aboriginal communities and the police. However, this engagement also highlighted that ACLOs are not required to demonstrate specific capabilities in relation to domestic and family violence, despite this comprising an important part of their role, and an important consideration in relation to building bridges between Aboriginal communities, women and police.

In considering how to progress this recommendation the Team worked with NSW Police in relation to issues around ACLOs and identified that capacity building in this space requires sustained attention to recruitment and practice.

Accordingly the Team recommends:

## Recommendation 22

That the NSW Police Force Aboriginal Coordination Team update the Aboriginal Client Liaison Officer position description to include an additional criteria under the 'Knowledge, Skills and Experience' section, namely the 'Ability to work effectively in dealing with domestic, family and community violence in the local community and in particular an ability to advocate for and reinforce the importance of supporting victims of domestic violence.'

Viewing this issue rather more broadly, the Team also considered the importance of interventions within this space supporting Aboriginal women's rights and interests in respect of participating in formulating solutions to issues that affect them. Aboriginal women are experts in their experiences, and supporting grass roots and community driven interventions and initiatives is more likely to produce positive outcomes for this cohort of victims.

In particular, the Team is of the perspective that a rights based approach is required in respect of supporting Aboriginal women to attend court in respect of domestic and family violence offences in which they are a victim or a witness. In a number of cases (for example Case Reviews 3508, 3428, and 3596) Aboriginal women do not attend court in relation to offences, or ADVOs, leading to charges being dismissed, withdrawn and the perpetrator being released without conviction.

The Team identified that while services such as WDVCS will often be available to support Aboriginal women in court settings, challenges arise in respect of overcoming the barriers related to getting to court - barriers that may include having to look after children or being unable to secure transport, or barriers arising where victims are pressured by perpetrators or family members to not attend court or progress charges.

Supporting Aboriginal women in respect of these issues is fundamental to securing access to justice. Accordingly to support and promote a sustained and appropriate intervention in this area, the Team recommends:

## Recommendation 23

**23.1** That the NSW Department of Justice, in partnership with Aboriginal community groups, develop a pilot program aimed at supporting Aboriginal women to attend court in relation to domestic violence offences in which they are a witness or victim.

**23.2** That the NSW Government fund the pilot program anticipated in 23.1.

### Women experiencing reproductive coercion

In its 2012/13 Report, the Team considered issues around assisted reproduction and identified the important role that these highly specialised service providers could play in domestic violence intervention and prevention. The Team made a recommendation to the peak body in this sector to promote identification and referral strategies for clients who are accessing assisted reproductive services and are experiencing or using domestic violence behaviours.<sup>97</sup>

The Team has again considered this issue in the current review period in light of Case Review 3316. In this case, the victim and her abusive partner went through multiple cycles on the IVF program. The victim suffered multiple miscarriages and the abuser would often make abusive comments to the victim about not being able to carry a pregnancy to full term.

The Team notes that there has been no progress in relation to its previous recommendation (see Chapter 7) and emphasises the need to pursue this important intervention and prevention strategy within this sector.

Considering this issue led to broader discussions around reproductive coercion and the critical role that reproductive and sexual health services can play in addressing this form of abuse. Reproductive coercion describes a range of abusive behaviours used by men against their female intimate partners such as controlling access to contraception, sabotaging contraception use, and violent or threatening behaviours in response to pregnancy options, including limiting access to abortion services or forcing a woman to terminate her pregnancy.<sup>98</sup> There is a growing

body of literature concerning reproductive coercion and effective intervention and prevention strategies in relation to this form of abuse which, by its very nature, can bring women into contact with healthcare services.<sup>99</sup>

In a number of cases in this review period (including Case Reviews 3341, 3517, 3575 and 3312) domestic violence victims had contact with healthcare service providers for the purpose of terminating a pregnancy.

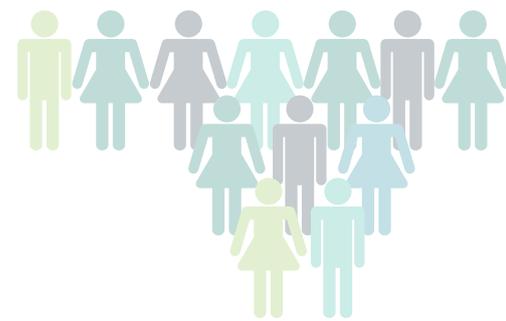
In Case Review 3429, a domestic violence abuser (and homicide perpetrator) violently assaulted one of his former partners (not the homicide victim) when he found out she had a termination, threatening her with a knife and trying to smother her with a pillow. In other cases (including Case Reviews 3312 and 3575) domestic violence abusers threatened to 'expose' or publically revealed the fact of a victim's termination in the course of their abusive behaviours. In Case Review 2347 (from the Team's 2013/15 Report) the victim was going to leave her abusive partner when she found out she was pregnant. The partner convinced her that she would develop cancer if she had a termination and she continued the pregnancy and stayed in the relationship with the abuser.

Reproductive and sexual health services are a critical intervention point for women, and maximising the effectiveness of this intervention point must be a priority in NSW. In order to achieve this, however, more research needs to be conducted to expose the prevalence or nature of this problem in NSW.

<sup>97</sup> Recommendation 16 of the Team's 2012/13 Report.

<sup>98</sup> Grace and Anderson, 'Reproductive Coercion: A Systematic Review' (2016) *Trauma, Violence & Abuse* 1.

<sup>99</sup> *Ibid*, see also Hunter et al, 'Experience of domestic violence routine screening in Family Planning NSW clinics' (2016) 14(2) *Sexual Health*; Grace and Fleming, 'A Systematic Review of Reproductive Coercion in International Settings' (2016) 8(4) *World Medical & Health Policy* 382; Clark et al, 'Reproductive coercion and co-occurring intimate partner violence in obstetrics and gynecology patients' (2014) 210(1) *American Journal of Obstetrics and Gynecology*.



Accordingly the Team recommends:

### **Recommendation 24**

That the NSW Government conduct or commission research examining the forms, prevalence and impact of reproductive coercion in NSW and use this, and the international evidence base, to develop a strategy for addressing reproductive coercion in its various manifestations, including through family planning clinics, women's health clinical services, termination providers, general practice and youth health services.

#### Supporting parents or carers looking after children with mental illness

Another vulnerable group considered in this and prior reporting periods are the parents of often adult children who are suffering mental illness and concurrently using violence. For children, and particularly adult children, who may be unwell with mental illness, parents or carers are often placed in a position where they are caring for their children in circumstances which compromise their safety.

This situation is evident across many of the Team's cases from this and prior reporting periods, including Case Reviews 3592, 3418 and 3345. In each of these cases the parents were caring for a child who was using violence and experiencing mental illness, and in each of these cases the child killed a parent.

The Team has considered this issue in prior reporting periods and identified that upon discharge from mental health institutions, or through other mental health processes there is little in the way of safety planning for the parents or carers of children who fall within this group. Often mental health discharge plans that place young or adult children with their parents focus on the health and wellbeing of the child without due attention to the safety of the parents. Further, parents or carers may be reluctant to engage with police or health workers in respect of their children due to concerns that they may again be taken or returned to a mental health facility, or charged with an offence. Conversely parents or carers may be pressured by their child not to report their behaviour.

The Team was of the perspective that urgent action is required to protect parents and carers in these circumstances, and accordingly the Team recommends:

### **Recommendation 25**

That NSW Health convene a working group to consider strategies to support the safety of family members or carers looking after or living with persons who are suffering from mental illness and concurrently using domestic and family violence (police reported or anecdotal).

The working group should consider risk assessment processes concerning the safety of family members or carers (including their risk of violence victimisation from their family member experiencing mental health issues) as part of Community Treatment Order assessments, discharge plans from mental health institutions or from other institutions who may be providing mental health care, and outpatient management plans.

Considering how to better support families and victims of violence has also led the Team to examine issues around family safety when a perpetrator is released from custody. In particular, an issue arising in Case Review 3049 was the safety of family members in circumstances where an abuser is held on remand until they are sentenced, and released from their sentencing hearing, or shortly thereafter, to return into the community.

In this case the abuser was held on remand for drug offences and as his sentence was backdated, the day he was sentenced he was also released from court. As the offender was released from court, CSNSW did not have the opportunity to conduct a comprehensive risk assessment, including with his family, to ensure their safety upon his release. Further enquiry into this issue highlighted that this is a common challenge due to the fact that CSNSW do not conduct risk assessments or similar for the remand population, and magistrates may regularly sentence offenders to time served, leading to the offender being directly release from court.

CSNSW has advised the Team that this challenge can only be overcome through changes to court practices, and achieving this practice change effectively requires

further information sharing and engagement between courts and CSNSW, so as to ensure that families are appropriately safeguarded and supported when an abuser is released. CSNSW has indicated that a period of several weeks is required to conduct a comprehensive risk assessment however it is evident that maximising opportunities for risk assessment must be balanced by the offender's right to a fair and appropriate sentence.

Accordingly, due to the complexity of this issue and the fact that identifying a solution vests within multiple agencies, the Team recommends:

### **Recommendation 26**

That Corrective Services NSW approach the Chief Magistrate to discuss strategies to ensure that Corrective Services NSW has sufficient time to conduct risk assessments for offenders who are on remand prior to the offender being sentenced and released. If it is determined that change in court practice is required, consideration should be given to how best to effect such change and whether the changes should be codified.

## **Employment focused intervention**

Another victim focused action that the Team considered in this reporting period was to highlight the role of employment as a site for intervention, education and support. According to Our Watch, drawing upon ABS data, as at 2005 almost two thirds of women who experienced violence at home also had paid jobs.<sup>100</sup> This highlights the importance of workplaces adopting policies around facilitating domestic violence leave for victims, and education and training for staff who in the course of their work will likely engage with co-workers and colleagues experiencing, or using, domestic or family violence.

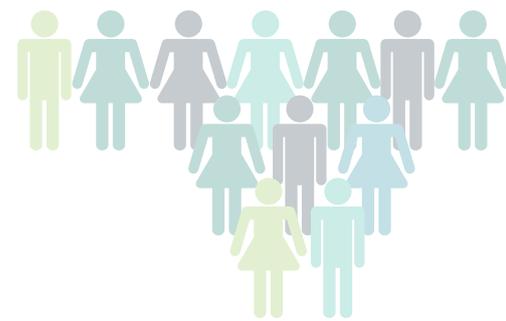
Although making recommendations in relation to employment is difficult given the plurality of sectors in which workers may be employed, one particular group that the Team considered in this report was victims who are employed in healthcare settings. In a number of cases in this, and prior review periods

(including Case Reviews 3692, 3409, 3374, and 3693) the homicide victims worked in helping roles, as nurses or aged care workers, and were concurrently being abused by their intimate partners or family members. In Case Reviews 3692 and 3693, it is clear that both domestic violence victims would have been screening women for domestic and family violence in the course of their employment, while at home they were concurrently experiencing abuse from their intimate partners.

Within NSW Health the Education Centre Against Violence (ECAV) provides training opportunities and support to health workers from various sectors in relation to domestic and family violence. NSW Health has advised the Team that within their networks they administer a series of intranets, and employ a significant number of workers. NSW Health also offers domestic and family violence leave under the NSW Government provisions. Accordingly NSW Health are positioned to lead the way in terms of best practice in providing education, training and support relevant to workers who may be experiencing violence.

The Commonwealth Government is also importantly positioned in this space due to their role in respect of aged care workers. For these reasons, and as a first stage moving forward in this important area, the Team recommends:

<sup>100</sup> See <https://www.ourwatch.org.au/Preventing-Violence/Professionals/At-work> (accessed 30 September 2017).



## Recommendation 27

**27.1** That NSW Health ensure that any domestic and family violence training delivered to NSW Health staff, or by NSW Health staff to healthcare service providers (such as by Education Centre Against Violence), discuss and provide referral information relevant to workers who themselves may be experiencing domestic and family violence.

**27.2** That NSW Health provide information about domestic and family violence leave to all staff by circulating a bulletin which should also include educational information about domestic and family violence. Information about supports available for workers should also be displayed on local health district intranets and other relevant intranets administered by NSW Health.

**27.3** That the Commonwealth Government require that all aged care providers deliver information to their staff about domestic and family violence, including information about how to access support.

Further to the issue of employment, the Team also considered domestic and family violence leave more generally and the way in which this leave operates in NSW. In order to claim leave victims must provide evidence in the form of either a document issued by police, a court, a doctor, a family violence support service or a lawyer. This may preclude victims from taking leave where they are experiencing coercive and controlling behaviours from an abuser, or have not attended police or a service in relation to episodes of physical violence.

The Team considered whether, in light of its cases, this evidence of domestic violence threshold was too high and would deter women from seeking leave under the provisions. Accordingly, the Team considered whether alternative forms of proof may be required to ensure appropriate access to domestic and family violence leave for a range of victims, and considered whether the inclusion of a signed statutory declaration as an option for evidence would go some way to fulfilling the proof requirement for victims of violence who have not, for whatever reasons, engaged with mainstream services.

Arising from these concerns, and to ensure parity in access to domestic and family violence leave for a range of victims experiencing violence, the Team recommends:

## Recommendation 28

**28.1** That the NSW Government give consideration to amending its domestic and family violence leave guidelines to include a statutory declaration as evidence of domestic and family violence.

**28.2** That the NSW Government monitor the uptake and use of the domestic and family violence leave provisions, including to monitor how frequently and on what grounds the leave provisions are being used.

## Supporting victims of violence through housing availability and reform

### Supporting victims who want to leave

A central concern arising from a number of cases in this reporting period was the limited availability of shelter accommodation and temporary housing for women escaping violence. While this issue as it relates to non-citizens has been discussed earlier in this chapter, this section focuses on availability of shelter and temporary accommodation more broadly in NSW.<sup>101</sup>

In Case Review 3223 the victim was unsuccessful in seeking refuge accommodation the night she was killed by her partner. The victim initially tried to seek help through the Domestic Violence Line while at the police station, but when she was unable to secure a bed, she refused to go to the FACS-Housing office to seek temporary accommodation. Upon further enquiry the Team identified that this was because the victim had exhausted her allocation of temporary accommodation through FACS-Housing. In relation to the length of assistance, FACS-Housing policy states that the total assistance provided will not exceed 28 days in a 12-month period other than in exceptional circumstances. Each extension is subject

<sup>101</sup> Temporary accommodation is limited accommodation provided by FACS-Housing in low cost motels and other commercial or NGO facilities. Shelter accommodation is provided by Specialist Homelessness Services in refuges or other crisis accommodation properties managed by them, or by other organisations who are not funded by FACS-Housing.

to assessment and extensions beyond 28 days require escalation to a more senior officer. In Case Review 3223, the victim was killed the night she was unable to secure accommodation, and the Team was of the perspective that her death may have been prevented if she was successful in securing accommodation.

In light of this case, the Team raised concerns about the limitations placed on housing accommodation. The Team was advised during the course of these enquiries that if the victim had disclosed that she was experiencing violence, she may have been granted an additional accommodation allocation to help her escape the abuse (as this would constitute 'exceptional circumstances'). The Team queried why, in this case, information about the additional allocation available to domestic violence victims was not known to the DVLO who was assisting the victim at the time, and why it wasn't more widely known (including to the victim) that FACS-Housing had discretion to increase the allocation of accommodation for domestic violence victims. The Team discussed the importance of police and other service providers being aware that additional temporary accommodation may be provided in exceptional circumstances to support domestic violence victims to access this assistance.

As a related issue, the Team also queried the application of Link2home which is a service auspiced by FACS-Housing for people who are homeless at risk of homelessness. People who go through Link2home can be provided with temporary accommodation if they are eligible. In the course of these inquiries the Team was advised that Link2home has recently implemented a process where women, with or without children, who are escaping domestic violence, gain access to initial temporary accommodation regardless of whether or not they meet the eligibility criteria. In 2015 FACS-Housing undertook a review of the Link2home assessment with regard to domestic and family violence. This review was done with DVNSW and domestic violence service providers who listened into phone calls and assessments. The review resulted in the following questions being asked when people contact Link2home for assistance;

1. Do you feel safe?
2. Do you have concerns about your safety and or the safety of your children?
3. Are there any locations where you do not feel safe?

Link2home then refers clients to Specialist Homelessness Services or other relevant domestic violence services who then undertake a more detailed assessment.

The Team was of the perspective that the engagement between DVNSW, domestic violence service providers and FACS-Housing in relation to the Link2Home assessment represented positive collaboration in relation to this issue, and highlighted the importance of ongoing monitoring and work in this space.

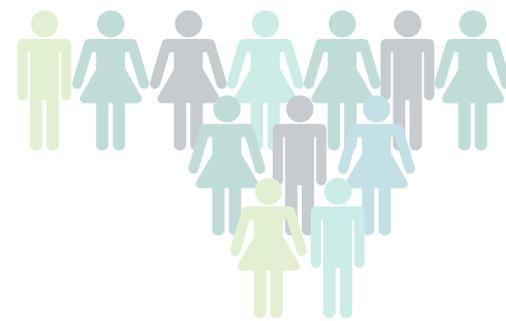
Accordingly, in light of these issues, and highlighting the importance of refuge and temporary accommodation for women escaping violence, the Team recommends:

## Recommendation 29

**29.1** That the NSW Government fund FACS-Housing to expand its allocation of housing for clients escaping domestic and family violence.

**29.2** That FACS-Housing include information about the availability of temporary accommodation on its website, Link2Home highlighting that for victims and domestic violence such accommodation is not subject to the 28-day limit.

**29.3** That FACS-Housing continue to liaise with DVNSW and other relevant stakeholders to ensure that the Link2home processes for clients experiencing domestic or family violence remain appropriate.



## Overcoming barriers: Housing availability and perpetrators

Another issue the Team considered in this period was how to further support victims to remain safe and in their own homes when they wish to permanently separate from an abuser, or if they wish to leave temporarily to address their safety needs.

While it has long been acknowledged that women experiencing violence may need refuge assistance to escape abuse – and the Team seeks to reinforce the importance of available, accessible, acceptable and quality refuge accommodation for all women – a number of cases in this review period highlight that a perpetrator having no alternative accommodation can further endanger women experiencing abuse.

In a number of cases in this review period (including Case Reviews 3693, 3696, and 3495) and prior review periods (Case Reviews 3298, 3301 and 3004) victims and abusers continued to cohabit after separation due to challenges around the availability of appropriate and accessible accommodation for perpetrators. While it has long been recognised, including through policies such as Staying Home Leaving Violence, that victims should not have to leave their homes when they leave abuse, there continue to be only limited resources available for perpetrators to leave and be accommodated elsewhere. This can lead to the abuser and the victim remaining together in the home – circumstances which in many of this Team's cases have been ongoing at the time of the homicide.

In the course of its discussion around the issue of perpetrator accommodation availability FACS-Housing advised the Team that it is currently undertaking a pilot project to provide perpetrators with temporary accommodation linked to referrals and support. The Team was of the perspective that this work is valuable for promoting the safety of victims, and in light of the Team's cases and the goals of the Blueprint, should be evaluated and supported on a continuous basis.

Accordingly, the Team recommends:

### Recommendation 30

That FACS-Housing evaluate its current pilot project which provides perpetrators with temporary accommodation linked to referrals and support.

## Supporting FACS-Housing clients in respect of their rights and responsibilities

In the Team's 2013/15 Report it made a number of recommendations supporting both FACS-Housing clients and police. The Team recommended that FACS-Housing distribute a hard copy z-card outlining tenancy information in relation to FACS-Housing clients. This recommendation arose from a case in which a FACS-Housing tenant was asking for an unauthorised household occupant (who was not named on the lease) to be removed from his house. Police refused to remove the occupant and the tenant killed the unauthorised occupant.

The recommendation was not supported on the basis that:

- 1) The Police can access real time information in an urgent situation by contacting the Housing Contact Centre 24/7;
- 2) Police can remove an aggressor regardless of tenancy status;
- 3) Information on a static card would be quickly out of date and could be counter productive; and
- 4) FACS-Housing was developing a smart-phone 'app' for use by clients that shows real time information, including offline information.

The Team discussed this response and a number of members expressed concern that electronic information in the form of an 'app' may not be accessible for all clients. FACS-Housing advised the Team that it would not support any provision of hard copy information due to concerns about that information not being dynamic enough to accommodate changing tenancy arrangements, and instead highlighted that it would evaluate uptake of its digital platforms as part of rolling out its digital strategy.

The Team will retain a watching brief in relation to this issue via Recommendation 31 set out below.

In relation to the issue of supporting police to understand tenancy rights and responsibilities and how to work with FACS-Housing, the Team has previously recommended that FACS-Housing work collaboratively with police to develop an information bulletin regarding the rights and rules pertaining to social housing tenants to be circulated statewide within 12 months.<sup>102</sup> This action has been completed and the Team is of the perspective that this bulletin should be regularly updated by FACS-Housing and should be usable by police in the course of their duties, including to form part of Standard Operating Procedures.

In another case during this reporting period (Case Review 3223) a FACS-Housing client presented to the onsite security desk in the FACS-Housing complex she lived in after hearing a neighbour experiencing what she suspected was domestic violence. In this case the FACS-Housing security subcontractors did not render any assistance or call 000. This led the Team to consider current training or policy arrangements for security subcontractors at FACS-Housing properties. In relation to this issue, FACS-Housing has advised the Team that since this case, security contracts have been retendered and contractual requirements updated.

FACS-Housing has advised the Team that security contractors are required to report person/s who are acting aggressively or violently towards other people to police – a requirement which requires workers to call 000 in relation to episodes of violence they witness. However, in this particular case the episode was not directly witnessed by security staff and accordingly this policy would not apply.

FACS-Housing has also advised the Team that current Asset Maintenance Contracts (as at April 2016) require contractors and subcontractors to report a number of matters, including domestic violence. Protocols and forms have been developed and training has been delivered to contractors and subcontractors who must notify FACS-Housing via the Housing Contact Centre (24/7) if they attend a FACS-Housing managed property and identify one or more of the following situations:

- Fire
- Self-harm
- Suicide threat
- Domestic and Family Violence
- Child at risk
- Injury to person

If an incident is notified as above, then the Housing Contact Centre will take appropriate action.

The Team welcomes the FACS-Housing action in this space, and to support FACS-Housing staff and clients, and to respond to the various issues described in this section, the Team recommends.

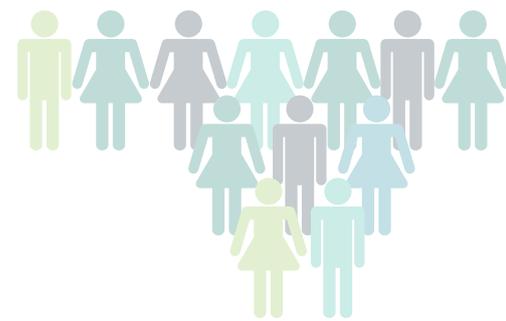
## Recommendation 31

**31.1** That FACS-Housing monitor the uptake and use of its new client information and service 'app' once launched, and consider strategies to ensure the 'app', and the broader Housing Connect Program, is accessible to clients, and in particular culturally and linguistically diverse clients and clients who are not digitally savvy.

**31.2** That FACS-Housing update its security contracts to require that subcontractors call police where they see, suspect or are informed about domestic violence episodes occurring on, or in relation to, FACS-Housing properties.

**31.3** That FACS-Housing work with the NSW Police Force to ensure the provision of timely and up to date housing information for use by officers (including in relation to the information referred to in Recommendation 29.2).

<sup>102</sup> Recommendation 11 of the Team's 2013/15 Report.



## Reframing the broader service system

### Reviewing the operation of the DVSAT

In recent years, as highlighted in this report, NSW has adopted a co-ordinated domestic violence service delivery model across the state through the Safer Pathway reforms.<sup>103</sup> This model includes key components such as the common Domestic Violence Safety Assessment Tool (DVSAT) which covers both domestic and family violence, a central referral point electronic management tool, a statewide network of local coordination points, Safety Action Meetings (SAMs) for victims at serious threat of death, disability or injury as a result of domestic and family violence, and is accompanied by information sharing legislation designed to promote a coordinated and integrated response.

In the course of its activities the Team has raised some queries about the operation of the DVSAT including the range of risk indicators covered within the tool, its suitability for both domestic and family violence given the differing characteristics of these kinds of abuse (and the plurality of different risk indicators across different kinds of family violence), and the equal weighting of risk indicators within the tool (compared to a weighted tool, as is used in some other jurisdictions). While it is acknowledged that the tool encompasses a professional judgement component, the Team has also queried the range of risk indicators chosen and their suitability, in particular, for older women, or women who do not have children.

Despite the Team's recommendation in its 2013/15 report that the NSW Department of Justice work collaboratively with the Team on any future evaluations of the DVSAT, the Team has not, to date, been invited to participate in any evaluations of the tool. Justice has indicated that an evaluation is currently taking place and is being coordinated by Victims Services (NSW Department of Justice) in collaboration with Women NSW (see Chapter 7 for detail).

Given that the Team collects relevant qualitative information concerning domestic violence deaths, including to exhaustively examine the characteristics of domestic violence in these cases, it is unfortunate that the current evaluation of the DVSAT is not seeking to draw upon the Team's expertise as part of the ongoing development of this important tool. It is the Team's perspective that this represents a missed opportunity for the work of the Team to contribute to the ongoing development of the DVSAT and the Safer Pathway system more broadly.

The Team has been advised by Women NSW that the evaluation of the DVSAT will be finalised in the next 18 months. The Team eagerly awaits these findings and will retain a watching brief in relation to any changes made as a consequence of the evaluation.

## Picking up the pieces and supporting survivors

The final component of this chapter focuses on the period following a homicide, or the period following episodes of violence. While this report highlights the complex and continuous interrelationship between prevention, intervention and redress, this section refocuses on supporting victims in the aftermath of violence, highlighting the importance of managing trauma, supporting survivors and making remedies accessible and possible for families.

### Supporting survivors with their immediate needs post homicide

A primary consideration for victims in the aftermath of a homicide is the immediate concern of cleaning up the crime scene when a loved one has been killed. In Case Review 3596 the victim was seriously assaulted in her home (a home she shared with other relatives) and died a short time later in hospital. Following the victim's assault, police established a crime scene and conducted forensic tests relevant for the police investigation. After finishing with the crime scene police officers left the house, and the victims' relatives – including her young teenage niece – cleaned up the scene so that they could return home. Particularly in

<sup>103</sup> NSW Department of Justice, *It Stops Here: Safer Pathway Overview* (2014) available at [http://www.domesticviolence.nsw.gov.au/\\_\\_data/assets/file/0013/301180/Overview\\_Safer-Pathway.pdf](http://www.domesticviolence.nsw.gov.au/__data/assets/file/0013/301180/Overview_Safer-Pathway.pdf) (accessed 30 September 2017). See also [https://www.women.nsw.gov.au/violence\\_prevention/It\\_Stops\\_Here\\_Safer\\_Pathway](https://www.women.nsw.gov.au/violence_prevention/It_Stops_Here_Safer_Pathway) (accessed 30 September 2017);

light of its concerns related to intergenerational trauma the Team was very concerned with this outcome.

Upon conducting further enquiry into relevant practices and policies, the Team was advised that while there is currently a general practice whereby police officers facilitate the cleaning of crime scenes by contacting contract cleaners, this practice is not enshrined in policy and accordingly, is not required to be observed. A number of Team members were of the perspective that not having a formal policy in place as to roles and responsibilities in relation to engaging crime scene cleaners resulted in the unacceptable outcome in Case Review 3596.

The Team also considered the issue of payment in respect of crime scene clean up. Under the *Victims Rights and Support Act 2013* (NSW), financial assistance for the cost of cleaning a crime scene following a homicide (up to \$5,000), can be claimed as an 'immediate need' by family members. Other 'immediate needs' assistance anticipated under this scheme includes funeral costs, assistance in relocating to a safer location, and implementation of safety measures such as changing locks.

The Team has been advised that to access this financial assistance an application must be lodged with the Commissioner of Victims' Rights in the approved form and with necessary supporting evidence to verify the need for and amount of assistance sought. Once received, the Commissioner makes a determination based on the eligibility and needs of the applicant, and sends written notification of the decision.

A number of Team members considered this process onerous for families in the aftermath of traumatic events and queried whether the time in processing applications may result in family members cleaning crime scenes themselves where there is no alternative accommodation for other family members residing in the premises. Again, this was an area a number of Team members considered should be addressed by way of recommendation.

The issues arising in Case Review 3596 led the Team to consider, more generally, the adequacy of supports available to surviving family members in the period immediately following a homicide. In its discussions with homicide victims support agencies, the Team identified that secondary victims of homicide

experience a range of pressing and particular needs immediately after these traumatic events, and that unless they immediately engage with support groups, they are not necessarily provided with relevant information. The Team was of the perspective that the development of a specialist information package for secondary victims of homicide, and a strategy for dissemination of such a package, should fall to Victims Services and NSW Police Force working with specialist homicide victims support organisations and other relevant organisations.

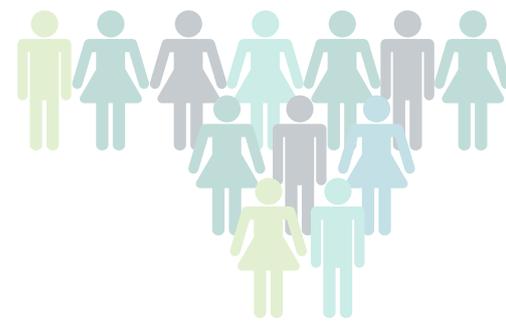
Accordingly the Team recommends:

## Recommendation 32

**32.1** That Victims Services work with the NSW Police Force to formalise a policy or memorandum of understanding in relation to crime scene clean up in all cases where a crime scene is established following a homicide or very serious assault from which death may result. This policy should clearly articulate each agencies role in ensuring that crime scene clean up is coordinated in a timely fashion and that families are appropriately supported in accessing financial assistance where required.

**32.2** That Victims Services and the NSW Police Force work together with homicide victims support organisations to develop or update any existing information package, such as the *Family Members of Homicide Victims* brochure, for secondary victims of homicide. This package should contain clear and plain English information about victims' immediate needs, actions required of the secondary victim, support services available and how to engage support, and next steps after a family member or loved one is killed. Agencies should develop a strategy for making this package available to all secondary victims of homicide as soon as practicable after the fatal assault.

Another key issue considered by the Team in this review period was the response to surviving children and in particular managing the trauma of children who have a parent or sibling kill, or be killed, in a homicide. In this case review period alone, there are at least 74 child survivors of homicide under the age of 18, where a parent/s or a sibling was killed, or a parent/s perpetrated a domestic violence homicide. This figure represents a traumatised cohort for whom there is



currently no integrated, specific or consistent service response within the current system. This is despite earlier recommendations of this Team<sup>104</sup>.

The Team's cases highlight that while some child survivors of homicide apply for and receive counselling through Victims Services, many children do not have opportunities to work with grief specialists following these life-changing events. Further, unless children are placed in the care of the Minister following a homicide, FACS-Community Services do not have a continuous engagement with surviving children and it falls to family carers to manage a surviving child's complex trauma needs.

In light of these challenges, the Team engaged with stakeholders to discuss promising initiatives, as well as gaps, in the current response. The Team's inquiries highlighted the importance of specialist agencies providing support for families following a homicide, and that these agencies are working to address challenges in the current response to these families. For example, Homicide Victims Support Group are currently establishing 'Grace's Place' in Sydney, which will be a bespoke trauma centre catering to young people, children and their families who are recovering from a homicide.<sup>105</sup> This centre will provide counselling, therapeutic programs and will assist young people and their families to rebuild following this unique loss and trauma. The establishment of a facility such as Grace's Place highlights that domestic violence prevention and intervention must be understood as closely aligned with recovery and remediation, and prevention and intervention efforts must focus on supporting children and young people who experience trauma in their lives.

While the Team welcomes the development of initiatives such as Grace's Place, it remains concerned that despite its earlier recommendations, many of the same issues continue to arise in respect of the response to surviving children of homicide. In *Recommendation 9* of the 2012/13 report, the Team recommended that the NSW Police Force notify FACS in relation to any surviving children in homicide cases, required FACS to co-ordinate an inter-agency response to ensure counselling and service availability to children, and required the NSW Government to develop a strategy and additional support services tailored for this group of child victims in cases where family members

are reluctant to engage. This recommendation was supported by the NSW whole of government response but in monitoring responses received by this Team it is evident that the anticipated system has not been developed. The Team's review of FACS-Community Services records for surviving children throughout 2016 and 2017 also highlights that there continues to be a lack of comprehensive interagency response to this cohort of children.

The Team seeks to reinforce its 2012/13 recommendation by making a further recommendation. Accordingly, the Team recommends:

### Recommendation 33

That Victims Services, Family and Community Services, NSW Health, the Department of Education and Communities other relevant organisations work together to improve access to support and advocacy for young people and children who are a secondary victim to a homicide, including where carers may be reluctant to engage with services.

### Restitution for payments made to victims of crime

Another issue the Team considered in this review period was the operation of restitution – the process whereby Victims Services seek to recover, from offenders, support/compensation payments made to victims of crime. Upon reviewing restitution orders made in two cases in this period (Case Reviews 3378 and 3494), the Team identified that in these orders the victim of crime was a relative of the offender, and the restitution order had been pursued against an offender in circumstances where the victim and offender had an ongoing relationship.

For instance, in Case Review 3378, the offender was ordered to pay restitution in relation to compensation received by her children after she had killed her abusive partner. In this case the offender served a short sentence and would have commenced paying restitution orders in relation to this compensation while the children were in her care. She lodged an objection to the order and it was reduced to nil.

<sup>104</sup> Recommendation 9 in the Team's 2012/13 report.

<sup>105</sup> See <http://hvsg.com.au/index.php/fundraising-events-2/graces-place/> (accessed 30 September 2017).

In Case 3494, the offender killed his mother's abusive partner and was issued a restitution order in relation to victim's compensation payments received by his mother. There was evidence that the offender's mother remained supportive of the offender and that the offender would be returning to live with her at the end of his term of imprisonment for manslaughter.

These cases highlighted a challenge in the operation of the current process and gave the Team cause to consider the appropriateness of Victims Services seeking restitution in circumstances where the offender and victim have an ongoing relationship and/or where such an order may have a negative impact on the safety and/or wellbeing of a victim of violence.

In the course of its enquiries the Commissioner of Victims' Rights advised the Team that at the point of making a Provisional Order for restitution (the first step in the restitution action process), the Commissioner has access to only limited information, including the name of the offender and victim, conviction details and some information regarding the offence for which a victim received compensation. The Commissioner does not have access to information pertaining to the offender's familial or financial circumstances. The Team discussed whether the issues identified in these cases and the overall effectiveness of the restitution process would be enhanced by the provision of more detailed information before a Provisional Order is made. The Team was advised, however, that due to the high volume of Provisional Orders issued, this would not be practicable.

As noted above in relation to Case Review 3378, an offender may lodge an objection to a Provisional Order, setting out in writing the reasons why the Commissioner should vary or revoke the order. The grounds for objection are not prescribed by the legislation, however information on the Victims Services website, as well as in material provided to offenders when a Provisional Order is made, sets out a number of grounds of objection an offender may seek to rely on in their submission to the Commissioner. The Team was of the perspective that this information should include reference to the offender's ongoing relationship with the victim as one such ground.

Accordingly the Team recommends:

## Recommendation 34

That Victims Services update its online information and any material that accompanies the making of a Provisional Order for restitution to indicate that the defendant can challenge the making of an order in circumstances where the defendant has an ongoing relationship with a victim who has been granted compensation.

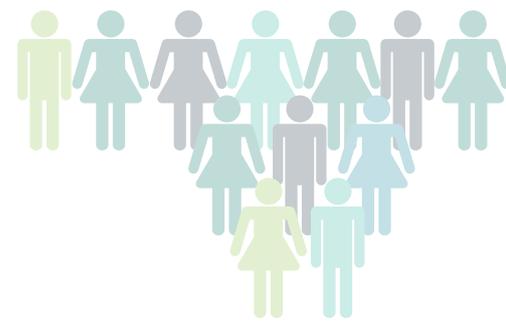
## Supporting victims navigating forensic mental health processes

### Victim Impact Statements

A key issue the Team considered in this reporting period was the provision of a Victim Impact Statement (VIS) in cases where perpetrators are subject to special hearing and found not guilty by reason of mental illness (NGMI). In a number of cases in this period (including Case Reviews 3592, 3035, 3571, 3541, 3345, 3517 and 3418) homicide perpetrators were found not guilty by reason of mental illness and accordingly, as they did not receive a sentence for the purposes of *Crimes (Sentencing Procedure) Act 1999* (NSW), secondary victims (such as family members of the deceased) were unable to tender a VIS. While understanding this challenge, the Team was of the perspective that the rationale for VIS's remains valid in these cases – namely to respect and remember the victim and reflect on the way in which homicides impact surviving family members.

In its 2013 report, *Criminal Responsibility and Consequences*, the NSW Law Reform Commission considered whether the legislation should be amended to facilitate greater victim involvement in cases where a perpetrator of crime is found NGMI or unfit and not acquitted (UNA).<sup>106</sup> In this report the Commission considered whether this should include provision for victims to tender a VIS following a finding of NGMI or UNA. In informing this report, a number of stakeholders, including the Office of the Director Public Prosecutions, the Mental Health Review Tribunal and Homicide Victims' Support Group indicated their view that victims should be provided with this opportunity.

<sup>106</sup> NSW Law Reform Commission, *Criminal Responsibility and Consequences*, Report 138, 2013, p. 229.



Ultimately the Commission identified that the provisions for making a VIS under the *Crimes (Sentencing Procedure) Act 1999* (NSW) should be extended to apply in circumstances where the defendant was found UNA or NGMI. The Commission identified that VIS's can play an important role in the grieving process for victims of crime and the effect a crime has on its victims is not diminished despite the outcome in these cases (the defendant not being legally responsible). The report also recognised that tendering VIS's gives victims a 'voice' before the court.

Accordingly the Commission recommended that:

8.4 (1) The provisions relating to the making of a victim impact statement to the court under Part 3, Division 2 of the *Crimes (Sentencing Procedure) Act 1999* (NSW) should be extended to apply to circumstances where the defendant is found unfit and not acquitted or not guilty by reason of mental illness under the *Mental Health (Forensic Provisions) Act 1990* (NSW).

The Team, in light of its cases and its concern with surviving victims of homicide, accordingly recommends:

### Recommendation 35

That the NSW Government review legislation to allow for the making of Victim Impact Statements in circumstances where the defendant is found unfit and not acquitted, or not guilty by reason of mental illness under the *Mental Health (Forensic Provisions) Act 1990* (NSW).

### Specialist supports for victims in forensic processes

A further issue the Team considered in this report was the limited support available to victims of crime in circumstances where the offender is a forensic patient and accordingly subject to a special hearing or similar forensic processes.

In one case in this review period (Case Review 3035) review of the FACS-Community Services file for the surviving child post-homicide highlighted challenges in the ways in which the Mental Health

Review Tribunal was communicating with the family of the deceased in relation to its management of the offender. Every 6 months forensic patients have their circumstances reviewed, and in the lead up to this taking place the family received an update by way of pro-forma letter notifying them about the upcoming review of the offender's circumstances. The FACS-Community Services file highlights that receiving this communication greatly upset the surviving child and traumatised the family, who believed, based on the information in the letter, that the review meant the offender was being released. The Team considered that there appeared to be little support or liaison through these processes for victims of crime, and that this method of notifying family members was liable for misinterpretation, and may further traumatise victims.

The Team engaged with the Mental Health Review Tribunal in considering this issue and was advised that the tribunal was limited in the extent to which they can currently provide support and education to victims about a forensic patient's pathway through the system. The Team was advised that other jurisdictions have developed specialist responses to this cohort of victims, such as the Queensland Health Victims' Support Service which provides counselling, support and information to victims of crime when the offender has been assessed as having a mental illness or intellectual disability.<sup>107</sup>

The Team considered that the rights and interests of this group of victims needs to be promoted and protected and accordingly, the Team recommends:

### Recommendation 36

That NSW Health together with the Mental Health Commissioner review the adequacy of supports available for victims of domestic and family violence or secondary victims of domestic violence related homicides in NSW, where the person charged has been assessed as having a mental illness or intellectual disability.

The review should consider strategies to improve the identification of domestic violence cases by mental health professionals, including the Mental Health Review Tribunal.

<sup>107</sup> See <https://www.health.qld.gov.au/qhvs> (accessed 30 September 2017).

## Intergenerational Trauma

Another issue the Team considered in this reporting period was intergenerational trauma, noting that many cases highlight that victims, abusers and family members experience serious histories of trauma and abuse. It remains of concern that in the Team's database there are a number of cases in which a child has witnessed the homicide of a parent by another parent and that child has grown up to kill an intimate partner themselves. Although intergenerational homicide appears to be an extreme example, these cases highlight the consequence of trauma, including failures to effectively address trauma following a homicide. This is relevant more broadly to this, and earlier sections of this report.

Other cases illustrate the extent to which trauma has both an individual and collective dimension, particularly for Aboriginal and Torres Strait Island Australians for whom trauma must be understood in connection with processes of colonisation, dispossession and entrenched racism. Other cases in this review period highlight the extent to which trauma and abuse can become normalised within families and communities, and highlight the extent to which violence acceptance has a radiating impact.

In one case during this review period (Case Review 3224) an abuser murdered his wife, leaving the children- who were present in the house at the time of their mother's murder – without any suitable relatives to care for them in the period immediately following the homicide. Accordingly, FACS-Community Services assumed care and protection of the children and appointed a caseworker until suitable family members could be located.

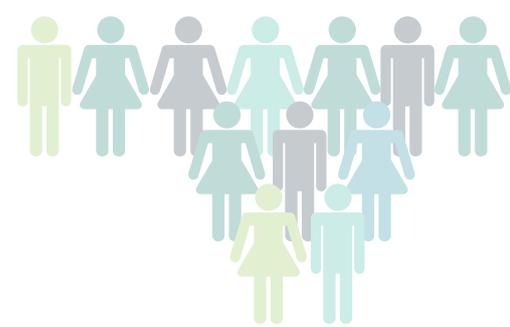
FACS-Community Services placed the children into crisis short term foster care with a departmental carer. While the children were with the departmental carer the carer contacted the children's caseworker seeking advice about 'the best way to care for Muslim children' and told the children's caseworker that the extent of her knowledge was that she suspected that they had dietary restrictions. This case led the Team to consider the adequacy of training and supports in place for foster carers, who assume crisis care of extremely vulnerable children, not only in relation to cultural competency but also in relation to managing the grief and trauma of children who have just lost a parent or family member to a homicide.

While Case Review 3224 related to a departmental carer, the foster care system in NSW comprises non-government as well as departmental carers. In the course of further enquiries, the Team was advised that FACS-Community Services do not monitor training and/or uptake of training for non-government out of home care providers, including in relation to cultural competency. The Team was advised that non-government organisations in this role are overseen by the Children's Guardian and, as part of their compliance requirements, non-government foster care organisations must demonstrate appropriate training strategies to support out of home care service delivery to this office. What was not clear to the Team, however, was whether this oversight function extends to cultural competency training for culturally and linguistically diverse children or Aboriginal children. The Team undertakes to engage with the Children's Guardian in relation to cultural competency and will monitor this issue in subsequent reports.

In respect of this issue the Team also considered the related issue of the supports available to foster carers more generally, including where foster carers may have questions or issues arising outside of business hours. FACS-Community Services advised the Team that this system is currently being revised, and as a consequence, the Team determined to also monitor this aspect of the foster care system with a view to considering this further in subsequent reports.

### The trauma of child removal

Review of the Team's cases also reveals that histories of child removal, and its associated traumas, are often intergenerational. In a number of the Team's cases the narrative illustrates that victims or abusers were removed from their parent/s as children, and then had their own children removed from their care as adults due to behaviours or social issues arising often from their own histories of trauma and removal (for example, Case Review 3307 from the Team's 2013/15 Report). In some cases, Aboriginal families reflect on intergenerational loss and the impact of family being removed through the Stolen Generation; loss that remains in the living memory of many families and communities, punctuated by the removal of children within the current generation (including, Case Reviews 3420 and 3596).



The dislocation of children from their families and communities, and the fracturing of kinship relationships, is a repeated story within many of the Team's cases and highlights the impact that losing a child or children can have on a family, and the impact that removal has on the child. This is evident in a number of cases (including Case Reviews 3517 and 3596), which illustrate not only the challenging circumstances that can lead to a child being removed, but highlight the individual and collective impact of this loss and the lack of follow up to these complex traumas for the adults from whom children are removed.

There continues to be significant movement in this space, and a great deal of attention to, in particular, the interaction between child protection systems and Aboriginal children. A recent NSW Parliamentary Inquiry into child protection recommended that, inter alia, the NSW Government work with Aboriginal organisations, including Grandmothers Against Removals, to provide a far greater degree of Aboriginal self-determination in relation to child protection, child removals and supporting families.<sup>108</sup> Long term investment in Aboriginal people and agencies is a necessity in overcoming the overrepresentation of Aboriginal children in out of home care and the recommendation for increased self-determination acknowledges that cultural competency alone may be insufficient to overcome issues of entrenched racism, discrimination and narrow conceptions of Aboriginal children's cultural needs.

In 2016 the NSW Government announced that Professor Megan Davis would chair a review, conducted by Aboriginal leaders, examining the case files of 1200 Aboriginal children and young people involved in FACS-Community Services.<sup>109</sup> Accordingly, in light of the work, the Team was of the perspective that it would await the outcome of Professor Davis' review and continue to monitor issues arising.

## Supporting older children

Another issue the Team considered in this review period was the issue of supporting older children who are exposed to violence or abused. In a number of

cases in this and prior review periods, older children are being exposed to domestic violence, or being directly abused by a parent but are not reaching the threshold to be considered at Risk of Serious Harm (ROSH) by FACS-Community Services, possibly as a result of their age and resulting perceptions about their vulnerability.

In Case Review 3693 police attended the domestic violence victim's house on a number of occasions and applied for an ADVO protecting both the victim and her children (aged 16 and 17 at the time) from the abuser. The Team is advised that FACS-Community Services has no record of either child despite their appearing on the ADVO as PINOPs, and despite the fact that they were known to police as children exposed to domestic violence. It is not clear whether police did not notify FACS-Community Services, or whether police notified FACS-Community Services about the children and they did not reach the threshold to be screened in. In any event there is no record. The victim (mother) in this case was ultimately murdered by her abusive partner, the children's father, who then killed himself.

In another case (Case Review 3393), the abuser locked his partner and her child out of the house during an episode of domestic violence. Police attended and spoke to the abuser and victim, and the victim told the officers that she would sleep with her 12 year old son in their car. On the police computer system, the son is listed as a young person at risk at this event, but there is no FACS-Community Services record of this episode and the police system notes that there is 'no ROSH' for this child, indicating that the report did not screen in. There is significant evidence that this 12 year old child was exposed to domestic violence and was directly abused by his stepfather (the abuser) over a number of years.

FACS-Community Services advised the Team that given the changes to policy and practice within FACS-Community Services since this time it is likely that this case would now screen in and receive a response.

The issue of supporting older children has been considered by the NSW Ombudsman in a number of its reports concerning child protection.<sup>110</sup> In its

<sup>108</sup> General Purpose Standing Committee No. 2, *Report 46: Child Protection*, (NSW Parliament, 2017) 140, available at <https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/ReportAcrobat/6106/Final%20report%20-%20Child%20protection.pdf> (accessed 30 September 2017).

<sup>109</sup> See [https://www.facs.nsw.gov.au/about\\_us/media\\_releases/media\\_release\\_archive/nsw-to-review-cases-of-aboriginal-kids-in-care](https://www.facs.nsw.gov.au/about_us/media_releases/media_release_archive/nsw-to-review-cases-of-aboriginal-kids-in-care) (accessed 30 September 2017).

<sup>110</sup> NSW Ombudsman, *Keep them Safe?* (2011); NSW Ombudsman, *Service provision challenges in responding to very vulnerable older children and young people* (2012); NSW Ombudsman, *Responding to Child Sexual Assault in Aboriginal Communities* (2012); NSW Ombudsman, *Review of the NSW Child Protection System: Are things improving?* (2014).

2012 confidential report to FACS, the Ombudsman specifically identified older children and adolescents as a highly vulnerable group within the child protection system and emphasised the need for a comprehensive and integrated response for this cohort. This led to FACS establishing the *Vulnerable Teenagers Review*, now known as *Better Lives for Vulnerable Teenagers*, the purpose of which was to develop strategies and reforms that would ensure improved outcomes for vulnerable children and young people (aged 9-24 years).<sup>111</sup> The review convened an expert advisory panel that undertook consultations with young people about their experiences with FACS as well as consultation across a range of NSW and Commonwealth Government agencies.

The review identified a range of system issues that actively contribute to adverse outcomes for vulnerable young people and described the system as siloed, fragmented, and uncoordinated for this cohort.<sup>112</sup> The review identified the importance of early identification and intervention, the need for person-centred and flexible support for vulnerable young people, and the centrality of developing a 'clear policy framework that articulates a consistent, integrated system-wide approach to identifying and supporting vulnerable young people and provides a basis for building systemic capacity.'<sup>113</sup>

Following the Team's enquiries as to the implementation of strategies identified in the review, FACS-Community Services advised the Team that while the *Better Outcomes for Vulnerable Teens* report continues to guide the work of that agency, implementation of the reform agenda imagined by the review now vests with the Office of the NSW Advocate for Children and Young People. That Office was established in 2014 to lead the development of a whole of government plan to support and enhance the safety, welfare and wellbeing of children and young people. In July 2016 the *NSW Strategic Plan for Children and Young People 2016-2019* was released<sup>114</sup> and the Team is advised that the *Better Lives for Vulnerable Teens* report was considered in the development of the Strategic Plan.

From the Team's perspective, the issue of supporting older children also bears on Safer Pathway framework, as this may assist to bring some vulnerable older children into the system through SAMs.<sup>115</sup> Under this framework when police attend an episode of domestic violence they are required to complete the DVSAT, which results in either a rating of being 'at risk' or 'at serious threat'. Both ratings produce a response; either a referral for victims at threat, or for events where victims are rated at serious threat, these victims are brought into the SAM. The format of the SAM is such that it is designed to develop an integrated and interagency response to victims, perpetrators and their families, and the needs of older children should be considered within this framework.

The Team remains concerned about this cohort of older children and, in the course of its surveillance of surviving children post homicide, continues to identify challenges in respect of the FACS-Community Services response. As the intersection between child protection, domestic violence and safety assessment continues to be a priority for this Team, it will seek to monitor the implementation of strategies identified in the *Better Lives for Vulnerable Teenagers* through the *Strategic Plan*, with a view to making future recommendations should these be required.

111 Dowse, *Better lives for vulnerable teens. FACS review. Summary paper* (Family and Community Services, 2014) available at [http://www.community.nsw.gov.au/\\_data/assets/pdf\\_file/0007/335167/better\\_lives\\_for\\_vulnerable\\_teens\\_review.doc.pdf](http://www.community.nsw.gov.au/_data/assets/pdf_file/0007/335167/better_lives_for_vulnerable_teens_review.doc.pdf) (accessed 30 September 2017).

112 Ibid.

113 Ibid 19.

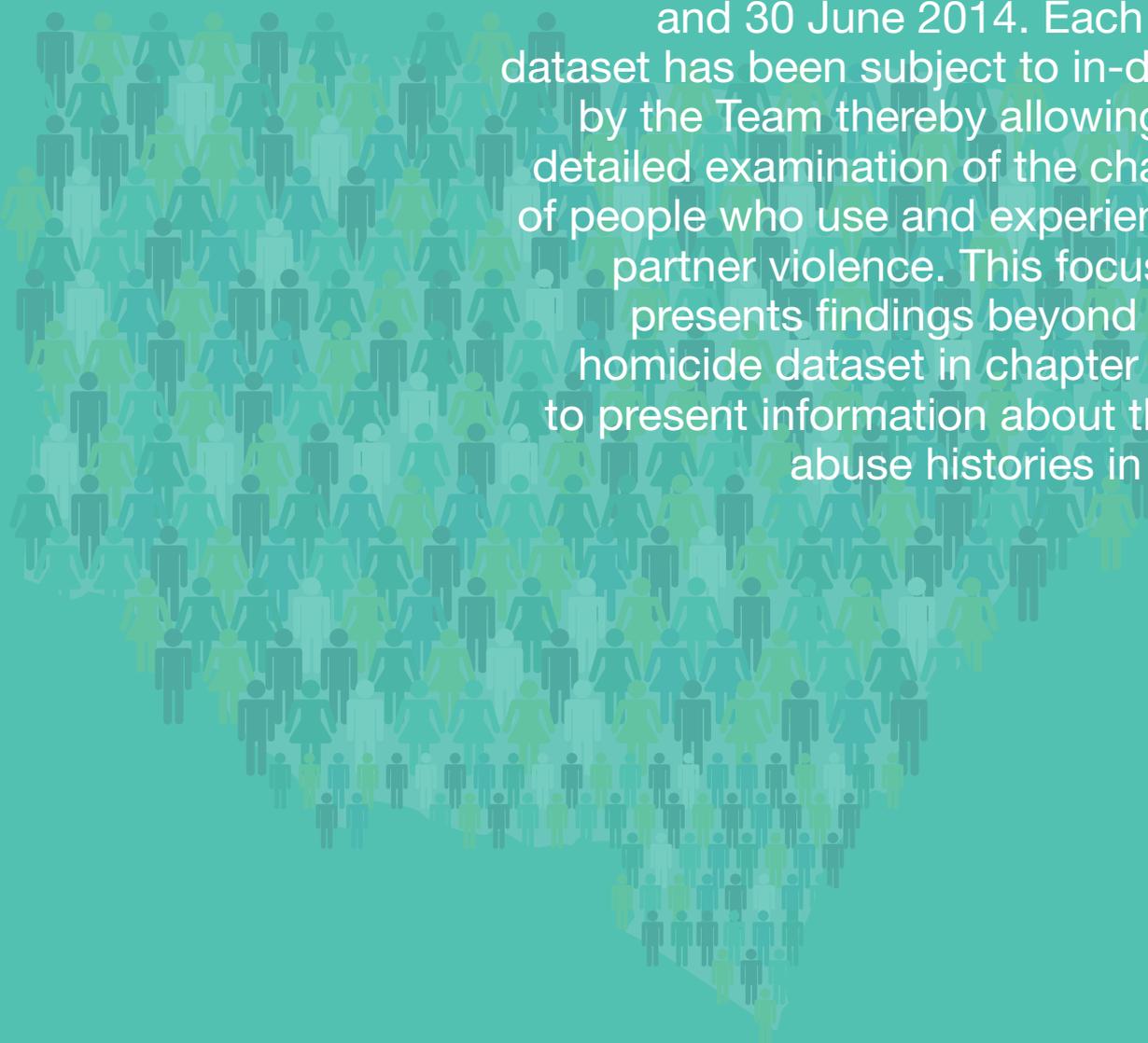
114 Office of the Advocate for Children and Young People, *The NSW Strategic Plan for Children and Young People 2016-2019* (2016) available at <http://cdn2.hubspot.net/hubfs/522228/documents/acyp/NSW-Strategic-Plan-for-Children-and-Young-People-2016-to-2019.pdf?t=1505428017124> (accessed 30 September 2017).

115 See [https://www.women.nsw.gov.au/violence\\_prevention/It\\_Stops\\_Here\\_Safer\\_Pathway](https://www.women.nsw.gov.au/violence_prevention/It_Stops_Here_Safer_Pathway) (accessed 30 September 2017).

# Focus on Intimate Partner Violence

## Victims and Abusers, 2008-2014

This chapter provides an extended data analysis in relation to all intimate partner homicides occurring in a domestic violence context in NSW between 10 March 2008 and 30 June 2014. Each case in this dataset has been subject to in-depth review by the Team thereby allowing for a more detailed examination of the characteristics of people who use and experience intimate partner violence. This focused chapter presents findings beyond the broader homicide dataset in chapter 2, including to present information about the nature of abuse histories in fatal cases.



## Introduction

Domestic, or intimate partner, violence describes a spectrum of behaviours whereby a 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 relationship.

At the heart of this definition is the abuser's use of coercive and controlling behaviours to assert and maintain power and dominance over the victim.

Research has demonstrated that the vast majority of domestic or intimate partner violence is perpetrated by men against women.<sup>116</sup> This has led to an understanding that domestic violence is a gendered harm.

The Team acknowledges that domestic or intimate partner violence requires particular consideration in light of these characteristics and accordingly has used this report to further develop its dataset.

To date the Team has undertaken in-depth reviews of all 78 intimate partner domestic violence homicides that occurred in NSW between 10 March 2008 and 30 June 2014.<sup>117</sup>

Due to its review methodology the Team is uniquely placed to undertake enhanced data analysis derived from these reviews.

This chapter accordingly provides further data in relation to all 78 intimate partner domestic violence homicides that occurred between 10 March 2008 and 30 June 2014, but frames this data primarily in terms of the abuser/victim relationship (rather than focusing throughout on the homicide perpetrator/victim). This enables a more accurate framing of the gendered patterns of these behaviours: highlighting that most men who killed an intimate partner, and most men who were killed by an intimate partner, were the primary domestic violence abuser within the relationship.

## Intimate partner domestic violence homicide

Between 10 March 2008 and 30 June 2014 there were 92 intimate partner homicides in New South Wales. Of these 92 homicides, 78 (85%) were classified by the Team as having occurred in a domestic violence context.

For the 14 homicides that were categorised as *not* occurring in a domestic violence context (cases that were excluded from this dataset), there was no identifiable history of domestic violence prior to the fatal episode. These cases instead occurred in circumstances, including:

- suicide pact/assisted suicide where the homicide victim had a chronic illness (N=2);
- sexual misadventure/ accident (N=3);
- financial motivation (N=1);
- dementia/mental illness (N=4); and
- where there was otherwise no identifiable history of domestic violence (N=4).

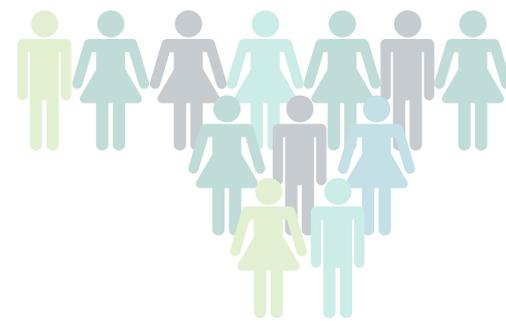
Given the limitations inherent in relying on the brief of evidence, including the affidavits and statements of friends, family members and often the accused homicide perpetrator, it is acknowledged that these cases may include histories of violence that were not disclosed or known. Accordingly, the resulting dataset may represent an undercount of intimate partner homicides occurring in a domestic violence context.

The 78 intimate partner domestic violence homicides in this dataset were perpetrated by 68 men and 10 women. The 68 men killed 66 female and 2 male current or former intimate partners, and the 10 women killed 10 male current intimate partners.

Although these figures already highlight that domestic violence homicide is a gendered pattern of behaviour primarily perpetrated by males against females, examining the history of domestic violence in these

<sup>116</sup> Australian Bureau of Statistics, *Personal Safety Survey Australia 2005*, ABS cat. No 4906.9, 2006, Canberra; Chan and Payne, *Homicide in Australia: 2008-09 to 2009-10 National Homicide Monitoring Program Annual Report*, (Australian Institute of Criminology, Canberra, 2013); Dobash, Dobash, Wilson and Daly, 'The myth of sexual symmetry in marital violence' (1992) 39(1) *Social Problems* 71; Grech and Burgess, *Trends and patterns in domestic violence assaults: 2001 to 2010*, (NSW Bureau of Crime Statistics and Research, Sydney, 2011).

<sup>117</sup> There were two additional cases where the homicide occurred in NSW but the case was more closely linked to another jurisdiction and accordingly in-depth review was undertaken by the domestic violence death review mechanism in that jurisdiction.



cases represents a unique contribution that death review bodies can make in understanding the nature of domestic violence.

## Domestic violence victim/abuser status

For 77 of the 78 intimate partner homicides considered in this dataset there was a clear primary domestic violence victim and a primary domestic violence abuser. This signifier relates to violence within the relationship, prior to the fatal episode, and reflects that the fatal episode may have been perpetrated by a primary domestic violence abuser against a primary victim, or a primary domestic violence victim against an abuser (such as in self-defence).

There was one case in which both the homicide victim and homicide perpetrator used violence against one another throughout the relationship, prior to the fatal episode of violence.

Importantly, 75 of the 77 primary domestic violence victims in this dataset were women and two were men. For these cases, all 77 primary domestic violence abusers in this dataset were men.

In the remaining case where violence went both ways, a female homicide perpetrator killed her male intimate partner after a history in which they both used violence against one another. This was the only case in which a female in this dataset was using domestic violence behaviours against a male.

Of all 78 cases in this focus dataset:

- 67 (86%) involved homicides where male and female primary **domestic violence victims** were killed by their **male intimate partner**, the primary domestic violence abuser;
- 10 (13%) involved homicides where a male primary domestic violence abuser was killed by a female primary domestic violence victim; and
- 1 (1%) involved a homicide perpetrated by a female who was both a domestic violence victim and abuser, against her male intimate partner, who was also a domestic violence victim and abuser, i.e. the violence went both ways.

Of the 67 primary domestic violence victims who were killed by an abusive current/former male intimate partner (the primary abuser), 65 were women and two were men.

All 10 of the primary domestic violence abusers who were killed by their current/former intimate partner were men, and all were killed by a female domestic violence victim.

These findings highlight that domestic violence is a gendered behaviour, as these intimate partner homicides demonstrate that the majority of domestic violence abusers in relationships were male.

## Relationship characteristics

### Relationship status

#### Current relationship

In two-thirds of the cases in this dataset, the homicide victim and homicide perpetrator were in a current relationship at the time of the homicide (N=52, 67%). This included 14 cases where the relationship was current however the victim of domestic violence in the relationship had indicated to friends, family or the abuser that they were intending to end the relationship with the abuser

In each of the 14 cases where the domestic violence victim had indicated an intention to end the relationship, the abuser (all male) killed them.

#### Separated

In the remaining 26 cases (33%), the homicide victim and homicide perpetrator were no longer in a relationship at the time of the homicide.

In 14 of these cases, the relationship had ended within 3 months of the homicide (54%). This included four cases where a domestic violence victim was killed by a male abuser within one week of ending her relationship with that abuser (and in two cases the day after a female domestic violence victim ended her relationship with the male abuser).

## Separation as a factor

Overall, separation (actual or intended) was a characteristic in over half of all intimate partner domestic violence context homicides (N=40, 50%).

Separation was not a characteristic of the one case in which violence went both ways.

## Violence/abuse histories

Another unique contribution that death review processes may make is to better highlight histories of violence and abusive behaviours that precede fatal episodes of violence, whether those fatal episodes involve an abuser killing a victim, or a victim killing an abuser. This section accordingly discusses this dataset in terms of the primary victim and primary abuser of violence within the relationship so as to highlight the nature of domestic violence behaviours in fatal cases.

In 77 of the 78 cases in this dataset (99%), the relationship between the domestic violence victim and the domestic violence abuser was characterised by the abuser's use of coercive and controlling behaviours towards the victim. In each of these cases the domestic violence abuser (all male) perpetrated various forms of abuse against the victim, including psychological abuse and emotional abuse.

As is noted above, in the case where violence went both ways, both the male and female used various abusive behaviours against one another throughout the relationship.

## Verbal abuse

Almost all of the 77 cases involving a primary domestic violence victim and abuser involved the domestic violence abuser (all male) using verbally abusive behaviours towards the victim (N=74, 96%).

This included the abuser using language that was belittling, derogatory, humiliating, and insulting towards the victim, or otherwise using language in ways with the apparent intention of undermining the victim's self-esteem and self-empowerment.

In the three cases that did not include reported histories of such behaviours, the abuser's passive

aggressive behaviours towards the victim (including emotionally abusive actions) formed part of their coercive and controlling behaviours.

In 33 of the 74 cases (45%) verbally abusive behaviours included a history of the domestic violence abuser (all male) directly threatening to kill the domestic violence victim.

In the case where violence went both ways, both male and female used verbal violence against one another, and each had threatened to kill the other.

## Social abuse

In over half of the 77 cases where there was a primary domestic violence victim and abuser in the relationship, the domestic violence abuser (all male) socially controlled the domestic violence victim (N=39, 51%).

This included the abuser using such behaviours as:

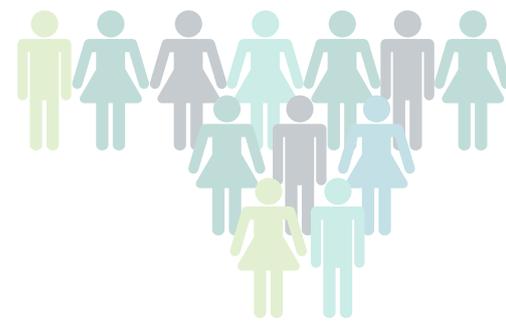
- preventing the victim from seeing friends and family;
- systematically isolating the victim by way of being abusive or rude to friends and family;
- the domestic violence abuser intentionally relocating the victim away from support networks, friends and family; and
- controlling the victim's appearance, for example, only allowing certain clothes or hair styles.

Social control was not a feature of the case in which violence went both ways.

## Financial abuse

Of the 77 cases involving a primary domestic violence victim and abuser, 28 cases (36%) involved the primary domestic violence abuser (all male) exercising financial control over the domestic violence victim.

This included behaviours such as withholding and controlling use of bank cards, cash and other forms of money, controlling access to bank accounts, scrutinising the victim's spending and setting apparently unrealistic expectations for the cost of groceries and other necessary expenditures.



Other cases included the domestic violence abuser preventing the victim from working or seizing and controlling the victim's earnings from her work. A number of cases also included the domestic violence abuser forcing the victim to borrow money from third parties.

Financial abuse was not a feature of the case in which violence went both ways.

### Physical abuse

In 66 of the 77 homicides involving a primary domestic violence victim and abuser, physically abusive behaviours were known to form part of the male domestic violence abusers violence towards the victim (86%). These behaviours ranged from hitting, slapping, shoving, kicking, and pulling the domestic violence victim's hair (physical assaults without weapon) to strangulation, and assaulting the victim with weapons.

The frequency of physical assaults ranged from one or two assaults reported to friends and family, to extensive and sustained patterns of physical abuse and physical torture by the male abuser against the victim.

Of the 66 cases where the abuser was known to use physical violence, in 21 cases (32%) this included the abuser (all male) using a weapon to assault the domestic violence victim.

In 20 of the 66 cases where male abusers used physical violence (30%), the male abuser had attempted to strangle the domestic violence victim prior to the fatal assault.

Physical abuse was a characteristic of the case where violence went both ways, with both the male and female using physical violence against each other during the relationship. Strangulation did not form part of the physical abuse used by either party in this case.

### Sexual abuse

On the material available to the Team, only six homicide cases included histories (8%) where the male domestic violence abuser sexually abused the victim. Each of these cases involved a male abuser sexually assaulting a female victim.

This is a significantly lower figure than other total population estimations which suggest that between 40-45% of women who are physically abused are also sexually abused by their intimate partner.<sup>118</sup> It is therefore suspected that the figure derived from this dataset may not reflect the true prevalence of sexual violence in these relationships.

There are a number of reasons this could be the case including that the domestic violence victim may not have disclosed histories of sexual violence to friends and family or other service providers (whose testimonies are relied upon for the review process) prior to the homicide. Additionally, it has been recognised that victims may not recognise or characterise the abuse they are experiencing from their partners as sexual violence.<sup>119</sup>

Similarly, it is recognised that sexual violence may attract particular stigma and victims may be more unlikely to disclose these experiences to others.

### Stalking

In 31 of the 77 cases (40%) involving a primary domestic violence victim and abuser, stalking formed part of the domestic violence abuser's (all male) coercive and controlling behaviours towards the victim prior to the homicide. Stalking included behaviours such as: following the victim, parking outside their house/workplace, breaking into the victim's house, and reading the victim's diary.

In over half of these 31 cases (N=19, 25% of all cases involving a primary domestic violence victim and abuser), stalking behaviours included the abuser using technology to stalk the victim, such as persistent text messaging, checking the domestic violence victim's phone, covertly recording the victim's activities, installing key logger software on the victim's computer, and engaging with the victim on social media/dating sites under a false identity.

In 16 of the 31 cases where stalking formed part of the abuser's behaviour, the relationship was current at the time of the homicide. Of the other 15 cases, in 13 cases the abuser stalked the victim both while the relationship was ongoing and after it had ended and in two cases the stalker commenced stalking the victim only after the relationship had ended.

118 Wall, *Asking women about intimate partner sexual violence* (Australian Centre for the Study of Sexual Assault: Australian Institute of Family Studies, 2012) available at <http://www3.aifs.gov.au/acssa/pubs/sheets/rs4/rs4.pdf> (accessed 30 September 2017).

119 Ibid.

Stalking was not a characteristic of the case in which violence went both ways.

## Criminal offending by abuser against victim

Of the 77 homicides in which a primary domestic violence victim and primary domestic violence abuser was identifiable, in 34 cases (44%) there was a recorded history of the abuser's domestic violence behaviours against the primary domestic violence victim. In 9% of cases (N=7) the domestic violence abuser had been convicted of a domestic violence offence against their victim (N=7), and 4% had previously served a custodial sentence in relation to domestic violence offences (N=3).

In the case where violence went both ways the female had been convicted of a domestic violence offence against the male, and served a short period of imprisonment in relation to this offence.

## Criminal offending by abuser against prior partners

Looking further to the domestic violence histories within these homicide cases, this review process also presents data in this report around domestic violence offending histories against prior partners.

Of the 77 cases where there was a primary domestic violence victim and abuser identifiable, for 16 of these cases (21%) the (all male) abuser's relationship with the victim was their only significant intimate relationship (i.e. they had had no prior intimate partners).

For the remaining 61 cases, the material reviewed by the Team revealed that at least 37 (61%) primary domestic violence abusers (all male) had been abusive in prior intimate relationships (including both recorded and unrecorded histories of violence against other intimate partners).

In 25 of these 37 cases (68% of cases where there was an identifiable history of offending against prior partners) the male abuser had been convicted of assaults against a prior partner.

In the case where violence went both ways, the male homicide victim had a history of offending against one

of his prior female partners, and there was anecdotal evidence that the female homicide perpetrator had used violence against one of her former male intimate partners.

These figures highlight that abusers often repeatedly use violence against different intimate partners.

## ADVO histories

Of all 78 intimate partner domestic violence homicide cases in this review period, in 11 cases a male abuser killed a female victim when that victim was protected under an ADVO naming the male abuser as the defendant.

For an additional 12 female domestic violence victims, they had been protected under an ADVO naming their male abuser as the defendant but this had expired at the time of the homicide. Eight of the 12 women who had previously been protected under an ADVO were killed and four women killed their abusive partner.

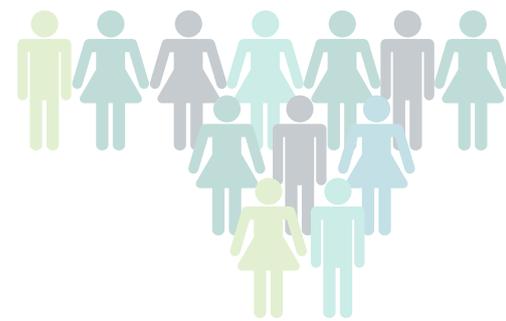
In the one case where violence went both ways, the female homicide perpetrator had previously been named as a defendant under an ADVO protecting the male homicide victim.

## Abuser histories of alcohol and drug use

### Alcohol use

Of the 77 cases where there was a primary domestic violence victim and abuser identifiable, 38 of the abusers (49%), all male, had a history of problematic alcohol use identifiable from information on the brief. A significant proportion of these abusers were using alcohol at the time they killed, or were killed (N=29, 38% of all abusers).

In the one case where violence went both ways, the female homicide perpetrator and the male homicide victim both had histories of problematic alcohol use and both were using alcohol at the time of the homicide.



## Drug/substance use

Of the 77 cases where there was a primary domestic violence victim and abuser identifiable, 30 of the abusers (39%), all male, had a history of regular psychoactive substance use. Under half (N=12) of these 30 abusers (16% of all abusers) used cannabis as well as one or more substance/s such as heroin, cocaine, meth/amphetamines, misuse of prescription medication or inhalants. A similar proportion used cannabis only (N=11, 14% of all abusers).

At the time of the homicide 18 of the 30 abusers (all male) who had a history of regular psychotic substance use were using at the time they killed, or were killed.

In the one case where violence went both ways neither the female nor male had histories of regular psychoactive substance use and neither were using at the time of the homicide.

## Co-occurrence of alcohol and drug use

Of the 77 cases where there was a primary domestic violence victim and abuser identifiable, 28 abusers (all male) had a history of both problematic alcohol and psychoactive substance use (36% of all abusers). All but one of these abusers had been in contact with the criminal justice system having been convicted of one or more criminal offences.

## Surviving children

The domestic violence victims and domestic violence abusers in this dataset were parents (either together or separately) to at least 109 children who were aged less than 18 years at the time of the homicide.

Accordingly, for the 78 intimate partner domestic violence homicides in this focused dataset, the Team identified that there were at least 109 child (<18 years) survivors of homicide.

Of the 109 child survivors of homicide, 17 children (16%), were present during the fatal assault.

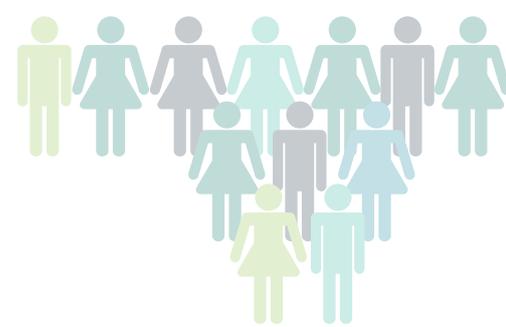
As discussed in Chapter 4, this group of 109 children represents a traumatised cohort for whom integrated, specific and consistent service responses are critical.

# Domestic Violence & Suicide

## DFV as a characteristic of completed suicides in NSW

This chapter presents the first stage findings of the DVDRT Secretariat's review of all completed suicides in NSW in the 6-month period July to December 2013 with a view to reporting preliminary prevalence and demographic data, histories of police reported domestic violence and suicides where domestic violence perpetration or victimisation or separation was identifiable as a triggering or proximal event.





## Introduction

To date, the Domestic Violence Death Review Team has published findings in relation to homicide and homicide-suicides occurring in a domestic violence context.

Under its legislation, however, the Team's scope of review includes all deaths that occur in a context of domestic violence – a mandate that is taken to also include domestic violence related suicides<sup>120</sup> and accidents.

In 2016 the Secretariat of the Team commenced an initial 6 month whole-of-population pilot study examining closed suicides in NSW (July-December 2013), with a view to reporting preliminary prevalence and demographic data, histories of police reported domestic violence and suicides where domestic violence perpetration or victimisation or separation was identifiable as a proximal characteristic of the suicide. This initial stage is being completed with a view to better understanding the relationship between suicide and domestic violence victimisation and perpetration, and uncovering opportunities for intervention and prevention in relation to this cohort.

This chapter provides an overview of the literature in relation to domestic violence suicide, describes the methodology adopted for this study and reports some preliminary findings.

## Domestic violence and suicide: Background to study

The effects of intimate partner violence in particular on individuals' mental and physical health have been examined in a number of studies,<sup>121</sup> suggesting that intimate partner violence victimisation is a risk factor for women developing mental health issues.<sup>122</sup>

Only in more recent years, however, have publications sought to explore the complexity of the relationship between domestic violence, mental health and suicidality amongst women and girls.<sup>123</sup>

To date, relatively few studies have investigated the relationship between suicide and intimate partner violence, and of those that have, most have not examined completed suicides, but rather the prevalence of and associations between suicidal ideation and attempts, and intimate partner violence.<sup>124</sup>

Of those studies that have examined suicidality and attempts, a number have interpreted the extensive data derived from the World Health Organisation's study of women's health and domestic violence, undertaken between 2000 and 2003 at 13 sites, rural and urban, across a number of countries.<sup>125</sup> For instance, using this data Devries et al identified that intimate partner violence victimisation was significantly associated with suicide attempts and suicidal ideation.<sup>126</sup> Other studies utilising WHO data, such as that by Garcia-Moreno et al, have reported that women demonstrate increased rates of suicidal ideation, and increased numbers of prior attempts, where they had experienced physical or sexual violence from a partner.<sup>127</sup>

120 This chapter uses the language of 'suiciding' rather than committing suicide, to reflect that suicide is not a criminal offence in NSW.

121 Dillon et al, 'Mental and Physical Health and Intimate Partner Violence Against Women: A review of the literature' (2013) *International Journal of Family Medicine* 5.

122 Golding, 'Intimate partner violence as a risk factor for mental disorders: A meta-analysis' (1999) 14 *Journal of Family Violence* 99; Lipsky et al, 'Is there a relationship between victim and partner alcohol use during an intimate partner violence event?' (2005) 66 *Journal of Studies on Alcoholism* 407.

123 Taft, 'Promoting women's mental health: The challenges of intimate/domestic violence against women' (2003) 8 *Australian Domestic Violence Clearinghouse Issues Paper*.

124 See for example, Devries et al, 'Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies' (2013) 10(5) *PLoS Medicine*, available at <https://doi.org/10.1371/journal.pmed.1001439> (accessed 30 September 2017).

125 World Health Organisation, *WHO Multi-country Study on Women's Health and Domestic Violence against Women. Initial results on prevalence, health outcomes and women's responses* (2005) available at [http://apps.who.int/iris/bitstream/10665/43310/1/9241593512\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/43310/1/9241593512_eng.pdf) (accessed 30 September 2017).

126 Devries et al, 'Violence against women is strongly associated with suicide attempts: evidence from the WHO multi-country study on women's health and domestic violence against women' (2011) 73(1) *Social Science & Medicine* 79.

127 Garcia-Moreno et al, 'Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence' (2006) 368(9543) *Lancet* 1260.

Other studies have derived their own data from interviews or other sources. Of these studies, a relationship between physical and sexual domestic violence experience and suicide attempts and ideation has been identified by researchers such as Vachher and Sharma within an Indian colony.<sup>128</sup> Other studies, such as that by Ishida et al in Paraguay<sup>129</sup>, have also purported to examine emotional violence, finding it to have less of an effect on suicidal ideation within 12 months than either sexual or physical violence. Other studies have highlighted more varied results regarding types of violence and effect on suicidal ideation,<sup>130</sup> but these studies have consistently identified some correlation between women having experienced domestic violence in relationships, and suicide attempts or ideation.

According to the systematic review completed by MacIsaac et al in 2016,<sup>131</sup> 38 studies had been undertaken examining completed female suicides following histories of interpersonal violence. Of these 38 studies, few examined victims and perpetrators and of the three that did, the study methodologies did not include comprehensive checks of police systems. While information may have been available on systems used, this may not have included police reported histories of violence that did not result in charges or convictions.

It is not difficult to identify some of the challenges facing researchers who may wish to examine the relationship between completed suicide and intimate partner violence victimisation or perpetration. A primary challenge is that in a completed suicide the person best positioned to report on causal or other factors in relation to that suicide is deceased. In the absence of a suicide note, or in the absence of relevant service contacts, it can be extremely difficult to ascertain what factors influenced the individuals' decision to end their life, or indeed what factors might have been decisive in that decision. This makes it difficult to conduct effective research examining causal factors, and makes it difficult for researchers to draw firm conclusions around other aspects of the completed suicide. Some researchers have sought to conduct interviews in

close proximity to suicides with a close friend or family member, acting as a proxy for the victim, to overcome some of these challenges.<sup>132</sup>

Notwithstanding these challenges, much can be learned from completed suicides and the information contained in briefs of evidence and coronial files.

This study accordingly seeks to use information available to the Team, including information derived from police data systems, to examine reported and unreported histories of domestic violence in the lives of individuals who have completed suicides between 1 July and 31 December 2013.

## Methodology

### Stage 1 – case identification

For the first stage of this study the Secretariat of the Team designed a search query using the National Coronial Information System (NCIS) to identify all reportable deaths in NSW that were coded in that system as intentional self-harm (either when initially reported or when the case was completed) and closed for the period 1 July 2013-31 December 2013.

This search yielded 330 cases, all of which were cross checked and verified with the NSW court data system (JusticeLink) and the COPS system. One case was removed due to incorrect coding (the case finding (accidental) did not match the NCIS coding), and an additional case was identified through an expansion of the search (where the deceased died before the end of the year but the NCIS entry reflected a 2014 number).<sup>133</sup>

This resulted in a final dataset of 330 suicides, for which demographic information including age, date of birth, address, occupation, cause of death and mechanism were recorded in the DVDRT Suicide Database. For all 330 suicides the Secretariat also reviewed the P79A (police report of death to the

128 Vachher and Sharma, 'Domestic Violence Against Women and Their Mental Health Status in a Colony in Delhi' (2010) 35 *Indian Journal of Community Medicine*, 403.

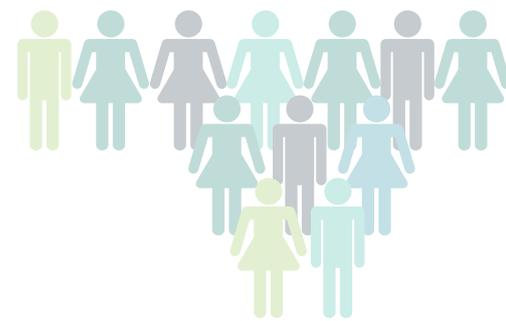
129 Ishida et al, 'Exploring the associations between intimate partner violence and women's mental health: Evidence from a population-based study in Paraguay' (2010) 71(9) *Social Science & Medicine* 1653.

130 See for example, Naved and Akhtar, 'Spousal Violence Against Women and Suicidal Ideation in Bangladesh' (2008) 18(6) *Women's Health Issues* 442.

131 MacIsaac et al, 'The association between exposure to interpersonal violence and suicide among women: a systematic review' (2017) 41(1) *Australian and New Zealand Journal of Public Health* 61.

132 See for example, Bailey et al, 'Risk factors for violence death of women in the home' (1997) 157(7) *Archives of Internal Medicine* 777.

133 This may likely be an undercount due to issues with incorrect coding in the NCIS system and the fact that some cases remain open for this time period.



Coroner) form and narrative and captured information about the circumstances surrounding the death on its database. This form was sourced from either the NCIS (where available), the COPS system or JusticeLink. The Secretariat provisionally coded information about the circumstances of the death, including whether the death occurred following an identifiable history of domestic or family violence, or where the suicide occurred in a context of a relationship conflict or where the relationship was breaking down.

## Stage 2 – case analysis

For the second stage of this study, the Secretariat reviewed each of the 330 suicides using the NSW Police Force COPS system to review the deceased's complete police record to determine whether the deceased was known to police for domestic violence (either as a victim, an offender or as both), including prescribed domestic violence offences, 'DV no offence' callouts, applied for or finalised apprehended violence orders, incorrectly coded offences where domestic or family violence was an aspect of the complaint/circumstances, or convictions. Due to this system being limited to NSW, where it was known that the deceased had previously resided in other states or territories, information was sought from other jurisdictions.

The purpose of this analysis was to obtain preliminary data around prevalence of police reported domestic and family violence both proximal and distal to the suicide. The secondary purpose was to obtain preliminary data around where domestic and family violence, or relationship breakdown, was a characteristic in the circumstances surrounding the suicide.

## Findings

Of the 330 cases of completed suicide, 85 (26%) were female and 245 (74%) were male. This distribution accords with broader Australian data reported by Australian Bureau of Statistics which found that around three quarters of people who suicided in Australia during 2013 were male, and one quarter were female.<sup>134</sup>

### Females who suicided

#### Age – females

The 85 females who suicided ranged in age from 13 to 88 years of age.

The average age of females who suicided was 45.5 years. The median age for females who suicided was 47 years.

Of the 85 females who suicided, three were under the age of 18.

#### Police history of domestic and family violence – females

Of the 85 females who suicided, 33 (39%) had prior contact with NSWPF in relation to domestic or family violence (either as a victim, an offender, or both).

For an additional 9 females, there was an apparent unreported history of domestic or family violence; proximal relationship conflict or evidence that their current relationship was breaking down at the time of their suicide. This information was derived from the police narrative attached to the report of death.

Accordingly, of the 85 female suicides in the reporting period, 42 (49%) had a recorded or apparent history of domestic and family violence, relationship conflict or relationship breakdown.

<sup>134</sup> Australian Bureau of Statistics, *Causes of Death, Australia, 2013*, cat. 3303.0, 31, March 2015, Canberra, available at <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2013~Main%20Features~Key%20Characteristics~10009> (accessed 30 September 2017).

### Intimate Partner Violence (IPV) victimisation/perpetration

Of the 33 females who had a police recorded history of domestic or family violence, 16 were known to police only in relation to intimate partner violence.

Of these 16 females:

- 11 were known to police as victims of IPV,
- 1 was known as a perpetrator of IPV;
- 3 were known to police as both victims and perpetrators of IPV; and
- 1 female was known to police for intimate partner violence, however it is not clear whether she was a victim or a perpetrator due to the limited information in the police narrative.

### Family Violence (FV) victimisation/perpetration

Of the 33 females who had a police recorded history of domestic or family violence, 9 females were known to police in relation to family violence only.

Of these 9 females:

- 7 were known to police as victims of FV, and
- 2 were known as both a victim and perpetrator of FV.

### Both IPV and FV victimisation/perpetration

Of the 33 females who had a police recorded history of domestic and family violence, 8 females were known to police in relation to both intimate partner violence and family violence. Of these 8 females:

- 4 were known to police as victims of IPV and victims of FV;
- 2 were known to police as victims of IPV but as perpetrators of FV;
- 1 was known to police as a victim of IPV, and as both a victim and perpetrator of FV; and
- 1 was known to police as both a victim and perpetrator of IPV, and also a victim and perpetrator of FV.

### Proximity of police recorded DFV contact to suicide – females

Of the 33 females who had a police recorded history of domestic and family violence, 15 (45%) had contact with police in relation to domestic and family violence within 12 months of their suicide.

Of these 15 females:

- 1 had police contact in relation to intimate partner violence the day prior to her suicide.<sup>135</sup>
- 7 females had police contact in relation to either domestic or family violence within 3 months, but not more than a week prior to their suicide.
- 3 females had police contact in relation to domestic and family violence between 3 and 6 months of their suicide; and
- 4 females had police contact in relation to domestic and family violence between 6 and 12 months of their suicide.

Of the 33 females who had a police recorded history of domestic and family violence, 18 (55%) had police contact in a period greater than 12 months prior to their suicide.

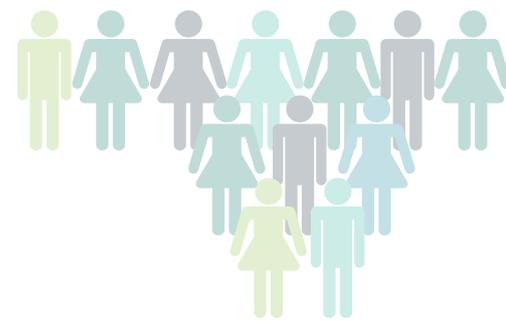
### Childhood histories of domestic and family violence – females

Of the 33 females who had a police recorded history of domestic and family violence, 7 (21%) were known to police in relation to exposure to domestic or family violence during their childhood.

### ADVO histories – females

Of the 33 females who had a police recorded history of domestic and family violence, 24 (73%) had been a PINOP or a Defendant (or both) in an ADVO at some time prior to the suicide (including both interim and finalised orders).

<sup>135</sup> That contact involved police applying for an ADVO protecting the former female partner of the woman who suicided. In that case, there was a lengthy recorded history of violence between the woman and her former partner, including contests around parenting arrangements and both the woman and her former partner had at different times been identified in police records as the aggressor in the relationship.



### ADVOs current at time of suicide

Of the 24 females who had been either a PINOP or a Defendant in an ADVO, in 8 cases the ADVO was current and enforceable at the time of the suicide (9% of all females who suicided).

The 8 cases where the ADVO was current at the time of the suicide included:

- 7 females who were named as a PINOP under a current enforceable ADVO, and
- 1 female who was named as a Defendant and PINOP (a current cross-ADVO).

Of the 7 females who were named as a PINOP:

- 5 were a PINOP in an ADVO with their male current or former intimate partner; and
- 2 females were a PINOP in an ADVO with family members (one with the victim's daughter as a defendant, and one with the victim's brother as a defendant).

### Expired ADVOs

Of the 24 females who had been a PINOP or a Defendant (or both) in an ADVO, in 16 cases the ADVO had expired at the time of their suicide. This included:

- 8 females who had been a PINOP with their current or former male intimate partner named as a defendant;
- 6 females were named as PINOPs in family violence ADVOs (naming a family member as a defendant); and
- 2 females had been both a family violence ADVO defendant, and a PINOP in an ADVO naming their male intimate partner as the perpetrator.

## Males who suicided

### Age – males

The 245 males who suicided ranged in age from 16 to 97 years of age.

The average age of males who suicided was 48.3 years. The median age for males who suicided was 47 years.

Of the 245 males who suicided, three were under the age of 18.

### Police history of domestic and family violence – males

Of the 245 males who suicided, 94 (38%) had prior police contact in relation to domestic violence before their death (either as a victim, an offender, or both).

For an additional 33 males, there was an apparent unrecorded history of domestic violence, relationship conflict or relationship breakdown evident from the police record of death.

Accordingly, of the 245 male suicides in the reporting period, 127 (52%) had a history of domestic and family violence, relationship conflict or relationship breakdown, either proximal or distal to the suicide.

### Intimate Partner Violence (IPV) victimisation / perpetration

Of the 94 males who had a police recorded history of domestic or family violence, 39 (41%) were known to police only in relation to intimate partner violence.

Of these 39 males:

- 34 were known to police as perpetrators of IPV;
- 2 were known as victims of IPV; and
- 3 were known to police as both victims and perpetrators of IPV.

Of the five males known to police as victims of IPV, in three of these cases the aggressor was a female, and in two of these cases the aggressor was a male.

### Family Violence (FV) victimisation/perpetration

Of the 94 males who had a police recorded history of domestic or family violence, 33 (35%) were known to police in relation to family violence only.

Of these 33 males:

- 20 were known to police as perpetrators of FV; and
- 13 were known to police as victims of FV.

### IPV and FV victimisation/perpetration

Of the 94 males who had a police recorded history of domestic and family violence, 21 (22%) were known to police in relation to both IPV and FV.

Of these 21 males:

- 15 were known as perpetrators of both IPV and FV;
- 2 were known as perpetrators of IPV but victims of FV;
- 2 were known as perpetrators of IPV, and as victims and perpetrators of FV;
- 1 male was known to police as a perpetrator and a victim of IPV, and as a victim FV; and
- 1 male was known to police as a perpetrator and victim of IPV, and as a perpetrator and victim of FV.<sup>136</sup>

### Proximity of police reported episodes to suicide – males

Of the 94 males who had a police recorded history of domestic and family violence, 35 (37%) had contact with police in relation to domestic and family violence within 12 months of their suicide.

Of these 35 males:

- 9 had police contact in relation to intimate partner or family violence within 7 days of the suicide;<sup>137</sup>

- 12 had police contact in relation to either domestic or family violence within 3 months, but not less than a week prior to the suicide;
- 5 had police contact in relation to either domestic or family violence between 3 and 6 months prior to their suicide' and
- 9 had police contact between 6 and 12 months prior to their suicide.

Of the 94 males who had a police recorded history of domestic and family violence, 59 (63%) had contact with police in relation to domestic and family violence over 12 months prior to the suicide.

### Murder before suicide – males

Three cases during this period involved males who had murdered their female intimate partner. This included one perpetrator who suicided within moments of murdering his intimate partner, one perpetrator who suicided in custody one month after murdering his intimate partner and one perpetrator who suicided 27 years after murdering his wife.

### Childhood histories of domestic and family violence – males

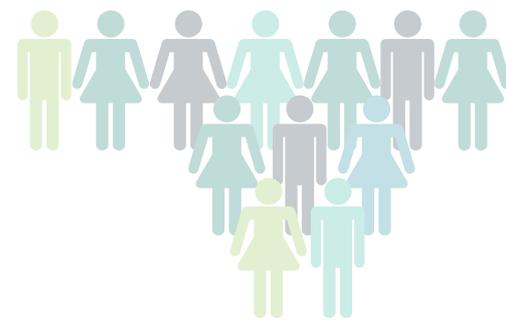
Of the 94 males who had a police recorded history of domestic and family violence, 9 (10%) were known to police in relation to exposure to domestic or family violence during their childhood.

### ADVO histories – males

Of the 94 males who had a police recorded history of domestic and family violence, 50 (53%) had been either a PINOP or a Defendant (or both) in an ADVO at some time prior to the suicide (including both interim and finalised orders).

<sup>136</sup> One additional man who suicided was known to police in relation to what was coded as a domestic violence call out where he assaulted a man who made a sexual advance towards his intimate partner.

<sup>137</sup> This included 7 cases in which the male who suicided perpetrated an episode of intimate partner violence and two cases in which the male had perpetrated an episode of family violence. Of the 7 males who had perpetrated intimate partner violence, three had perpetrated violence against their intimate partner the same day they suicided.



### ADVOs current at time of suicide

Of the 50 males who had been either a PINOP or a Defendant in an ADVO, in 16 cases the ADVO was current at the time of their suicide (7% of all males who suicided). In all 16 cases the male was a Defendant to the current enforceable ADVO.

Of the 16 males subject to a current enforceable ADVO at the time of their suicide:

- 11 were Defendants with their intimate partner as PINOP; and
- 5 were Defendants with a family member/s as the PINOP.

Of the 11 males who were named as a Defendant under a current enforceable ADVO with an intimate partner at the time of their suicide:

- 6 males had not previously been subject to an ADVO;
- 3 males had also been Defendants under prior ADVOs with an intimate partner/s;
- 1 male had also been a PINOP under prior ADVOs with an intimate partner/s; and
- 1 male had also been a Defendant in prior ADVOs with both an intimate partner/s and family members;

Of the five males who were named as a Defendant under a current enforceable ADVO with a family member/s at the time of their suicide:

- 4 males had not previously been subject to an ADVO; and
- 1 male had also been a Defendant in prior ADVOs with a family member/s

### Expired ADVOs

Of the 50 males who had been either a PINOP or a Defendant in an ADVO, for 34 males (68%) the ADVO had expired or was historical at the time of their suicide. This included:

- 13 males who had previously been a Defendant with a current or former intimate partner;

- 1 male who had previously been a PINOP with a current or former intimate partner;
- 1 male who had previously been both a Defendant and a PINOP with a current or former intimate partner;
- 5 males who had previously been both a Defendant with a current or former intimate partner, and a Defendant with a family member/s;
- 8 males who had previously been a Defendant with a family member/s; and
- 6 males who had previously been a PINOP with a family member/s.

### Place of residence – Remoteness (Australian Statistical Geography Standard)

Across all 330 suicides in the reporting period, the majority of females (76%) and the majority of males (64%) lived in major cities.

Of the 85 females who suicided, 18% of females lived in inner regional areas, 5% lived in outer regional areas, and only one female lived in a remote area.

Of the 285 males who suicided, 22% of males lived in inner regional areas, 8% lived in outer regional areas and less than 1% lived in remote areas.

No females or males who suicided lived in very remote areas.

Five males (2% of all males) were homeless when they suicided, and 2% of males lived outside of NSW, but suicided in NSW (Fig.44).

## Suicide method

Overall, the most common suicide method in the reporting period was hanging (45%), followed by overdose (15%), jumping from a height (9%), carbon monoxide or other gassing (7%), shooting (6%), drowning (4%), train (4%), plastic bag asphyxia (3%), cutting (3%), other (including immolation and electrocution, 2%), intentional motor vehicle accident (1%) and other poison (including pesticide) (>1%).

There were gender differences across the methods used by males and females who suicided.

While almost half (49%) of all males who suicided completed suicide by hanging, for females this dropped to just over a third (34%). Overdosing on drugs or medication was the suicide method adopted by 26% of females compared with only 11% of males.

In terms of raw numbers, while only one female suicided via shooting, this was the method used by 18 males (Fig.45).

## Aboriginal and Torres Strait Islander status

New South Wales has the largest Aboriginal and Torres Strait Islander population in Australia (approximately 216,176 permanent residents) which represents approximately 2.8% of the total New South Wales population.<sup>138</sup>

Of the 85 females who suicided during the review period, five (6%) identified as Aboriginal. Of the 245 males who suicided during the review period, 8 (3%) identified as Aboriginal.

Accordingly, of the 330 people who suicided during the review period, 13 identified as Aboriginal (4%).

This highlights that Aboriginal people are overrepresented in respect of the suicide population. This figure is likely an undercount as the recording of information about Aboriginal and Torres Strait Islander status is often unreliable.

## Discussion and conclusions

Findings from this study highlight a number of issues of interest in respect of the relationship between suicide and domestic and family violence.

While there is a gender disparity between males and females who suicided, with males accounting for 74% of all suicides and females accounting for 26% of all suicides, an almost equal proportion of males and females who suicided were known to police for domestic violence (39% of females; 38% of males).

When considering the number of cases where the person who suicided is either known to police for violence, or the report of death indicates relationship conflict, a history of violence or relationship breakdown, this figure increases to around half (49% of all females who suicided; 52% of males who suicided). This figure appears high, but it must be born in mind that this does not necessarily highlight that the violence was causal: in some of these cases the violence was historical and may have had no bearing on the person's decision to end their life. Caution must be exercised in deriving meaning from this figure and this study does not purport to go into detail about causal factors.

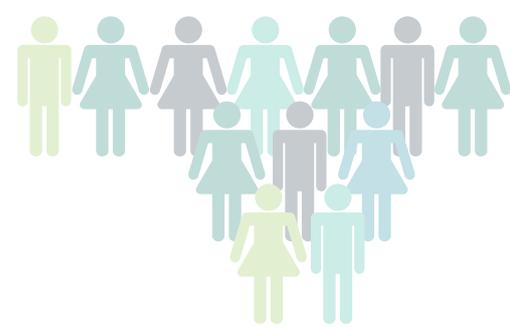
In relation to females who suicided and were known to police in relation to domestic violence, less than half (45% of females) had had police contact in relation to domestic or family violence within 12 months of their suicide - 8 of these females had contact with police within 3 months and one had contact with police the day prior to the suicide.

Of particular note is the number of females who were currently subject to an enforceable ADVO, 9% of all females who suicided. This appears to be a higher rate than the general population rates for ADVOS in NSW in recent years,<sup>139</sup> but this could be attributable to the relatively small size of this sample.

The findings also highlight that females are mostly known as victims of domestic and family violence, and some are known as both victims and perpetrators.

138 Australian Bureau of Statistics, *Census of Population and Housing 2016*, cat. No. 2001.0, 27 June 2017, Canberra, available at <http://www.abs.gov.au> (accessed 30 September 2017).

139 See [https://www.women.nsw.gov.au/women\\_in\\_nsw/current\\_report/safety\\_and\\_access\\_to\\_justice/topic\\_3\\_the\\_criminal\\_justice\\_system/3.2\\_apprehended\\_domestic\\_violence\\_orders\\_granted](https://www.women.nsw.gov.au/women_in_nsw/current_report/safety_and_access_to_justice/topic_3_the_criminal_justice_system/3.2_apprehended_domestic_violence_orders_granted) (accessed 30 September 2017).



Few women are known as domestic or family violence perpetrators only. This accords with understandings of domestic violence as a gendered behaviour, as discussed at the beginning of this report.

In relation to males who suicided and were known to police in relation to domestic violence, less than half (37%) had contact with police in relation to domestic or family violence within 12 months, but 9 had contact with police within 7 days of their suicide.

In regards to ADVOs, 7% of males were currently subject to an enforceable ADVO when they died, and in each case the male was a defendant (11 with their intimate partner and five with a family member). This appears to be a high rate, but this too could be attributable to the relatively small size of this sample.

These findings also highlight that males are mostly known as perpetrators of domestic and family violence, but some are known as victims and perpetrators, and fewer are known only as victims.

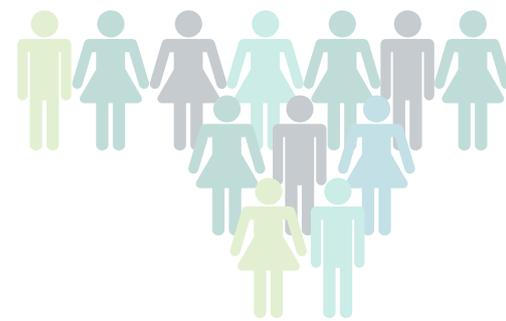
In progressing this research, the Secretariat will conduct further statistical analysis of this data and will attempt to maintain case surveillance to identify and track characteristics of these cases over time.

However, due to the Team's capacity, this work will only be facilitated by the creation of a suicide register in NSW. The Team is of the perspective that maintaining an accurate and accessible register of these cases is important not only to inform intervention and prevention efforts in relation to domestic and family violence, but to improve intervention and prevention efforts in respect of all violent and unnatural deaths.

This study represents an important first stage in the expansion of the Team's work to include analysis of domestic violence as a characteristic in completed suicides, however caution must be exercised in drawing firm conclusions from this preliminary descriptive data. In order to build on this project, the Secretariat will conduct qualitative review of coronial briefs of evidence and further derive data in relation to histories of violence, conflict or relationship breakdown and other characteristics proximal to the suicide. It is anticipated that this will facilitate the roll out and capture of further data in respect of these issues.

# Monitoring Recommendations

Section 101J(2) of the *Coroners Act 2009* (NSW) provides that the Team is to report on the extent to which previous recommendations made by the Team have been accepted. Accordingly, this chapter details the 52 recommendations made by the Team to date together with the whole of government response and agency status report in relation to those recommendations.



## Introduction

As has been noted earlier in this report, the complexity of domestic violence and the domestic violence service system is reflected in the nature and scope of the Team's recommendations.

These recommendations are aimed at the NSW and Commonwealth Governments as well as non-government agencies. To date the Team has made 52 recommendations with respect to legislation, policies, practices and services, including recommendations that call for significant system reform and others that anticipate more modest or incremental change.

Monitoring implementation and uptake of these recommendations is key to the Team fulfilling its prevention mandate. Additionally, s101J(2) of the Coroners Act 2009 (NSW) calls on the Team to publically report on the extent to which recommendations have been accepted. By publically monitoring implementation and uptake of recommendations, the Team aims to promote agency accountability and transparency in relation to its processes.

In June 2017 the Team wrote to the various agency heads seeking a comprehensive status report on all recommendations made to date. The responses to these enquiries are set out below. Where recommendations have not progressed or the Team is of the view that the agency response does not adequately address the issues identified in the recommendation, recommendations may be restated or revisited in future reports.

## 2013-2015 DVDRT Report

The Team's 2013/15 Report was tabled in NSW Parliament in October 2015 and made 15 Recommendation to government and non-government agencies. The whole of government response in relation to the 2013/15 Report was received in May 2016 and can be accessed via the NSW State Coroners Court website.

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### Recommendation 1 (2013/15 report)

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That the NSW Domestic Violence Death Review Team and the NSW Judicial Commission work collaboratively to:

- a) improve learnings around domestic violence and victim visibility in remarks on sentence/judicial commentary; and
- b) develop an information sharing protocol in relation to referring judgments and remarks on sentence to the Commission for consideration where the representation of domestic violence, including perpetrator accountability and victim visibility, could be improved.

**Whole of government response:** Supported

**Lead agency:** DVDRT, NSW Judicial Commission

**Whole of government commentary:** 'The DVDRT Secretariat will meet with the NSW Judicial Commission in the first six months of 2016 to plan the implementation of this recommendation. It is anticipated that this implementation will include the preparation of a research monograph by the Team's Secretariat which will be provided to the Commission for dissemination to its members.'

## Agency update – 2017

Throughout 2016 and 2017 the DVDRT Secretariat met with representatives of the NSW Judicial Commission on a number of occasions to progress this recommendation. In July 2017 the DVDRT Secretariat published an article concerning language and stereotypes and perpetrator accountability in judicial sentencing remarks related to domestic violence homicides.

The DVDRT Secretariat and the Judicial Commission have committed to holding quarterly meetings in which the Secretariat will refer judgments and remarks on sentence to the Commission for consideration. These meetings will also provide an opportunity to explore additional strategies in relation to how the learnings of the Team can further inform and support the work of the Commission.

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## Recommendation 2 (2013/15 report)

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That the NSW Domestic Violence Death Review Team work collaboratively with the Victim Impact Statement Working Group, convened by Victims Services NSW (NSW Department of Justice), to examine ways in which victim visibility may be enhanced through the process of preparing and providing Victim Impact Statements to the Court.

**Whole of government response:** Supported

**Lead agency:** DVDRT, Victim Impact Statement Working Group (NSW Department of Justice)

**Whole of government commentary:** 'This work is ongoing. The DVDRT Secretariat has commenced working with Victims Services NSW in 2016, including participating in the Reducing Domestic Violence Re-Offending Workshop. Similarly, the DVDRT Secretariat has arranged initial meetings with the Victim Impact Statement Working Group to progress this recommendation.'

## Agency update – 2017

In December 2016 the DVDRT Secretariat contacted the Victim's Commissioner to arrange a meeting to progress this recommendation. The DVDRT Secretariat met with the Commissioner in February 2017 and was advised that the Victim Impact Working Group had been disbanded but that Victim's Services had recently commenced working with the Witness Assistance Scheme (ODPP) to revise the current VIS package and to develop a VIS package specifically for children. Victim's Services has indicated that it will seek the Secretariat's feedback in relation to this work when it has further progressed further.

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## Recommendation 3 (2013/15 report)

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That the NSW Domestic Violence Death Review Team work collaboratively with the Office of the Director of Public Prosecutions (NSW), the NSW Bar Association, the Law Society of NSW and the NSW Public Defenders' Office to develop appropriate strategies to better support lawyers in recognising and responding to domestic violence.

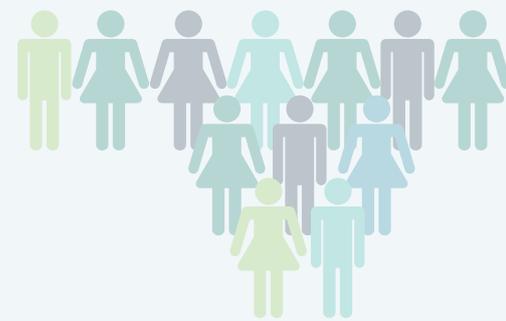
**Whole of government response:** Supported

**Lead agency:** DVDRT, ODPP, NSW Bar Association, NSW Public Defender's Office, Law Society of NSW

**Whole of government commentary:** 'The DVDRT Secretariat will contact the Office of the Director of Public Prosecutions (NSW), the NSW Bar Association, the Law Society of NSW and the NSW Public Defenders' Office in the first 6 months of 2016 to progress this recommendation.'

## Agency update – 2017

In late 2016 the DVDRT Secretariat contacted representatives from the nominated agencies to progress development of this recommendation. On 31 May 2016 State Coroner Michael Barnes in his role as convener of



the DVDRT chaired the first legal representative roundtable to progress this recommendation.

During this meeting the participants identified a range of training, education and awareness raising strategies for ongoing development and rollout in 2017 and 2018. A follow up roundtable will take place in the first 6 months of 2018.

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## Recommendation 4 (2013/15 report)

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That NSW Health work collaboratively with the NSW Domestic Violence Death Review Team to:

- a) identify all homicides occurring in NSW from March 2008 where the perpetrator had received care or treatment from a NSW Health service for mental health issues within 6 months of the homicide;
- b) provide to the Team all final Severity Assessment Code 1 Root Cause Analysis Reports prepared in relation to the cases identified in the audit process foreshadowed in a);
- c) provide to the Team all de-identified thematic analyses prepared by the Clinical Excellence Commission in relation to the cases identified in the audit process foreshadowed by a); and
- d) develop an information sharing mechanism whereby the Team may seek input from the CEC in relation to cases where mental health issues are identified.

**Whole of government response:** Supported

**Lead agency:** NSW Health

**Whole of government commentary:** 'NSW Health mental health services only come in contact with a small number of persons accused of domestic violence-related homicide. Alternatively, perpetrators may have received treatment for diagnosed mental illness through general practitioners, private psychiatrists and other private health professionals. Others, as the Domestic Violence Death Review Team Report suggests, have not had contact with any services in relation to a diagnosable mental illness. Root Cause Analysis reports are based on the findings from reviews of the medical record and interviews with clinicians and families/carers. The reports identify local systemic improvement opportunities, on many occasions these will be unrelated to the circumstances of the homicide. Given the relative rarity of incidents of homicide involving patients of NSW Health mental health services and the nature of Root Cause Analysis recommendations, there has not been sufficient information to allow for 'thematic' analysis' of such incidents. This is not to say that individual Root Cause Analysis reports may highlight a local issue and response that may point to a helpful 'statewide' intervention.'

### Agency update – 2017

No formal response has been received from NSW Health in relation to this recommendation.

In progressing components of this recommendation attributable to the DVDRT, the DVDRT Secretariat had ongoing contact with the Clinical Excellence Commission (CEC) throughout 2016 and 2017. In relation to part a) of the recommendation, the DVDRT Secretariat identified and referred relevant cases within the time period to the CEC.

In relation to b) the CEC advised the DVDRT Secretariat that it cannot identify the relevant reports from the names provided, however it has identified the relevant local health districts for each case. This required the DVDRT Secretariat to write to each Local Health District to access the relevant reports which was completed in 2017. Accordingly component c) of the Recommendation is in progress.

In relation to component d), the CEC has appointed the Manager of the DVDRT Secretariat to its Mental Health Drug and Alcohol RCA Classification Group so as to improve oversight and discussion of the intersection between mental health issues and domestic violence relevant to the cases examined by this Committee.

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## Recommendation 5 (2013/15 report)

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That the NSW Domestic Violence Death Review Team and the NSW Health Mental Health Drug and Alcohol Office work collaboratively to develop an information sharing mechanism whereby the Team may seek input from that Office in relation to cases where mental health and/or drug and alcohol issues are identified.

**Whole of government response:** Supported

**Lead agency:** DVDRT, NSW Health (MHDAO)

**Whole of government commentary:** 'The DVDRT Secretariat will engage with the NSW Health Mental Health Drug and Alcohol Office in the first six months of 2016 to progress this recommendation.'

### Agency update – 2017

The DVDRT Secretariat had regular contact with NSW Health throughout 2016 and 2017 to progress this recommendation. As noted above, that engagement resulted in the Team's Manager being appointed to the MHD&A RCA Classification Group. The DVDRT Secretariat now has the benefit of regular contact with mental health and drug and alcohol specialists via the group and can seek information and input from that expert panel to inform the work of the Team as required.

Further, as is discussed below, in 2016 A/Prof Adrian Dunlop, Chief Addiction Specialist (NSW Ministry of Health) was appointed to the Team which now has the benefit of his high level expertise, knowledge and clinical experience in relation to drug and alcohol issues.

No formal response has been received from NSW Health in relation to this recommendation.

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## Recommendation 6 (2013/15 report)

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That the NSW Government give consideration to expanding the current membership of the Team to include:

- a) a permanent member with expertise in the area of Mental Health treatment and service provision; and
- b) a permanent member with expertise in the area of Drug and Alcohol treatment and service provision.

**Whole of government response:** Supported

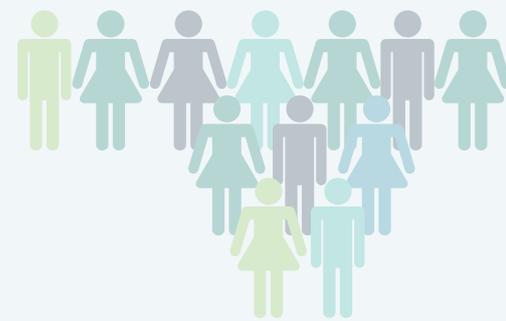
**Lead agency:** NSW Department of Justice, NSW Health

**Whole of government commentary:** 'The Department of Justice will consider this recommendation in consultation with the DVDRT and relevant agencies. NSW Health considers that it may be a way of providing the Domestic Violence Death Review Team with a greater understanding of the spectrum of mental health issues, the concerns identified in Root Cause Analysis reports, the service delivery options and drug and alcohol treatment interventions. The Mental Health and Drug and Alcohol Office would also like to suggest that representatives are selected for their clinical expertise in the selected field, and experience in the provision of generalist mental health and drug and alcohol services.'

### Agency update – 2017

The Department of Justice responded to the Team's monitoring of this recommendation on 13 July 2017 and indicated that:

- a) This has been satisfied with the appointment of A/Prof Adrian Dunlop in late 2016.
- b) NSW Ministry of Health is best placed to provide a status report in response to recommendation b) – appointment of a mental health specialist.'



As yet, no mental health specialist has been appointed to the Team and no response has been received from NSW Health in relation to this recommendation.

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## Recommendation 7 (2013/15 report)

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That Ageing, Disability and Home Care (ADHC) (Department of Family and Community Services) give consideration to developing mandatory internal reporting protocols to enable action to be taken when staff suspect clients are at risk from domestic violence in the home.

That consideration also be given to establishing a notification process between frontline FACS-Housing teams and ADHC operated and funded services when staff suspect that domestic violence is occurring. This may be modelled on the current notification obligations of maintenance workers who identify child protection issues in their contact with tenants. This notification triggers a client service visit from tenancy team staff to enable support, information and appropriate referrals to be made.

**Whole of government response:** Supported

**Lead agency:** Family and Community Services

**Whole of government commentary:** 'The NDIS will be responsible for specialist disability services from July 2018. Until then, FACS could provide information for disability staff to assist them to identify and respond to domestic violence. Thereafter NSW will need to establish how It Stops Here will support people with disability. FACS (ADHC) will discuss an approach with FACS (Housing) for notifying when staff have concerns about social housing tenants with disabilities who are suspected to be at risk of DFV.'

## Agency update – 2017

Family and Community Services responded to the Team's monitoring of this recommendation on 26 July 2017 and indicated that:

'FACS existing safeguards include mandated quality requirements and the reportable incidents scheme under the Disability Inclusion Act 2014 (NSW) to ensure appropriate reporting and notifications occur in relation to incidents of abuse and violence.

The NSW Quality Framework e-learning module assists FACS staff and funded service providers in understanding FACS (ADHC)'s quality requirements including application of the NSW Disability Service Standards (NSW DSS). The module takes users progressively through the NSW DSS and each of the related training components. They can also navigate freely around the module and access specific topics of interest. The module has been updated and reconstructed as a result of user testing by FACS staff and funded service providers.

In relation to client on client matters in FACS operated services, the NSW Ombudsman's Reportable Incident Scheme includes client on client incidents, which are reportable under the Scheme. Part 3C of the Ombudsman Act 1974 (NSW), requires the Ombudsman to keep under scrutiny the systems of the FACS and funded providers for preventing, handling and responding to, [sic] reportable incidents involving people with disability who live in supported group accommodation.

The Secretary of FACS, or head of a funded provider, must give the Ombudsman notice, within 30 days, of a reportable incident of which the Secretary or head of a funded provider becomes aware. FACS has developed forms and guidelines to assist FACS-operated services and staff to meet their obligations. This is an allegations based Scheme which means that an alleged incident is notifiable to the NSW Ombudsman's office. There are four categories of reportable incidents, one being client on client incidents in supported group accommodation. In addition to developing forms and guidelines, FACS (Performance Improvement) has conducted briefings across the state targeting front line staff and managers.

The NSW Ombudsman has also conducted training sessions across FACS operated services on recognising and reporting incidents.'

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## Recommendation 8 (2013/15 report)

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That the NSW Government approach the Commonwealth to highlight Recommendation 10 of the Team's 11/12 Report (see below for detail of that recommendation) and suggest it be taken into account in public awareness campaigns including that being progressed through the Commonwealth of Australian Governments, and that any future NSW campaigns are also informed by that recommendation.

**Whole of government response:** Supported

**Lead agency:** Women NSW

**Whole of government commentary:** 'Women NSW has written to the Commonwealth and the letter sent on 27/10/2016.'

### Agency update – 2017

Family and Community Services responded to the Team's monitoring of this recommendation on 26 July 2017 and indicated that:

'Women NSW wrote to the Commonwealth in January 2016 regarding this recommendation. The NSW government provided support for the National Campaign to Reduce Violence against Women and their Children "Stop it at the Start" (launched on 20 April 2016) through the Council of Australian Governments. This campaign focused on bringing together families and communities to positively influence young people's attitudes towards respectful relationships and gender equality. It encourages adults to think about the impact of what they say and do, and start conversations about respect with boys and girls.

The campaign was informed by research by Taylor Nelson Sofres that shows that although the vast majority of Australians agree domestic violence is wrong, too often influencers of young people minimise disrespectful behaviours and instances of gender inequality. In doing so, people can unwittingly excuse the behaviour in boys, and teach girls to accept it.

The Department of Social Services will be undertaking an evaluation of the impact of the campaign at the end of the three years (2019).

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## Recommendation 9 (2013/15 report)

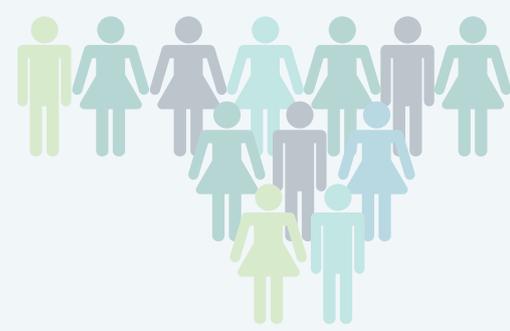
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That the NSW Police Force investigate additional strategies and processes that will promote increased compliance with policies concerning ADVOs and breaches of ADVOs and report to the Team in relation to these initiatives. Strategies and processes should include the use of the Team's case reviews to inform existing training in relation to ADVO compliance.

**Whole of government response:** Supported

**Lead agency:** NSW Police Force

**Whole of government commentary:** 'The NSWPF have advised that they support this recommendation and intend to refer case studies provided to their Education and Training command so that they can be utilised to improve training of officers in relation to Apprehended Domestic Violence Orders. The NSWPF are implementing a range of initiatives intended to address domestic violence, including extending "Suspect Target Management Plans" (STMPs) to domestic violence. Under STMPs, offenders considered to be at high risk of reoffending will be subject to both overt and covert monitoring. High risk offender teams are also working to address the problem of recidivism in relation to domestic violence. The Office for Police at the Department of Justice will work with the NSWPF to ensure compliance with policies in relation to ADVOs. This will include regular reports and oversight of NSWPF activity.'



## Agency update – 2017

NSWPF responded to the Team’s monitoring of this recommendation on 9 August 2017 and indicated the following:

‘The NSWPF consistently reviews strategies and processes that will promote increased compliance with policies concerning ADVOs and breaches of ADVOs.

### Breach of ADVO-quality of police response project:

In 2014, the NSWPF DV Team initiated a review of the police response to breach of ADVOs (a copy of which has been supplied to the DVDRT). The DV Team analysed in-depth 100 cases that involved a report of a breach of ADVO but which ended up with no legal action taken. This occurred to see if there were any systemic issues or failures by police. The DV Team did not find any systemic issues and supplied a copy of the report to the Department of Justice and other government partners. The conclusion in the report stated:

*In summary, and despite the five instances of question marks being present about the quality and sufficiency of an investigation, there is no evidence of a systematic failure on the part of investigating police in relation to reports of breach of ADVOs. Rather the evidence strongly suggests that the police response is robust and is very much inclined towards the initiation of a prosecution upon the receipt of an allegation of a breach of an ADVO.*

### Police Issued ADVOs:

In 2014, all operational police underwent ADVO specific training pertaining to ‘Police Issued ADVOs’ and the accompanying new direction and detention powers. This training was completed by mid-2014 and involved on line training and face to face training. The Police Issued ADVOs project involved expensive and time consuming changes to WebCops but resulted in a new streamlined response to the application for and immediate enforcement of provisional ADVOs. Feedback from police and from the Cabinet Review of this initiative is that this has increased the effectiveness of police responses to DV and made the court process more efficient and effective.

Whilst other victims focused initiatives are not specifically directed towards breach of ADVOs (such as DVEC) these initiatives have also complemented the NSWPF response to breach of ADVOs and ADVOs generally.

### Perpetrator Accountability Model:

In 2016, the NSWPF adopted a three tiered approach to combating DV offending with a particular focus on re-offending and a proactive approach to breach of ADVOs. The three tiered approach is based on the different level of risk posed by offenders.

1. Domestic Violence High Risk Offender Teams (DVHROT): The NSWPF will implement a DVHROT in all six regions by December 2018, as Government funding becomes available. Currently they are in operation in Central Metropolitan, Northern and South West Metropolitan Regions. The DVHROT target the most serious and high risk offenders who have demonstrated a history of violence and breaches of court orders.
2. DV Suspect Targeting Management Plans (DVSTMP): the DVSTMP initiative was rolled out statewide in March 2016 and the results to date have been impressive with a real focus on re-offenders and as a result the breach of ADVOs. The DVSTMP is now considered business as usual and focuses on mid-level offenders. This initiative was funded from existing resources.
3. ADVO Compliance: is targeted towards proactively deterring and detecting breaches of ADVO by early police interactions with both offenders and protected persons after an order has been made. The program was rolled out statewide in May 2017. This initiative was funded from existing resources.

This three tiered model has involved considerable expense and effort in terms of extra positions, change management and field testing.

Training delivered to police during the period of the recommendations has evolved in line with changes to relevant legislation and Standard Operating Procedures (SOPs) at the time. The sessions listed relate to the Domestic Violence Liaison Officers Course and the Investigation of Domestic & Family Violence Workshop. The sessions are viewed as those most relevant to each of the recommendations.

#### Domestic Violence Liaison Officers Course:

- Session 1, there is reference to the 'DV Continuum, the Duluth Wheel (power and control) and the cycle of violence.
- Session 3 covers the role of a DVLO in terms of job description, compliance with policies concerning ADVOs with reference to the Command Management Framework (CMF), the AVO system, Court Notice System; all compliance mechanisms assist the DVLO to ensure AVO compliance within their Command.
- ADVO List Day at Court and repeat victims and offenders is also covered during Session 3.
- Session 4 covers legislation, policy and procedures as they relate to domestic and family violence, in particular obligations in making and serving ADVOs.
- Session 12 covers the process to follow when applying electronically for an AVO.

#### Investigation of Domestic & Family Violence Workshop:

- Session 4 covers domestic and personal violence legislation .and examines NSWPF policy and SOPs governing police response to domestic and family violence.'

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### Recommendation 10 (2013/15 report)

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That the NSW Department of Justice continue to work closely with the NSW Domestic Violence Death Review Team in identifying and informing future evaluations of the Domestic Violence Safety Assessment Tool (DVSAT).

**Whole of government response:** Supported

**Lead agency:** NSW Department of Justice

**Whole of government commentary:** 'This work is already underway, and the Department will continue to work collaboratively with the DVDRT in the evaluation of the DVSAT. The evaluation of the DVSAT is planned for 2017/2018.'

#### Agency update – 2017

The NSW Department of Justice responded to the Team's monitoring of this recommendation on 13 July 2017 and indicated that:

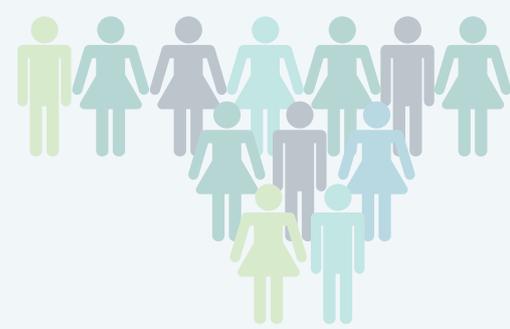
'Victims Services is working with Women NSW on this initiative and the evaluation will go to tender shortly – the evaluation of the DVSAT is planned for 2017/2018.'

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### Recommendation 11 (2013/15 report)

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That the Department of Family and Community Services – Housing NSW work collaboratively with the NSW Police Force to develop an information bulletin regarding the rights and rules pertaining to social housing tenants. This bulletin should be circulated statewide within 12 months.



**Whole of government response:** Supported

**Lead agency:** NSW Police Force, FACS (Housing)

**Whole of government commentary:** 'FACS will collaborate with the NSW Police Force to determine what information would be most useful to include in a bulletin or fact sheet. NSWPF is actively collaborating with Housing NSW. Officers from the NSWPF will be meeting with FACS officers to discuss the development of the information bulletin. Once the bulletin is available, the NSWPF will disseminate the bulletin. Copies will also be provided to the NSW Police Education and Training command for use in training in relation to domestic violence.'

### Agency update – 2017

NSWPF responded to the Team's monitoring of this recommendation on 9 August 2017 and indicated the following:

'In 2016 the Corporate Sponsor and DV Team met with representatives from housing and as a result an information bulletin was produced for circulation to all operational police. On 3 May 2016, this information bulletin was sent out to the field for circulation to all operational police. The method of circulation was twofold;

1. Direct contact with the DVLOs and Regional DV Coordinators and
2. A statewide information message via the NSWPF nemesis messaging system.'

FACS responded to the Team's monitoring of this recommendation on 26 July 2017 and indicated that:

'The NSW Police Force Information Bulletin was finalised with NSW Police in April 2016 and distributed to all frontline Police.

DFSI is currently finalising amendments to the Residential Tenancies legislation which includes amendments relating to DFV. Once this Bill has passed, the Bulletin will be further updated and redistributed.'

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### Recommendation 12 (2013/15 report)

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That the Department of Family and Community Services – Housing NSW develop a z-card for tenants that identify their status as a "head" tenant with the right to request removal of unauthorised occupants of the property. This z-card should be distributed by Housing NSW to new and existing tenants.

**Whole of government response:** Not Supported

**Whole of government commentary:** 'FACS has investigated the feasibility and effectiveness of a z-card through a pilot and in discussions with NSW Police Force has agreed that it is not feasible. The NSW Police Force have indicated that they already have the necessary powers to remove offenders. FACS is in the process of releasing an 'app' which would provide more up to date information about tenancy status.'

### Agency update – 2017

No agency update as recommendation was not supported as has accordingly not been progressed.

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### Recommendation 13 (2013/15 report)

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That the Minister for Domestic and Family Violence convene an interfaith roundtable within the next 12 months with a view to progressing Recommendation 12 of the Team's 11/12 Report (see below).

**Whole of government response:** Supported

**Lead agency:** Women NSW

**Whole of government commentary:** 'An interfaith roundtable will be held in 2016. Planning for the roundtable is currently underway.'

### Agency update – 2017

See below, Recommendation 12 of the Team's 2011/12 Report.

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### Recommendation 14 (2013/15 report)

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That the Family Court of Australia and the Federal Circuit Court of Australia:

- a) update their webpages concerning family violence to incorporate a quick close button to facilitate the safe and rapid exit from the webpage;
- b) give consideration to updating information in relation to safety and separation included on their respective websites; and
- c) give consideration to including family violence referral information in their brochures 'Marriage, Families & Separation' (prescribed brochure) and 'Separated but living under one roof?' This referral information should be reflected in both the online and hardcopy versions of these brochures, and should include referrals to 1800 RESPECT.

**Whole of government response:** Supported

**Lead agency:** Women NSW

**Whole of government commentary:** 'Women NSW has written to the Family Court of Australia and the Federal Circuit Court of Australia and the letters were sent on 30/03/2016.'

### Agency update – 2017

Women NSW (FACS) responded to the Team's monitoring of this recommendation on 26 July 2017 and indicated that:

'Women NSW wrote to the Family Court of Australia and the Federal Circuit Court of Australia in March 2016 regarding the implementation of this recommendation.

Based on a review of the Courts' websites it does not appear that the relevant brochures have been updated, nor quick close buttons incorporated.

Women NSW will contact the Family Court and the Federal Circuit Court to ask for an update on the earlier request.'

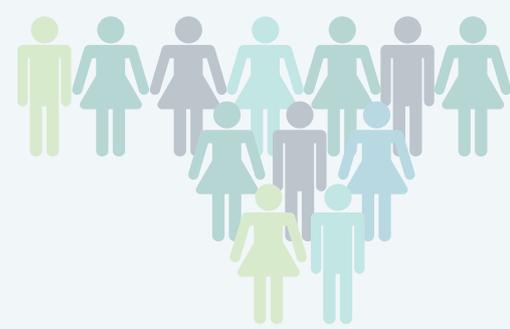
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### Recommendation 15 (2013/15 report)

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That the NSW Ombudsman gives consideration to developing a protocol which will enable deaths involving both domestic violence and child protection issues to be subject to a joint meeting between the NSW Ombudsman's Office and the NSW Domestic Violence Death Review Team. The purpose of this meeting will be to share learnings in relation to child protection and domestic violence issues.

**Whole of government response:** Supported



**Lead agency:** NSW Ombudsman

**Whole of government commentary:** ‘The NSW Ombudsman suggests enhanced collaboration between death review functions to minimise overlap and potential.’

## Agency update – 2017

The DVDRT Secretariat and representatives of the NSW Ombudsman met on a number of occasions throughout 2016 and 2017 to progress this recommendation and to formalise information sharing protocols.

Following its most recent meeting in July 2017, it was agreed that in addition to continuing to provide the DVDRT Secretariat with copies of its reports as requested, the NSW Ombudsman will ensure that the DVDRT Secretariat has access to its joint FACS/Ombudsman Integrated Governance Framework.

The framework incorporates all systemic recommendations relating to that agency’s work, including recommendations arising from child death review. It was further agreed that both agencies will continue to share information and advice on case-related and systemic issues to inform the work of each review body.

## 2012-2013 DVDRT Report

The Team’s 2012/13 Report was tabled in NSW Parliament in March 2015 and made 23 Recommendations to government and non-government agencies. The whole of government response in relation to the 2012/13 Report was received in May 2016 and can be accessed at the Coroners Court website.

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### Recommendation 1 (2012/13 report)

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That the NSW Police Force review and revise their recruitment and field based domestic violence operational skills training materials to ensure that such materials:

- a) promote a comprehensive understanding and awareness of the broad spectrum of domestic violence behaviours, including non-physical manifestations of domestic violence;
- b) include specific training concerning where non-physical domestic violence behaviours manifest as coercive and controlling conduct by the perpetrator; and
- c) address and acknowledge the professional challenges which officers may experience in the context of responding to domestic violence in the community, in particular responding to repeat offenders and victims of domestic violence.

**Whole of government response:** Supported

**Lead agency:** NSW Police Force

**Whole of government commentary:** ‘This work is ongoing. The NSW Police Force regularly updates training materials and provides ongoing training for all officers. The Constable Development Program and the Investigation of Domestic Violence Workshop includes instruction about physical and non-physical behaviours, power and control, and repeat party involvement.’

## Agency update – 2017

NSWPF responded to the Team’s monitoring of this recommendation on 9 August 2017 and indicated the following:

'Training delivered to police during the period of the recommendations has evolved in line with changes to relevant legislation and SOPs at the time. The sessions listed relate to the Domestic Violence Liaison Officers Course and the Investigation of Domestic & Family Violence Workshop. The sessions are viewed as those most relevant to each of the recommendations.

#### Domestic Violence Liaison Officers Course-presently:

- Session 6 covers DV and Cyber Crime which looks at non-physical forms of DV, the impact on victims and investigative avenues available to prosecute offenders.
- The broad spectrum of DV behaviours is covered in Session 1 as part of the Cycle of Violence along with Power and Control.
- Session 3 deals with the topics of 'Repeat Offenders' and 'Repeat Victims'.
- Session 5 covers some of the challenges police may face in terms of the absence of a victim statement, reluctant victims and conflicting offender/victim versions.
- In terms of victim support and the police response, Session 7 covers support for victims through the 'Women's Domestic Violence Court Advocacy Program (WDVCAP) and Session 8 covers Customer Service (victims) and Victim Care.
- Session 10 covers networking, resources and referrals thereby making police aware of the external agencies and internal services available to assist with D&FV investigation.

#### Investigation of Domestic & Family Violence Workshop:

- Session 2 covers power and control in abusive relationships including the tactics and mechanisms used by abusers to establish and maintain power and control.
- Session 2 also covers the cycle of violence as well as strategies to be used when interviewing traumatised persons.
- Session 7 covers customer service and victim care. Part of this session looks at identifying strategies to reduce the impact of vicarious trauma on self and colleagues.'

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### Recommendation 2 (2012/13 report)

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That the NSW Police Force give consideration to developing a mentoring program whereby Region Domestic Violence coordinators provide strategic support and assistance to all officers to help acknowledge and address the professional challenges and barriers presented by repeat offenders and victims of domestic violence.

**Whole of government response:** Supported in principle

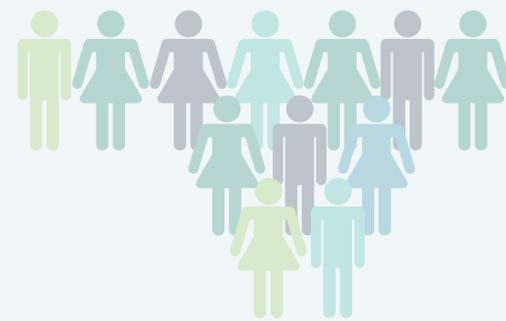
**Lead agency:** NSW Police Force

**Whole of government commentary:** 'NSW Police Force provides mentoring for officers in relation to domestic and family violence through the continued education and training of police.'

#### Agency update – 2017

NSWPF responded to the Team's monitoring of this recommendation on 9 August 2017 and indicated the following:

'The NSWPF considered developing a mentoring program but ultimately decided not to pursue this option due to a number of factors:



- The role of the Regional Coordinators and their limited numbers did not lend itself towards providing all officers with such a mentoring program
- Such support exists locally with the specialist DVLO role
- Support is given to police in the context of continued education and training of police
- Support is given via our DVLOs and RDVCs by utilising existing DVLO Regional Forums and Conferences and
- Support is given via our DVLOs by our DVLO Coordinator in the DV Team.'

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### Recommendation 3 (2012/13 report)

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That the NSW Police Force incorporate into its Domestic and Family Violence Safety Assessment Tool the following questions:

- a) Do the perpetrator and victim continue to live at the same residence after the relationship has ended?
- b) Are there any criminal, family law or other relevant proceedings on foot?

**Whole of government response:** Supported in principle

**Lead agency:** NSW Police Force

**Whole of government commentary:** 'NSW Police Force supports the use of the current Domestic Violence Safety Assessment Tool (DVSAT), to be evaluated in 2017.'

### Agency update – 2017

NSWPF responded to the Team's monitoring of this recommendation on 9 August 2017 and indicated the following:

'The DV Safety Assessment Tool (DVSAT) was developed as part of a whole of government response to risk assessment and management under the Safer Pathways Model. The DVSAT contains 25 fixed questions that are specific to intimate partner violence. These questions were formulated in conjunction with our colleagues from other agencies involved in the Safer Pathways project and were the result of looking at practice and research from other parts of Australia and the world. The DVSAT has been applied statewide since July 1, 2015 and already contains two questions that relate to legal proceedings:

- Q 17: Is/has your partner currently on bail, parole, served a time of imprisonment or has been released from custody in relation to offences of violence?
- Q 22: Is there any conflict between you and your partner regarding child contact or residency issues and/or current Family Court Proceedings?

The NSWPF proposes that these two questions adequately cover the issue about the questions of legal proceedings being on foot.

The DVSAT does not contain a question concerning 'residency under one roof'. At this point in time the NSWPF does not intend to implement this part of the recommendation as the DVSAT is being formally reviewed in 2017 after a full two years of operation. The whole of government review is being led by Women NSW and Victim Services with appropriate input from NSWPF. This recommendation will be considered by the review. Until the review is completed the NSWPF cannot adjust the content of the current DVSAT. It should be noted that any adjustments will come at significant expense and difficulty due to required changes to IT, education and training. '

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## Recommendation 4 (2012/13 report)

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That the Domestic and Family Violence home page on the NSW Police Force corporate internet site be updated to incorporate a quick close button to facilitate the safe and rapid exit from the webpage. This website should also contain easily accessible information concerning how to delete internet history from the browser.

**Whole of government response:** Supported

**Lead agency:** NSW Police Force

**Whole of government commentary:** 'This recommendation has not yet been implemented by the NSW Police Force.'

### Agency update – 2017

NSWPF responded to the Team's monitoring of this recommendation on 9 August 2017 and indicated the following:

'The NSWPF inserted two quick exit buttons to its Internet DV Homepage. The information about deleting or hiding history has recently been added by way of a hyperlink to similar information available on the Women NSW internet site.'

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## Recommendation 5 (2012/13 report)

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That the relevant and appropriate NSW Police Force policies and procedures be amended to create a requirement for police to complete a COPS Event in all cases where:

- a) Officers make an assessment as to whether an individual needs to be detained under the Mental Health (Forensic Provisions) Act 1990 (NSW); or
- b) Officers issue any directions/provide any advice to a person who is on bail.

**Whole of government response:** Supported in principle

**Lead agency:** NSW Police Force

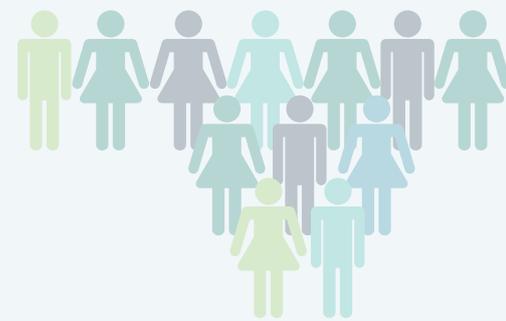
**Whole of government commentary:** 'NSW Police Force agrees that where police use a power to detain a person subject to the Mental Health (Forensic Provisions) Act 1990 (NSW) then a COPS event should be created. Similarly the Bail Act 2013 (NSW) will require an officer making a bail decision to make records which are recorded in WebCOPS.'

### Agency update – 2017

NSWPF responded to the Team's monitoring of this recommendation on 9 August 2017 and indicated the following:

'To the extent that NSWPF makes records in accordance with their legal and operational policy obligations for dealing with mental health and bail issues. The NSWPF agreed that where police used a power to detain a person subject to the Mental Health (Forensic Provisions) Act 1990 (NSW) then a WebCops event record should be created.'

The NSWPF also agreed that where a formal bail decision is made then a record should be made within policing systems. This requirement is also reflected in the relatively new Bail Act 2013 (NSW). The requirements to make such records are contained within the guidelines for these specific policing areas and were initiated independently of this recommendation.



The NSWPF did not adopt a wider interpretation of the recommendation to the extent that if an officer considered using a power or spoke to a person about their bail status. This was because police have to consider multiple factors before making operational decisions and it would be unrealistic (and not operationally viable) to expect such a decision making process to be reduced to a record on every occasion.'

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### Recommendation 6 (2012/13 report)

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That the NSW Police Force develop a communication strategy to reiterate to officers the operational requirements set out in the Domestic NSWPF Violence Standard Operating Procedures, and in particular the requirements that officers:

- a) Record all domestic and family violence incidents reported to them;
- b) Refer all parties involved, who give written consent, to appropriate services; and
- c) Investigate all domestic and family violence incidents coming to their notice, by gathering background information and physical evidence, including pictures, video recordings, clothing and statements from all victims and witnesses.

That the NSW Police Force update its Complaints Management System (c@tsi) to include domestic violence as an 'associated factor' to ensure that any complaint that is domestic violence related can be readily identified.

**Whole of government response:** Supported in principle

**Lead agency:** NSW Police Force

**Whole of government commentary:** 'This work is ongoing. The NSW Police Force continues to regularly update training materials and provides ongoing training for all officers. Officers are currently instructed to:

1. Record all domestic violence incidents reported to them.
2. Complete the Domestic Violence Safety Assessment Tool which will result in an automatic referral to support services.
3. Investigate matters thoroughly and use video evidence where appropriate.'

### Agency update – 2017

NSWPF responded to the Team's monitoring of this recommendation on 9 August 2017 and indicated the following:

- a) The NSWPF DVSOPs mandate the making of appropriate records when responding to or investigating DV incidents. This is supported by ongoing training (see below). Policing systems are also set up to communicate and oversight this with Computer Assisted Dispatch (CAD) records being linked to events. The DV Team consistently promote compliance with these DVSOPs in DV forums with DVLOs, RDVCS and Regional Sponsors. DVLOs in turn then lead the way in overseeing the appropriateness of a police response and record making. A generic narrative template is used by Police to systemically and consistently record reported DV incidents. Like recommendation 9 of 2013 to 2015 report, the NSWPF is consistently working towards maximising compliance with our DV SOPs.
- b) All persons deemed to be a victim of DV are now subject of a fully automated referral process utilising the DVSAT which transits via Victim Services to a Local Coordination Point. This is a non consent based referral system and has been fully operational statewide since July 1 2015. Its inception and implementation was done independently of this recommendation and was very costly in areas of change management, IT changes and education and training.

- c) The quality of investigations into reports of DV has increased and has been aided by both education and training initiatives (see below) and by the inception and implementation of the Domestic Violence Evidence in Chief project (DVEC) in June 2015 . Over 27,000 DVEC recordings have been completed since this time and over 40% of all of our legal actions for DV offences are DVEC based (over 50% for DV assaults). DVEC was a large project that was costly and difficult in terms of change management, systems and equipment changes and education and training.

Training delivered to police during the period of the recommendations has evolved in line with changes to relevant legislation and SOPs at the time. The sessions listed relate to the Domestic Violence Liaison Officers Course and the Investigation of Domestic & Family Violence Workshop. The sessions are viewed as those most relevant to each of the recommendations.

#### Domestic Violence Liaison Officers Course:

Session 14 covers the processes involved in conducting quality reviews of CAD messages, cases and intelligence reports involving domestic and family violence. The Webcops quality review part of the session draws attention to legislation, policy guidelines and SOPs to ensure reviews are conducted through dip samples as required.

#### Investigation of Domestic & Family Violence Workshop:

Session 3 covers the role of police when attending and investigating domestic and family violence incidents. The session expands on identifying primary aggressor and primary victim, methods used by DVLOs to impact on repeat victims and offenders. The use of DVSAT is also examined.

Session 5 covers attending and investigating D&FV incidents including physical evidence gathered at a crime scene, DVEC use at a crime scene, interviewing victims, witnesses and offenders.

Session 6 covers children and young people involved in D&FV and Family Law. Relevant legislation and police responsibilities as 'mandatory notifiers' is examined. 'Significant risk of harm' is addressed along with the Young Offenders Act 1997 (NSW).'

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### Recommendation 7 (2012/13 report)

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That the NSW Police Force review and revise both its recruitment and field based domestic violence operational skills training materials to ensure that such materials promote an understanding of kinship and an appreciation of the unique challenges that Aboriginal people may face when interacting with the legal system.

**Whole of government response:** Supported

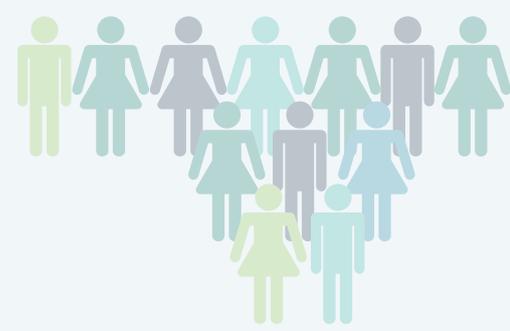
**Lead agency:** NSW Police Force

**Whole of government commentary:** 'This work is ongoing. The NSW Police Force conducts 'Policing Aboriginal Communities' courses in 41 Local Area Commands around the state. This course specifically includes education on kinship and domestic violence issues.'

#### Agency update – 2017

NSWPF responded to the Team's monitoring of this recommendation on 9 August 2017 and indicated the following:

'The NSWPF Aboriginal Coordination Team- conducts 'Policing Aboriginal Communities' courses in 41 Local Area Commands around the state. This course includes education on kinship and DV. The course involves a full day's instruction at Local Area Commands and half a day of instruction to students at the Goulburn Police Academy. This course has been running since 2012/2013.'



Training delivered to police during the period of the recommendations has evolved in line with changes to relevant legislation and SOPs at the time. The sessions listed relate to the Domestic Violence Liaison Officers Course and the Investigation of Domestic & Family Violence Workshop. The sessions are viewed as those most relevant to each of the recommendations.

#### Domestic Violence Liaison Officers Course:

Session 9 covers responding to Domestic and Family Violence across communities and involving the Command Multi-cultural Liaison Officer, Aboriginal Liaison Officer, Gay Lesbian Liaison Officer, Vulnerable Communities Liaison Officer, Youth Liaison Officer and the Crime Prevention Officer. The use of interpreters is also covered in the Domestic and Family Violence interaction/investigation. Information is also included in Session 1 about the impact of Domestic and Family Violence on Aboriginal women particularly homicide rates.

#### Investigation of Domestic & Family Violence Workshop:

Session 1 there is reference to the impact of Domestic and Family Violence on Aboriginal women in terms of the incidence of homicide, higher possibility of being exposed to Domestic and Family Violence particularly as a victim and the high rate of hospital admissions as a result of being a victim of Domestic and Family Violence.'

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### Recommendation 8 (2012/13 report)

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1. That the NSW Police Force and Juvenile Justice (DAGJ) co-ordinate to train police officers, and implement procedures whereby in all suitable cases involving bail, the Bail Assistance Line (BAL) is used to arrange appropriate accommodation for young people, particularly in cases involving violent offences and/or offences against family members.
2. That NSW Department of Attorney General and Justice conduct a feasibility study in relation to expanding the BAL to regional centres in NSW.

**Whole of government response:** Supported

**Lead agency:** NSW Police Force, NSW Department of Justice

**Whole of government commentary:** 'The service to Police has expanded statewide and BAL now is first point of contact for police out of hours for bail advice and admissions to juvenile justice centres. BAL has revised funding model for accommodation support and is working in closer collaboration with Going Home Staying Home providers for support services.'

#### Agency update – 2017

The NSW Department of Justice responded to the Team's monitoring request on 13 July 2017 and indicated:

'NSW Police Force will provide a status report on this recommendation directly.'

NSWPF responded to the Team's monitoring of this recommendation on 9 August 2017 and indicated the following:

'The service to Police has expanded across the state and BAL is now the first point of contact for custody managers in dealing with juvenile offenders with accommodation issues. The use of BAL was initiated independently of the recommendations and involved training and raising awareness of officers who are making bail decisions and who are in charge of persons in custody.'

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## Recommendation 9 (2012/13 report)

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That the NSW Police Force amend its Domestic and Family Violence policy to provide that when any domestic homicide event occurs, police should notify FACS of any known biological or non-biological surviving children of the deceased or perpetrator (including children who may not be ordinarily resident with the deceased or perpetrator).

Once a notification is made, FACS should co-ordinate with agencies including DEC and Victims Services to ensure that counselling and services appropriate to the specific trauma experience, age and geographic location of the child/ren is made available to those children in a timely fashion.

Victims Services, DEC and FACS should co-ordinate to develop a strategy and develop additional support services tailored for this group of child victims, in cases where their families or carers are reluctant to engage with counselling and support services.

**Whole of government response:** Supported

**Lead agency:** NSW Police Force, Family and Community Services, NSW Department of Justice (Victims Services), Department of Education and Communities

**Whole of government commentary:** 'The NSW Police Force is currently undertaking a review of the Domestic and Family Violence Standard Operating Procedure which will include the requirement for police to notify FACS of any known surviving children of the deceased or perpetrator in the event of a domestic related homicide.

Victims Services NSW continues to work closely with FACS to ensure all referrals for surviving children of domestic violence homicide victims or perpetrators receive a timely and appropriate response. This includes a referral to an appropriate counsellor, made within 48 hours of a referral to Victims Services as well as an assessment for immediate needs, economic loss and/or recognition payments.

Victims Services has provided detailed guidance to FACS to ensure all applications submitted on behalf of surviving children are complete and can be expedited through the assessment process. Victims Services and FACS meet every two months to ensure that this referral process is working and to discuss any issues that may arise.'

### Agency update – 2017

NSWPF responded to the Team's monitoring of this recommendation on 9 August 2017 and indicated the following:

'The DVSOPs have been updated and information disseminated to relevant squads.'

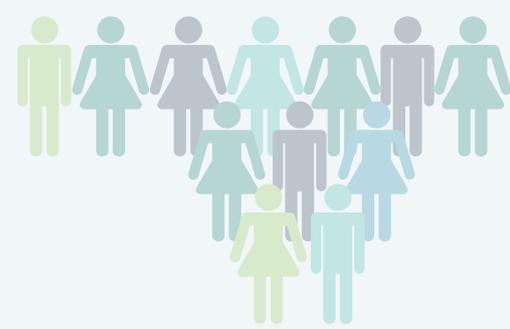
FACS responded to the Team's monitoring of this recommendation on 26 July 2017 and indicated that:

'All DFV related reports received by the Helpline are assessed using the Screening and Response Priority tools. Domestic violence is referenced throughout the screening tool under physical abuse, neglect and psychological harm categories as well as some parental risk factors.

A referral to Victims Services NSW would be made by FACS where there is ongoing casework involvement with a child or young person and their care.'

The Department of Justice responded to the Team's monitoring request on 13 July 2017 and indicated:

'NSW Force will provide a status report on this recommendation directly. Victims Services continues to work with FACS to ensure support under the Victim Support Scheme is available to victims of crime. This initiative is an ongoing initiative.'



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## Recommendation 10 (2012/13 report)

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That NSW Health co-ordinate the development and implementation of a domestic violence identification and referral strategy for the Ambulance Service of NSW and all NSW Hospital Emergency Departments. This strategy should include:

- a) The development of policies and procedures by NSW Health to ensure that timely and effective information exchange occurs between NSW Ambulance staff and Emergency Department staff to facilitate the identification of and response to injuries sustained from domestic violence.
- b) That NSW Ambulance staff are encouraged to utilize the functionality within the Electronic Medical Record (eMR) form to record incidents of domestic violence, particularly when the victim, police or other informant has stated that the injury was sustained as a result of domestic violence.
- c) The adoption and implementation by NSW Health of the proposed NSW government Domestic and Family Violence Reforms to facilitate the identification of high-risk victims who have sustained injuries resulting from domestic violence, and referral (through Emergency Department Social Work Teams) to Safety Action Meetings (SAMs) when a victim(s) is identified as 'high-risk'.
- d) The development of targeted professional development and mandatory training for all persons working within NSW Emergency Departments and Ambulance Services in relation to domestic violence. This training should:
  - i. Include the identification of domestic violence dynamics, and explore issues of safety (for both patients and staff); and
  - ii. Address responding to patients who present with cumulative social issues (including being drug and/or alcohol affected) or are otherwise difficult patients.
- e) The development and implementation of a policy promoting and facilitating the discharge of patients into a safe environment free from domestic violence. This policy should recommend that those patients suspected of sustaining injuries as a result of domestic violence receive the Domestic Violence Hurts Your Health Z-Card, produced by the Education Centre Against Violence (ECAV). This policy may incorporate the provision of referral information where necessary, including in relation to emergency accommodation and other services.

**Whole of government response:** Supported

**Lead agency:** NSW Health

**Whole of government commentary:** 'NSW Kids and Families is in the process of reviewing the current NSW Health Policy Directive PD2006\_084 Domestic Violence - Identifying and Responding. This policy will apply to all NSW Health services, including the Ambulance Service of NSW and hospital Emergency Departments. The revised policy will give clear direction regarding the importance of information exchange by NSW Health workers to support the care of children, young people and adults who have experienced domestic violence, and the importance of referral to SAMs where a victim is at serious threat who presents to any NSW Health service, including the Ambulance Service of NSW and hospital Emergency Departments.'

The revised Domestic and Family Violence policy will include the importance of safe and confidential referral to appropriate services within and external to NSW Health, and will promote use of the Domestic Violence Hurts Your Health Z-Card with domestic violence information. The z-cards are available in 17 languages, are offered to all women at the time of screening and explain a range of behaviours that constitute domestic and family violence.

NSW Health considers the Domestic Violence Safety Assessment Tool currently being rolled out as part of the NSW Safer Pathway is too long for use given the time constraints that characterise Emergency Departments. NSW Kids and Families is planning work with two NSW Emergency Departments as part of a review of the Domestic Violence Routine Screening tool. The Emergency Department project will trial a shorter, 5 question risk assessment tool. This tool will still identify clients at High Risk and can be used to guide referral into broader Safer Pathway initiatives including Safety Action Meetings. Trials of Domestic Violence Routine Screening in these two sites are currently under negotiation and will be evaluated with a view to future roll out throughout NSW Emergency Departments.'

## Agency update – 2017

NSW Health responded to the Team's monitoring of this recommendation on 2 August 2017 and indicated that:

- a) 'In 2015 the operations of NSW Kids and Families were transferred to the NSW Ministry of Health. A new unit called the Prevention and Response to Violence Abuse and Neglect (PARVAN) was established and located within the Health and Social Policy Branch. The revised NSW Health Domestic and Family Violence Standards and Guidelines are currently being finalised for stakeholder consultation by PARVAN.

PARVAN will conduct consultation with the NSW Ambulance Service on the update of information relating to identification and referral strategies to be included in the final version of this document from September 2017.

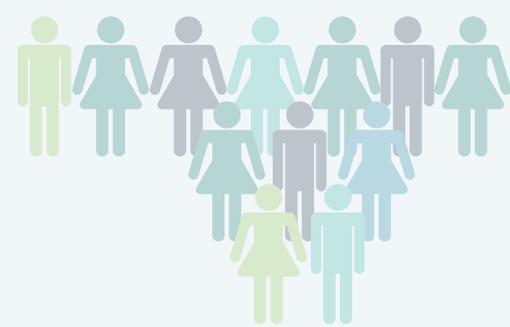
- b) Paramedics record a detailed history of patient injuries, and mechanism of injury in the free text area of the Electronic Patient Record. Paramedics exercise discretion and judgement in accordance with their training regarding the transport of patients who are the victims of abuse, with the aim of transporting the victim to hospital rather than antagonising the situation in a pre-hospital environment.
- c) As per previous advice, NSW Health considers the Domestic Violence Safety Assessment Tool (DVSAT) currently being rolled out as part of the NSW Safer Pathway is too long for use given the time constraints that characterise Emergency Departments. PARVAN is currently working with the Safer Pathway Implementation Working Party to look at which clinical areas the DVSAT may be applicable to and to develop plans for trial based implementation of this tool.

PARVAN is able to advise that the trial of screening and risk assessment (alternative to the DVSAT) for domestic violence in Emergency Departments is currently underway. The Innovation in Care: Evaluating the Implementation of Domestic Violence Screening and Response in NSW Emergency Departments Project commenced on 22 May 2017. The project and will be conducted over a 6 month data collection period in Emergency Departments at Wagga Wagga Rural Referral Hospital, St Vincent's Health Network in Sydney and Lismore Base Hospital.

The study aims to support women to disclose DV through routine screening in NSW Health Emergency Departments and also to facilitate their access to support services. Treating nurses in the Emergency Department will implement a four-item screening instrument, the HITS tool (Hitting or physical hurting, Insults, Threats, Screaming or swearing) to women aged 16-45 years, which produces a score to guide the required response. Nurses will refer women whose answers score over a set threshold to a social worker/ psychosocial worker to provide a timely local response.

The Emergency Care Institute advised through the Agency for Clinical Innovation that previous routine screening of women attending EDs for domestic violence (a NSW health pilot was conducted in two emergency departments in 2001) have been unsuccessful for the following reasons:

- EDs have no redundant capacity and are virtually always suffering from excess demand for their services;
- EDs do not have the ability to maintain privacy during screening;



- EDs are rightly focused on clinical treatment for the sickest and most unstable new patients, and thus resources must be focused on this, whereas opportunistic screening of relatively well patients will divert resources and not be able to be achieved;
- Many women attending EDs are very sick when they present and unlikely to want to answer, or be able to focus on, the screening questions;

The Innovation in Care project aims to address the specific nature of the Emergency Department and work within the constraints of this busy clinical environment. The aim of the project is to determine the extent to which targeted screening and response for domestic violence in hospital Emergency Departments has been implemented as planned to inform recommendations for up-scaling across NSW. The evaluation will determine the screening completion, response and referral rates, implementation costs, impact on hospital waiting times, as well as obtaining feedback from hospital staff about their experiences implementing DV routine screening in Emergency Departments.

In relation to current practice, it should be noted that Emergency Departments already focus on identifying where patients are affected by domestic violence, and implement follow up and support as appropriate. The current NSW Health Policy and Procedures for Identifying and Responding to Domestic Violence (PD2006\_084) applies to clinicians working in emergency departments. The Australasian College for Emergency Medicine (ACEM) also has policy on Domestic and Family Violence (p.39) that provides guidance on the identification, notification and referral of relevant patients.

All EDs are required to have a local procedure or policy documented for contacting social work and/or other relevant agencies when victims of domestic violence are referred for assistance. The content of these local procedures or policies should include a brief explanation of the problem, contact and referral numbers and process and other considerations (e.g. child at risk, notification or notification to police, provision of safe accommodation etc.).

- d) Currently, NSW Ambulance provides education to paramedics on domestic violence in the context of child protection. Domestic violence education forms part of the routine ED education program. All junior doctors receive social work orientation at the start of the intern year.

The Emergency Care Institute has also developed clinical tools (available <https://www.aci.health.nsw.gov.au/networks/eci/clinical/clinical-resources/clinical-tools/reporting-abuse-or-neglect>) on child protection, domestic violence and elder abuse to provide emergency clinicians a quick, succinct resource to facilitate the identification, reporting and subsequent steps to take when posed with a patient at risk. This was developed in collaboration with NSW Health Kids and Families in 2015. In addition, the ECI Leadership Forum on 9 June 2017, discussed the legal and clinical aspects of domestic violence in the ED as a plenary session. This content was filmed and has also been uploaded onto the ECI website (available <https://vimeo.com/222655896>). Training on domestic violence is not mandatory for NSW health workers, however, in addition to face to face courses provided by the Education Centre Against Violence (ECAV) the Health Education and Training Institute (HETI) online My Health Learning modules also include:

1. Recognising Domestic and Family Violence
2. Domestic and Family Violence Routine Screening
3. Surviving Domestic and Family Violence

These modules are not currently prescribed as mandatory training for NSW Ambulance clinical staff. NSW Health will review domestic violence training as a mandatory requirement for NSW Ambulance in 2017-2018.

- e) Current NSW Health Policy already identifies that every effort should be made to discharge patients into a safe environment, where domestic violence is disclosed in an Emergency Department (Policy and Procedures for Identifying and Responding to Domestic Violence PD2006\_084). The current Innovation in

Care project includes the trialling of provision of Domestic Violence Hurts Your Health Z-Card with domestic violence information to all women in the study co-hort.'

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## **Recommendation 11 (2012/13 report)**

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1. That NSW Kids and Families (NSW Health), liaise with Priority Programs, Integrated Care (Ministry of Health) on the planned review of its Policy Directive Interpreters - Standard Procedures for Working with Health Care Interpreters [PD 2006\_053], to ensure that:
  - a. Wherever possible, the patient is consulted as to their preferences for an interpreter in relation to gender; and
  - b. All patients are made aware of their right to an accredited interpreter who has professional obligations to uphold patient confidentiality and impartiality.
2. That NSW Kids and Families (NSW Health), in undertaking a review of Policy Directive Domestic Violence - Identifying and Responding [PD2005\_413], enhances policies and procedures to ensure that:
  - a. Where possible, prior to any domestic violence screening being undertaken, information about domestic violence is provided to the woman being screened in her own language (for instance, by providing her with the Domestic Violence Hurts Your Health Z-Card published by ECAV);
  - b. Where possible, the medical professional, through an appropriate interpreter, discusses with the patient the range of behaviours that may constitute domestic violence, as well as asking questions of the patient in a way which respects her culture; and
  - c. Medical professionals use accredited interpreters who are trained and adhere to standards of confidentiality and impartiality to identify and/or reduce the potential for power imbalances or other issues arising between the patient being screened and the interpreter (for example, ethnic conflict between the interpreter and patient; conflict on the basis of age or gender; and confidentiality issues).

**Whole of government response:** Supported

**Lead agency:** NSW Health (NSW Kids and Families, Ministry of Health)

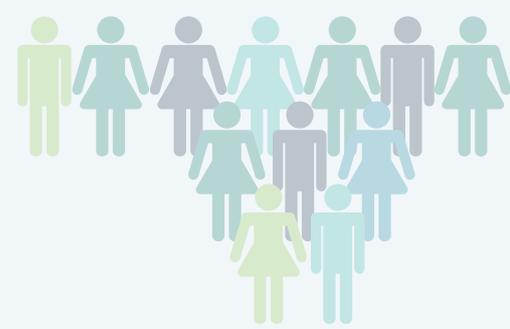
**Whole of government commentary:**

1. NSW Kids and Families will contribute expert domestic and family violence representation to the review of Policy Directive Interpreters - Standard Procedures for Working with Health Care Interpreters (PD 2006\_053) when it commences. NSW Kids and Families will make contact with Priority Programs, Integrated Care as a matter of priority and offer policy review support.

NSW Kids and Families notes that the number of available translators in some areas may make it difficult to fulfil gender preference requests by clients, however we will support it wherever practicable.

NSW Kids and Families notes that the Education Centre Against Violence (ECAV) provides high quality training relating to domestic and family violence free of charge to all NSW Health interpreters, however there is no current requirement for accredited interpreters to receive such training, which we would recommend as part of the accreditation process.

2. NSW Health conducts domestic violence routine screening for all women attending antenatal services; all women attending child and family health services; women aged 16 years and over who attend mental health services, and women aged 16 and over who attend alcohol and other drugs services. NSW Health



provides Domestic Violence Hurts Your Health Z cards with domestic violence information, free of charge to all NSW Health DVRS services. The Z-cards are available in 17 languages. The Z-cards explain a range of behaviours that constitute domestic and family violence.

Contextual information about domestic and family violence is given prior to screening, via an appropriately accredited or professional interpreter where appropriate. The Z card is offered at the end of this process to ensure that carrying the information will not place the patient at any further risk, and to ensure the patient understands the information.

PD2006\_084 Domestic Violence - Identifying and Responding replaced PD2005\_413. The current Domestic Violence - Identifying and Responding policy is now under review and is due for completion in 2015/16. The current policy contains requirements for the use, wherever possible, of accredited interpreters during Domestic Violence Routine Screening (DVRS). This provision will be maintained in the review process.

NSW Health notes that the screening and information is provided by a range of NSW Health workers, rather than by 'medical professionals'.

Workshops are available through ECAV for Health workers and Health interpreters in responding to domestic violence to ensure a culturally sensitive and competent response. These courses are free for interpreters and are heavily subsidized or free for other Health workers. The specific training for Health interpreters address issues including responding in a trauma informed approach to practice, ethnic conflict between the interpreter and patient, conflict on the basis of age or gender; confidentiality issues and vicarious trauma.

## Agency update – 2017

NSW Health responded to the Team's monitoring of this recommendation on 2 August 2017.

In relation to part 1) of the recommendation NSW Health indicated that:

'The review date for this policy has only just occurred. PARVAN will contact the integrated Care Team to enact the previous commitment above in July 2017.

As a part of this ongoing dialogue, the NSW Health Education Centre Against Violence (ECAV) recently held a forum focussing on domestic violence routine screening with women from culturally and linguistically diverse cultures. Over 200 staff attended including Health Care Interpreters. ECAV, in partnership with the Health Care Interpreter Service (HCIS), has also developed a DVD which was launched on the day, titled "Engaging Interpreters with a Trauma Informed Approach: Screening for DV in NSW Health Services". An accompanying resource booklet was also developed titled "Information for Health Workers when Engaging Interpreters in DV Screening".

In relation to part 2) of the recommendation NSW Health indicated that:

'The revised NSW Health Domestic and Family Violence Standards and Guidelines are currently being finalised for stakeholder consultation. The revised Policy gives guidance to interpreters.

The Education Centre Against Violence (ECAV) also enhances policy directives and clinical guidance in this area through the provision of education. ECAV delivers 2 x 2 day courses for Health Care and Multicultural NSW Interpreters on domestic violence and sexual assault- "Interpreting for people who have experienced domestic violence" and "Interpreting for people who experience sexual assault". The aim of these courses is to work effectively with counsellors, social workers and healthcare professionals, it is important that interpreters have a clear understanding of the nature of these crimes, the effects on the victim and how they can impact upon the interpreting environment. Issues explored include, the importance of maintaining professional boundaries,

effective strategies in working with healthcare professionals and other service providers in the context of violence and roles and responsibilities in relation to relevant policy and protocol. Interpreters are eligible for 20 professional development points under NAATI re-validation process. Each course is delivered 3-4 times per year and have been delivered by ECAV for over 15 years. These courses are offered at a subsidised rate of \$80 per person.

ECAV also hosts an annual Practice Forum for Interpreters and Bilingual Community Educators (BCE): the focus is on emerging issues, critical concerns and models of collaborative and effective practice by interpreters and BCEs and those working in NSW Health services. This forum is free of charge. ECAV has trained approximately 400 interpreters between 2014-2017.

In addition to training, ECAV has an established partnership with Health Care Interpreter Services Managers and are working on co-hosting the Interpreter and BCE Practice Forum in November 2017, the focus will be on building capacity around responding to family violence in health care settings.'

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### **Recommendation 12 (2012/13 report)**

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That the National Accreditation Agency for Translators and Interpreters (NAATI) encourage the development of, and participation in, programs for practitioners certified by NAATI, which examine the dynamics and behaviours of domestic violence. This should also constitute part of any continuing professional development programs offered by NAATI.

**Whole of government response:** Supported

**Lead agency:** Community Relations Commission (now Multicultural NSW)

**Whole of government commentary:** 'Since 2006, Multicultural NSW has collaborated with the Education Centre Against Violence (ECAV) to provide training for interpreters in the area of domestic violence and sexual assault. Multicultural NSW has committed to including key elements of the training in its induction program for new interpreters commencing from the beginning of 2016.'

### **Agency update – 2017**

Multicultural NSW responded to the Team's monitoring of this recommendation on 12 July 2017 and indicated that:

'Multicultural NSW has been working with NAATI to ensure the accreditation and testing processes for interpreters require an understanding of the nature and dynamics of family violence. To further support this initiative, Multicultural NSW has committed to make available free personal development training on interpreting in family violence contexts to NAATI credentialed interpreters (including, if possible, training on dealing with vicarious trauma) in NSW.

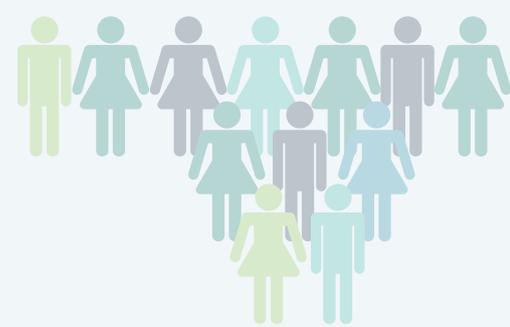
Multicultural NSW supports and works with NAATI on other initiatives to ensure interpreters are trained and equipped to work effectively in the challenging situation of domestic and family violence. These initiatives include promoting the incorporation of training, and the assessment of competency in interpreting in family violence situations, as part of Higher Education degrees in interpreting.'

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### **Recommendation 13 (2012/13 report)**

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That the Community Relations Commission incorporate into its induction training for all interpreters and translators, a mandatory unit examining the dynamics and behaviours of domestic violence.



**Whole of government response:** Supported

**Lead agency:** Community Relations Commission (now Multicultural NSW)

**Whole of government commentary:** As per whole of government response for Recommendation 12, above.

### Agency update – 2017

Multicultural NSW responded to the Team's monitoring of this recommendation on 12 July 2017 and indicated that:

Multicultural NSW, through the Education Centre Against Violence, conducts up to 8 course every year to train new and existing interpreters and translators on domestic and family violence issues. Multicultural NSW has been conducting this training for many years and is committed to do so in the future.

Multicultural NSW appreciates that the DVDRT recognises the additional barriers during domestic violence screening when using interpreters, and the need for available interpreters who are trained to understand the complexities and dynamics of domestic violence.

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### Recommendation 14 (2012/13 report)

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1. That the Law Society of New South Wales develop and host on its website information to assist practicing solicitors to make appropriate referrals in response to domestic violence disclosures made by clients. Once developed, this information should be publicised in Monday Briefs and the Law Society Journal; and
2. That the Specialist Accreditation Scheme Advisory Committees for Children's Law, Criminal Law, Dispute Resolution and Family Law, include the identification of and response to domestic violence disclosures in the assessments to be set for the Scheme in future years.

**Whole of government response:** Supported

**Lead agency:** NSW Department of Justice to work with Law Society, Specialist Accreditation Scheme Advisory Committees for Children's Law, Criminal Law, Dispute Resolution and Family Law

**Whole of government commentary:** 'The Department of Justice has written to the Law Society seeking its views and a response to the recommendations. The Law Society of NSW provided a response advising the following:

#### Recommendation 14(1)

Legal Aid NSW publishes a factsheet that has information on services that can assist people in domestic violence situations, including contact details for:

- Women's Domestic Violence Court Advocacy Program
- LawAccess NSW
- NSW Police Force
- Department of Community Services Domestic Violence Line
- Mensline · National Disability Abuse and Neglect Hotline
- Safe Relationships Project

The Legal Aid website also includes links to other resources about domestic violence, including domestic and family violence guidelines for lawyers and family violence best practice principles published by the Family Court: <http://www.legalaid.nsw.gov.au/for-lawyers/resources-and-tools/domesticviolence>

Links to the factsheet and the Legal Aid website were published in Monday Briefs on 30 November 2015. The Criminal Law and Family Issues sections of the Law Society's website have also been amended to include these links.

Legal Aid NSW has also written an article for the February 2016 edition of the Law Society Journal about initiatives and services it provides for victims of domestic violence. The Law Society also reproduced the referral factsheet alongside this article.

#### Recommendation 14(2)

The DVDRT's recommendations, and links to the factsheet and other information on the Legal Aid Website, were included in the Specialist Accreditation Newsletter on 11 December 2015. The Newsletter is sent to all practitioners who have obtained accreditation under the scheme.

The following areas of law will be offered as part of the Law Society's 2016 Specialist Accreditation Program:

- Dispute Resolution
- Employment and Industrial Law
- Government and Administrative Law
- Immigration Law
- Local Government and Planning Law
- Personal Injury Law

The assessment for the Dispute Resolution program will be amended to include the identification of and response to domestic violence disclosures in 2016. The assessment for Children's Law, Criminal Law and Family Law will be updated when and if these areas of law are offered as part of the 2017 Specialist Accreditation program.

### **Agency update – 2017**

The Department of Justice responded to the Team's monitoring request in relation to this recommendation on 13 July 2017 and indicated that:

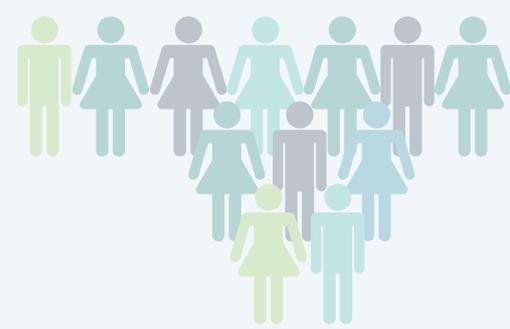
'The information referred to in the previous [whole of government] response 2012-13, continues to be hosted on the Law Society's website. These resources can be accessed at: <http://www.lawsociety.com.au/resources/areasoflaw/index.htm>

In December 2016, the Law Society published Guidelines for Contact with the Complainant in Apprehended Domestic Violence Matters. The Guidelines can be accessed at:

<http://www.lawsociety.com.au/cs/groups/public/documents/internetcontent/008726.pdf>

The Law Society is preparing a Domestic Violence Best Practice Guideline as a resource to practising solicitors to identify and draw attention to some key issues and to make appropriate referrals in response to domestic violence.

As foreshadowed in the previous (Government) response 2012-13, the assessment for Dispute Resolution in 2016 and Children's Law, Criminal Law and Family Law in 2017 all include domestic and family violence.'



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## Recommendation 15 (2012/13 report)

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That the NSW Judicial Commission develop and implement training and guidelines for all NSW judicial officers in relation to domestic and family violence, which:

- a) promotes awareness and understanding in relation to the dynamics of domestic violence and the broad spectrum of relationships that may be characterised by such violence; and
- b) emphasises and supports the use of a common language in relation to domestic violence that does not minimise violence.

**Whole of government response:** Supported

**Lead agency:** NSW Department of Justice, NSW Judicial Commission

**Whole of government commentary:** 'Department of Justice has written to the Judicial Commission seeking their views and response to the recommendations. The NSW Judicial Commission provided a response advising the following:

The Judicial Commission of NSW offers a conference and seminar program for judicial officers in each court, ranging from induction courses for new appointees to specialist conferences. As part of this curriculum, the Commission has been providing special seminars on the topic of domestic and family violence both as stand-alone sessions and part of the conference programs. Presentation of conference papers covering domestic violence, sexual assault and sentencing in domestic violence matters has been a high priority for the Education Committees of each court. This training is focused on assisting judicial officers with keeping up to date with current developments in specific aspects of the law and legal procedure relating to domestic and family violence and also serves to maintain their awareness of continuing developments in dealing with domestic violence in court.

One such example is a seminar entitled "Dealing with domestic violence in court" presented by His Honour Magistrate Leslie Mabbutt and Her Honour Magistrate Vivien Swain, Local Court of NSW on 12th November 2015. This session explored a range of issues relating to domestic violence cases, and took participants through the progress of a case from start to finish, including bail, evidence and service of brief. Another is "Managing AVO applications" presented by Her Honour Magistrate Jaqueline Trad, Local Court of NSW, on 29th April 2015, which explored some of the issues that arise in relation to apprehended violence orders and examined some techniques for the effective and efficient management of applications from first mention to finalisation.

Throughout 2015, efforts have been made to enhance training in the understanding of family violence, its impact on victims and children, and good practice in its management by the court, including judicial commentary. To this end, the Judicial Commission's education program also includes ongoing training and resources in addressing sentencing principles and guidelines. Case studies addressing use of a common language and domestic violence relationship dynamics will be developed for inclusion in the annual Local Court of NSW Magistrates Orientation Program for 2016.

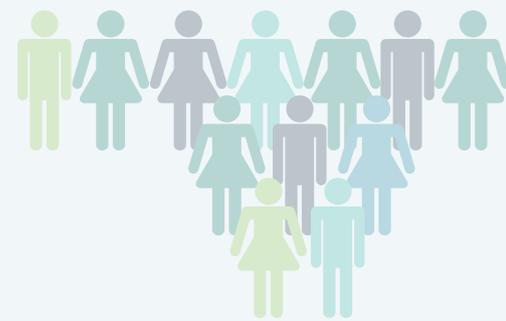
Magistrates have also been, and continue to be, provided with regular training and education in domestic violence through updates to Bench Books relating to legal developments on domestic violence.

To ensure that the Commission is kept abreast of current and emerging issues in this area, the Commission's staff attend various Department of Justice meetings, including those conducted by the Apprehended Violence Legal Issues Coordinating Committee, the DVEC Reforms Monitoring Group and convenors of the Behavioural Insights Domestic Violence Project.

## Agency update – 2017

The Department of Justice responded to the Team’s monitoring request in relation to this recommendation on 13 July and indicated that:

- The Judicial Commission of NSW offers a conference and seminar program for judicial officers in each court, ranging from induction courses for new appointees to specialist conferences. As part of this curriculum, the Commission has been providing special seminars on the topic of domestic and family violence both as stand-alone sessions and part of the conference programs. Presentation of conference papers covering domestic violence, sexual assault and sentencing in domestic violence matters has been a high priority for the Education Committees of each court. This training is focused on assisting judicial officers with keeping up to date with current developments in specific aspects of the law and legal procedure relating to domestic and family violence and also serves to maintain their awareness of continuing developments in dealing with domestic violence in court.
- Magistrates have also been, and continue to be, provided with regular current information about legal developments relating to domestic violence through updates to Bench [sic].
- The Commission researched and published a comprehensive review of sentencing in DV matters, “Sentencing for domestic violence” Sentencing Trends Number 45, June 2016.
- Sentencing Trends Number 46, May 2017 “Common offences in the NSW Local Court 2015” covers common offences with two in the top 20 being family violence related.
- The Commission’s JIRS database has recently been restructured to allow a more comprehensive method of searching, allowing fast access to legislation, case law, bench books and other materials pertaining to family violence.
- The Commission endeavours to ensure all regional programs for the Local Court address the issue of family violence. This has been successful in the offer of two regional programs per annum, one each for Northern and Southern NSW> Articles and publications are regularly provided to judicial officers as another way of keeping them informed and educated.
  - Throughout recent years, efforts have been made to enhance education in the understanding of family violence, its impact on victims and children, and importantly, good practice in its management by the court, including judicial commentary. To this end, the Judicial Commission’s education program also includes ongoing training and significant resources in addressing sentencing principles and guidelines. Case studies addressing use of a common language and domestic violence relationship dynamics will be developed for inclusion in the annual Local Court of NSW Magistrates Orientation Program for 2017.
- Article to be published in the July 2017 Judicial Officers’ Bulletin entitled: What’s language got to do with it” Learning from discourse, language and stereotyping in domestic violence homicide cases by Emma Buxton-Namisnyk and Anna Butler, NSW Domestic Violence Death Review Team.
- A lead article was published in the Judicial Officers’ Bulletin written by Anastasia Krivenkova, Senior Policy Officer, Department of Justice with the assistance of Judicial Commission staff, “New evidentiary procedures for domestic violence complainants.” Published in June 2015, 27(5) Judicial Officers’ Bulletin 39. This article advises about procedural reforms effected by the Criminal Procedure Amendment (Domestic Violence Complainants) Act 2014 (NSW).
- An article was published in the Judicial Officers’ Bulletin “Violence at home is everybody’s business: joint seminar”, published in June 2015, 27(5) Judicial Officers’ Bulletin 44. This is a report of a joint seminar organised by the Judicial Commission, the NSW Bar Association, and the NSW Law Society.



- As there were no new appointments in 2016 the Judicial Commission was unable to hold a Magistrates Orientation Program in that year and so the case studies were unable to be trialled. However there have been 13 new appointees so far in 2017. An Orientation program will be held in late November 2017.'

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### Recommendation 16 (2012/13 report)

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That the Fertility Society of Australia together with the Australian and New Zealand Infertility Counsellors Association and the Fertility Nurses of Australasia, develop a communication strategy which ensures that practitioners providing assisted reproductive services (including doctors, nurses and counsellors) are recognising and providing appropriate referral information to clients who are experiencing or demonstrating domestic violence behaviours.

**Whole of government response:** Supported

**Lead agency:** NSW Health, Fertility Society of Australia, ANZICA, Fertility Nurses of Australia

**Whole of government commentary:** 'NSW Kids and Families will contact the Fertility Society of Australia, the Australian and New Zealand Infertility Counsellors Association and the Fertility Nurses of Australasia in the first half of 2016 to discuss the potential for implementing domestic violence routine screening into assisted reproductive services and to highlight the resources available through NSW Health relating to domestic and family violence (including z-cards).'

### Agency update – 2017

NSW Health responded to the Team's monitoring of this recommendation on 2 August 2017 and indicated that:

'NSW Health wrote to the peak body, the Fertility Society of Australia, in 2016 regarding this recommendation and offering support to implement this recommendation. This offer has not been responded to. PARVAN will follow up with the peak body before... [sic].'

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### Recommendation 17 (2012/13 report)

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In order to facilitate the implementation of Recommendation 10 from the NSW Domestic Violence Death Review Team's 2011/12 Annual Report, it is recommended that the Office of Communities (DEC) expand the Tackling Violence program into five new regional locations.

Tackling Violence is a successful and evaluated education and prevention program that uses regional rugby league clubs to deliver anti domestic violence messages.

A model for implementing Tackling Violence in the western suburbs of Sydney - for possible further expansion in other Sydney metro areas - should also be developed.

This work should be undertaken in partnership with key stakeholders including local councils, sporting and voluntary groups and Aboriginal communities.

The Office of Communities should co-ordinate with Women NSW to promote the positive evaluation findings from this initiative.

**Whole of government response:** Supported

**Lead agency:** Department of Education and Communities

**Whole of government commentary:** 'The Tackling Violence program is now part of Women NSW. In 2011/12 there were 21 teams in the Tackling Violence program. The program grew to 28 clubs in 2014 including two metropolitan clubs (Redfern All Blacks and East Campbelltown Eagles).

The program was evaluated again in 2014 by Eva Cox and Jumbunna House of Indigenous Learning and recommended for continuation and expansion.

In 2015, the Commonwealth Government funding ceased, reducing the number of clubs, schools and communities from 28 to 19. The localised regional TV advertising campaign, which featured local men from the footy clubs, was also reduced from six regional ads to one statewide ad.

The program curriculum is comprehensive and includes discussion about what domestic and family violence is, who it affects, what the law is, what a domestic and family violent relationship looks like, healthy relationships, bystanders and how to get help or help someone you know.

More than 50 per cent of player participants are Aboriginal.'

## Agency update – 2017

Family and Community Services responded to the Team's monitoring of this recommendation on 26 July 2017 and indicated that:

'Women NSW now commissions the Education Centre Against Violence (ECAV) to deliver Tackling Violence. This arrangement was entered into in March 2017. Since the time of this recommendation the program has expanded into an additional 14 regional locations.

Under its arrangement with Women NSW, ECAV is required to provide evaluation and outcome reports to Women NSW and the Department of Premier and Cabinet. Since its inception in 2009 Tackling Violence has been regularly evaluated, with positive results in relation to attitude and behaviour change.'

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## Recommendation 18 (2012/13 report)

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That, as part of the Aboriginal Child Youth and Family Strategy, FACS develops and implements a trauma-informed parenting program aimed at educating and supporting Aboriginal fathers. Consideration could be given to co-ordinating with the Office of Community Services for rollout of this program through the initiative discussed in Recommendation 17.

**Whole of government response:** Supported

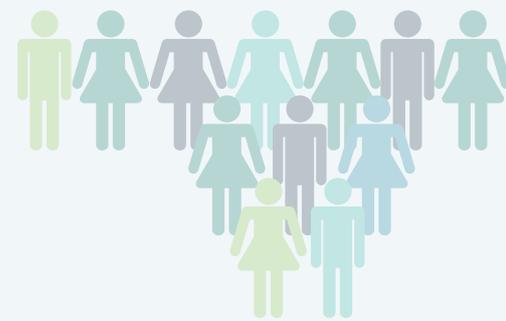
**Lead agency:** Family and Community Services, Department of Education and Communities

**Whole of government commentary:** 'The NSW Aboriginal Child, Youth and Family Strategy (ACYFS) is a prevention and early intervention strategy that aims to provide Aboriginal families with children the best start in life.

The strategy has a particular focus on supporting Aboriginal families expecting a baby or with children aged up to five years. Current activities include parenting programs, supported playgroups, capacity building.

In addition, the Aboriginal Child and Family Centres (ACFCs) provide integrated and culturally appropriate targeted services to Aboriginal children, families and communities. Services include Parenting and Family Support, Parent/family information resources, parenting and family skills development, counselling services and other related activities.

FACS (Families and Place) will undertake consultation with appropriate stakeholders to ascertain the appropriateness – both procedurally and culturally – about the development of a targeted trauma-informed parenting program aimed at Aboriginal fathers. Consultation will be enhanced with an appropriate scoping exercise to identify existing services, needs analysis and other elements to complement the development of such a program.'



## Agency update – 2017

Family and Community Services responded to the Team’s monitoring of this recommendation on 26 July 2017 and indicated that:

‘The NSW Aboriginal Child, Youth and Family Strategy (ACYFS) is a prevention and early intervention strategy that aims to provide Aboriginal families with children the best start in life.

The strategy focussed on supporting Aboriginal families expecting a baby or with children aged up to five years. Current activities include parenting programs, supported playgroups, capacity building. In 2015/16, 116 families attended ACYF funded parenting programs. While specific data was not collected on fathers experiencing trauma, ACYFS identified that 36% of regular carers that attended parenting programs were fathers, and a further 38% were occasional carers. One hundred percent of parents surveyed reported an improved relationship with their children since attending the parenting program.

In addition, the Aboriginal Child and Family Centres (ACFCs) provide integrated and culturally appropriate targeted services to Aboriginal children, families and communities. Services include Parenting and Family Support, Parent/family information resources, parenting and family skills development, counselling services and other related activities.

As part of the Targeted Earlier Intervention Reforms FACS is currently consulting with AbSec to identify and support the development of culturally appropriate and evidence informed parenting programs for parents with high needs, including targeted trauma-informed parenting programs aimed at Aboriginal fathers.

The ACYFS program, and its activities, will be incorporated in the new TEI program commencing 1 July 2018.’

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## Recommendation 19 (2012/13 report)

That the NSW DEC homepage be updated to ensure clear and accessible links to domestic violence and referral information is available, aimed at both:

- a) students, if they are experiencing or exposed to domestic violence within the home, and/or they are aware that someone they know is being exposed to or experiencing domestic violence; and
- b) parents, if they are experiencing domestic violence.

**Whole of government response:** Supported

**Lead agency:** Department of Education and Communities

**Whole of government commentary:** ‘Supported and completed’.

## Agency update – 2017

No further update.

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## Recommendation 20 (2012/13 report)

That NSW Health, DEC and NSW Department of Attorney General and Justice co-ordinate to prioritize the provision of domestic violence information (including referral information) on their various intranet home pages through an easily accessible portal. It is suggested that these agencies work in connection with Women NSW to formulate each information and referral portal, or link to the following portal: [www.domesticviolence.nsw.gov.au](http://www.domesticviolence.nsw.gov.au). This should be undertaken as a priority within the next 12 months.

**Whole of government response:** Supported

**Lead agency:** NSW Health, Department of Education and Communities, NSW Department of Justice, Family and Community Services

**Whole of government commentary:** ‘Supported and completed’.

### Agency update – 2017

Family and Community Services responded to the Team’s monitoring of this recommendation on 26 July 2017 and indicated that:

‘There are clear links to information on DFV, including referral information, on the FACS intranet page.

Based on the 2012-2013 whole of government response for other agencies listed as lead agencies for this recommendation, it is confirmed that they have also implemented this recommendation.’

NSW Health responded to the Team’s monitoring of this recommendation on 9 August 2017 and indicated that:

‘The NSW Health internet has been updated (available at: <http://www.health.nsw.gov.au/kidsfamilies/protection/Pages/default.aspx>).

A NSW Health domestic violence focussed intranet portal is currently under construction and will be launched alongside the revised Domestic and Family Violence Standards and Guidelines.’

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### Recommendation 21 (2012/13 report)

That Family and Community Services develop, incorporate and prioritise on the Seniors Card NSW website a module outlining information about domestic violence including intimate partner violence and elder abuse (including referral information).

**Whole of government response:** Supported

**Lead agency:** Family and Community Services

**Whole of government commentary:** ‘NSW Seniors Card has recently released a new website that is focused on pulling together content to better inform seniors in NSW and will be dedicating a page under the Health section of the new website called Personal and Family Safety that will include information on domestic and family violence including partner and elder abuse, this will also include referral information to assist seniors.’

### Agency update – 2017

FACS responded to the Team’s monitoring of this recommendation on 26 July 2017 and indicated that:

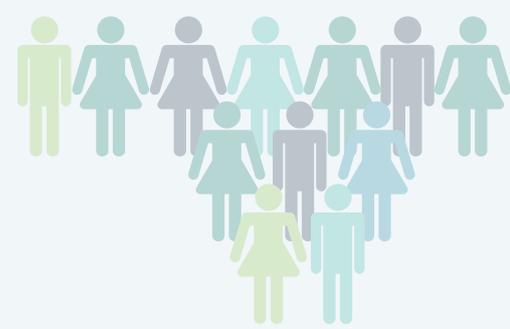
‘Since March 2013 the Elder Abuse Helpline and Resource Unit is the main source of information on DFV involving older people and elder abuse.

The Seniors Card website contains a link to the Helpline at <http://www.seniorscard.nsw.gov.au/governmentinformation/family-and-community-services/inquiry-intoelder-abuse> and regularly advertises the Helpline in e-newsletters, the annual Discount Directory and on the website.’

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### Recommendation 22 (2012/13 report)

That the NSW Steering Committee on the Prevention of Abuse of Older People, through Women NSW, report to the NSW Domestic Violence Death Review Team in relation to the use of the NSW Elder Abuse Helpline and Resource Unit.



This information should be contained in a report which includes:

- a) demographic information of users;
- b) nature of enquiry/service being sought;
- c) any details of the abuse being experienced (including relationship); and
- d) outcomes and referrals made in each case.

**Whole of government response:** Supported

**Lead agency:** Women NSW

**Whole of government commentary:** 'The NSW Steering Committee on the Prevention of Abuse of Older People was convened as a time-limited committee. Women NSW will work with the NSW Elder Abuse Helpline and Resource Unit to develop a report.'

### Agency update – 2017

Family and Community Services responded to the Team's monitoring of this recommendation on 26 July 2017 and indicated that:

'The Steering Committee for the Prevention of Elder Abuse was reconstituted by the Interdepartmental Committee on Ageing on 16 June 2017.'

Women NSW has been added to the membership and this information will be progressed through that forum. The first Steering Committee is being held on 26 July 2017.'

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### Recommendation 23 (2012/13 report)

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That the Cancer Institute (NSW Health), in consultation with NSW Kids and Families (NSW Health), co-ordinate the distribution of domestic violence information to every woman in NSW who has a mammogram.

**Whole of government response:** Supported

**Lead agency:** NSW Health (Cancer Institute, NSW Kids and Families)

**Whole of government commentary:** 'NSW Kids and Families will liaise in 2015/16 with the Cancer Institute, NSW Health, to support the recommendation that all women in NSW receiving a mammogram safely receive information relating to domestic and family violence.'

NSW Kids and Families notes that this will likely be in the form of the provision of Domestic Violence z-cards produced by ECAV, and note that there will be a cost impact incurred as a result of the increased distribution.

BreastScreen NSW has recognised there are several health and social issues that are pertinent to older women and for which BreastScreen NSW may be a channel for the provision of information. BreastScreen NSW is in the process of working with its Screening and Assessment Services to develop a policy on the passive dissemination to BreastScreen NSW clients of health-related information that is not directly related to breast cancer.

The policy is necessarily one of passive dissemination, as BreastScreen staff do not have the skills or training to provide advice on health and social matters that do not pertain to breast cancer screening, or to respond to enquiries on such issues. The policy will include formal referral pathways, to ensure BreastScreen NSW staff can refer women to appropriate services. It will also contain principles for evaluating materials and information to ensure they are of a high standard and do not produce unintended consequences, such as increasing the anxiety of women attending screening or assessment or deterring women from participating in the program.

As domestic violence has been identified as a national and state priority, it would be appropriate to include it within the policy.

However, it should be noted that only 51% of the 50-74 year old NSW population currently routinely participates in the program. In addition, victims of domestic violence may be less inclined to utilise community health services than other women, which may further limit the potential for BreastScreen to provide this group with information.'

### **Agency update – 2017**

NSW Health responded to the Team's monitoring of this recommendation on 2 August 2017 and indicated that:

'PARVAN notes that this action is incomplete and that sign off on actioning this item is currently pending sign off procedures. Action is due to be completed by August 2017.'

## **2011-2012 DVDRT Report**

The Team's 2011-12 Report was tabled in NSW Parliament in October 2012 and made 14 recommendations to a range of government agencies. The whole of government response in relation to the report was received in May 2013. Detail of the whole of government response is set out in the Team's 2012/13 Report at pages 35-49.

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### **Recommendation 1 (2011/12 report)**

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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.

**Whole of government response:** Supported

**Lead agency:** NSW Department of Justice

### **Agency update – 2017**

Recommendation completed and implemented by amendments to the Coroners Act 2009 (NSW) in 2013.

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### **Recommendation 2 (2011/12 report)**

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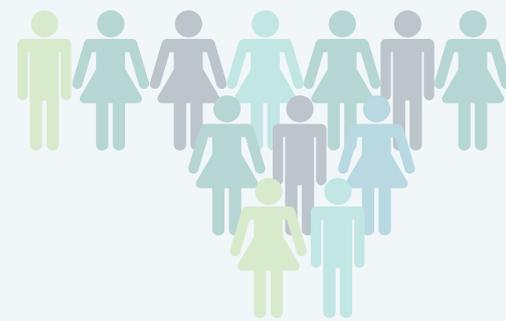
That section 101C(1)(d) of the Coroners Act 2009 (NSW) be amended to omit the words and there have been previous episodes of domestic violence between them.

**Whole of government response:** Supported

**Lead agency:** NSW Department of Justice

### **Agency update – 2017**

Recommendation completed and implemented by amendments to the Coroners Act 2009 (NSW) in 2013.



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### Recommendation 3 (2011/12 report)

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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).

**Whole of government response:** Supported

**Lead agency:** NSW Department of Justice

#### Agency update – 2017

Recommendation completed and implemented by amendments to the Coroners Act 2009 (NSW) in 2013.

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### Recommendation 4 (2011/12 report)

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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.

**Whole of government response:** Supported

**Lead agency:** NSW Police Force

#### Agency update – 2017

NSWPF responded to the Team's monitoring of this recommendation on 9 August 2017 and indicated that:

'The NSWPF has incorporated this recommendation into our DV SOPs. This recommendation was difficult to implement as our standard DV event structure did not support such records being made. Any change to the 'Event' structure within WebCops is difficult and expensive due to the relative antiquity of the base system.

The DV Team researched the options and the result is that such reports were mandated to be contained in our Intelligence based system within WebCops. This requirement was communicated to the field by:

1. Communicating directly with our DVLOs, RDVCs, Education and Training specialists and Region Sponsors.
2. Communicating to operational police utilising the statewide messaging system; 'nemesis'.
3. Anna Butler from the DVDRT Secretariat presented on these recommendations for 2011-2012 at the 2013 DVLO Conference.'

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### Recommendation 5 (2011/12 report)

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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)?

**Whole of government response:** Supported

**Lead agency:** NSW Police Force

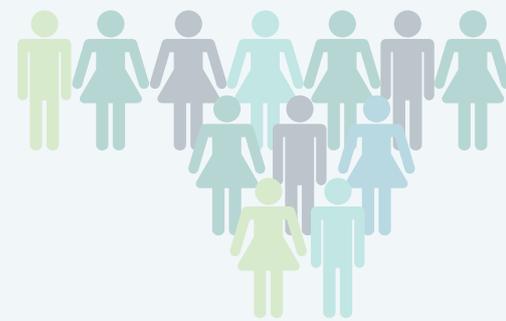
### Agency update – 2017

NSWPF responded to the Team’s monitoring of this recommendation on 9 August 2017 and indicated that:

‘At the time of the receipt of these recommendations, the NSWPF was already working with our government partners to develop the DVSAT and the DVSAT that was ultimately adopted for operational use statewide in July 1, 2015 and contains 25 questions including (disregard the numbering):

1. Has your partner ever threatened to harm or kill you?
2. Has your partner ever used physical violence against you?
3. Has your partner ever choked, strangled, suffocated you or attempted to do any of these things?
4. Has your partner ever threatened or assaulted you with any weapon (including knives and/or objects)?
5. Has your partner ever harmed or killed a family pet or threatened to do so?
6. Has your partner ever been charged with breaching an apprehended domestic violence order?
7. Is your partner jealous towards or controlling of you?
8. Is the violence or controlling behaviour becoming worse or more frequent?
9. Has your partner stalked or constantly harassed or texted/e-mailed you?
10. Does your partner control your access to money?
12. Does your partner or the relationship have financial difficulties?
14. Does your partner have mental health problems (including undiagnosed conditions) and/or depression?
16. Has your partner ever threatened or attempted suicide?
17. Is/has your partner currently on bail, parole, served a time of imprisonment or has recently been released from custody in relation to offences of violence?
22. Is there any conflict between you and your partner regarding child contact or residency issues and/or current Family Court proceedings?
23. Are there children from a previous relationship present in the household?

The DVSAT was developed independently of the DVDRT recommendation and was expensive and difficult to implement. The DV Team made a conscious decision not to implement (f) asking the perpetrator- as it was considered that the most accurate information would be sourced from the victim and that the additional checklist question would be duplicitous for police. The DVSAT is now business as usual for NSWPF and our partnerships with the agencies who receive these referrals- Victim Services and Women’s Domestic Violence Advocacy Program – is very effective.’



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## Recommendation 6 (2011/12 report)

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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.

**Whole of government response:** Supported

**Lead agency:** NSW Police Force

### Agency update – 2017

NSWPF responded to the Team's monitoring of this recommendation on 9 August 2017 and indicated that:

'The above recommendations are related and the following responses are provided for both recommendations:

- The current DV SOPs (2012) contain guidelines for police to use when dealing with victims who decline to make statements or engage with the investigative process.
- The NSWPF has rolled out DV Clinics across the state to support and empower women who are victims of DV and are facing the prospect of giving evidence in a defended hearing for either criminal matters or ADVO applications, and who may be reluctant to pursue the legal pathway. DV Clinics offer education/information and practical tips as to how to deal with giving evidence and undergoing cross examination. Very positive feedback has been received from victims and prosecutors as to the effectiveness of DV Clinics.
- The NSWPF developed a video resource- "Your Time to be Heard"- that has been supplied to women's court support groups to assist in educating and supporting women who cannot attend a DV Clinic and who may be reluctant to pursue the legal pathway. This cost \$40,000 as it was also translated into four different languages and is available for playing at DV list days.
- The DVSAT has been developed and the preamble has the following wording that is relevant to alerting the victim to the risks of harm when the risk identification questions are asked:
- **"Preamble:** I'm going to ask you a number of questions that relate to identifying the risk of future harm of domestic violence. Your answers will help us to assess your safety needs and your details will be provided to a specialist domestic violence service who will contact you."
- The NSWPF developed, printed and supplied DV victim referral cards to all Local Area Commands to be used by operational police and left at every DV incident they attend. A communication campaign to the field and DVLOs supported the implementation of these recommendations. There was (and is ongoing) significant cost in the printing and supply of these cards.

These recommendations were implemented with variable levels of difficulty and cost. To a large degree the subsequent development of the DVSAT has made the victim referral card somewhat obsolete.

There have been a number of educational packages made available to the organisation in relation to addressing the DVDRT recommendations- particularly in relation to recommendation 9 (2013-15) and recommendation 1 and 6 (2012-13). The packages (below) consist of one MCPE in this time frame (2011 - 2015) and a number of SMITS and PIPJ articles.

## **Mandatory Continuing Police Education and Training for 2013-2014 included the:**

Investigation of Domestic & Family Violence Offences (core program) -1314/1. This training was mandatory for all operational police and delivered face to face

## **Policing Issues in Practice Journal published the following relevant articles:**

Through a Victim's Eyes July 2011

Domestic Violence - Part 1: Attitudes and Assaults Sep/Dec 2013

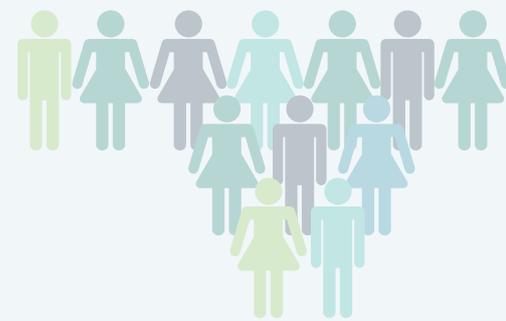
Domestic Violence - Part 2: Investigative Issues Sep/Dec 2013

Domestic Violence Part 3 - Contemporaneous Notes and Statements July/Sep 2014

Domestic Violence Part 4 - ADVOs July/Sep 2014

**Six Minute Intensive Training sessions (SMITs)** refers to short refresher training delivered by way of a discussion of scenarios at the beginning of shifts at Local Area Commands. The following SMITs are relevant:

- OP001 - Provisional Apprehended Domestic Violence Orders
- OP002 – Non Urgent Domestic Violence Orders
- OP005 – Domestic Seizing Firearms
- OP006 – Domestic (Breach AVO)
- OP007 – Domestic Violence - No Offence
- OP008 - DV Action or No Action?
- OP009 - Response to a DV Offender
- OP010 - Response to a DV Offender
- OP011 - Domestic Violence Intimidation
- OP014 - Identifying the Primary Victim in a DV Incident
- OP020 - Updating final service details of ADVOs in CNSM
- OP026 - Police Issued ADVO
- OP027 - Police Issued ADVO 2 - considerations giving directions
- OP028 - Police Issued ADVO 3 - form of direction and safeguards
- OP029 - Police Issued ADVO 4 - direction to remain at police station
- OP030 - Police Issued ADVO 5 - refusal of direction to remain at police station
- OP031 - Police Issued ADVO 6 - senior officer considerations
- OP032 - Police Issued ADVO 7 - who can determine application for provisional order
- OP033 - Police Issued ADVO 8 - property recovery
- OP034 - Police Issued ADVO 9 - order to be made by Central Justice Panel
- OP035 - Police Issued ADVO 10 - conditions to place on order defendant under 16
- OP036 - Police Issued ADVO 11 - detention vs. arrest
- OP039 - Domestic Violence Evidence in Chief (DVEC) - Victim affected by alcohol/drug
- OP040 - Domestic Violence Evidence in Chief (DVEC) - Interview Structure
- OP041 - Domestic Violence Evidence in Chief (DVEC) - Service of DVEC on defendant
- OP042 - Domestic Violence Evidence in Chief (DVEC) - NO DV offence detected
- OP043 - Domestic Violence Evidence in Chief (DVEC) - Presence of Children
- OP044 - Domestic Violence - Choking, suffocation and strangulation



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### Recommendation 7 (2011/12 report)

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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.

**Whole of government response:** Supported

**Lead agency:** NSW Police Force

#### Agency update – 2017

See above.

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### Recommendation 8 (2011/12 report)

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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.

**Whole of government response:** Not Supported

#### Agency update – 2017

No agency update as recommendation was not supported.,

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### Recommendation 9 (2011/12 report)

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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.

**Whole of government response:** Supported

**Lead agency:** Family and Community Services

#### Agency update – 2017

Family and Community Services responded to the Team's monitoring of this recommendation on 26 July 2017 and indicated that:

'The NSW Government convened the NSW Steering Committee on the Prevention of Abuse of Older People. Membership included the Ministerial Advisory Committee on Ageing.

The Committee developed the Elder Abuse Helpline and Resource Unit which commenced in March 2013.'

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## Recommendation 10 (2011/12 report)

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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.

**Whole of government response:** Supported

**Lead agency:** Family and Community Services (Women NSW)

## Agency update – 2017

See update above from FACS in relation to Recommendation 8 of the 2013/15 Report.

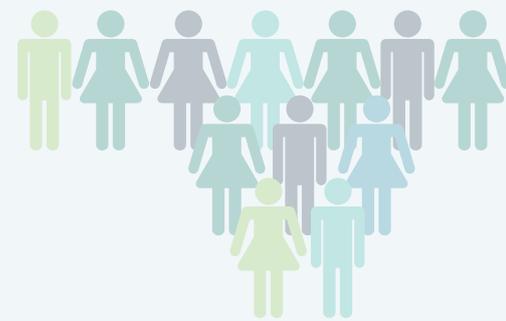
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## Recommendation 11 (2011/12 report)

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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.

**Whole of government response:** Supported

**Lead agency:** Family and Community Services (Women NSW)

### Agency update – 2017

FACS responded to the Team’s monitoring of this recommendation on 26 July 2017 and indicated that:

‘The NSW Government, together with the other states and territories and the Commonwealth, provides annual funding to the Australia’s National Research Organisation for Women’s Safety (ANROWS). In its 2016-2017 Budget the NSW government specifically committed an additional \$2.2 million to ANROWS in relation to research into domestic violence and reducing violence against women and their children.

In January 2016 ANROWS published the Existing knowledge, practice and responses to violence against women in Australian Indigenous communities: State of knowledge and Key findings and future directions papers, which examines Indigenous women’s experiences of DFV.’

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### Recommendation 12 (2011/12 report)

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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.

**Whole of government response:** Supported

**Lead agency:** Family and Community Services (Women NSW)

### Agency update – 2017

Family and Community Services responded to the Team’s monitoring of this recommendation on 26 July 2017 and indicated that:

‘This recommendation was reframed as recommendation 13 of the 2013-2015 Annual Report:

That the Minister for Domestic and Family Violence convene an interfaith roundtable within the next 12 months with a view to progressing recommendation 12 of the Team’s 11/12 Report.

While there was some delay to convening the Interfaith Roundtable it was held on 18 July 2017 at Parliament House.

The roundtable was attended by the Minister for the Prevention of Domestic Violence and Sexual Assault, the NSW State Coroner, and faith leaders. A discussion regarding the role that faith leaders can play in the prevention, identification and response to domestic and family violence was facilitated by Dr Norman Swan.’

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### **Recommendation 13 (2011/12 report)**

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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.

**Whole of government response:** Supported

**Lead agency:** Family and Community Services (Women NSW)

### **Agency update – 2017**

Family and Community Services responded to the Team’s monitoring of this recommendation on 26 July 2017 and indicated that:

‘The NSW government has written to the Department of Immigration and Citizenship, as the Department of Immigration and Border Protection was previously known, to encourage the development of appropriate training for officers in relation to DFV, particularly in an immigration context. We understand that officers now receive training in relation to how to respond in situations of DFV, including guidance about the interaction of DFV and visa status.’

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### **Recommendation 14 (2011/12 report)**

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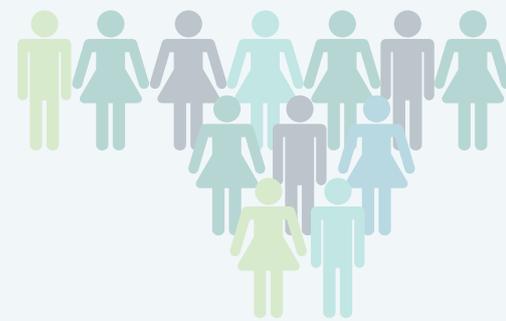
That the Department of Family and Community Services – Housing NSW remind operational staff to inform tenants of domestic violence services, where appropriate, when they become aware of domestic or family violence occurring within a public housing property.

**Whole of government response:** Supported

**Lead agency:** Family and Community Services (Housing)

### **Agency update – 2017**

FACS responded to the Team’s monitoring of this recommendation on 26 July 2017 and indicated that:

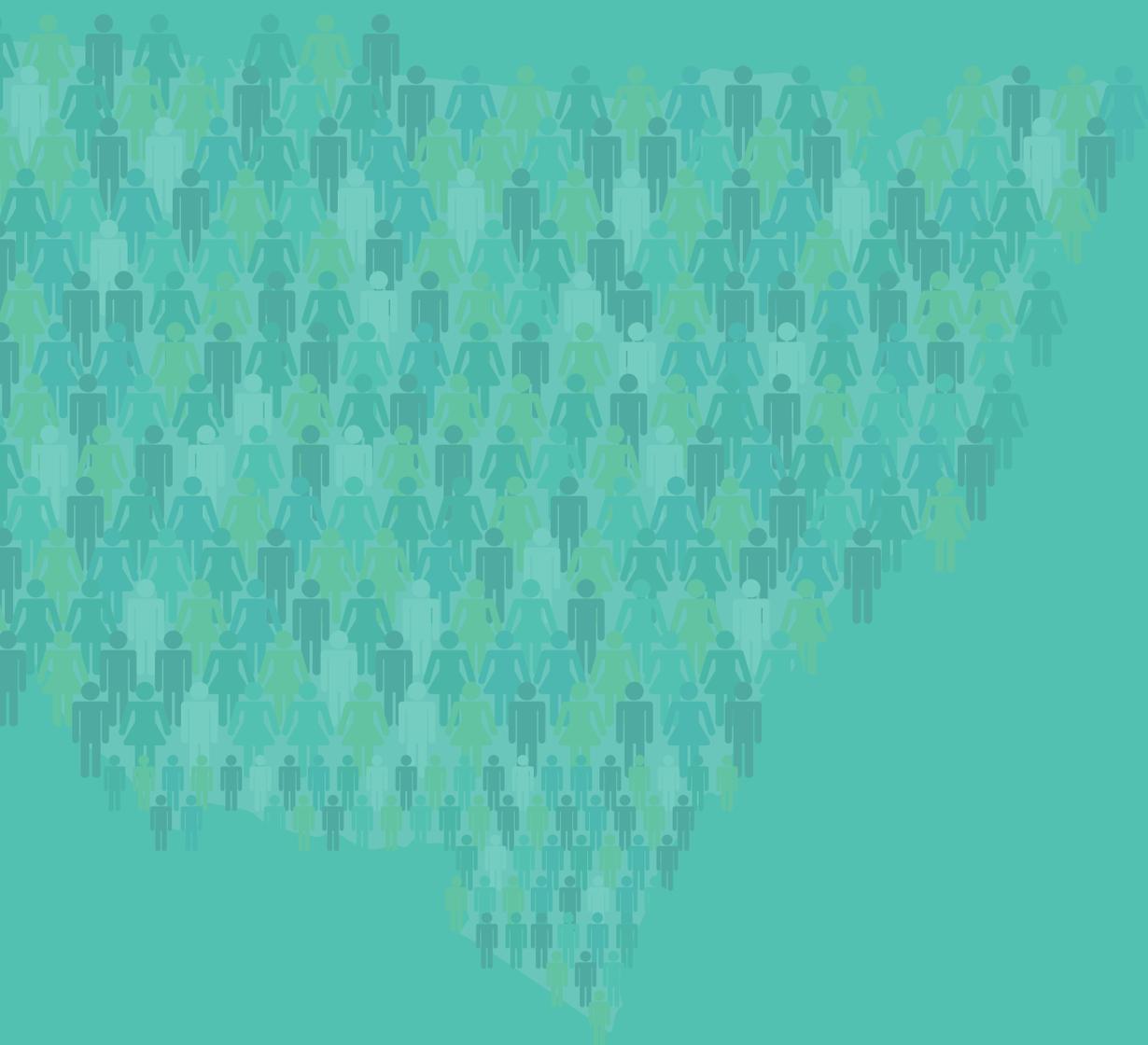


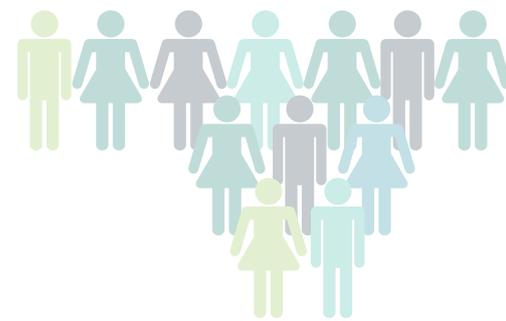
'In 2013, Housing NSW issued a notice to remind Housing NSW staff of their responsibility to recognise indicators of domestic violence and make referrals to local domestic violence services where appropriate. The notice included information about Staying Home Leaving Violence, child protection and how to make referrals.

In 2015, FACS-Housing issued a notice to remind all FACS-Housing staff of their responsibility to recognise and respond appropriately to clients who present with indicators of domestic and family violence and make referrals to domestic violence services. The notice included information about Safer Pathway, child protection, Staying Home Leaving Violence and how to make appropriate referrals.'

# Appendix A:

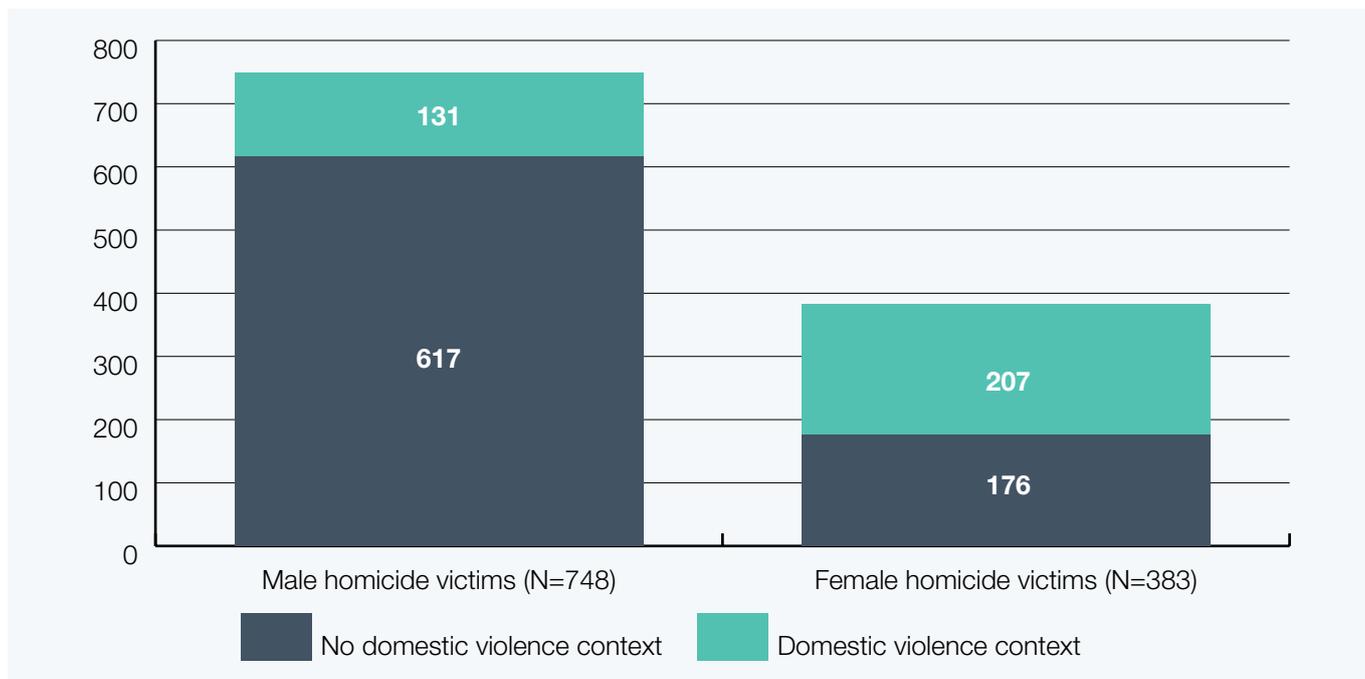
**Domestic Violence Homicide  
in NSW, 2000-2014**





## Homicide in NSW, 2000-2014

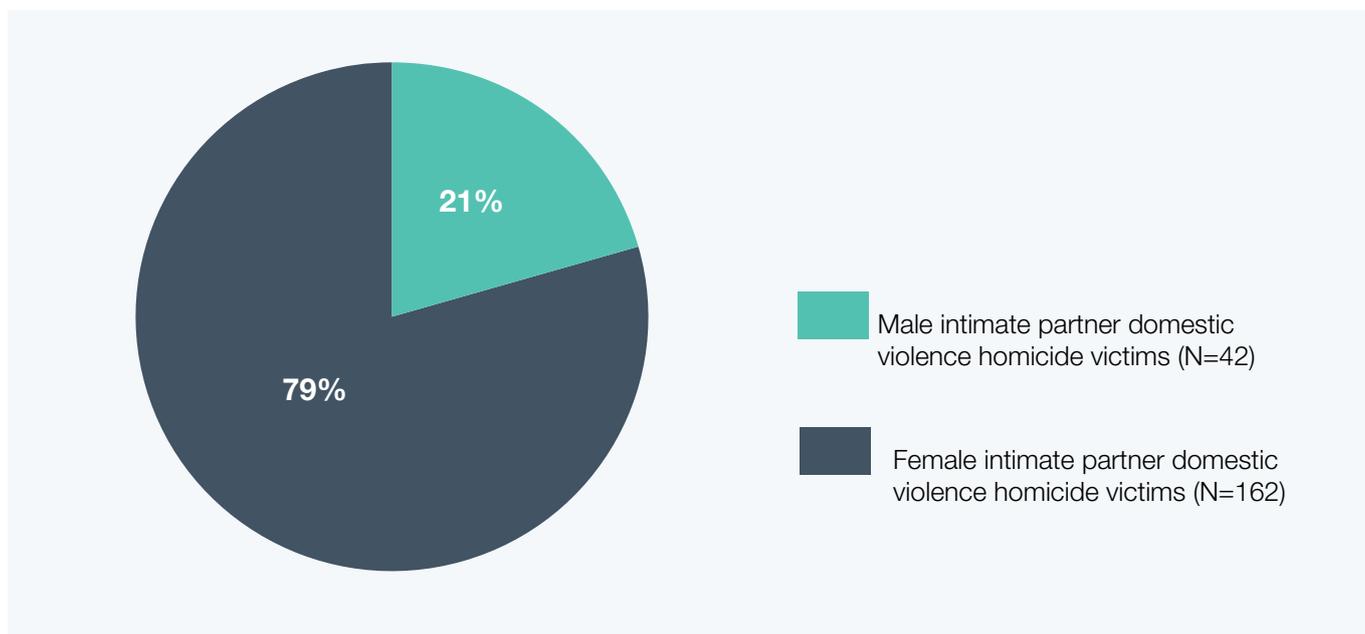
**FIGURE 1:** All homicide victims by domestic violence context, NSW, 2000-2014\*



\*There was one transgender homicide victim and that victim was not killed in domestic violence context

## Intimate partner domestic violence homicide, NSW, 2000-2014

**FIGURE 2:** Intimate partner domestic violence homicide victims by gender, NSW, 2000-2014



**FIGURE 3:** Relationship of homicide perpetrator to female intimate partner domestic violence homicide victim, NSW, 2000-2014

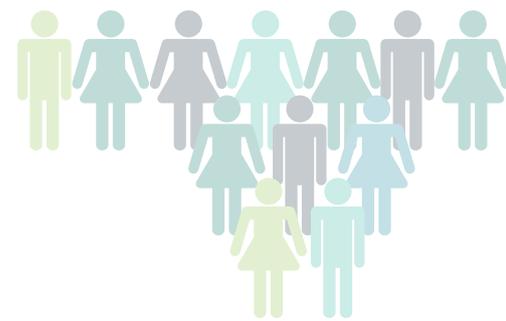
Relationship type	Female intimate partner homicide victim	%
De Facto Husband	47	29%
Husband	45	28%
Boyfriend	9	6%
Divorced/Estranged Ex Husband	26	16%
Former De Facto Husband	23	14%
Former Boyfriend	11	7%
3rd Party To Intimate Relationship	1	1%
<b>TOTAL</b>	<b>162</b>	<b>100%</b>

**FIGURE 4:** Intimate partner homicide victim by victim/abuser status in relationship, NSW, 2000-2014

Domestic violence 'status'	Male intimate partner homicide victim	Female intimate partner homicide victim
Primary Domestic Violence Victim	7*	159
Primary Domestic Violence Abuser	31	0
Evidence Of Violence And Abuse Used By Both Parties	3	3
Neither Domestic Violence Victim Nor Abuser	1#	0
<b>TOTAL</b>	<b>42</b>	<b>162</b>

\* All 7 male intimate partner homicide victims who had been the primary domestic violence victims in the life of the relationship were killed by a male intimate partner.

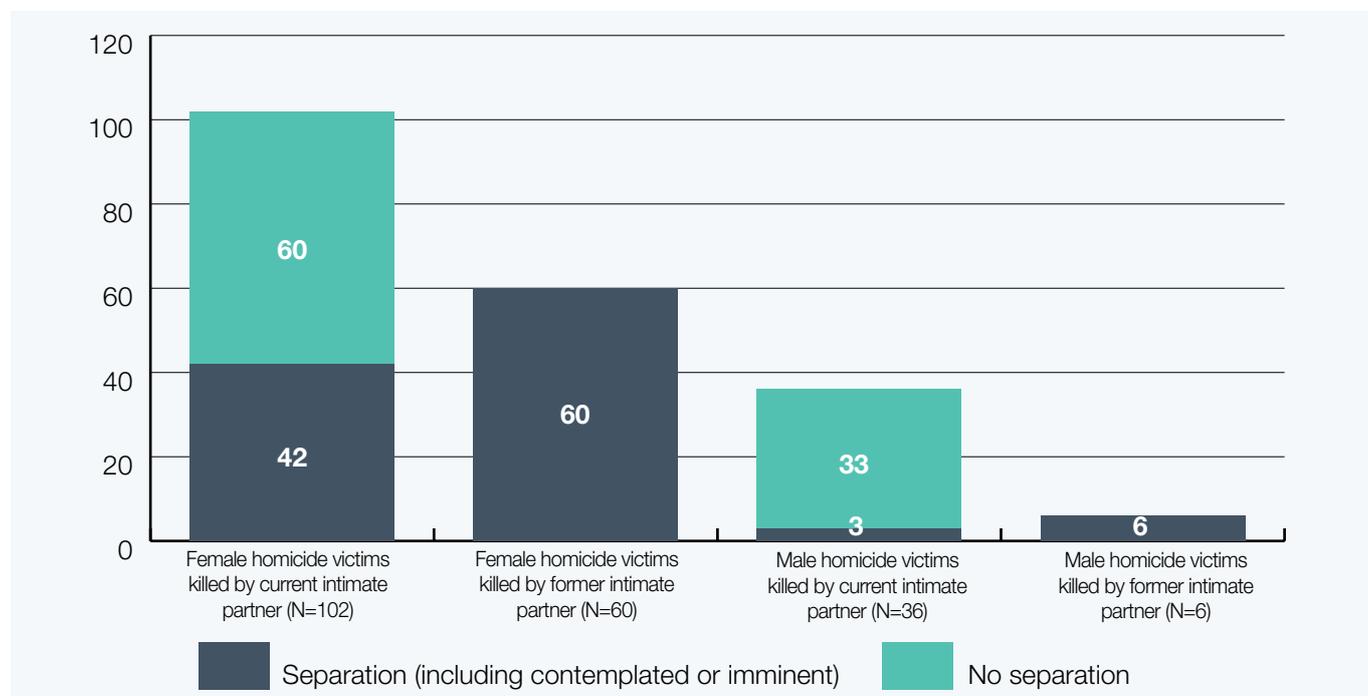
# One male was the extramarital intimate partner of a woman and was killed by her and her abusive husband acting together.



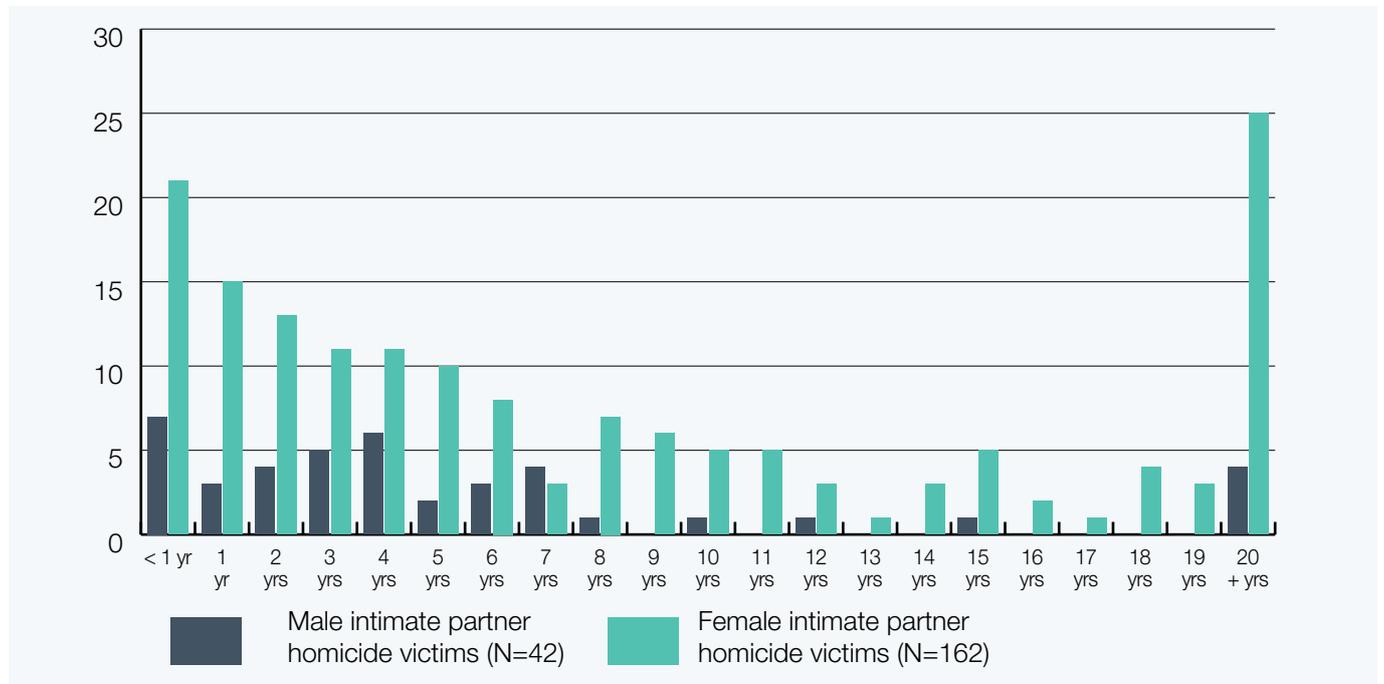
**FIGURE 5:** Relationship of homicide perpetrator to male intimate partner homicide victim, NSW, 2000-2014

Relationship type	Male intimate partner homicide victim (N=36)	%
De Facto Wife	22	52%
Wife	5	12%
Girlfriend	2	5%
De Facto Husband	4	10%
Boyfriend	2	5%
Divorced/Estranged Wife	2	5%
Former De Facto Wife	2	5%
Former Girlfriend	1	2%
Former Boyfriend	1	2%
3rd Party to Intimate Relationship	1	2%
<b>TOTAL</b>	<b>42</b>	<b>100%</b>

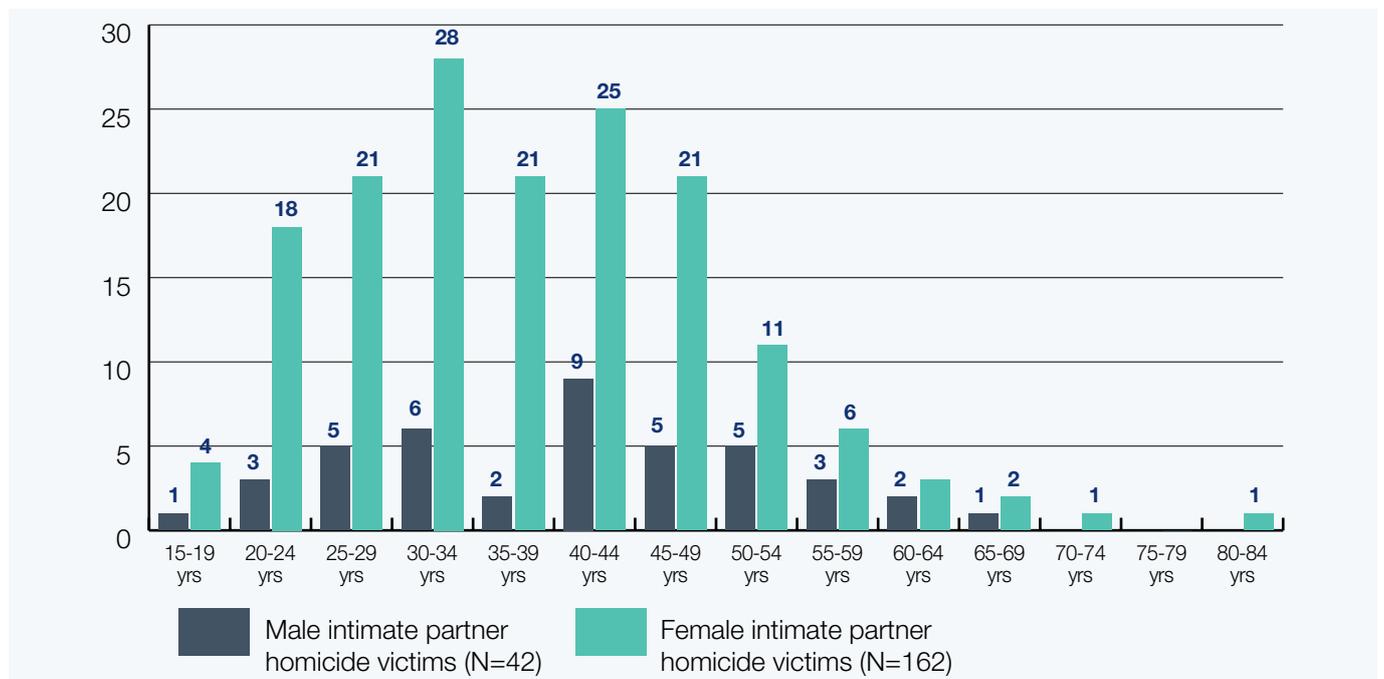
**FIGURE 6:** Intimate partner domestic violence homicide victim by relationship separation, NSW, 2000-2014

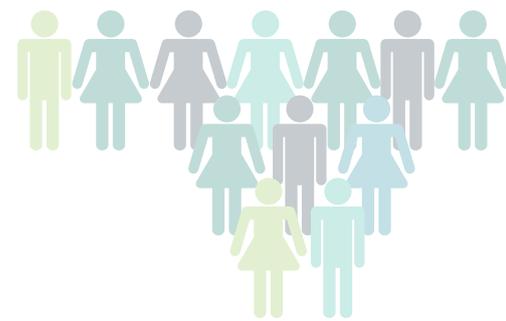


**FIGURE 7:** Intimate partner domestic violence homicide victim by relationship length, NSW, 2000-2014



**FIGURE 8:** Age of intimate partner domestic violence homicide victim, NSW, 2000-2014





**FIGURE 9:** Map of NSW Police Regions and Local Area Commands



**1 CENTRAL METROPOLITAN REGION**

- Botany Bay LAC
- Eastern Beaches LAC
- Eastern Suburbs LAC
- Harbourside LAC
- Kings Cross LAC
- Leichhardt LAC
- Miranda LAC
- Newtown LAC
- Redfern LAC
- Rose Bay LAC
- St George LAC
- Surry Hills LAC
- Sutherland LAC
- Sydney City LAC

**2 NORTH WEST METROPOLITAN REGION**

- Blacktown LAC
- Blue Mountains LAC
- Hawkesbury LAC
- Holroyd LAC
- Kuring Gai LAC
- Mount Druitt LAC
- North Shore LAC
- Northern Beaches LAC
- Parramatta LAC
- Penrith LAC
- Quakers Hill LAC
- Ryde LAC
- St Marys LAC
- The Hills LAC

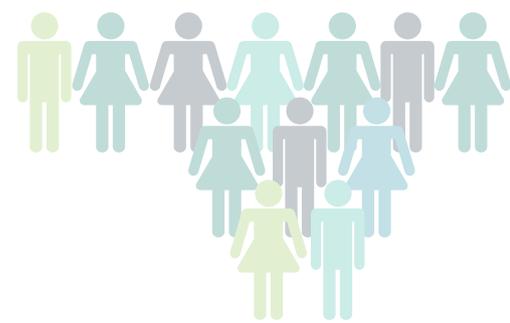
**3 SOUTH WEST METROPOLITAN REGION**

- Ashfield LAC
- Bankstown LAC
- Burwood LAC
- Cabramatta LAC
- Camden LAC
- Campbelltown LAC
- Campsie LAC
- Fairfield LAC
- Flemington LAC
- Green Valley LAC
- Liverpool LAC
- Macquarie Fields LAC
- Marrickville LAC
- Rosehill LAC

4 SOUTHERN REGION	5 NORTHERN REGION	6 WESTERN REGION
Albury LAC	Brisbane Water LAC	Barrier LAC
Cootamundra LAC	Central Hunter LAC	Barwon LAC
Deniliquin LAC	Coffs-Clarence LAC	Canobolas LAC
Far South Coast LAC	Hunter Valley LAC	Castlereagh LAC
Griffith LAC	Lake Macquarie LAC	Chifley LAC
Lake Illawarra LAC	Manning-Great Lakes LAC	Darling River LAC
Monaro LAC	Mid North Coast LAC	Lachlan LAC
Shoalhaven LAC	Newcastle City LAC	Mudgee LAC
The Hume LAC	Port Stephens LAC	New England LAC
Wagga Wagga LAC	Richmond LAC	Orana LAC
Wollongong LAC	Tuggerah Lakes LAC	Oxley LAC
	Tweed-Byron LAC	

**FIGURE 10:** Intimate partner domestic violence homicide victim by NSW Police Force Region, NSW, 2000-2014

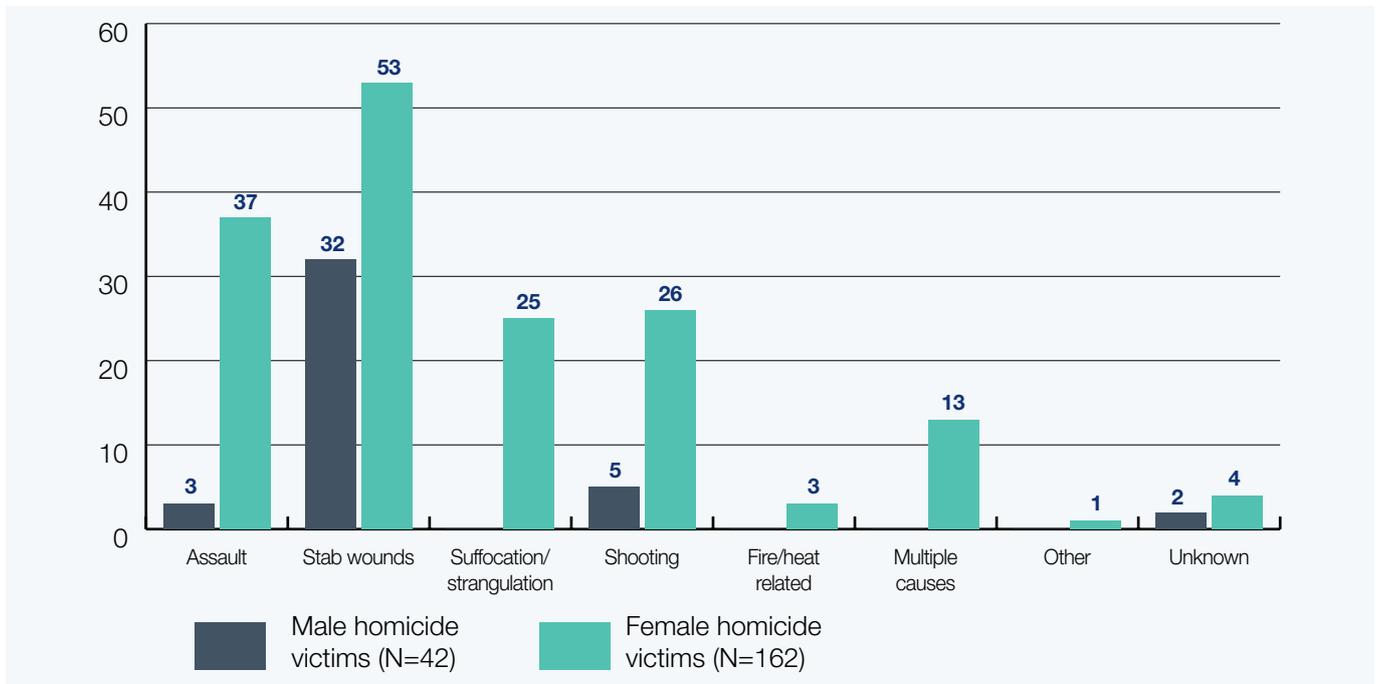
NSW Police Force Region	Male intimate partner homicide victims (N=42)	Female intimate partner homicide victims (N=162)	Total (N=204)	%
Central Metropolitan	7	24	31	%
North West Metropolitan	7	35	42	%
South West Metro	4	28	32	%
Northern Region	10	36	46	%
Southern Region	6	17	23	%
Western Region	6	16	22	%
No Fixed Abode	1	2	3	%
Interstate/Overseas	1	4	5	%
<b>TOTAL</b>	<b>42</b>	<b>162</b>	<b>204</b>	<b>100%</b>



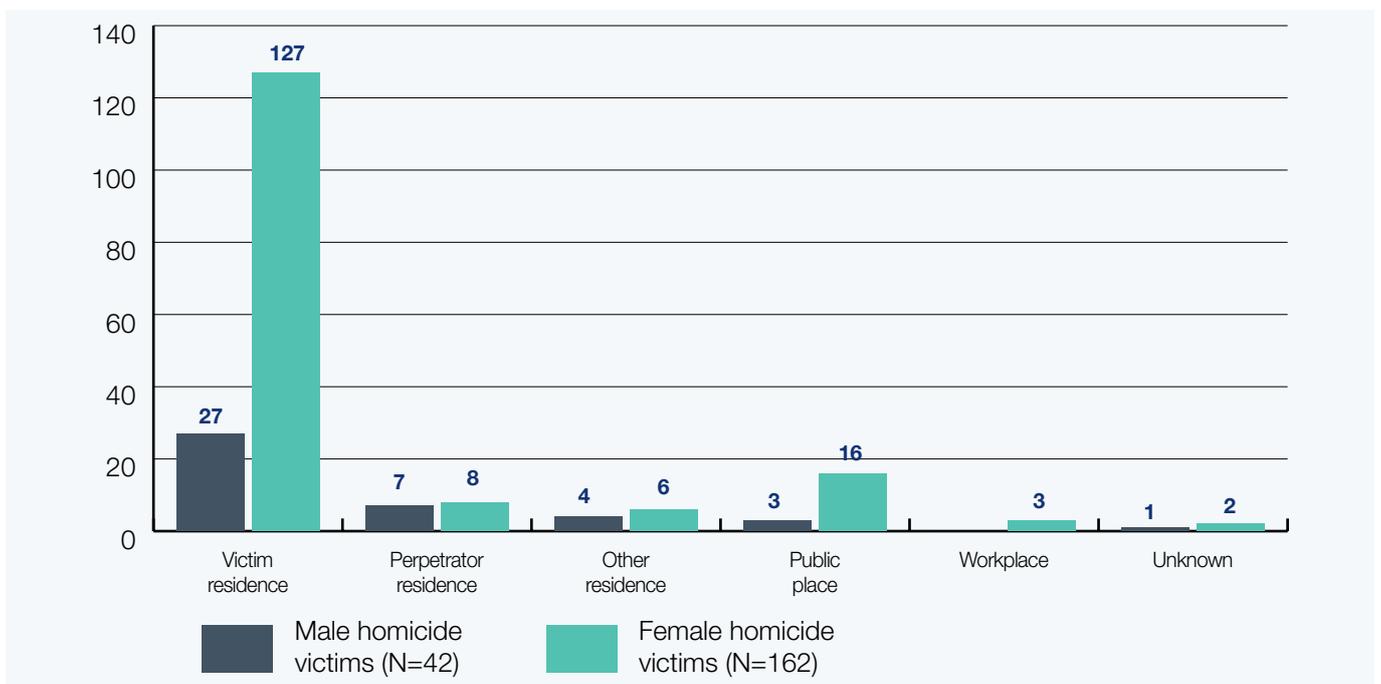
**FIGURE 11:** Intimate partner domestic violence homicide victim by country of birth, NSW, 2000-2014

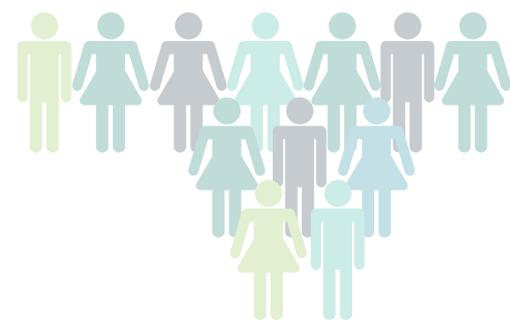
Country of birth	Male homicide victim (N=42)	Female homicide victim (N=162)	Total
Australia	33	112	145
New Zealand	2	5	7
Lebanon	1	5	6
India	0	5	5
Serbia	0	2	2
Fiji	1	4	5
Scotland	0	1	1
Britain	0	1	1
Canada	0	2	2
Malta	0	1	1
Croatia	0	1	1
Macedonia	0	1	1
United States	1	0	1
Greece	0	1	1
Romania	1	0	1
Poland	0	1	1
Russia	0	1	1
Egypt	0	1	1
Sudan	0	2	2
Turkey	0	2	2
Vietnam	0	3	3
Indonesia	0	2	2
Malaysia	0	1	1
China	1	3	4
Korea	0	1	1
Sri Lanka	0	1	1
Argentina	0	1	1
Brazil	0	1	1
Chile	0	1	1
Unknown	1	1	2
<b>TOTAL</b>	<b>42</b>	<b>162</b>	<b>204</b>

**FIGURE 12:** Intimate partner domestic violence homicide victim by manner of death, NSW, 2000-2014

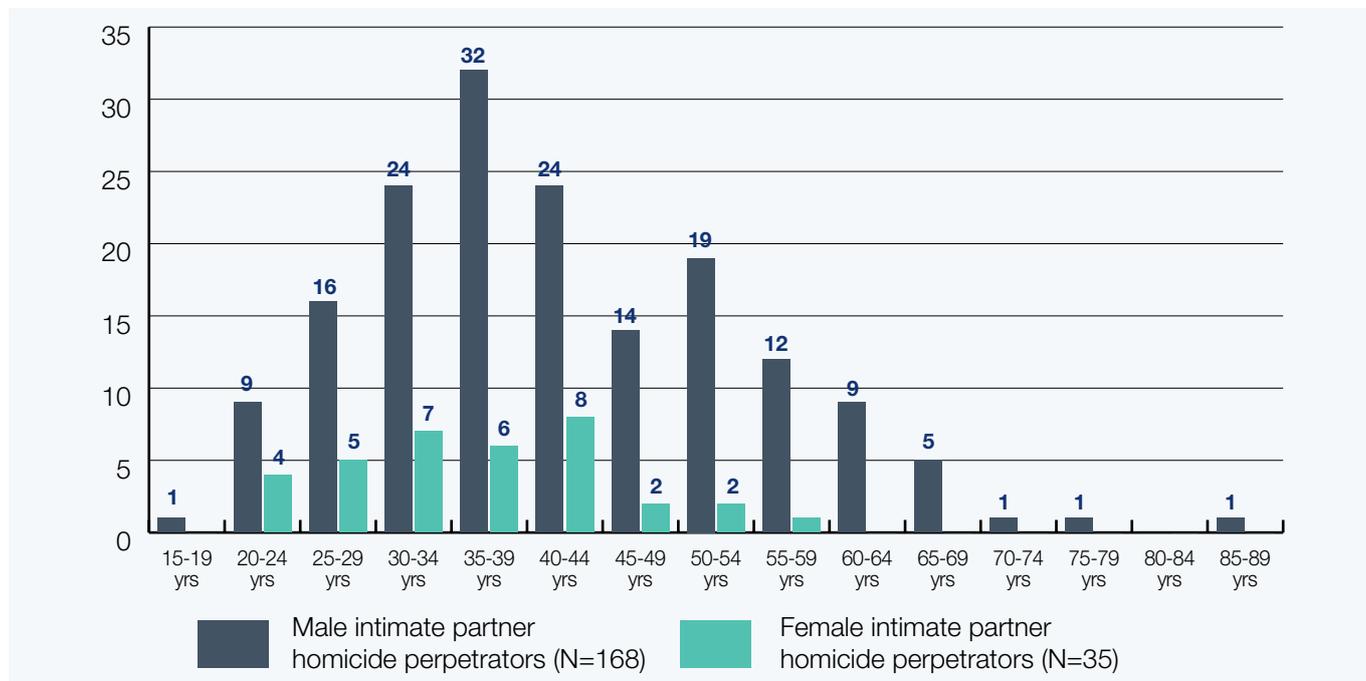


**FIGURE 13:** Intimate partner domestic violence homicide victim by location of fatal episode, NSW, 2000-2014





**FIGURE 14:** Age of intimate partner domestic violence homicide perpetrator, NSW, 2000-2014

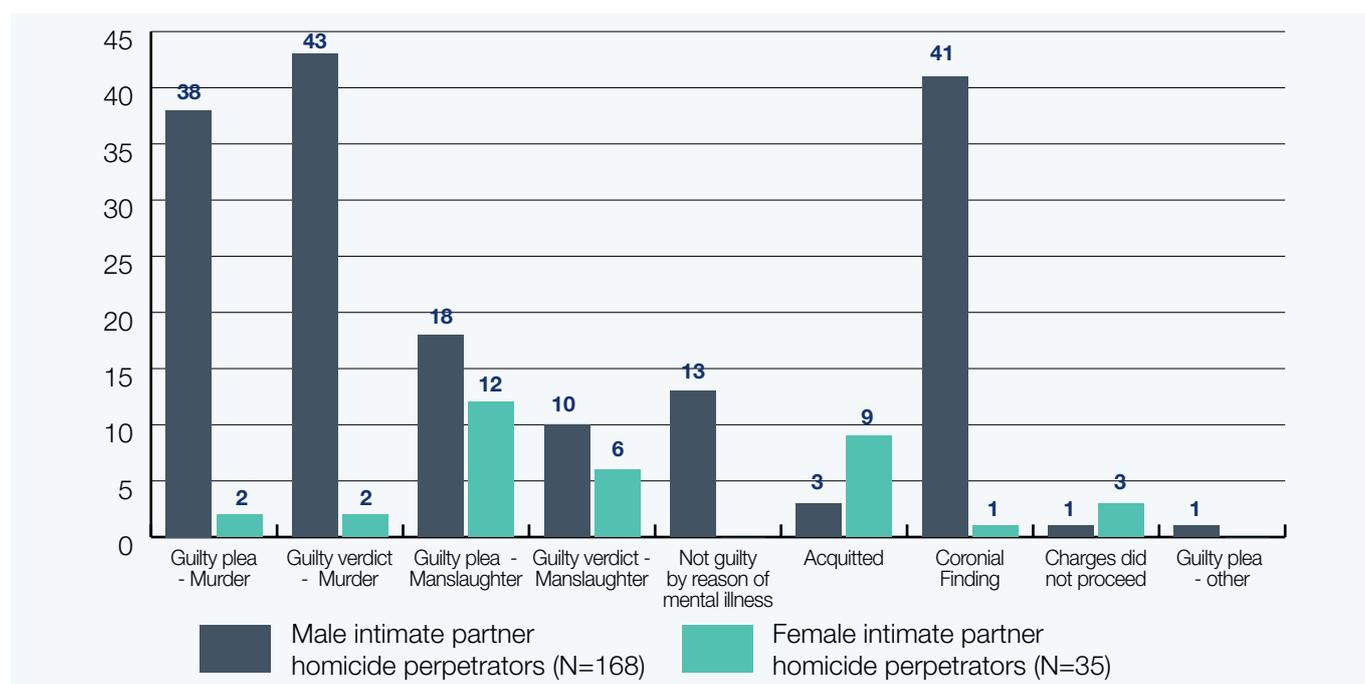


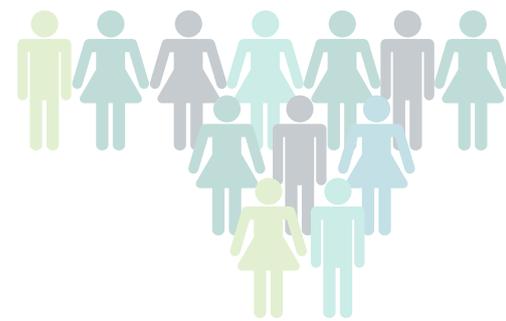
**FIGURE 15:** Intimate partner domestic violence homicide perpetrator by country of birth, NSW, 2000-2014

Country of birth	Male intimate partner homicide perpetrator (N=168)	Female intimate partner homicide perpetrator (N=34)	Total
Australia	112	30	142
New Zealand	6	0	6
Lebanon	5	0	5
India	5	0	5
Serbia	2	0	2
Czechoslovakia	1	0	1
Armenia	0	1	1
United States	1	0	1
Fiji	4	1	5
England	1	0	1
Samoa	1	0	1
Ireland	1	0	1
France	1	0	1
Finland	1	0	1

Croatia	2	0	2
Greece	2	0	2
Macedonia	1	0	1
Egypt	3	0	3
Poland	1	0	1
Sudan	2	0	2
Turkey	3	0	3
Vietnam	3	0	3
Indonesia	1	0	1
Malaysia	1	0	1
China	2	1	3
Korea	1	0	1
Sri Lanka	1	0	1
Argentina	1	0	1
Brazil	1	0	1
Chile	1	0	1
Unknown	1	2	3
<b>TOTAL</b>	<b>168</b>	<b>35</b>	<b>203</b>

**FIGURE 16:** Intimate partner domestic violence homicide perpetrator by outcome, NSW, 2000-2014





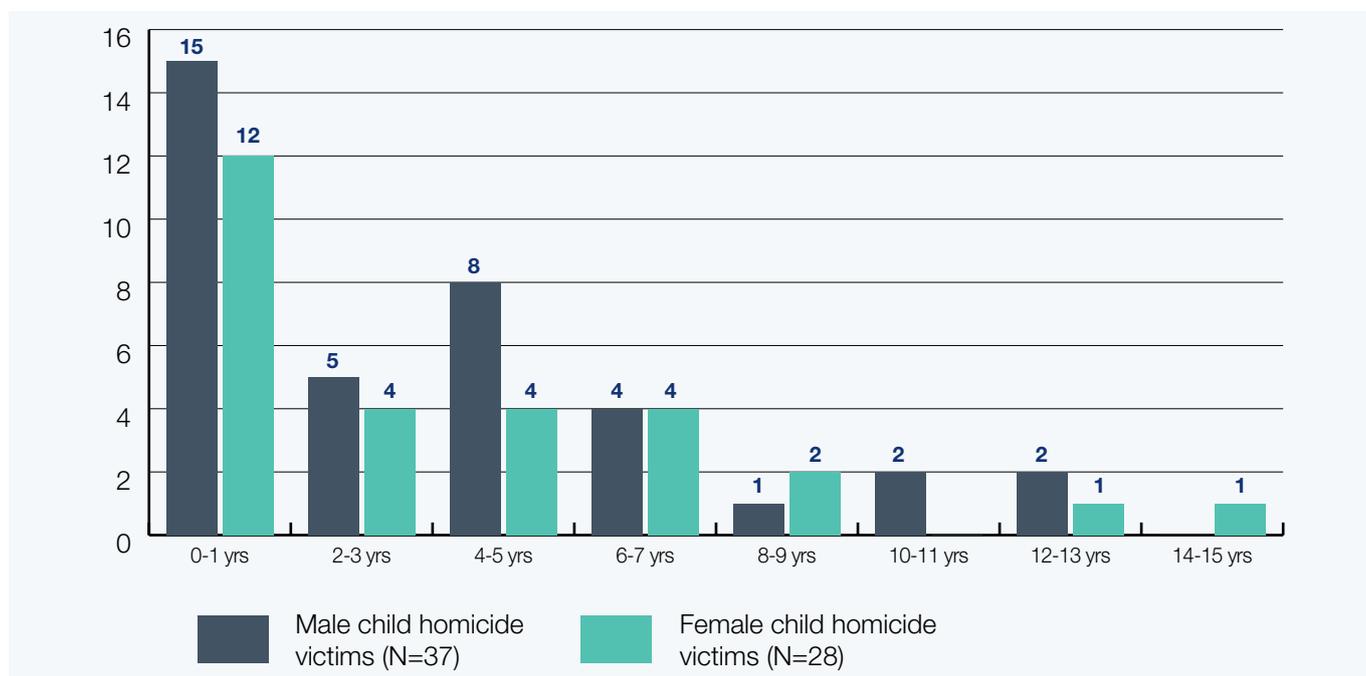
## Relative/kin domestic violence homicides, NSW, 2000-2014

### Child homicide victim

**FIGURE 17:** Relationship of perpetrator to child relative/kin domestic violence homicide victim, NSW, 2000-2014

Relationship of homicide Perpetrator to child homicide victim	N	%
Biological father	27	42%
Step-father/de facto step-father	12	18%
Biological mother	17	26%
Step-mother/foster mother	2	3%
Grandfather	2	3%
Mother & father/step-father acting together	5	8%
<b>TOTAL</b>	<b>65</b>	<b>100%</b>

**FIGURE 18:** Age of child relative/kin domestic violence homicide victim, NSW, 2000-2014



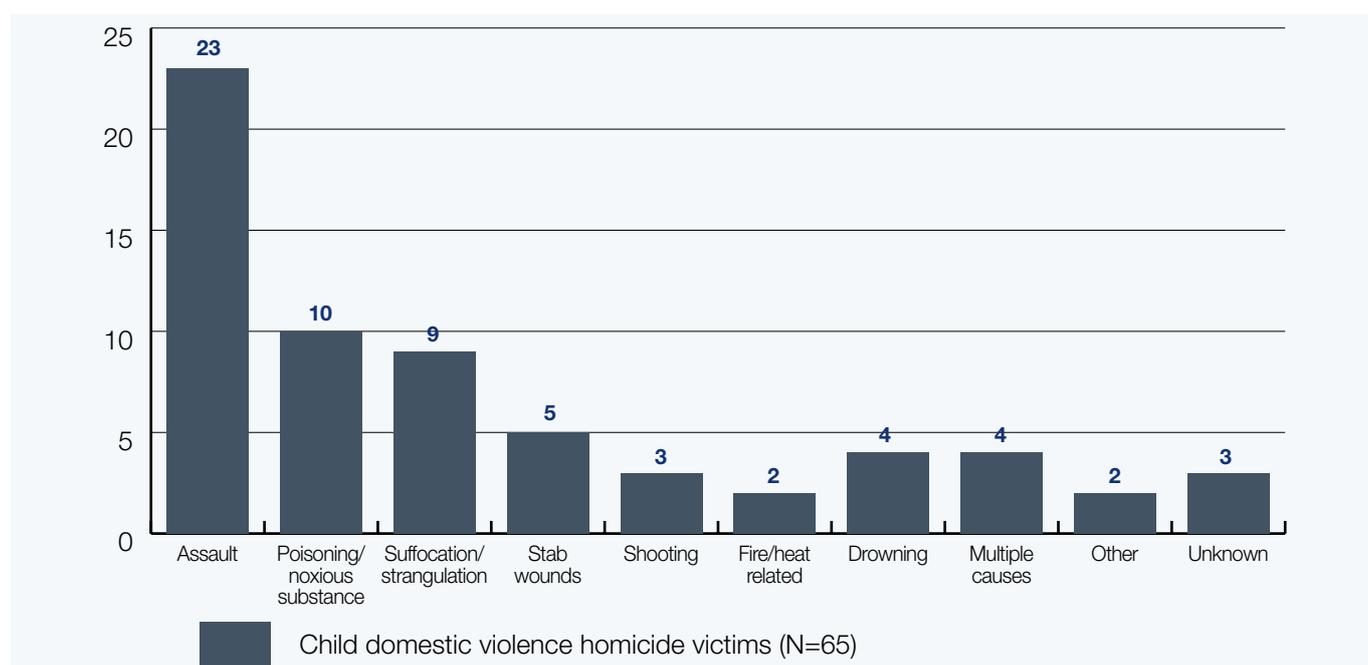
**FIGURE 19:** Child relative/kin domestic violence homicide victim by NSW Police Force Region, NSW, 2000-2014

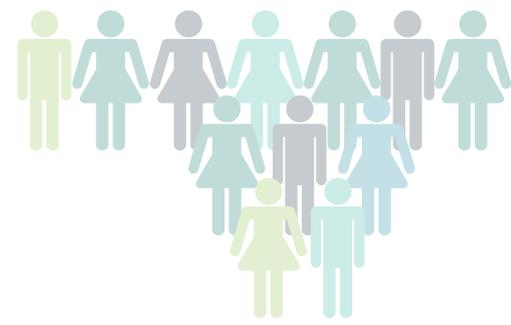
NSW Police Force Region	Child domestic violence homicide victim (N=65)	%
Central Metropolitan	6	9%
North West Metropolitan	9	14%
South West Metropolitan	14	22%
Northern Region	18	28%
Southern Region	13	20%
Western Region	4	6%
Interstate/Overseas	1	2%
<b>TOTAL</b>	<b>65</b>	<b>100%</b>

**FIGURE 20:** Child relative/kin domestic violence homicide victim by country of birth, NSW, 2000-2014

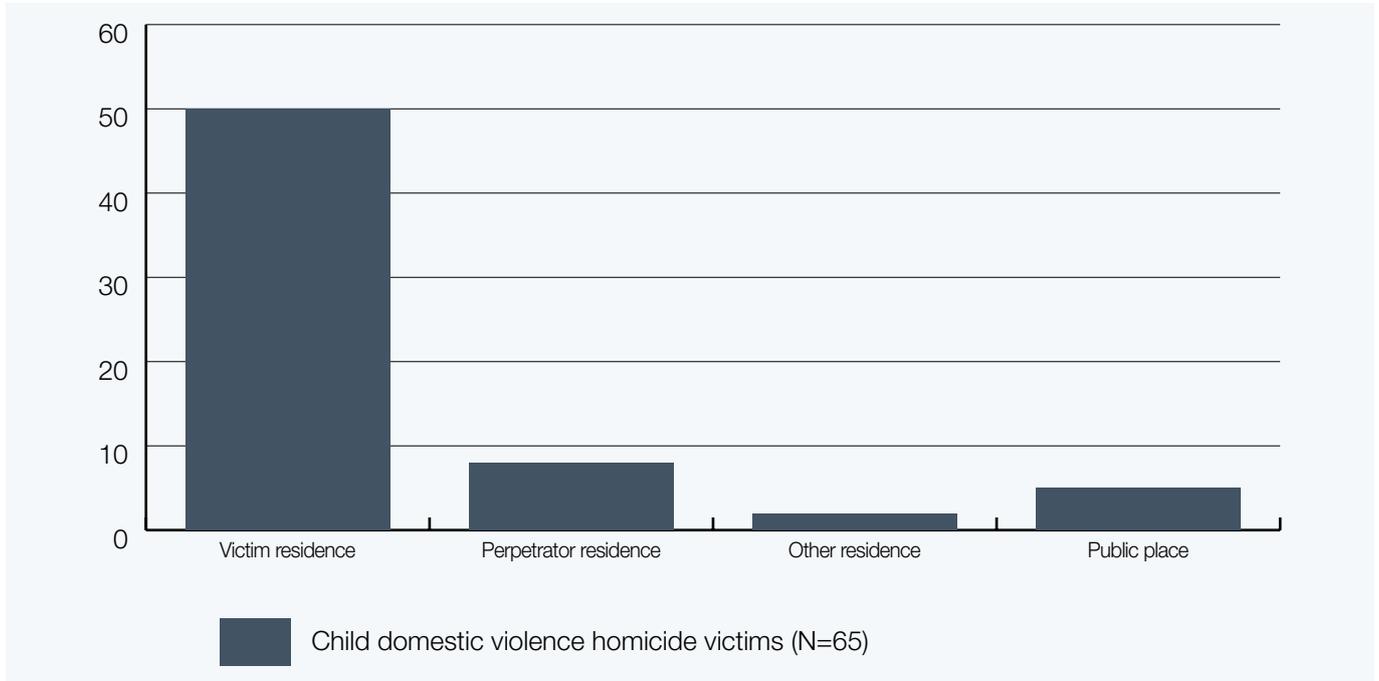
Country of birth	Child domestic violence homicide victim (N=65)	%
Australia	64	98
India	1	2
<b>TOTAL</b>	<b>60</b>	<b>100%</b>

**FIGURE 21:** Child relative/kin domestic violence homicide victim by manner of death, NSW, 2000-2014

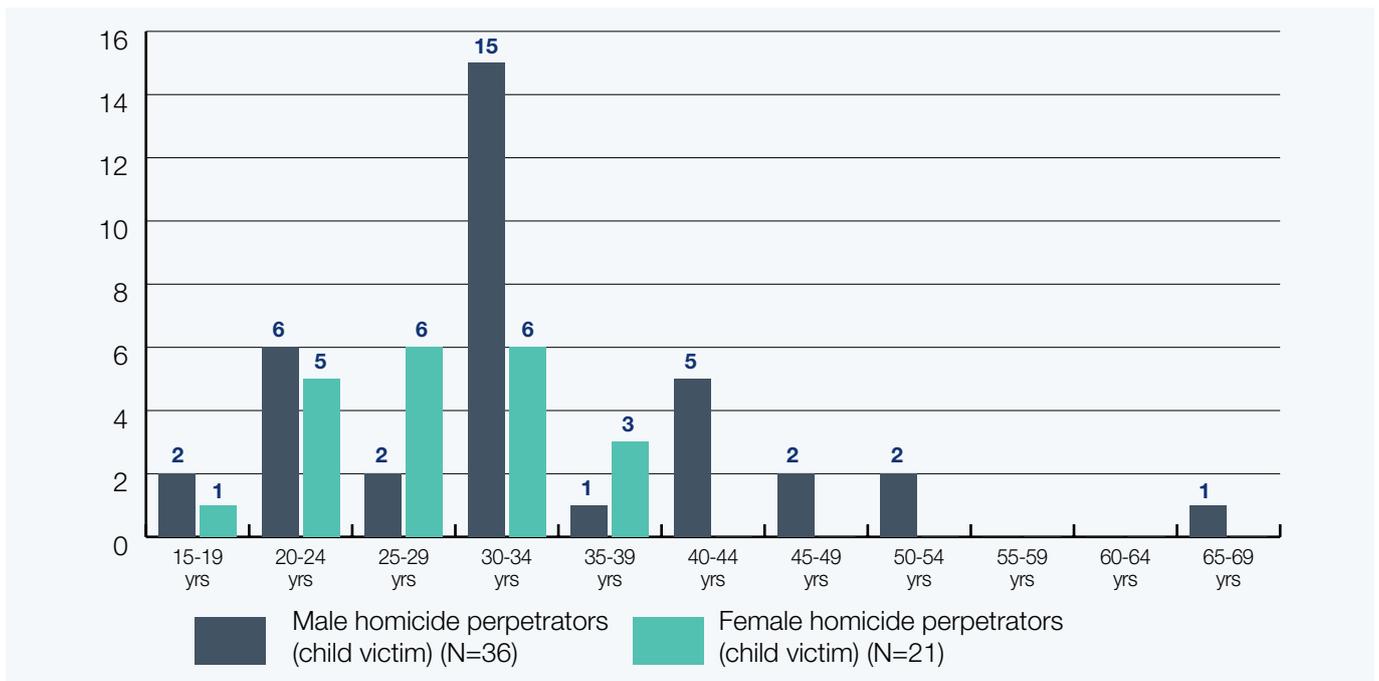




**FIGURE 22:** Child relative/kin domestic violence homicide victim by location of fatal episode, NSW, 2000-2014



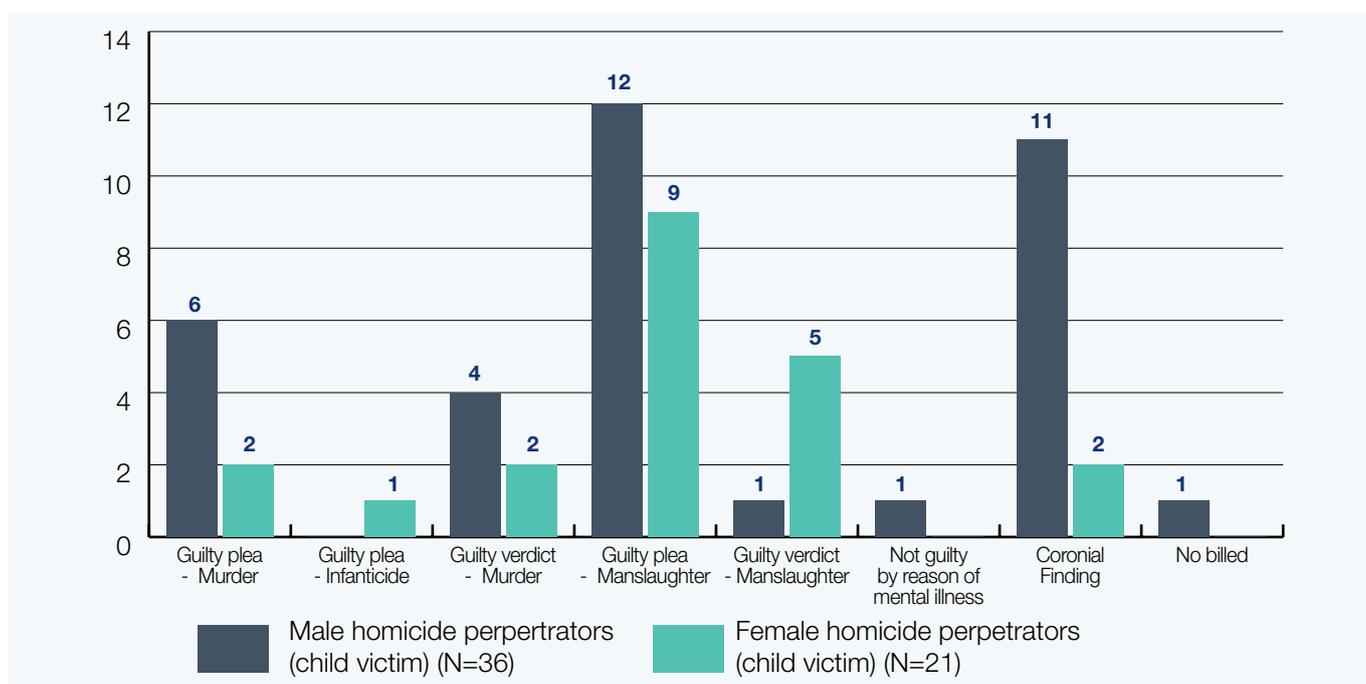
**FIGURE 23:** Age of child relative/kin domestic violence homicide perpetrator, NSW, 2000-2014

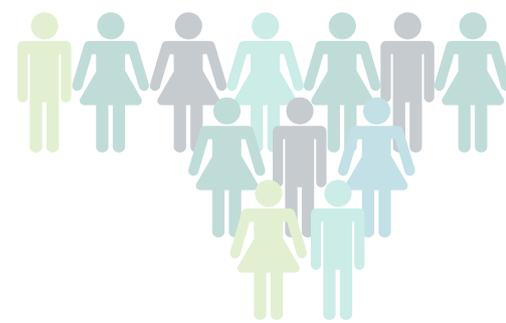


**FIGURE 24:** Child relative/kin domestic violence homicide perpetrator by country of birth, NSW, 2000-2014

Country of birth	Male homicide perpetrator (child victim)	Female homicide perpetrator (child victim)	Total
Australia	26	19	45
New Zealand	2	1	3
Tonga	1	0	1
United Kingdom	1	0	1
Ireland	1	0	1
Egypt	1	0	1
Iran	1	0	1
Thailand	1	0	1
Vietnam	0	1	1
India	1	0	1
Afghanistan	1	0	1
<b>TOTAL</b>	<b>36</b>	<b>21</b>	<b>57</b>

**FIGURE 25:** Child relative/kin domestic violence homicide perpetrator by outcome, NSW, 2000-2014





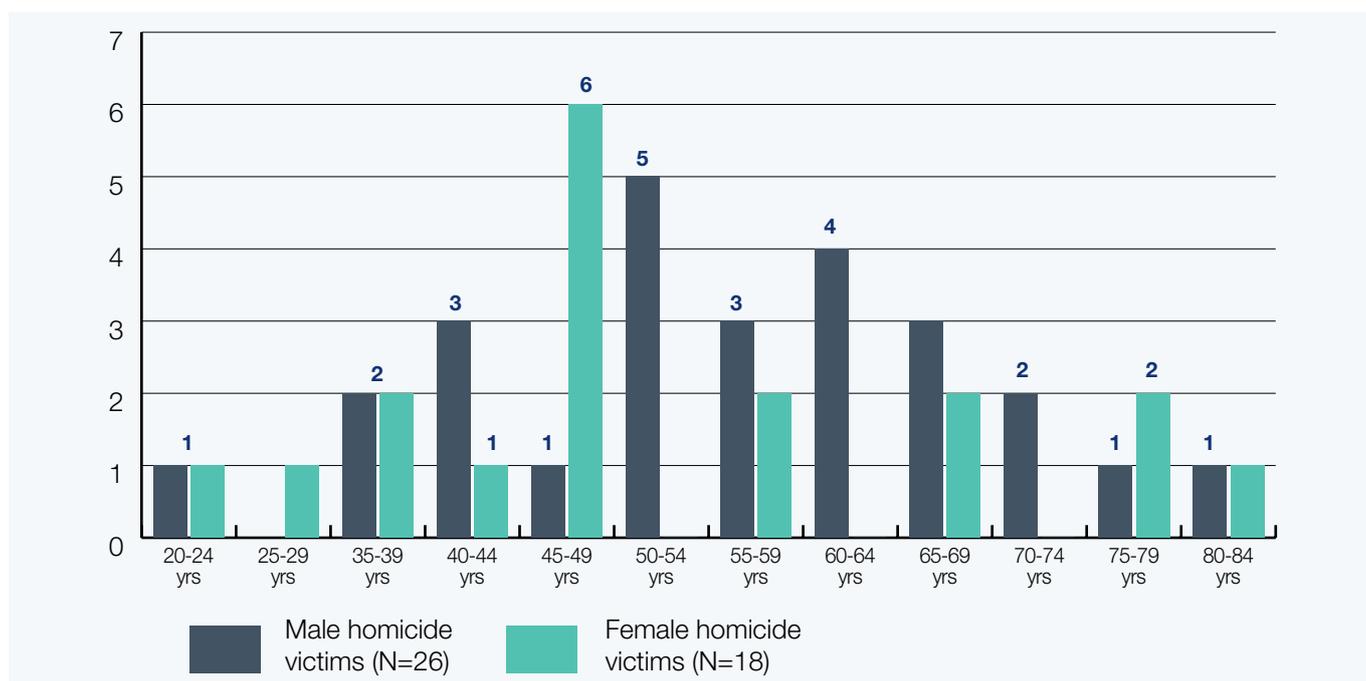
## Relative/kin domestic violence homicides, NSW, 2000-2014

### Adult homicide victims

**FIGURE 26:** Relationship of homicide perpetrator to adult relative/kin domestic violence homicide victim, NSW, 2000-2014

Relationship of homicide perpetrator to deceased	Male homicide victim (N=26)	Female homicide victim (N=18)	Total
Son/Step-Son	12	9	21
Daughter/Step-Daughter	3	3	6
Son & Daughter (Acting Together)	0	1	1
Son & Grandson (Acting Together)	1	0	1
Brother	2	0	2
Brother-In-Law	2	1	3
Father	1	0	1
Mother-In-Law	1	0	1
Nephew	1	1	2
Son-In-Law (Including De Facto)	3	1	4
Extended Family/Kin	0	1	1
Cousin	0	1	1
<b>TOTAL</b>	<b>26</b>	<b>18</b>	<b>44</b>

**FIGURE 27:** Age of adult relative/kin domestic violence homicide victim, NSW, 2000-2014



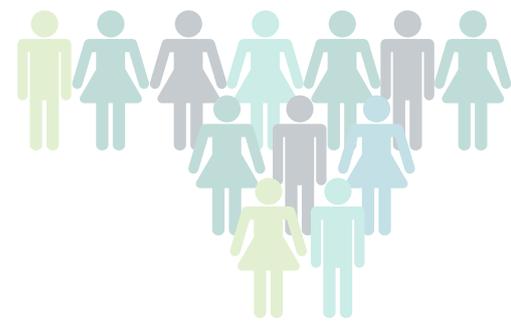
**FIGURE 28:** Adult relative/kin domestic violence homicide victim by NSW Police Force Region, NSW, 2000-2014

NSW Police Force Region	Adult relative/kin domestic violence homicide victim (N=44)	%*
Central Metropolitan	4	9%
North West Metropolitan	11	25%
South West Metropolitan	11	25%
Northern Region	13	30%
Southern Region	1	2%
Western Region	4	9%
<b>TOTAL</b>	<b>44</b>	

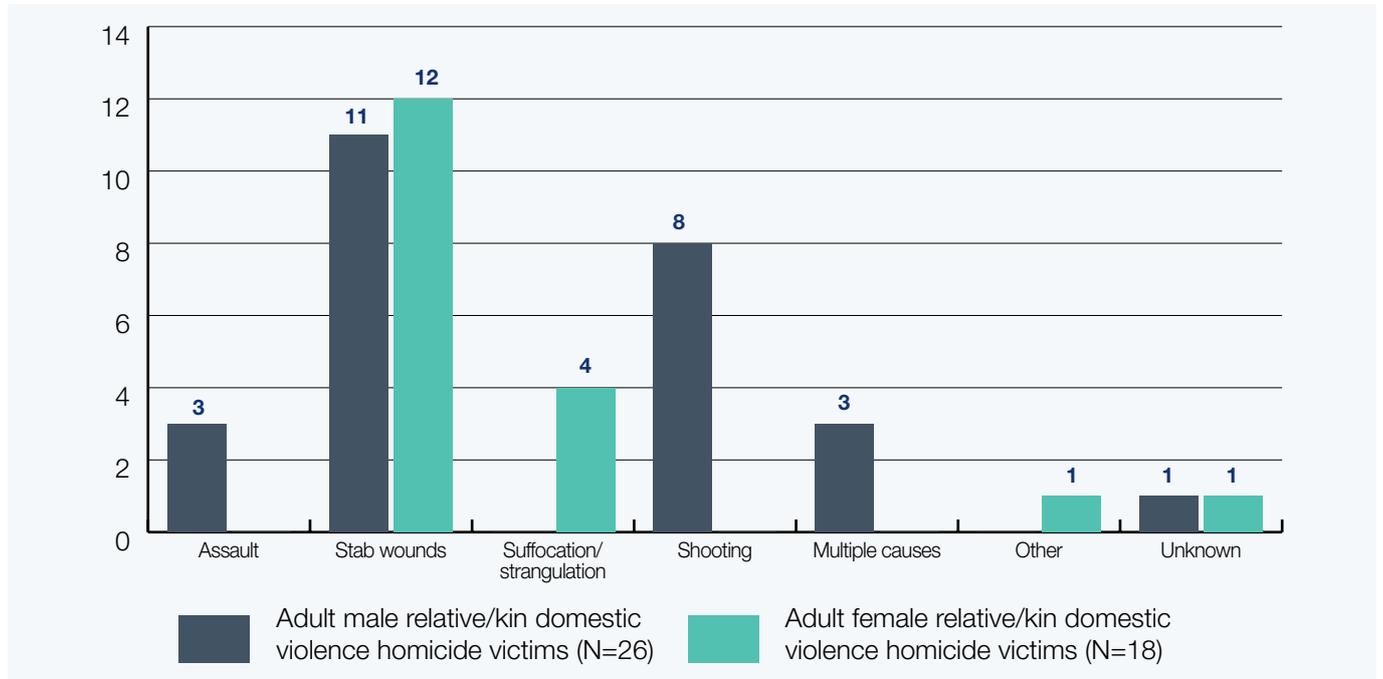
\*percentages do not add to %100 due to rounding

**FIGURE 29:** Adult relative/kin domestic violence homicide victim by country of birth, NSW, 2000-2014

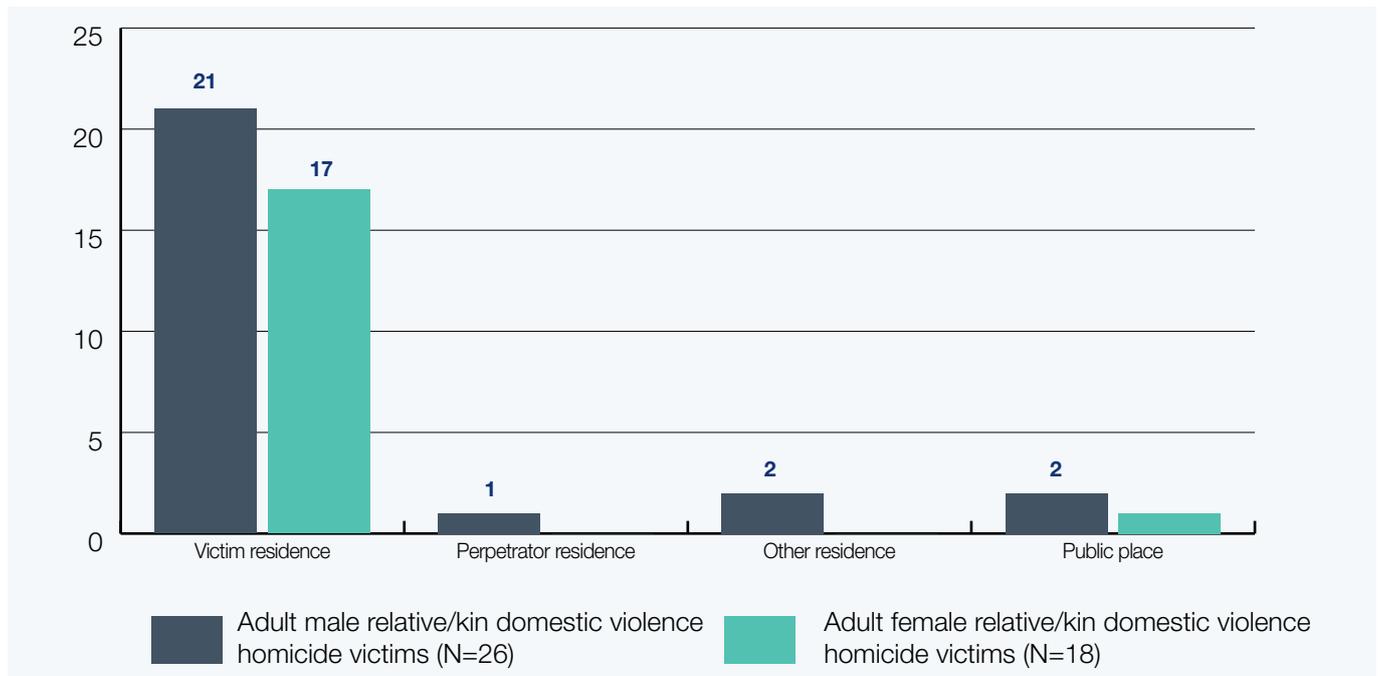
Country of birth	Adult male relative/kin domestic violence homicide victims (N=26)	Adult female relative/kin domestic violence homicide victims (N=18)	Total
Australia	15	13	28
Lebanon	3	0	3
FIJI	0	1	1
United Kingdom	2	1	3
New Zealand	1	0	1
CHINA	0	1	1
PHILLIPINES	0	1	1
indonesia	0	1	1
Italy	1	0	1
Romania	1	0	1
POLAND	1	0	1
Iraq	1	0	1
croatia	1	0	1
<b>TOTAL</b>	<b>26</b>	<b>18</b>	<b>44</b>



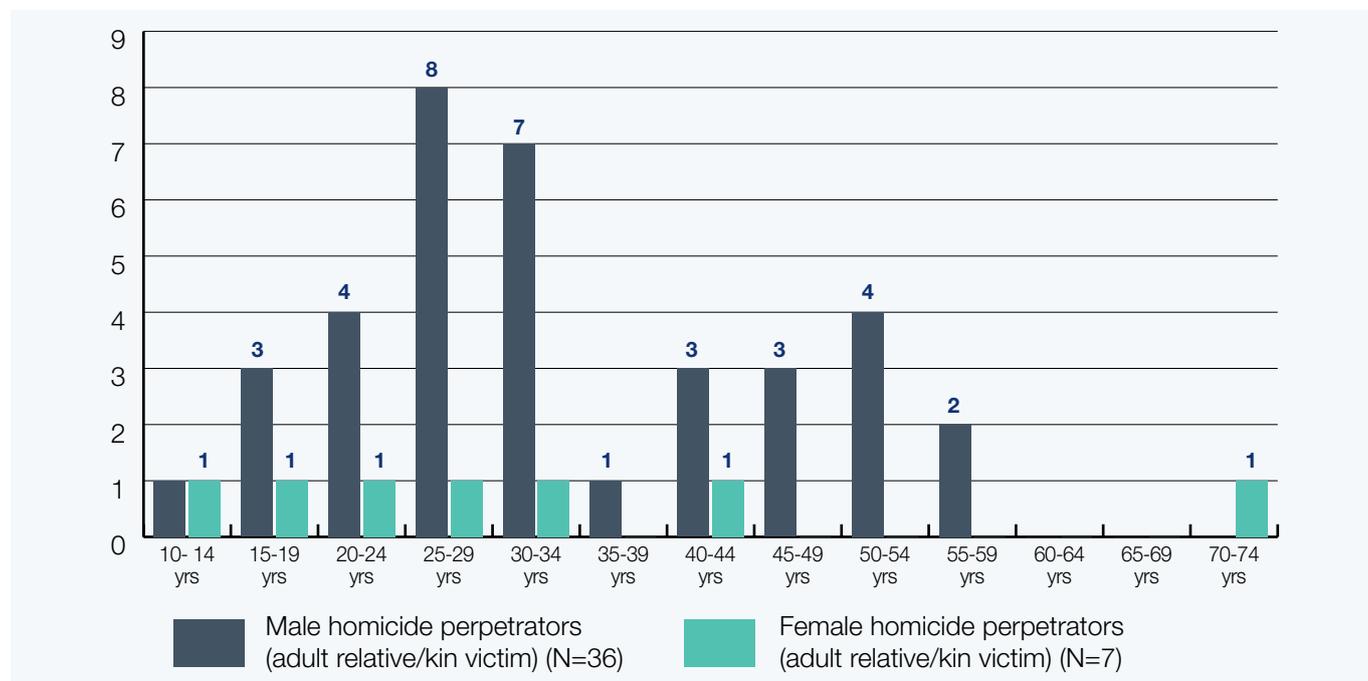
**FIGURE 30:** Adult relative/kin domestic violence homicide victim by manner of death, NSW, 2000-2014



**FIGURE 31:** Adult relative/kin domestic violence homicide victim by location of fatal episode, NSW, 2000-2014

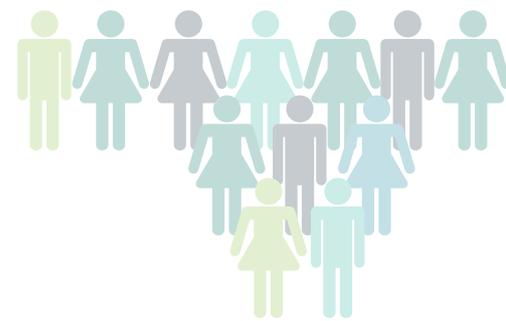


**FIGURE 32:** Age of adult relative/kin domestic violence homicide perpetrator, NSW, 2000-2014

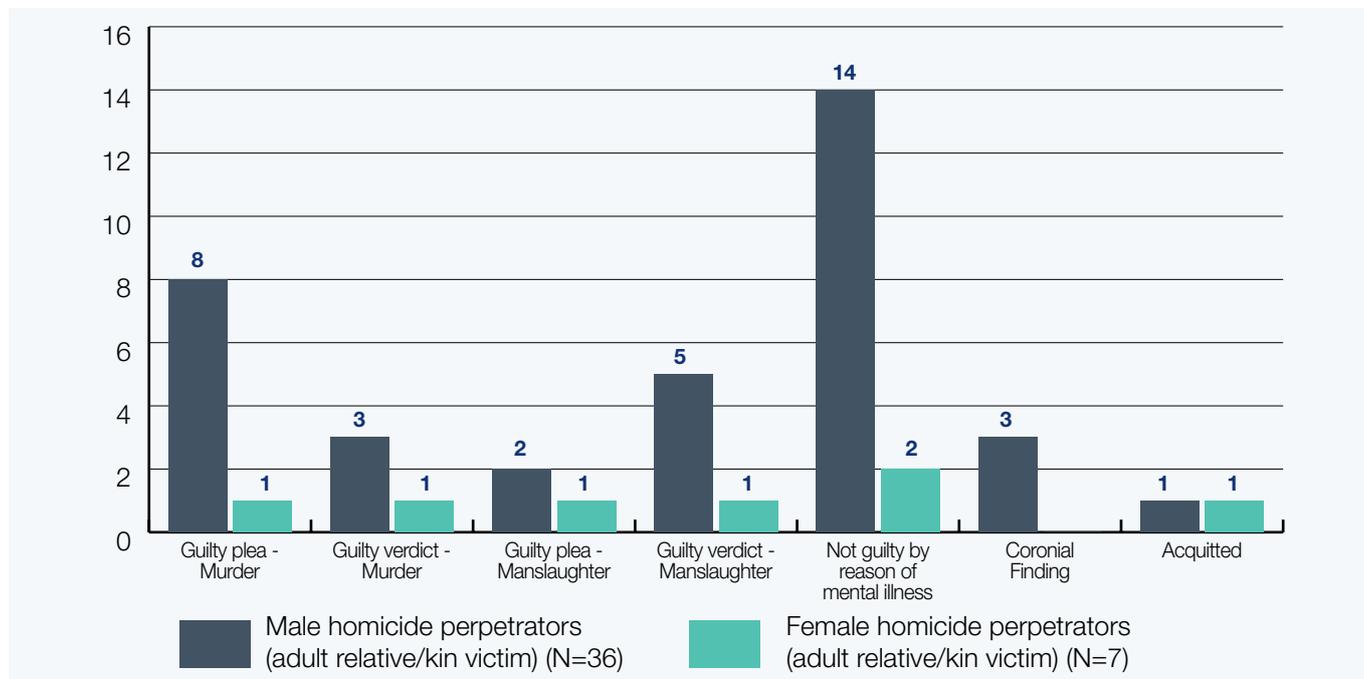


**FIGURE 33:** Adult relative/kin domestic violence homicide perpetrator by country of birth, NSW, 2000-2014

Country of birth	Male homicide perpetrator (adult relative/kin victim)	Female homicide perpetrator (adult relative/kin victim)	Total
Australia	23	6	29
Fiji	1	0	1
United Kingdom	0	1	1
Italy	1	0	1
Romania	1	0	1
Poland	1	0	1
Iraq	1	0	1
Lebanon	3	0	3
Thailand	1	0	1
Phillipines	2	0	2
Indonesia	1	0	1
China	1	0	1
<b>TOTAL</b>	<b>36</b>	<b>7</b>	<b>43</b>

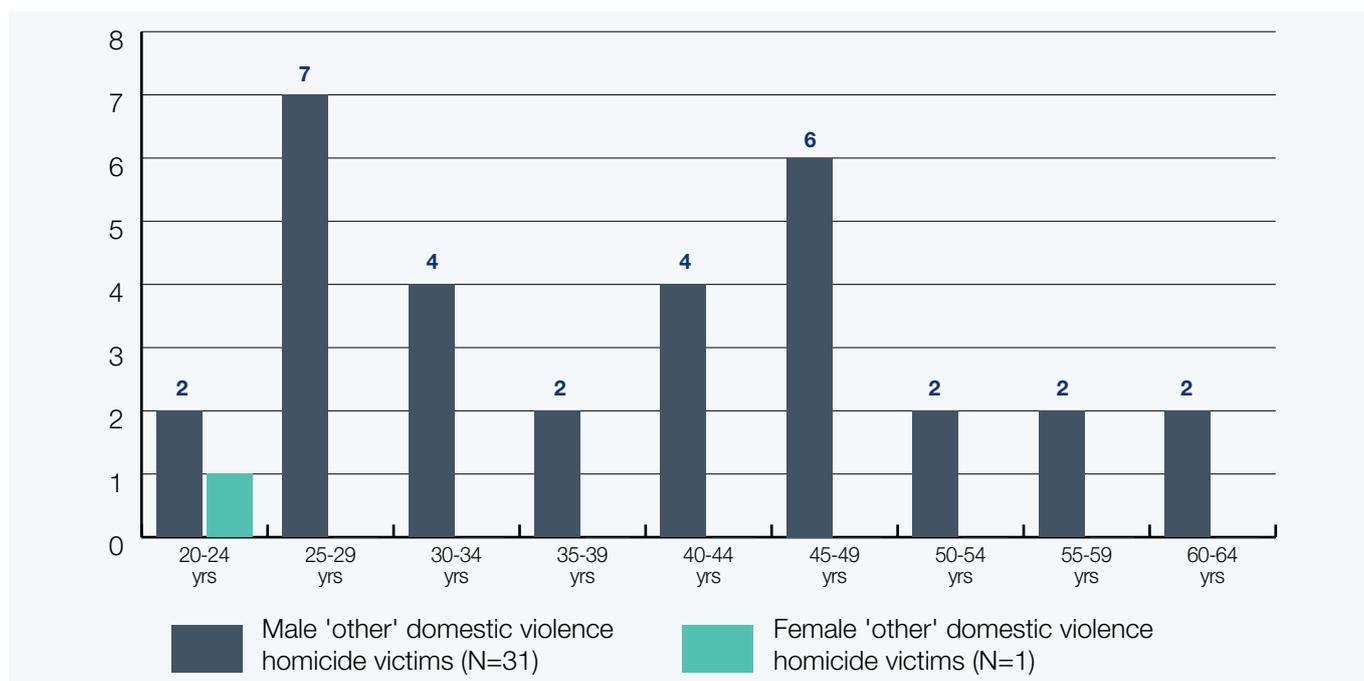


**FIGURE 34:** Adult relative/kin domestic violence homicide perpetrator by outcome, NSW, 2000-2014



## 'Other' domestic violence homicides, NSW, 2000-2014

**FIGURE 35:** Age of 'other' domestic violence homicide victim, NSW, 2000-2014



**FIGURE 36:** 'Other' domestic violence homicide victim by NSW Police Force Region, NSW, 2000-2014

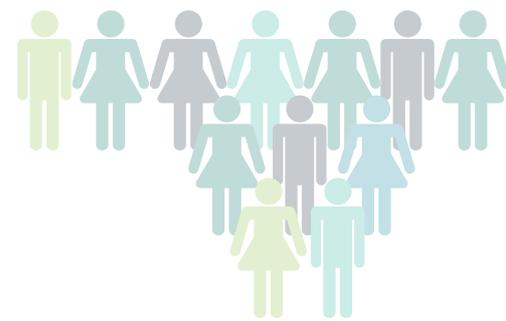
NSW Police Force Region	'Other' domestic violence homicide victim (N=32)	%
Central Metropolitan	5	16%
North West Metropolitan	5	16%
South West Metropolitan	4	13%
Northern Region	7	22%
Southern Region	4	13%
Western Region	5	16%
INTERSTATE	2	6%
<b>TOTAL</b>	<b>32</b>	<b>*</b>

\* Figures don't add to 100 due to rounding.

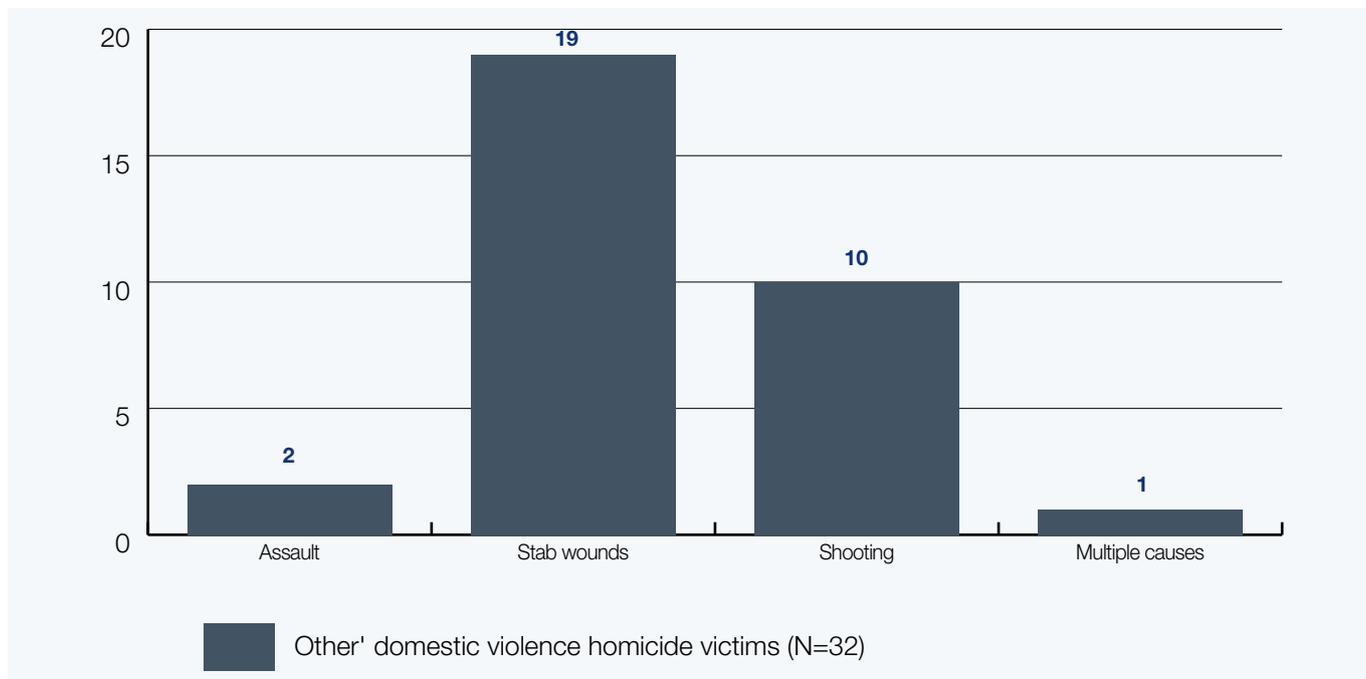
**FIGURE 37:** 'Other' domestic violence homicide victim by country of birth, NSW, 2000-2014

Country of birth	'Other' domestic violence homicide victim (N=32)	%
Australia	24	75%
India	1	3%
New Zealand	1	3%
Malaysia	1	3%
Cook Islands	1	3%
Fiji	1	3%
United Kingdom	1	3%
Netherlands	1	3%
Korea	1	3%
<b>TOTAL</b>	<b>32</b>	<b>*</b>

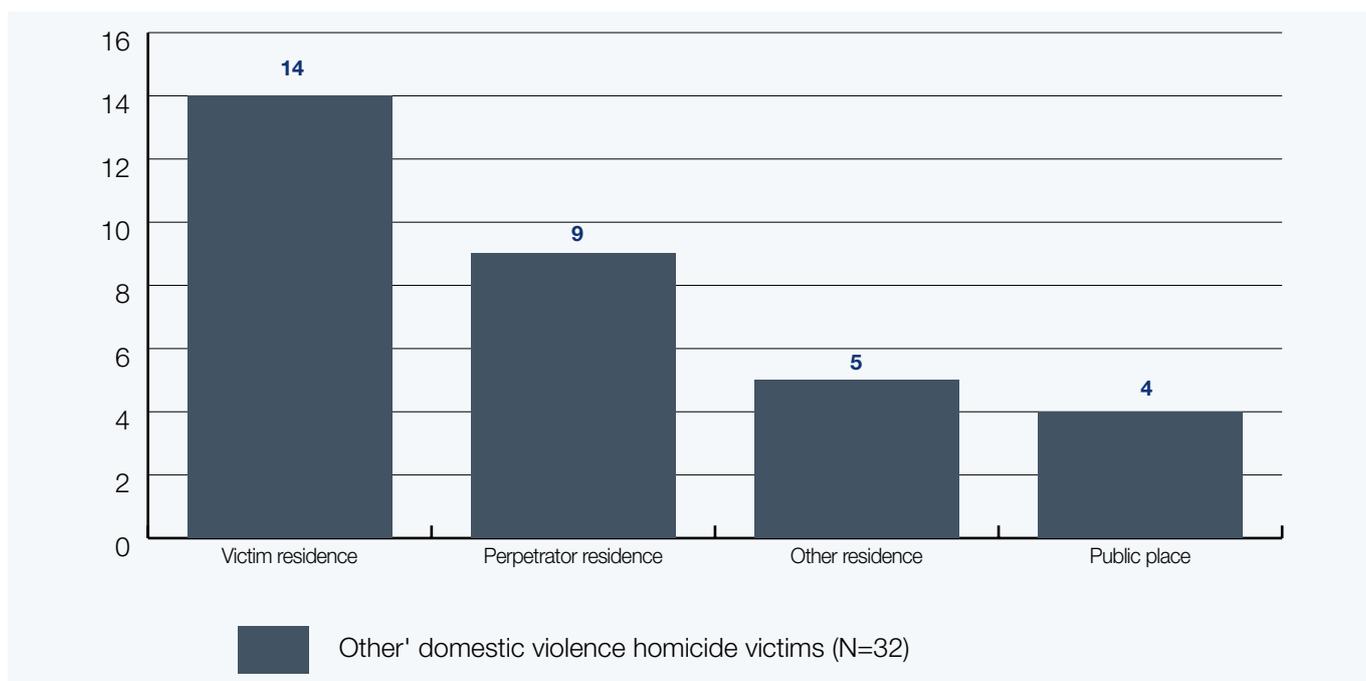
\* Figures don't add to 100 due to rounding.



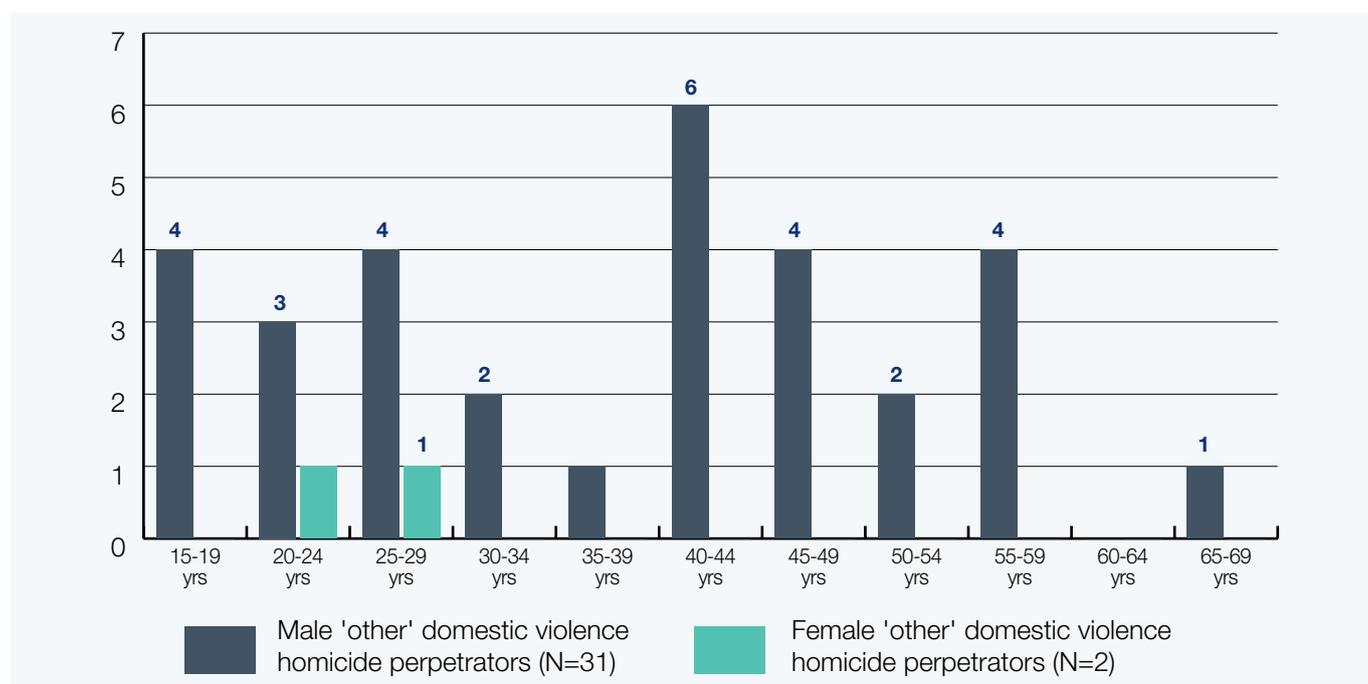
**FIGURE 38:** 'Other' domestic violence homicide victim by manner of death, NSW, 2000-2014



**FIGURE 39:** 'Other' domestic violence homicide victim by location of fatal episode, NSW, 2000-2014

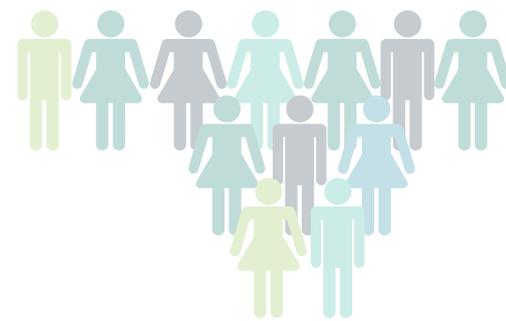


**FIGURE 40:** Age of 'other' domestic violence homicide perpetrator, NSW, 2000-2014

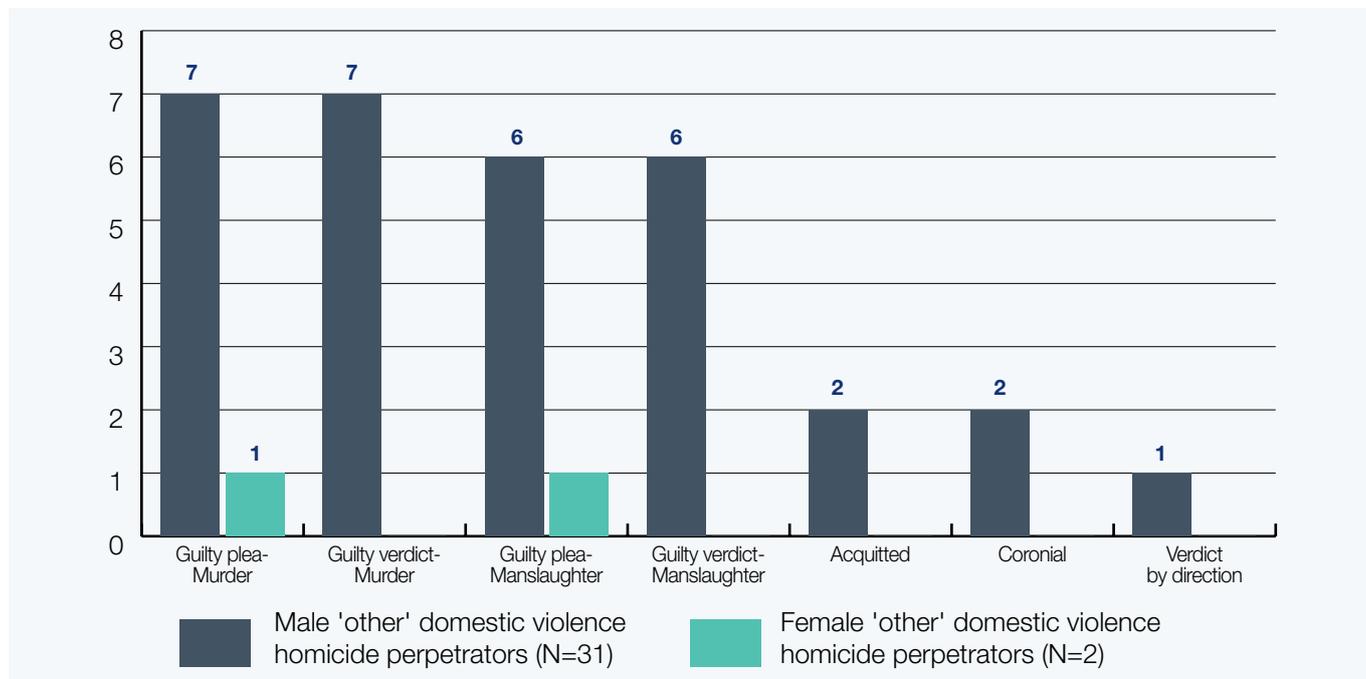


**FIGURE 41:** 'Other' domestic violence homicide perpetrator by country of birth, NSW, 2000-2014

Country of birth	Male 'other' domestic violence homicide perpetrators (N=31)	Female 'other' domestic violence homicide perpetrators (N=2)	Total
Australia	20	2	22
New Zealand	1	0	1
Indonesia	2	0	2
Lebanon	1	0	1
Cook Islands	1	0	1
Fiji	1	0	1
Britain	1	0	1
Netherlands	1	0	1
Korea	1	0	1
Hungary	1	0	1
Philippines	1	0	1
<b>TOTAL</b>	<b>31</b>	<b>2</b>	<b>33</b>



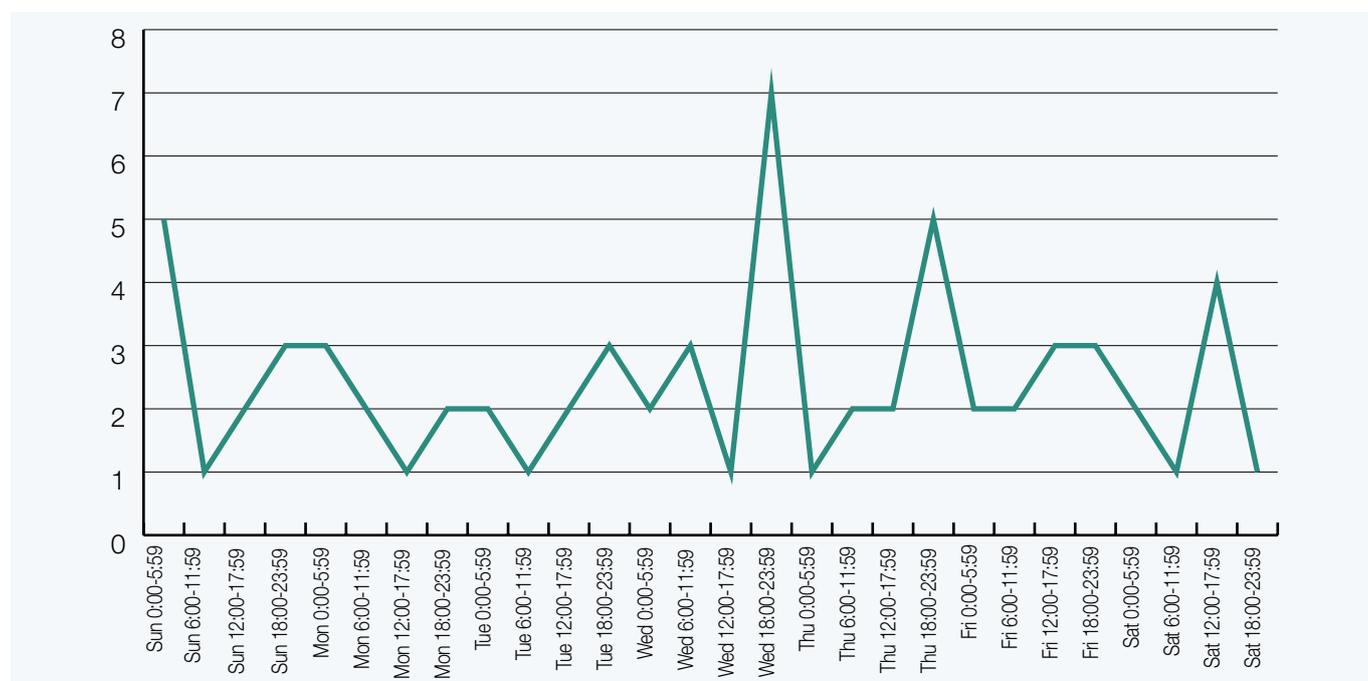
**FIGURE 42:** 'Other' domestic violence homicide perpetrator by outcome, NSW, 2000-2014



**FIGURE 43A:** Temporal pattern of focus intimate partner homicides, 2008-2014

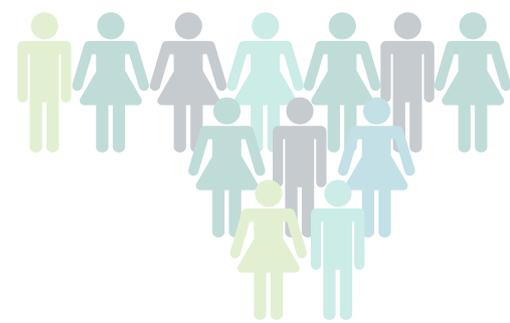
Day of the week	N=78
Sunday	12
Monday	10
Tuesday	11
Wednesday	15
Thursday	10
Friday	10
Saturday	9
Unknown	1
Time of day	N=78
00:00-5:59	17
6:00-11:59	12
12:00-17:59	15
18:00-23:59	24
Unknown	10

**FIGURE 43B:** Temporal pattern of focus intimate partner homicides, 2008-2014



**FIGURE 44:** Domestic violence related suicide - place of Residence (Remoteness scale)

Classification	Females who suicided	Males who suicided	All people who suicided
Major Cities	65	158	223
Inner Regional	15	55	70
Outer Regional	4	20	24
Remote	1	1	2
Very Remote	0	0	0
No fixed abode	0	5	5
Outside NSW	0	6	6
<b>TOTAL</b>	<b>85</b>	<b>245</b>	<b>330</b>

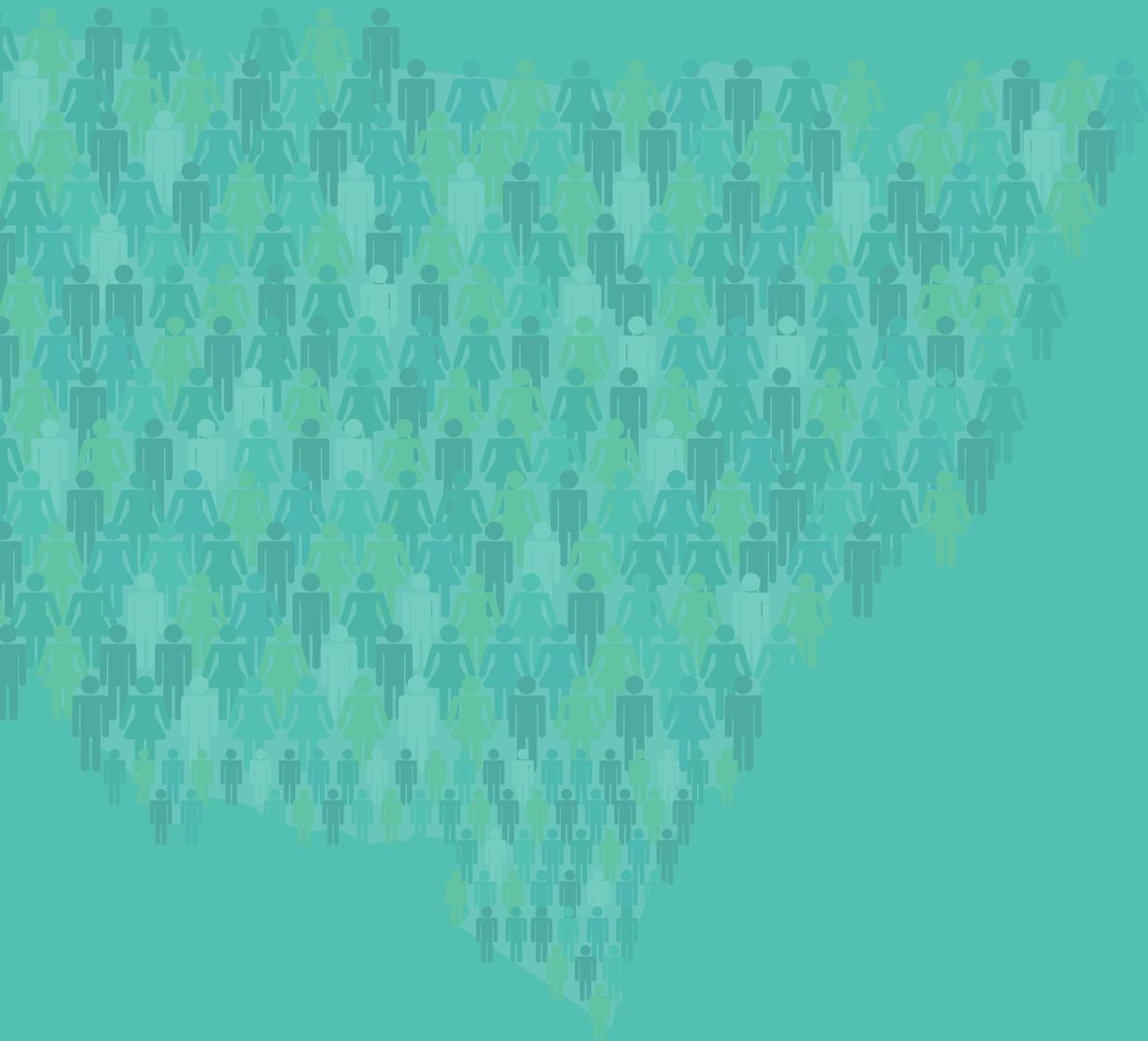


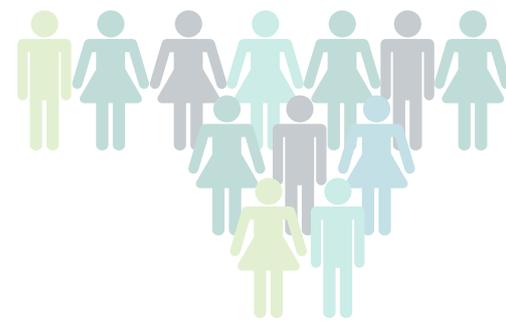
**FIGURE 45:** Method of suicide

Suicide method	Females who suicided	Males who suicided	All people who suicided
Jump from Height	6	24	30
Hanging	29	121	150
Drowning	4	9	13
Shooting	1	18	19
Carbon Monoxide/Gassing	7	16	23
Overdose	22	26	48
Other Poison	2	1	3
Cutting	3	7	10
Intentional MVA	2	2	4
Train	4	9	13
Plastic Bag Asphyxia	4	7	11
Other	1	5	6
<b>TOTAL</b>	<b>85</b>	<b>245</b>	<b>330</b>

# Appendix B:

Secretariat Activities Report, 2015-2017





The DVDRT Secretariat comprises a Manager and a Research Analyst and is permanently based in the State Coroner's Court in Sydney.

Since it tabled the Team's last report the Secretariat has adopted an enhanced role working with Coroners on open cases, worked closely with the Australian Domestic and Family Violence Death Review Network (the Network) and sought to promote the work of the Team through various forums.

## Open case function

Pursuant to the enhanced function of the Secretariat as described in the Report of the Statutory review of Chapter 9A of the *Coroners Act 2009* (NSW)<sup>140</sup> in 2016 the Secretariat started working with Coroners on open cases. In this role, the Secretariat can assist Coroners by preparing a domestic and family violence report based on the brief of evidence and other research, and can support Coroners in recommending additional brief requisitions to enhance the investigation. To date the Secretariat has assisted Coroners from the State Coroner's Court of NSW in a number of cases with a view to enhancing this function in coming years, including to circulate a memorandum alerting regional magistrates to the Secretariat's capacity in respect of open domestic violence related suicides and murders followed by a suicide.

## Activities with the Australian Domestic and Family Violence Death Review Network

Since its last report the Secretariat has continued to work with the Network including in respect of publishing and presenting at Conferences. In November 2015 after the last report was tabled the Secretariat presented on behalf of the Network at the 2015 *Asia Pacific Coroners' Society Conference* (November 2015). This included to canvass prior publications of the Team including in *Homicide Studies*

and to consider future directions in the work of the Network. Since this publication the Secretariat through the Network has published a Chapter in *Domestic Homicide and Death Reviews. An international perspective*, edited by Myrna Dawson.

The Network has also commenced the first stage of its Minimum Dataset data collection process which will produce a world first whole of population dataset concerning domestic violence intimate partner homicides in Australia. This research will form part of the Network's *Annual Activities Report*, and a number of conference presentations.

In its role as part of the Network the Secretariat also participated in the *International Domestic Violence Death Review Committee Roundtable: Examining the impact of domestic violence death review recommendations* in Brisbane in April 2017. This roundtable comprised experts from domestic violence death review processes in a number of jurisdictions including Canada, New Zealand and Australia, and leading academics working in the field of death review.

## Conferences, publications and other information sharing forums

In addition to producing the research and case reviews for the Team, the Secretariat has continued to promote the Team's research and function to different academic, sector and more general audiences.

In 2015 the Convenor of the Team supported by the Secretariat participated in the ABC documentary 'Hitting Home' by Sarah Ferguson, an investigative mini-series concerning domestic violence.

In 2017 the Secretariat of the Team prepared a publication for the *Judicial Officers' Bulletin* (Volume 29 No. 6, July 2017), 'What's language got to do with it? Learning from discourse language and stereotyping in domestic violence homicide cases.' This publication seeks to support judicial staff in using appropriate language when discussing issues related to domestic violence.

<sup>140</sup> Statutory Review of Chapter 9A of the *Coroners Act 2009* (NSW) – The Domestic Violence Death Review Team, available at [https://www.parliament.nsw.gov.au/la/papers/DBAssets/tabledpaper/webAttachments/67991/Report%20on%20the%20review%20of%20Chapter%209A%20of%20the%20Coroners%20Act%20\(Domes-tic%20Violence.pdf](https://www.parliament.nsw.gov.au/la/papers/DBAssets/tabledpaper/webAttachments/67991/Report%20on%20the%20review%20of%20Chapter%209A%20of%20the%20Coroners%20Act%20(Domes-tic%20Violence.pdf) (accessed 30 September 2017).

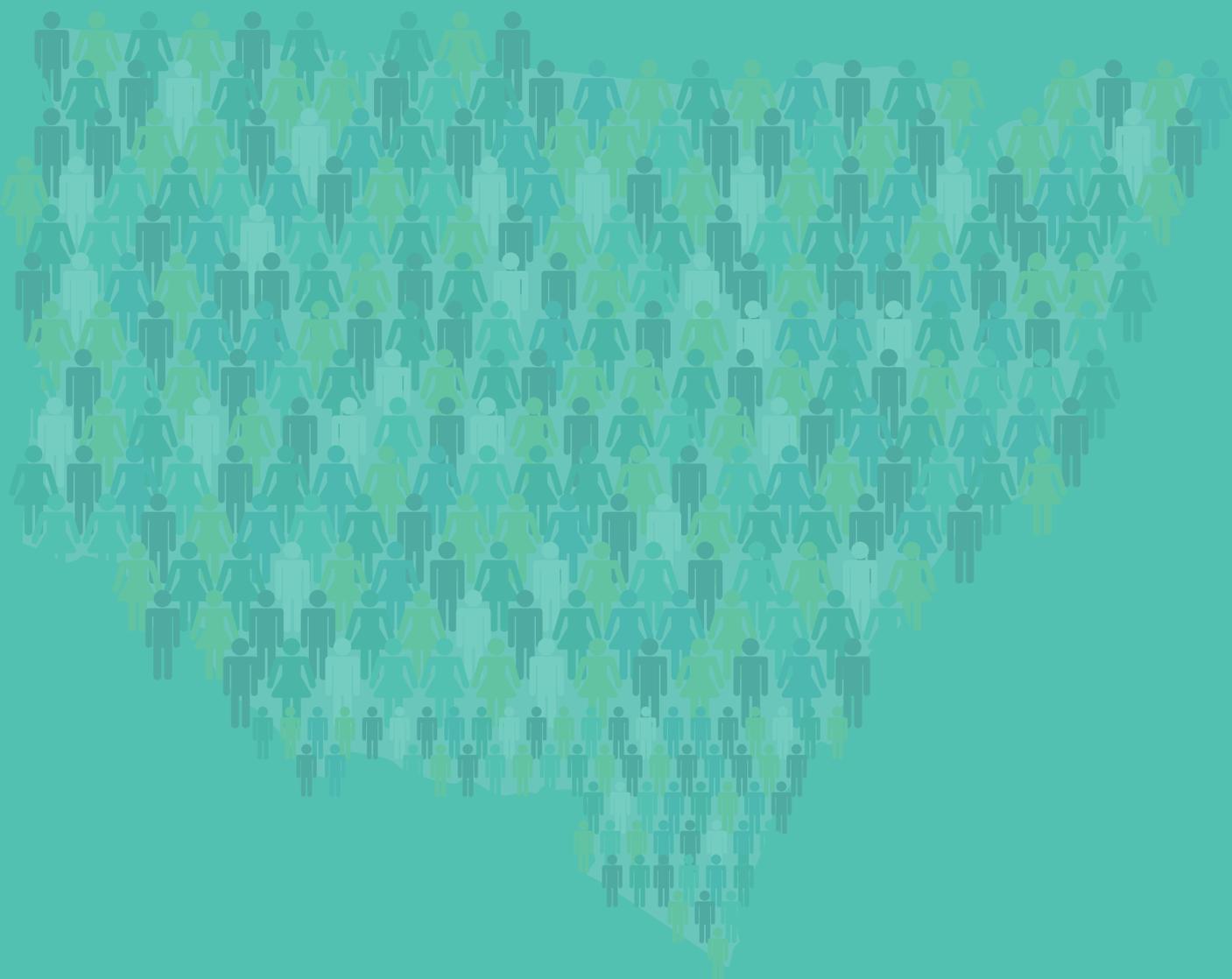
It also presented findings of its Intimate Partner study at the *Fighting Femicide: Cultural and Legal Interventions* conference in November 2015, and the *Australian STOP Domestic Violence Conference: Providing a platform for a uniform national voice* (December 2015, Canberra).

Other conference presentations include: *Breaking the Cycle of Domestic and Family Violence- Interagency Response and Intervention* (March 2016, Sydney), *NSW Health, Integrated Violence Prevention & Response Service, Nepean Blue Mountains LHD Briefing* (April 2016, Katoomba), *University of Western Sydney Forum: Older Women and Violence: Innovative Policies, Programs and Practices* (September 2016, Sydney), *ECAV Forum: Professional Development Update for NSW Interpreters and Bilingual Community Educators* (November 2016, Sydney), *Northern Beaches Domestic Violence Network White Ribbon Day Breakfast* (November 2016, Sydney), *Future Directions of Domestic and Family Violence in Central Queensland* (March 2017, Rockhampton), *Victim's Advisory Board Briefing* (March 2017, Sydney), *It's About Saving Lives: Responding to Homicide Forum* (April 2017, Brisbane), *ECAV Domestic Violence Routine Screening Forum: It's more than just language: Important considerations when engaging women from CALD backgrounds in domestic violence routine screening* (May 2017, Sydney) and *DVNSW 2017 Conference* (August 2017, Sydney).

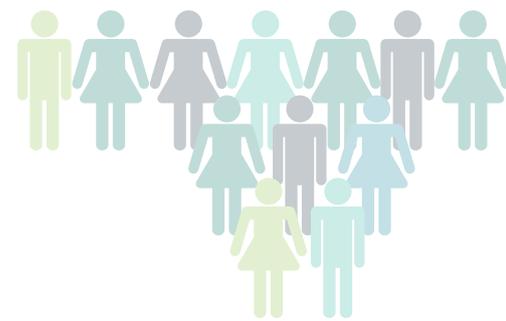
The Secretariat of the Team has also contributed its expertise and learnings from the Team with stakeholders in several roundtables including: the *NSW Justice Reducing Domestic Violence Reoffending Workshop* (March 2016, Sydney), *Review of the Family Violence Risk Assessment and Risk Management Framework in Victoria* (May 2016, Melbourne), and the *Interfaith Roundtable* (June 2017, Sydney).

# Appendix C:

## Glossary of terms



<b>Boyfriend</b>	A male person who has a relationship with another person, but the parties do not regularly cohabit.
<b>Bystander/informal support network</b>	Encompasses friends, family, neighbours, faith leaders, and other members of the community who have a formal or informal relationship with the domestic violence victim or abuser.
<b>NSW Police Force Computerised Operational Policing System (COPS)</b>	An operational database used by the NSW Police Force to record information relevant to all victims, offenders and incidents that require police action (including to create a record of an event only).
<b>Domestic violence</b>	A pattern of behaviour whereby a 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 relationship.
<b>Domestic violence hotspot</b>	A geographic region identified by the NSW Bureau of Crime Statistics and Research as having a high density of recorded domestic assaults.
<b>De facto husband</b>	A male who is in an intimate relationship with another person with whom they cohabit, but the parties are not married.
<b>De facto wife</b>	A female who is in an intimate relationship with another person with whom they cohabit, but the parties are not married.
<b>Fatal assault</b>	The assaultive injuries, actions, or inaction that lead to the death of the homicide victim (including negligence and starvation).
<b>Former girlfriend/de facto wife/wife</b>	A female person who was in a girlfriend/de facto wife/wife relationship with another person but that relationship has ceased with parties being separated or alienated. This is notwithstanding the fact one party may wish the relationship continue and/or where the parties continue to co-habit (in de facto wife/wife relationships).
<b>Former boyfriend/de facto husband/husband</b>	A male person who was in a boyfriend/de facto husband/husband relationship with another person but that relationship has ceased with parties being separated or alienated. This is notwithstanding the fact one party may wish the relationship continue and/or where the parties continue to co-habit (in de facto husband/husband relationships).
<b>Girlfriend</b>	A female who is in an intimate relationship with another person, but the parties do not regularly cohabit.
<b>Husband</b>	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.
<b>Intergenerational trauma</b>	The transmission of trauma and its negative consequences across generations. Intergenerational trauma can impact individuals, families and communities.
<b>Intimate partner domestic violence homicide</b>	A homicide where a person is killed by another person with whom they share or shared an intimate relationship, following an history of domestic violence.
<b>Intractable offender</b>	A repeat domestic violence abuser that is not dissuaded from offending by civil orders or criminal sanction.



<b>LGBTI</b>	In Australia, the Commonwealth Government uses the initials 'LGBTI' to refer collectively to people who are lesbian, gay, bisexual, trans, and/or intersex. These five distinct but sometimes overlapping groupings are part, but not all, of what we mean when we speak about 'LGBTI' communities/populations.
<b>Manner of death</b>	Describes the nature of the fatal assault in a homicide case and includes: assault, stab wounds, suffocation/strangulation, shooting, fire/heat related, poisoning/noxious substance and drowning. Where a manner of death is attributed to multiple causes in the post-mortem report, and the evidence indicates that multiple kinds of assaultive or injurious force were used against the deceased, the manner of death is recorded as 'multiple causes'.
<b>Multiple homicide event</b>	Cases where two or more deaths occur in the context of an episode of violence (excluding perpetrator suicides or unintentional perpetrator deaths).
<b>Opioid Treatment Program</b>	A program developed to reduce the social, economic and health harms associated with opioid use through the delivery of pharmacotherapy and associated services to opioid dependant patients in NSW.
<b>'Other' domestic violence homicide</b>	A homicide where a person is killed by another person with whom they share no domestic relationship but the death occurs in a context of domestic violence. For example, a bystander intervening in a domestic violence episode.
<b>Primary aggressor</b>	A person who uses a range of behaviours (physical and non-physical) to gain and maintain power over their intimate partner.
<b>Primary victim</b>	A person who is experiencing ongoing coercion and control by the primary aggressor.
<b>Relative/kin domestic violence homicide</b>	A homicide where a person is killed by another person with whom they share or shared familial or kin relationship, following an history of domestic violence.
<b>Reproductive coercion</b>	A range of abusive behaviours used by men against their female intimate partners such as controlling access to contraception, sabotaging contraception use, and violent or threatening behaviours in response to pregnancy options, including limiting access to abortion services or forcing a woman to terminate her pregnancy
<b>Retaliatory violence/ violent resistance</b>	Describes the use of violence by a primary victim in response to coercion and control by the primary aggressor.
<b>Secondary homicide victim</b>	Describes the surviving family, friends or other close associates of the homicide victim.



**Domestic Violence Death Review Team**

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